

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145752	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/29/2026
NAME OF PROVIDER OR SUPPLIER Landmark of Itasca Rehabilitation and Nursing Cent		STREET ADDRESS, CITY, STATE, ZIP CODE 535 South Elm Itasca, IL 60143	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>Based on interview and record review, the facility failed to ensure residents were free from physical abuse by employees. This applies to 2 of 3 residents (R3 and R4) reviewed for abuse in a sample of 10.R3's EMR (Electronic Medical Record) showed R3's diagnoses, including dementia, Alzheimer's disease, psychosis, mental disorder, schizophrenia, bipolar disorder, schizophrenia, major depressive disorder, and anxiety disorder. The writer made multiple attempts from 04/21/2026 to 04/24/2026 to speak with R3, but R3 refused to speak. R3's MDS (Minimum Data Set) dated 04/03/2026 showed that R3's cognition is intact and she is independent in her activities of daily living.R1's care plan dated 03/24/2026 showed R3 will remain safe, will be treated with respect and dignity, and reside in the facility free of mistreatment, including abuse/neglect.The facility's Abuse Prevention Program dated 02/2019 showed that the policy of the facility is to prohibit and prevent abuse against a resident in the facility.On 04/28/2026 at 9:02, V29 (Receptionist) stated that on 04/03/2026, around 7:00 PM, she was near the residents' area by the kitchen, and R3 came by looking for food or coffee. V29 said she witnessed V17 (Dietary Aide) yelling, pushing, and swearing at R3, and then he closed the kitchen door. V29 said R3 came to her, said V17 hurt her, and then V29 took R3 to the front desk, gave some cereal, and notified V6 (Social Service Assistant), V30 (Registered Nurse) who were in the building, and V1(Administrator).On 04/28/2026 at 12:56 PM, V27 (Social Service Assistant) said she was about to leave around 7:00 PM. V27 said V29 told her that she witnessed R3 asking V17 for food, that V17 was yelling, pushing R3 away from the door out of the kitchen, and that R3 was crying. V27 said she told V29 to report to the administrator. V6 said all residents have the right to be free from abuse.On 04/28/2026 at 1:49 PM, V3 (Assistant Director of Nursing) said V1 asked her to assist nurses in following up on the incident, and V1 conducted the investigation. On 04/28/2026 at 1:02 PM, V30 (Registered Nurse) said V29 (Receptionist) called her and made her aware of what had happened. Another nurse came to the receptionist area, assessed R3 for pain and/or injury, and called the police. The local police came and met with R3. V3 and V30 said all residents have the right to be free from abuse.On 04/28/2026 at 10:00 AM, V1 (Administrator) said he completed the investigation based on the information he received and stated that V17 is loud by nature and did not think abuse happened. V1 acknowledges that residents have the right to be free from abuse.2. The EMR (Electronic Medical Record) showed R4 has diagnoses, that includes depression, chronic obstructive pulmonary disease, and gastroesophageal reflux disease. MDS (Minimum Data Set) dated 03/29/2026 showed that R4's cognition is intact and that she is independent in her daily activities. On 04/23/2026 at 10:56 AM, R4 said that on 12/03/2025, when she returned from dinner, R9 whose room is next door and shares a bathroom with her, told her that V26 (Certified Nursing Assistant) had taken her dishes, which R4 had left on the bathroom sink. R4 said when she spoke to V26, she hit her with a garbage bag. R4 said she called the police, and they came to the facility. The next day, V1 (Administrator) spoke with her and did nothing about it.R4's nursing progress notes dated 12/03/2025 showed that the nurse on duty observed R4 confronting V26 about taking R4's cup and bowel and separated them. A few minutes later, the police arrived at the facility and told the nurse that R4 had called the police, alleging that V26 had hit R4 with a garbage bag. V26 made V1 (Administrator) and V2 (Director of Nursing) (continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 145752	If continuation sheet Page 1 of 5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145752	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/29/2026
NAME OF PROVIDER OR SUPPLIER Landmark of Itasca Rehabilitation and Nursing Cent		STREET ADDRESS, CITY, STATE, ZIP CODE 535 South Elm Itasca, IL 60143	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>aware.On 04/24/2026 at 2:30 PM, R9 said she witnessed V26 hitting R4 with a garbage bag. R9's EMR (Electronic Medical Record) showed R9 diagnoses, including bipolar disorder, schizophrenia, major depressive disorder, and anxiety disorder. The MDS (Minimum Data Set) dated 01/30/2026 showed R9's cognition was intact and that she was independent in her activities of daily living.On 02/23/2026, around 12:00 PM, the writer asked V1 for the incident report, and V1 said he hadn't investigated or reported the incident because he didn't see any significant concerns. V1 said after reviewing the progress notes now, he should have reported, investigated, and planned care appropriately.04/23/2026 at 12:30 PM, V2 (Director of Nursing) stated V1 is the abuse coordinator and that she was unaware that the investigation had not been completed.The facility's policy titled Abuse Prevention Program in part defined abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain, or mental anguish to a resident.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145752	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/29/2026
NAME OF PROVIDER OR SUPPLIER Landmark of Itasca Rehabilitation and Nursing Cent		STREET ADDRESS, CITY, STATE, ZIP CODE 535 South Elm Itasca, IL 60143	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to implement the facility's abuse prevention program policy that prohibits and prevents abuse, investigates allegations of abuse, protects residents during investigation, and reports abuse. This applies to 1 of 3 residents (R4) reviewed for abuse in a sample of 10. On 04/23/2026 at 10:56 AM, R4 said that on 12/03/2025, when she returned from dinner, R9, whose room is next door and shares the bathroom, told her that V26 (Certified Nursing Assistant) had taken her dishes, which R4 had left on the bathroom sink. R4 said that when she spoke to V26, she hit her with a garbage bag. R4 said she called the police, who came to the facility. The next day, V1 (Administrator) spoke with her and did nothing about it. R4's EMR (Electronic Medical Record) showed R4 has diagnoses, that included depression, chronic obstructive pulmonary disease, and gastroesophageal reflux disease. R4's MDS (Minimum Data Set) dated 03/29/2026 showed R4's cognition is intact and that she is independent in her daily activities. On 04/24/2026 at 2:30 PM, R9 said she witnessed V26 hitting R4 with a garbage bag. R9's EMR showed R9's diagnoses included bipolar disorder, schizophrenia, major depressive disorder, and anxiety disorder. R9's MDS dated [DATE] showed that R9's cognition was intact and that she was independent in her activities of daily living. On 02/23/2026, at 12:00 PM, this writer asked V1 (Administrator/Abuse Coordinator) if he reported this incident. V1 said he did not report the incident to the Illinois Department of Public Health (IDPH) at that time because he did not believe it met the facility's definition of abuse. V1 acknowledged the incident was not reported to IDPH until 04/22/2026 and indicated an internal investigation had been initiated. V1 said V26 (CNA) continued to work after the allegation an investigation had not been initiated. On 04/24/2026, V2 (Director of Nursing) and V3 (Assistant Director of Nursing) stated the facility overlooked the incident and the abuse allegation should have been addressed in a timely manner. The facility's policy titled Abuse Prevention Program with a revised date of 01/2019 in part showed the facility will not tolerate resident incidents of abuse, the policy will define how the investigations of abuse allegations will be conducted, outline the process of reporting, investigating, and arriving at a conclusion of allegations.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145752	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/29/2026
NAME OF PROVIDER OR SUPPLIER Landmark of Itasca Rehabilitation and Nursing Cent		STREET ADDRESS, CITY, STATE, ZIP CODE 535 South Elm Itasca, IL 60143	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on the interview and record review, the facility failed to implement policies and procedures to investigate and report employee abuse to the State Agency and to protect a resident from further abuse by the alleged employee. This applies to 1 of 3 (R4) residents reviewed for abuse in a sample of 10. On 04/23/2026 at 10:56 AM, R4 said that on 12/03/2025, when she returned from dinner, R9, whose room is next door and shares the bathroom, told her that V26 (Certified Nursing Assistant) had taken her dishes, which R4 had left on the bathroom sink. R4 said when she questioned V26, she hit her with a garbage bag. R4 said she called the police, who came to the facility. The next day, R4 said V1 (Administrator) spoke with her about the incident and did nothing about it. R4 said V26 is still working, and if she did the same thing to V26, the facility would have sent her to the hospital for evaluation, but nothing happened to V26. R4 said that if she thinks about it, she gets very upset. R4's EMR (Electronic Medical Record) showed R4 has diagnoses that included depression, chronic obstructive pulmonary disease, and gastroesophageal reflux disease. R4's MDS (Minimum Data Set) dated 03/29/2026, showed R4's cognition is intact and that she is independent in her daily activities. On 04/24/2026 at 2:30 PM, R9 said she witnessed V26 hitting R4 with a garbage bag. R9's EMR (Electronic Medical Record) shows R9's diagnoses, including bipolar disorder, schizophrenia, major depressive disorder, and anxiety disorder. R9's MDS (Minimum Data Set) dated 01/30/2026 showed that R9's cognition is intact and she is independent in her activities of daily living. On 02/23/2026, at 12:00 PM, this writer asked V1 (Administrator/Abuse Coordinator), if he reported the incident to the Illinois Department of Public Health (IDPH). V1 said he did not report the incident at that time because he did not believe it met the facility's definition of abuse. V1 acknowledged the incident was not reported to IDPH until 04/22/2026 and indicated an internal investigation had been initiated. On 04/24/2026, V2 (Director of Nursing) and V3 (Assistant Director of Nursing) stated that the facility overlooked the incident and that the abuse allegation should have been addressed. V2 and V3 said the employee should have been removed from the facility until the investigation was completed. V2 and V3 said the facility should have updated care plans and that the incident should have been reported in a timely manner. The facility's policy titled Abuse Prevention Program with a revised date of 01/2019 in part showed the facility will report, identify, investigate, remove the employees from the facility during investigation, complete the final investigation within five working days after the review of medical records, personnel records of employees, interview with residents and employees and addressing in quality Performance Improvement Approach, and updating intervention in care plans.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145752	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/29/2026
NAME OF PROVIDER OR SUPPLIER Landmark of Itasca Rehabilitation and Nursing Cent		STREET ADDRESS, CITY, STATE, ZIP CODE 535 South Elm Itasca, IL 60143	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>Based on record review and interview, the facility failed to ensure that an allegation of an employee abusing residents was thoroughly investigated and that corrective action was taken. This applies to 1 of 3 residents (R3) reviewed for abuse in a sample of 10.R3's EMR (Electronic Medical Record) showed R3 has diagnoses that included dementia, Alzheimer's disease, psychosis, schizophrenia, bipolar disorder, major depressive disorder, and anxiety disorder.R3's MDS (Minimum Data Set) dated 04/03/2026 showed that R3's cognition is intact and that she is independent in her activities of daily living.R3's care plan dated 03/24/2026 showed R3 will remain safe, will be treated with respect and dignity, and reside in the facility free of mistreatment, including abuse/neglect.The writer made multiple attempts from 04/21/2026 to 04/24/2026 to speak with R3, but R3 refused to speak. V2 (Director of Nursing) and V3 (Assistant Director of Nursing) said R3 tends not to speak; however, she makes her needs known.On 04/28/2026 at 9:02, V29 (Receptionist) stated that on 04/03/2026, around 7:00 PM, she was near the residents' area by the kitchen, and R3 came by looking for food or coffee. V29 said she witnessed V17 (Dietary Aide) yelling, pushing, and swearing at R3, then closing the kitchen door. V29 said R3 came to her, said V17 hurt her, and then V29 took R3 to the front desk, gave some cereal, and notified V6 (Social Service Assistant) and V30 (Registered Nurse), who were in the building, and the V1(Administrator)On 04/28/2026 at 12:56 PM, V27 (Social Service Assistant) said she was about to leave around 7:00 PM. V27 said V29 told her that V17 was yelling, pushing R3 away from the kitchen door, and that R3 was crying. V27 said she told V29 to report to the administrator. V6 said all residents have the right to be free from abuse.On 04/28/2026 at 1:49 PM, V3 (Assistant Director of Nursing) stated that V1 (Administrator) asked her to assist the nurses in following up on the incident, and V1 conducted the investigation. On 04/28/2026 at 1:02 PM, V30 (Registered Nurse) said V29 called him to report the incident. V30 said staff then got R3 to the unit, assessed for pain/injury/bruise and then called the police, who came to the facility and met with R3. V30 said R3 complained of pain and refused medication. V3 and V30 said all residents have the right to be free from abuse.On 04/28/2026 at 10:00 AM, V1 (Administrator) stated that V17 (Dietary Aide) is loud by nature and that he did not think abuse occurred.V1 stated that he completed the investigation based on the information he received and acknowledged that residents have the right to be free from abuse.The review of the incident report dated 04/06/2026 lacked the witness's factual statement and signature. V17 was suspended during the investigation, and the incident was not substantiated; no corrective actions were taken.The facility's Abuse Prevention Program, dated 02/2019, in part stated that the final report shall include facts determined during the investigation and a conclusion based on those facts. Policy further stated that the administrator or Director of Nursing shall review the findings of the investigation and determine whether any further training or corrective action is needed to prevent further actions.</p>		