STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. Building B. Wing	04/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Landmark of Cicero Rehabilitation and Nursing Cent	5825 West Cermak Road Cicero, IL 60804

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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide a decision maker for a resident with severely impaired mental status. This failure affected one (R1) resident reviewed for residents' rights in the total sample of 4 residents. Findings include:R1's admission Record documented R1's diagnoses include but are not limited to epilepsy, bipolar disorder, and hypertensive heart disease. R1's contact information include only himself as responsible party. R1's census list documented R1 was initially admitted to the facility on [DATE].R1's (02/02/2026) Minimum Data Set documented, Section C. Cognitive Patterns. C0500. BIMS (Brief Interview for Mental Status) Summary Score: 03. Indicating R1's mental status as severely impaired. Section I: Active Diagnoses: Medically complex conditions, heart failure, hypertension, psychotic disorder and, schizophrenia.R1's (09/30/2025) Minimum Data Set documented, Section C. Cognitive Patterns. C0500. BIMS (Brief Interview for Mental Status) Summary Score: 03. Indicating R1's mental status as severely impaired.R1's (12/19/2025) Report of Physician documented, IN THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS COUNTY DEPARTMENT, PROBATE DIVISION. Case No. (BLANK). Estate of: (Blank). Calendar: (blank). Alleged Person with a Disability: (blank). (V20 - Medical Doctor), a licensed physician, submits the following report on (R1), an alleged person with disability. Note: The evaluations upon which this Report is based must have been performed within three (3) months of the date the Petition for guardianship is filed. The following is a description of the nature and type of the Respondent's disability' and an assessment of how the disability impacts on the ability of the Respondent to make decision or to function independently, including an underlying diagnosis and a description of the manifestation of the disability: patient suffers from schizoaffective disorder which impairs ability to make decision and function independently. The following is my opinion as to whether guardianship is needed, the type and scope of the guardian ship needed, and the reasons for my opinion, including whether the respondent is totally or only partially incapable of making personal then financial decisions and if only partially, the kinds of decisions which the respondent can and cannot make: full guardianship is needed as patient is totally incapable of making personal or financial decisions.R1's (03/31/2026) Hospital discharge summary documented, GI Progress Note. No family available for consent, awaiting public guardian. Internal Medicine Progress Note: Legal Guardianship would then be pursued after discharge at the nursing home. R1'S (03/12/2026) Change in Condition documented, 1. Signs and symptoms identified. 3. Altered mental status. 3. Resident Representative Notification. 1. Name of family/resident representative Notification. SELF. R1's (09/04/2025) Progress Notes documented, Resident observed sitting on the floor inside the room. No family member contact on face sheet. Will continue with resident status care as needed. The (04/03/2026) email correspondence with V2 documented, I (V2) have reached out to the facility attorney regarding the guardianship (for R1), and I will let you know as soon as I get something. Facility failed to provide documentation the facility lawyer initiated guardianship for R1.On 04/02/2026 at 11:35am inside R1s' room with V13 (Licensed Practice Nurse), R1 was lying on bed, mumbling, and vocalizing ?haaaaa'. R1 did not nod nor turn his head left and right when this surveyor's inquired if he was wet. V13 stated he (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cannot communicate or hold a conversation. R1 has no POA (Power of Attorney) on his clinical record. V13 stated he should have one because he is not able to make a decision. V13 stated the importance of having a decision maker is to ensure the resident is getting proper care that suit his needs. The guardian can make the decision for him in the best interest of the resident. On 04/02/2026 at 11:46am, V5 (Social Services/Memory Care Coordinator) stated R1 mumbled, and V5 could not tell what R1 was saying. V5 stated he was in charge of completing the BIMS (Brief Interview for Mental Status) of the resident. V5 stated R1 has a BIMS of 3, meaning his mental status is severely impaired. V5 stated when it was determined the resident has severely impaired mental status, the facility should have initiated the process of getting a guardian or surrogate for R1. V5 stated on day of admission, it was determined that R1 was appropriate to be admitted on his current floor which was a dementia floor; he was initially admitted from a different floor, and he was moved to his current floor on 09/04/2025. V5 stated he is responsible for reviewing the resident admission packet; he probably reviewed the admission packet and might have missed one or few things including R1's guardianship. V5 stated he did not initiate guardianship for R1. V5 stated the importance of guardianship or surrogacy is to ensure someone is advocating for the resident; to ensure the resident is properly taken care of. V5 stated if he did not have a guardian or surrogate decision maker; the effect, potentially, his needs are not being met. On 04/02/2026 at 1:09pm, V9 (Admissions Director) stated the staff in charge of making sure the resident has the capacity to make a decision during admission or couple of days after admission is the Social Services. V9 stated she only reviews the referral packet for financial background of the resident, mainly for insurance purpose only. On 04/02/2026 at 2:14pm, V14 (Assistant Social Services Director) stated Section C of the MDS (Minimum Data Set) would tell the staff whether a resident is capable of making a decision. V14 stated if R1 has a BIMS of 3, it means the resident could not answer certain things correctly, indicating his mental status as severely impaired and cannot make a decision. V14 stated the resident should have a surrogate or guardian; and the process of getting one should start right after it was determined he could not make a decision; ask family members to see if they are willing to step in as the resident's decision maker. V14 stated the importance of having a decision maker for a resident who cannot make a decision for himself so there is someone they can contact in case of emergency or with any changes in condition who can make a decision for the resident. On 04/02/2026 at 4:30pm, V2 (Director of Nursing) stated if the resident did not have anyone on file as decision maker, Social Services should have initiated the process of asking the family for surrogacy and if that did not work, start the process of guardianship. It has to be initiated when the BIMS assessment is completed, Social Services should have investigated if he has a family; or check if guardianship is initiated. V2 stated there is a failure in getting a decision maker for him and the purpose of getting a decision maker for him is to make sure his needs are being met. On 04/06/2026 AT 9:33am, V19 (Guardian Representative - Office of the State Guardian) stated the person should be assessed by the doctor to make a determination the person needs guardianship; if no family is willing to take guardianship, the facility has to submit a referral to the State for guardianship. V19 stated R1's name is not on their file for guardianship.On 04/06/2026 at 3:41pm, V2 affirmed R1 has no decision maker on R1's clinical record. The (undated) Facility Policy on Adult Guardianship in the State documented, Background. It is the policy of this nursing facility to work with residents, family members and significant others to help residents receive appropriate representation and advocacy, as necessary, based upon their medical and mental health conditions. Guardianship for an adult in a long-term care facility may be necessary for an individual who is unable to make and communicate responsible decisions regarding personal care or finances due to a mental, physical or developmental disability. Courts ultimately determine the necessity of a legal guardian based on a thorough clinical evaluation and report. Guardianship is typically initiated by the Attending Physician or Psychiatrist. This individual will be responsible for completing the court mandated evaluation explaining the person's deficits/inability to provide self-care (in [NAME] County this is the CCP-211). Residents of LTC/SMHRF facilities should not (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have outside persons/entities soliciting them for matters of guardianship. This process needs to commence with a determination and discussion with the Physician(s). The facility will reach out upon admission to Guardian, including the identified representative of OSG or OPG (Cook County Office of Public Guardian). The Guardian's contact information shall be identified in the clinical record along with documents proving guardianship.The (undated) Your Rights and Protections as a Nursing Home Resident documented, What are my rights in a nursing home? As a nursing home resident, you have certain rights and protections under Federal and state law that help ensure you get the care and services you need. You have the right to be informed, make your own decisions, and have your personal information kept private. The nursing home must tell you about these rights and explain them in writing in a language you understand. They must also explain in writing how you should act and what you're responsible for while you're in the nursing home. This must be done before or at the time you're admitted , as well as during your stay. You must acknowledge in writing that you got this information. Get Proper Medical Care: You have the following rights regarding your medical care: Family members can also help with your care plan with your permission. To access all your records and reports, including clinical records (medical records and reports) promptly (on weekdays). Your legal guardian has the right to look at all your medical records and make important decisions on your behalf. Have Your Representative Notified: The nursing home must notify your legal representative or an interested family member when the following occurs: Your physical, mental, or psychosocial status starts to get worse. Your treatment needs to change significantly.