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	01/08/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure the dish machine had the correct concentration of chlorine to sanitize dishes, trays, and utensils; failed to ensure the floor of the dry storage room was kept clean and free of visible debris, mice droppings, and spilled grits. These failures have the potential to affect all 266 residents that receive oral food from the facility's kitchen. Findings include:On 1/5/26 after the entrance conference, V1(Administrator) presented the facility census as 266.On 1/6/26 at 2:56pm, V1 stated tall 266 residents receive oral foods from the kitchen and those who have gastrostomy tubes still eat kitchen food for pleasure feeding.On 1/5/26 between 10:05am and 10:20am during observation of the kitchen with V7(Dietary Manager), V7 stated the kitchen uses a low temperature dish machine with chlorine sanitizer. V7 showed the color code for the chlorine sanitizer. V7 dipped the test strip and found it to be less than 10 parts per million(ppm). V7 tested it the second and the third time dipping the test strip in different parts of the dish machine each time, but the test strip still did not change color. V7 stated the sanitizing solution should be 50 ppm, and the color of the test strip should be purple. The chlorine chemical container was empty, and staff replaced the chemical container. V7 stated the test strip did not change because the container that dispensed the chemical was empty, and now it will dispense from the full chemical container.The floor of the Dry Storage Area of the kitchen was observed with visible accumulated dust, visible dirt, spilled dried grits, and about 22 pieces of mice droppings were observed on the floor by the wall under the bottom shelf. V7 stated the floor of the whole kitchen is supposed to be cleaned daily. V7 was asked what kind of rodents' waste/droppings were on the floor. V7 stated they are mice droppings. V20 (Regional Director of Operations) stated the facility has problems with mice because the alley is very close to the kitchen (pointing at the left side that leads to the alley).Facility's policy titled Food Safety & Sanitation- Machine Dishwashing, dated 9/17/23, states: The Facility will clean and sanitize food service utensils, dishes, and tableware using approved equipment. Before dishes are washed, the sanitation temperature or level of chemical sanitizer in the dish machine should be tested with the correct test strip. (ii) Low temperature using sanitizer: Temperature should be 120-150 degrees. Dip the appropriate chemical sanitizer test strip in the water on the drain board nearest to the opening at the clean end of the dish machine. The test strip should turn the appropriate color to indicate 50 to 100 parts per million for chlorine or 200 parts per million for quaternary ammonium sanitizer.Facility's Policy titled Food Safety & Sanitation-Cleaning Schedule, dated 9/22/23, states: The food service department will be cleaned and sanitized on a routine basis according to written cleaning schedules. #5 states: The dietary manager will review cleaning schedules to evaluate the results and look for unsatisfactory areas or items.Facility's Policy titled Food Safety & Sanitation-Storage of Dry Foods/Supplies- The facility will have a room/area designated for storage of dry goods such as single serve items, canned goods, packaged foods. The area will be clean, lighted, well ventilated, dry, free from contaminants and kept at room temperature around 70 degrees. Routine cleaning and pest control procedures are followed. Areas are free from garbage or other waste.

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

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	01/08/2026

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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to ensure that 2 of 3 outside dumpsters garbage disposal were covered with the lids. This failure has the potential to harbor rodents which could cause infection and affect all 266 residents in the facility.Findings include:On 1/5/26 at 9:10am, 2 of 3 outside dumpsters were observed to be open without lids. On 1/5/26 at 11:10am during kitchen observation with V7(Dietary Manager), the same dumpsters were observed without covers. V7 stated leaving dumpsters open could cause rodents to come around the building, and the 2 dumpsters left open are mostly used by the Housekeeping and Laundry departments. V7 added she would notify their supervisors to remind staff to close the dumpsters. On 1/7/26 at 9:30am, V1(Administrator) stated she would speak with the laundry and housekeeping staff. V1 added, There's no reason to leave the dumpsters open because they have covers.Facility's policy and procedure manual titled Garbage and Refuse Disposal, dated 9/17/23, states: All garbage and refuse will be stored and disposed of daily in a sanitary manner. Garbage and refuse will be deposited in sealed dumpsters to prevent the harborage and feeding of rodents and pests.

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	01/08/2026

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 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on observation, interview, and record review, the facility failed to ensure the facility assessment was developed in accordance with all required information. This failure has the potential to affect all 266 residents that reside within the facility. Findings include:Facility census (1/5/2025) documents in part that 266 residents reside within the facility. On 1/5/26 at 1:39pm, V17, Registered Nurse, was asked about the current (4th floor) staffing. V17 (Registered Nurse) stated, It's just 2 Nurse's, sometimes they (residents) have a CNA and sometimes they don't. V17 was asked if any of the 4th floor residents require assistance. V17 responded Most of them (residents) need supervision. On 1/6/25 at 1:17pm, V32 (Assistant Director of Nursing) was asked why there was not a CNA assigned to 4th floor on 1/5/26 (dayshift). V32 (Assistant Director of Nursing) stated she was unsure and stated, On 4th and 8th floor most of them are independent. We have psych techs and security cover those floors because of the behaviors. We want to schedule all the floors with a (1) CNA and on 3rd and 6th floor in the morning they get 4 or 5. On 1/6/25 at 1:44pm, V2 (Director of Nursing) stated, We had multiple call-off yesterday (1/5/26), so we pulled people. We had a CNA on 4th floor and pulled them to 3. (V12/Security Director) is a CNA so he was sent to 4th floor. Surveyor inquired about dayshift staffing in the facility V2 responded, We have 2 nurses on every floor except for 5th floor there's one nurse. We have 5 on 3 and 6th and one CNA on 4, 5, and 8. Review of the facility assessment (dated 12/18/2025) was completed. The facility assessment lacked the following required information: A) The governing body (V4) participated in the development of the facility assessment B) Any direct care staff were involved in the completion of the facility assessment C) The residents/representatives participated in development of the facility assessment D) Direct care staffing (CNA) needs by unit and shift E) a recruitment and retention plan for direct care staffing. On 1/5/2026 at 11:09 am, the facility assessment was reviewed with V1 (Administrator). V1 stated the facility assessment was developed by V1, V2 (Director of Nursing), V9 (Chief Nursing Officer), and the Medical Director. V1 confirmed no direct care staff, residents or their representatives were included in the development of the facility assessment, and the facility assessment does not have documentation direct care staff, the residents, or representatives were involved in the development of the facility assessment. V1 confirmed CNA needs are not broken down by unit and shift and stated, No, I didn't do that. Surveyor inquired the facility's plan for recruitment and retention of staff within the facility assessment. V1 (Administrator) reviewed the facility assessment again and affirmed there is no plan for recruitment or retention of direct care staff. V1 affirmed the missing elements are required under the regulation and explained the purpose of the facility assessment is to ensure all resident needs can/are being met and summarizes the care the facility is able to provide.Facility policy titled, Facility Assessment documents, A facility assessment is conducted annually to determine and update the capacity to meet the needs of and competently care for residents during day-to-day operations (including nights and weekends) and emergencies . 2. The team responsible for conducting, reviewing, and updating the facility assessment includes the following: 1. leadership and management, including the: 1. administrator. 2. representative of the governing body. 3. medical director. 4. director of nursing services; and 5. other department heads (as needed). 2. direct care staff, including: 1. RNs. 2. LPNs/LVNs. 3. nursing assistants; and 4. representatives of the direct care staff (if applicable). 3. residents, representatives, and family members. 1. Input from residents, resident representatives, and family members may be obtained by methods such as questionnaires, surveys, and suggestion boxes prior to the facility assessment . 11. The facility assessment is used to identify current or potential gaps in care or services due to misalignment or lack of appropriate resources .13. The facility assessment is used to inform staffing decisions. 1. The facility assessment is used to ensure there is enough staff with appropriate competencies and skill sets to (continued on next page)

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	01/08/2026

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 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	meet the needs of the residents identified through the review of resident assessments and plans of care. 1. Staffing needs are considered for each unit and adjusted as necessary based on changes in the resident population. 2. Staffing needs are considered for each shift, including day, evening, and night shifts, and adjusted as necessary based on changes in the resident population. 2. The facility assessment is used to develop and maintain a direct-care staff recruitment and retention plan .

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	01/08/2026

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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, interview, and record review, the facility failed to have an effective pest control program to prevent and eliminate rodents/mice from the kitchen's dry storage area. This failure has the potential to affect all 266 residents in the facility. Findings include: Facility census (1/5/2025) documents 266 residents reside within the facility. On 1/5/26 at 10:26am during observation of the dry storage area of the kitchen with V7(Dietary Manager), the floor was observed with visible dirt, spilled dried grits, and about 22 pieces of mice droppings were observed on the floor by the wall under the bottom shelve. V7 was asked what kind of rodents' waste/droppings were on the floor; V7 stated, They are mice droppings. V20 (Regional Director of Operations) also observed the dry storage area. V20 stated the facility has problems with mice because the alley is very close to the kitchen (pointing at the left side that leads to the alley). V20 got a broom and dustpan and tried to sweep the droppings and stated the Pest control company comes regularly to the building. On 1/6/2025 at 10:45 am, the resident council unanimously agreed that pest control, including rodents and roaches, is an ongoing concern within the facility. R267 stated R267's room has rats and mice that run through it a few days a week, and R267 last saw rodents in the facility yesterday. On 1/7/26 at 10:20am, V7 was asked why there were so many mice droppings and why the person who took food items to cook breakfast in the morning did not clean the dirty floor including the mice droppings. V7 stated she was off work on Thursday, Friday, and the weekend, and she just returned to work on Monday, and the kitchen floor should be cleaned every day by staff. Facility's undated policy titled Pest Policy states: It is the policy of the facility to ensure that an effective pest control program is in place. An effective pest control program is defined as measures to eradicate and contain common household pests. #2: The maintenance staff and all the staff will be cognizant of the necessity to maintain a clean, safe, and comfortable homelike environment that is free of pests or rodents.

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	01/08/2026

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 - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review, the facility failed to ensure meals were served timely and failed to ensure dining room seating was available for four of 59 residents (R102, R108, R213, R241) in the sample reviewed for resident rights. Findings include:The facility meal-time schedule affirms the (4th floor) lunch is scheduled for 12:15pm-12:30pm.1.On 1/5/26 at 12:53pm, lunch was delivered to the 4th floor dining room via steam table. At 1:38pm V17 (Registered Nurse) affirmed R102, R108, and R241 had not received lunch. Most of the residents had completed their meal and had already left the dining room. R102, R108, and R241 had requested the alternate meal: hamburgers (per dietary cards). At 1:39pm, R241 inquired about lunch. V18 (Activity Aide) responded, We're waiting on hot burgers; they haven't come yet. At 1:45pm, hamburgers were delivered to the 4th floor dining room.2.On 1/5/26 at 1:25pm, R213 was served lunch on a tray at the steam table. He proceeded to carry the tray throughout the dining room to find a seat, however, no chairs were available. R213 stood in the dining room while holding the meal/tray and proceeded to eat half of a grilled cheese sandwich before staff provided a chair.On 1/7/26, surveyor requested the 4th floor dining room seating chart. At 1:52pm, V32 (Assistant Director of Nursing) presented a drawing with tables numbered 1-15, however, resident names were excluded. Surveyor inquired if the facility has a seating chart for each dining room to ensure that adequate seating is available. V32 responded, No, not with the resident names.The order of meals served policy (revised April 2022) states the Nursing Department will provide the Food Service Department with a seating chart for dining rooms. Every effort is made for the meals to be passed to the residents per table so everyone eating together receives their food together. Dining rooms that have open dining will serve the resident in a timely manner (after) being seated.

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	01/08/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, and record review, the facility failed to identify maintenance concerns, failed to document maintenance concerns/repairs, and failed to repair damaged ceilings/heater, for 54 (4th floor) residents reviewed for home-like environment.Findings include:The (1/4/26) facility census includes 54 (4th floor) residents. The 4th floor is a men's unit.On Monday (1/5/26) at 10:26am, R213's (metal) baseboard heater was falling off and severely bent away from the wall. Surveyor asked about concerns with the heater in R213's room. V13 (LPN/Licensed Practical Nurse) stated, That I'm not sure. V13 subsequently inspected the heater and responded, I could call maintenance; it's bent its metal.On (1/5/26) at 10:38am, the 4th floor shower/bathroom was inspected; large gaping holes were observed in the ceiling of both showers. Surveyor asked about concerns in the shower. V13 (LPN) stated, It's a hole in the ceiling. Upon further inspection, a blanket and toilet paper were observed on the floor in the toilet stall. On (1/5/26) at 10:45am, the hinge on R40's closet door (to lock the closet) was broken. Surveyor asked about concerns with the closet lock. R40 responded, It broke off. On (1/5/26) at 11:12am, R200 stated, My cabinet is broken and pointed to the closet door. R200 subsequently opened the left closet door, and it was dangling from the top bracket. The bottom bracket was observed to be broken.On (1/7/26) at 12:15pm, V8 (Maintenance Director) stated, We have 6 maintenance employees, one for each floor. Surveyor asked if V8 was aware of the large holes on the 4th floor shower ceiling. V8 stated, Yes ma'am; it was a plumbing issue. The p-trap was leaking, and we had to repair it. We got that covered up Monday (1/5/26). On (1/7/26) at 12:38pm, V8 presented the maintenance tablet. Surveyor requested to see the 4th floor shower ceiling work order request. V8 stated, We found it but honestly I didn't enter it. V1 (Administrator) responded, You (V8) should have entered it. Surveyor asked if the 4th floor broken closet doors and/or locks were entered in the maintenance tablet. V8 replied, Not on the 4th floor. The (undated) general maintenance policy includes purpose: to ensure that the nursing home environment is safe, sanitary, functional, and comfortable for residents, staff and visitors, in compliance with Illinois Department of Public Health rules and regulations, applicable life safety codes, and the Nursing Home Care Act. The facility shall maintain all buildings, systems, and equipment in good repair and safe operating condition at all times.The (undated) Physical plant - daily inspections policy states buildings are to be inspected daily. As areas needing repair or attention are identified, they should be dealt with immediately.

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	01/08/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview and record review, the facility failed to develop and implement comprehensive, person-centered, and individualized fall care plans for four residents (R2, R8, R230, R253) with a history of falls. These failures have the potential to affect four residents (R2, R8, R230, and R253) reviewed for care plans in the total sample of 59 residents. Findings include: 1.R2's face sheet documents, diagnoses that include but are not limited to fracture of right hand, all on same level from slipping, tripping and stumbling without subsequent striking against object, and dementia.R2's BIMS (Brief Interview for Mental Status) score, dated 10/14/25, is 14, which indicates R2 is cognitively intact.R2's Fall Risk Review, dated 2/19/25, documents a score of 13, which indicates R2 was at high risk for falls, and also documents, Does the resident have a history of falls within the last 3 months? Yes. R2's progress note, dated 10/08/25, documents, Resident (R2) c/o (complain) pain on her right wrist. Writer asked resident (R2) what happened, resident (R2) stated that she (R2) had fallen in her (R2) room. Resident (R2) stated that, she (R2) was reaching for her (R2) coffee cup and lost her (R2) balance and fell. Resident c/o pain in her (R2) right wrist. Resident (R2) was observed from head to toe. VS (vital signs) checked, Resident (R2) was noted to have swelling to her (R2) right wrist and c/o pain. Ordered a STAT Xray to the right wrist. R2's hospital records, dated 10/09/25, documents, Presenting after a fall, found to have right distal radial and ulna fracture. Orthopedics consulted and will reduce, splint.R2's Fall care plan, dated 4/13/2021, documents, Goal: (R2) will have a safe environment maintained thru the next review. 2.R8's face sheet documents diagnoses that include but are not limited to history of falling, epilepsy, acquired absence of right leg below knee, acquired absence of left leg above knee, dementia, and altered mental status. R8's BIMS (Brief Interview for Mental Status) score, dated 12/23/25, is 13, which indicates R8 is cognitively intact. R8's Fall care plan, dated 8/21/2024, documents, Goal: (R8) will have a safe environment maintained through next review. 3.R230's face sheet documents an admission date 3/22/2023.R230's face sheet documents diagnoses that include but are not limited to nondisplaced intertrochanteric fracture of right femur (onset date 11/10/25), dementia, schizoaffective disorder, and low back pain.R230's BIMS (Brief Interview for Mental Status) score, dated 11/11/25, is 10, which indicates R230's cognition is moderately impaired.R230's progress note, dated 10/27/25 at 11:46am, per V21 (Registered Nurse/RN), documents, Resident (R230) alert oriented x2 in the dining area sitting in a chair, repeatedly attempting to throw himself out of the chair, staff monitoring area. Will continue plan of care. R230's progress note, dated 10/27/25 at 12:58pm, per V21 (Registered Nurse/RN), documents, Resident (R230) noted sitting in dining area in chair, resident leaped onto floor, resident doesn't know why he threw himself onto floor, Resident assessed. Resident assisted to chair, with staff, monitoring dining area. No enhanced or one-to-one supervision was implemented prior to the fall.R230's Fall care plan, dated 3/23/2023, documents, Goal: (R230) will have a safe environment maintained through next review.4.R253's face sheet documents, diagnoses that include but are not limited to generalized arthritis, chronic pain, pain in left knee, syncope and collapse, weakness, and unspecified fall.R253's BIMS (Brief Interview for Mental Status) score, dated 12/05/25, is 15, which indicates R253 is cognitively intact.R253's Fall Risk Review, dated 1/04/26, documents a score of 14, which indicates R253 is at high risk for falls.R253's progress note, dated 8/21/25 at 5:30am, per V16 (Registered Nurse/RN), documents, Resident (R253) observed laying on floor in right lateral position, when asked what happened the resident stated I tried to get in my chair, and I fell.R253's Fall care plan, dated 1/18/2020, documents, Goal: (R253) will have a safe environment maintained thru the next review.On 1/06/26 at 12:28pm, V24 (MDS) Coordinator stated goals for care plans should be measurable and want to be specific to the resident. V24 further explained the fall goal, will have a safe environment maintained thru the next review, was system-generated and stated, It generates the goal, and we (staff) need to customize it, but acknowledged the goal as written was broad and general. V24 stated (continued on next page)

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	01/08/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	goals depend on the type of clientele and should be related to the need of the resident and measurable. V24 stated the fall goal was just a broad statement, better to be safe, and stated, I'd have to look at all the interventions, indicating the goal itself did not clearly define resident-specific, measurable outcomes.On 1/06/26 at 12:44pm, V41 (Restorative Nurse Consultant) stated, We (facility staff) care plan everyone to have a safe environment through next review for falls and explained the goal was to keep them safe. V41 said, I think it's a measurable goal, but also acknowledged goals should be measurable and should be person-centered or I-centered. V41 further stated the residents' care plan goals should be tailored to each resident specific and acknowledged the goal, will have a safe environment maintained thru the next review, was probably general, and not person-centered. V41 further stated, I don't find anything wrong with it (goal), but also stated if there is a fall, we (facility staff) should update the goal for them, indicating that the existing goal did not include resident-specific, measurable outcomes related to the individual's fall risk.Review of facility policy titled, Care Plan Policy and Procedure, undated, documents, Each resident will have a comprehensive assessment completed that will assist in the development of an individualized plan of care that will include goals and interventions aimed to improve or maintain the residents highest level of function, prevent decline, decrease risk of complications of medical conditions, medications and diagnosis, decrease risk of injury or to promote comfort ant end of life. Each resident will have a comprehensive assessment completed by the Interdisciplinary team upon admission, quarterly and with significant changes and an individualized care plan will be developed and updated as needed with quarterly assessments, re-admissions, and changes in condition. Residents care plans will be reviewed and updated as needed with re-admissions, quarterly re-assessments, annually, and with any significant changes in condition. Review of facility policy titled, Fall Prevention and Management Program, undated, documents, Strategies/Interventions list may be used to identify appropriate interventions. Approaches/Interventions should focus of risk factors identified. Review of facility policy titled, Incidents/Accidents/Falls, undated, documents, The CNA information sheet will be updated as indicated to reflect the plan of care. Review of pamphlet titled, RESIDENTS' RIGHTS' For People In Long-Term Care facilities, revised date 11/18, documents, Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life. Your facility must provide services to keep your physical and mental health, at their highest practical levels. Your facility must be safe, clean, comfortable, and homelike.Facility job description titled, MDS (Minimum Data Set) Coordinator, undated, documents, The primary purpose of this position is to coordinate, plan, organize, develop, evaluate and take part in, and to assure the quality of all facility services relating to the HCF A Minimum Data Set Assessment Instrument (MDS) and resident care planning (MDC/Care Planning); to safeguard the health, safety and welfare of all residents of the facility; to assure that all MDS/Care Planning is carried out in accordance with the facility's established policies and procedures, applicable federal and state laws and regulations, and the directions of your supervisors, who include the Administrator, Medical Director, and other members of the facility's management to whom such persons report; to do all things required of an MDS/Care Plan Coordinator; to implement the MDS/Care Planning policies established by, and assist in providing MDS. Conducts periodic review to ensure all documentation is informative and descriptive of nursing care and of the resident's response to that care.

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	01/08/2026

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide activities that are appropriate for the season. This failure affected one resident (R71) and has the potential to affect all 32 residents that reside within the 3rd floor dementia unit.Findings include:Facility census (dated 1/5/2026) documents 32 residents reside within on the 3rd floor.R71's admission record documents the following diagnoses: epilepsy, schizophrenia, schizoaffective disorder, bipolar disorder, cataracts, major depressive disorder, and asthma.R71's Minimum Data Set (12/10/2025) documents a Brief Interview of Mental Status (BIMS) summary score of 10, indicating R71 has cognitive impairment. R71's comprehensive activity assessment (9/9/2025) documents R71 is only oriented to self and has an active interest in listening to music. R71's quarterly activity review (12/10/25) documents R71 prefers to participate in activities in R71 room/the day room (dining room) and enjoys sitting listening to music.R71's care plan (12/10/2025) identifies R71 has impaired cognition, memory loss, is forgetful, and has interventions to address R71's cognitive impairment including but not limited to, Engage me in simple, structured activities per my preference that avoid overly demanding tasks, Keep my routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion., Provide a program of activities that accommodates my abilities, Communicate with myself/family/caregivers regarding my capabilities and needs, and Encourage me to participate in group activities and events of interest to increase socialization and decrease isolation. On 1/5/2026 at 10:28 am, residents were observed participating in activities in the dining room (listening to music, coloring), while activity staff set up the morning exercise group activity. Christmas music videos were playing on the television and could be heard throughout the room. R71 approached surveyor and stated, Santa is real and coming, he's coming to bring you and me gifts next week. He will bring gifts for all of us, I'm so excited. When asked why R71 thought Christmas was next week, R71 stated, Listen, you can hear the music R71 then began having flight of ideas including breaking out of prison, fast food, paranoia of other girls outside, and homeless shelters. On 1/5/2025 at 10:35 am, Christmas music videos were still playing on the television. V25 (Dementia Unit Coordinator) affirmed Christmas music videos were playing that were [NAME] by (artist) and were put on by activities staff. V25 affirmed Christmas had passed over a week and a half ago and Christmas music should not be playing after the Holiday had passed. V25 explained playing music after a holiday can increase confusion and disrupt the resident's sense of time. V25 affirmed V25 would change the playlist to provide more appropriate music. On 1/5/2026 at 10:39 am, a music video of Christmas by (artist) was playing on the television loudly within the dining room. On 1/5/2026 at 11:06 am, Christmas decorations were observed still hanging throughout the administration offices/conference rooms. V1 (Administrator) affirmed Christmas music is no longer appropriate for the time of year and playing Christmas music after the holiday may confuse residents. V1 confirmed the 3rd floor is the facility's specialized dementia care unit. Facility policy titled, Activity Department Program Policy (Revised 8/29/25) documents, It is the philosophy of City View to treat each resident as a unique individual with specific physical, psychological and spiritual needs. It is the policy of City View to provide a competent variety of therapeutic recreation opportunities designed to meet, in accordance with the comprehensive assessment, the interests and physical, mental and psycho-social well-being needs of each individual resident. Procedure The Activity Department shall provide a structured, series of meaningful programming. It shall be based upon the identified needs and interests of each resident and provide opportunities for residents to gain new leisure skills. The resident population shall be invited to take an active role in the planning, participation and evaluation of all therapeutic recreation programs . Departmental Goals The Department strives to achieve the following goals on a daily basis: .3. To choose activities that promote social, cognitive and physical functioning .5. To prevent further cognitive and sensory regression through provision of ability-appropriate (continued on next page)

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	01/08/2026

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interventions, especially suited for impaired residents (i.e., orientation programs, sensory stimulation, etc.) .

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	01/08/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, interview, and record review, the facility failed to ensure medications were administered within regulatory requirements and failed to document medication administration timely for 8 of 59 residents (R24, R30, R88, R159, R245, R267, R276, R286) in the sample.Findings include:On (1/6/26) at 9:10am, surveyor stated the am medication administration will be observed. V27 (LPN/Licensed Practical Nurse) responded, I'm done already. V27 was asked how many residents V27 is currently assigned to. V27 replied, 31. EMAR (Electronic Medication Administration Record) was asked to be reviewed. V27 stated, I haven't signed it out yet. While reviewing the EMAR, R245 approached V27 and requested scheduled medications that were not received. R245's EMAR affirmed Aspirin, Folic Acid, and Divalproex Sodium were scheduled for 9am administration - none of which were documented as administered at this time. V27 was asked if R245's 9am medications were administered. V27 stated, No and proceeded to dispense R245's medications.On (1/6/26) at 9:30am, V30 (Registered Nurse) affirmed the (6th floor) 9am medication administration was completed; however, she (V30) was s observed seated at the Nurse's station documenting R30's (9am) medication administration. V30 was asked why R30's 9am medications were not documented at the time of administration. V30 stated, My internet was acting up so maybe I skipped on.On (1/6/26) at 9:32am, V31 (LPN) was observed seated at the (6th floor) Nurse's station while documenting R159's (9am) medication administration; however, the resident was not present. The (6th floor) EMAR was reviewed and V31 was asked when R159's 9am medications were administered. V31 responded, She (R159) had it after breakfast about 8:20am. V31 was asked why R286's 9am medications were not documented if medication administration was completed. V31 responded, That's not mine, that's on (V30's) cart and affirmed V30 is assigned to R286.R24's POS (Physician Order Sheets) include (3/21/23) Benztropine Mesylate 2mg and (1/23/23) Divalproex Sodium 500mg (scheduled for 1pm administration). On 1/6/26 at 11:37am, V28 (LPN) administered R24's Benztropine Mesylate and Divalproex Sodium.R276's POS includes (11/7/20) Carbidopa-Levodopa 25-100mg (scheduled for 1pm administration). On 1/6/26 at 11:40am, V28 (LPN) administered R276's Carbidopa/-Levodopa.R88's POS includes (9/24/25) Sodium Chloride 1gm (gram) give 3 tablets (scheduled for 1:00pm administration). On 1/6/26 at 11:43am, V28 (LPN) administered R88's Sodium Chloride. V28 was asked about the requirement for medication administration. V28 stated, One hour before, one hour after. V28 was asked when medications scheduled for 1pm should be administered. V28 responded, 12:00 would be the right time. R267's POS includes (1/17/25) Clonidine 0.3mg (scheduled for 2pm administration). On (1/6/26) at 12:30pm, V30 (LPN) administered R267's Clonidine. V30 was asked about the requirement for medication administration. V30 stated, It's an hour before, an hour after. V30 was asked why R267's Clonidine was administered at 12:30. V30 responded, I can't remember everything. This is scheduled for 2 but the window is open now to give it. V30 was asked if the requirement is an hour before the scheduled time how is the 2pm window open at this time? V30 replied, Typically it's an hour before and a hour after.On (1/7/26) at 12:59pm, V1 (Administrator) was asked when staff should document medication administration. V1 stated, They should be doing it right when they're giving it out.The (undated) drug administration policy states medications are administered as prescribed, in accordance with good nursing principles and practices. The resident's MAR is initialed by the person administering a medication, in the space provided under the date, and on the line for that specific medication dose administration. Medications are administered within 60 minutes of scheduled time, except before or after meal orders, which are administered precisely as ordered.

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	01/08/2026

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure medications were not accessible to unauthorized individuals, failed to ensure medication room doors were locked, failed to store medications in locked cabinets/refrigerators, failed to maintain the medication refrigerator temperature between 36F (Fahrenheit) to 46F, and failed to store refrigerated medications within the required temperature range. These failures have the potential to affect a total of 94 residents residing on 5th and 6th floors. Findings include:The 1/4/26 census includes 25 (5th floor) residents and 69 (6th floor) residents.On 1/7/26 at 1:58pm, the (5th floor) medication room was inspected with V31 (Licensed Practical Nurse). The medication room door was noted to be ajar. V31 was asked if the medication room door was locked. V31 stated, I thought I closed it; it normally slams. V31 entered the medication room without using a key. The 5th floor medication refrigerator was unlocked; a lock was not present. V31 was asked where the medication refrigerator lock was located. V31 responded, That's a good question, I don't know what the heck happened to the lock because it was there yesterday. The refrigerator contained numerous insulins (Lantus, Lispro, Humulin R), Trulicity (GLP-1 receptor agonists) and Uzedy (Antipsychotic). V31 opened the (unlocked) cabinet which contained multiple OTC (Over the Counter) medications. V31 was asked if the medication cabinet was locked. V31 replied, No, but it's in a locked med room; however, the med room was unlocked prior to entry. V31 was asked about the requirements for medication storage. V31 stated, It's supposed to be in the medication room with a locked door and the refrigerator is supposed to have a lock as well. On 1/7/26 at 2:12pm, the (6th floor) medication room was inspected with V37 (Registered Nurse/RN). V37 pushed the medication room door open without using a key. V37 was asked if the medication room door was locked. V37 stated, I think this is stuck (referring to the handle) maybe they need to check it. The strike plate was misaligned with the door latch. The medication refrigerator was also unlocked; there was no lock present. V37 was asked if the medication refrigerator was locked. V37 responded, There's no lock on there. V37 was asked if the medication refrigerator is supposed to be locked. V37 replied, I think it should be. The refrigerator contained intravenous Vancomycin, Brinzolamide eye drops, and numerous insulins. V37 was asked about the medication refrigerator temperature. V37 stated, This says like 19; it says freezing. V37 was asked what the medication refrigerator temperature should be. V37 referred to the refrigerator temperature log (posted on the wall) and affirmed it should be 32-41F. V37 opened the unlocked medication cabinet which contained numerous OTC (over the counter) medications. V37 was asked if the medication cabinets were locked. V37 replied, No, these cabinets? They're open.The (undated) medication storage policy states medications and biologicals are stored safely, securely, and properly following the manufacture or supplier recommendations. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Medication rooms, carts, and medication supplies are locked or attended by person with authorized access. Medications requiring refrigeration or temperatures between 36 degrees Fahrenheit and 46 degrees Fahrenheit are kept in a refrigerator.

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	01/08/2026

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the facility failed to ensure sufficient plates were available, failed to provide meals timely, failed to ensure hamburgers appeared palatable, failed to ensure steam table lids fit properly, and failed to maintain food temperatures within requirements to prevent food borne illness. These failures affect 54 (4th floor) residents. Findings include:The (1/4/26) facility census includes 54 (4th floor) residents. The facility meal-time schedule affirms the (4th floor) lunch is scheduled for 12:15pm-12:30pm.On (1/5/26) at 12:53pm, lunch (pot pie, mashed potato, rice, hamburgers, grilled cheese sandwich) was delivered to the 4th floor dining room via steam table. All the steamtable lids were notably bent on each corner and not insulating the food. On 1/5/26 at 1:00pm, the (4th floor) lunch had not yet been served but scattered clumps of pot pie and smeared mashed potatoes were noted atop of the steam table. The pot pie was still covered with plastic wrap, however, (3) serving scoops covered in clumped; pot pie, mashed potato, and rice were noted on a piece of foil (placed atop of the mashed potato lid). V19 (Dietary Aide) was asked why the serving scoops were unclean (prior to food service). V19 (Dietary Aide) stated, I have one for the pot pie right here (referring to 1 clean scoop on the steam table); they were just sitting there, I'm going to call for another one and affirmed they were used on another unit. V19 was asked why the steam table lids were not fitting properly. V19 responded, I don't know. I can see like they're old and they're not straight. At 1:07pm, staff delivered plates to the 4th floor dining room. SV19 was asked why the plates were just now delivered. V19 replied, Cause they (facility) run out of plates. V19 was requested to obtain food temperatures prior to meal service, however, V19 stated, The thermometer is not working. On 1/5/26 at 1:10pm, V20 (Regional Director of Kitchen Operations) about the requirements for maintaining hot foods. V20 responded, Above 135. V20 proceeded to obtain the (4th floor) rice temperature and affirmed it was 119 F (degrees Fahrenheit) then directed V19 (Dietary Aide) to Put this (referring to the rice) in the microwave. The rice was noted to be in small plastic bowls. V20 obtained the (4th floor) hamburger temperature and stated, Its 100 F. The hamburgers were completely covered in water, notably pale in color, and did not appear palatable. V20 obtained the (4th floor) grilled cheese sandwich temperature and stated 107 F, however the actual temperature was 106.5F. V20 was asked why the steam table was not cleaned prior to meal service. V20 replied, We don't clean in between because we don't put chemicals before service. V20 was asked why the rice, hamburgers, and grilled cheese temperatures were out of compliance. V20 responded, We got 4 hours to reheat it to 165. The food naturally loses temperature after it has been taken out, however, the food was not removed from the steam table. V20 was asked about concerns with the steam table lids not fitting properly, and what's the purpose of the lids? V20 replied, They're meant to hold the temp then advised there was nothing wrong with the notably damaged lids. Concerns regarding the soiled scoops, unclean steam table (prior to use), and hazardous food temperatures were relayed to V20. V20 became hostile and argumentative instead of acknowledging the potential for food borne illness due to poor sanitation (re: scoops/steam table) and/or foods which were maintained in the temperature danger zone. The food temperature resident service policy (revised April 2022) states hot foods will be held at a minimum of 135F during tray assembly. Hot foods will be served to the resident at a temperature palatable and acceptable to the resident, general practice should not be less than 125F.

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	01/08/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to conduct hand hygiene prior to passing meal trays for four (R7, R57, R181, R211) of 59 residents reviewed for infection control.Findings include: On 1/05/26 at 12:07pm, V14 (Rehab Aide) performed hand hygiene using hand sanitizer to both her hands, retrieved a tray of food from the steamtable, walked to the table R12 was sitting at, and served R12 the tray of food. V14 then walked back to the steamtable, did not perform hand hygiene, retrieved another tray of food from the steamtable, walked to the table R181 was sitting at and served R181 the tray of food. After serving R181 the tray of food, V14 went back to the steamtable, did not perform hand hygiene, retrieved another tray of food from the steamtable, walked to the table R7 was sitting at and served R7 the tray of food. After serving R7 the tray of food, V14 went back to the steamtable, did not perform hand hygiene, retrieved another tray of food from the steamtable, walked to the table R57 was sitting at and served R57 the tray of food. V14 then then walked back to the steamtable, did not perform hand hygiene, and retrieved another tray of food from steamtable, walk to the table R211 was sitting at and served R211 the tray of food. On 1/05/26 at 12:24pm, V14 (Rehab Aide) said, We only have to wash our hands between passing trays to residents if we touch the resident when we're serving them the tray. Other than that, we just wash our hands before we start passing trays.On 1/07/26 at 12:03pm, V4 (Infection Preventionist) said according to facility policy, staff are required to perform hand hygiene after assisting with setting up for meals. V2 stated staff should use hand sanitizer between each resident while passing trays, to prevent the transfer of contaminants. V2 said, You may or may not see the potential organism, so you need to perform hand hygiene between each resident so you won't transfer anything that they may have from one resident to another resident.Review of facility policy titled, Hand Hygiene Program, undated, documents, To decrease healthcare associated infections, including infections due to antibiotic-resistant organisms, by improving hand hygiene practices and use of gloves among all staff through evidence based practice. Hand Hygiene is the single most important method for reducing the risk of cross contamination and infection in the healthcare setting. The Hand Hygiene Program is a comprehensive program that encompasses planning, performance, evaluations, and improvement into the program. Review of pamphlet titled, RESIDENTS' RIGHTS' For People In Long-Term Care facilities, revised date 11/18, documents, Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life. Your facility must provide services to keep your physical and mental health, at their highest practical levels. Your facility must be safe, clean, comfortable, and homelike.

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	01/08/2026

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview, and record review, the facility failed to ensure that the sixth-floor men's resident shower room and the eighth floor east wing community shower room were maintained in a clean and sanitary condition; and failed to cover an open electric wire on the wall of the eighth floor. These failures have the potential to affect 71 residents on the sixth floor and 37 residents on the east wing of the eighth floor, reviewed for sanitary and safe environment. Findings include: On 1/5/26 at 10:30am, V1 (Administrator) presented the facility census which shows there are 37 residents on the east wing of the 8th floor. On 1/5/26 at 10:58am during observation of residents on the 8th floor with V33 (LPN/Licensed Practical Nurse), the east wing community shower room was observed with the following: The last toilet stall which V33 stated was the handicapped toilet had malodorous liquid on the floor surrounding the toilet commode. V33 stated she was not sure if the toilet commode was leaking or if it was urine on the floor. There was a pervasive urine odor in the shower room. The ceiling tiles in the first shower stall was brownish with rust-like stains. There was an open electric wire sticking out on the wall close to a room on the east wing. V33 stated she would notify Maintenance staff. On 1/5/26 at 2:00pm, V8 (Maintenance Director) stated he would ensure all the above stated maintenance issues are fixed and everything will be in good working condition. E-mail from V1 (Administrator), dated 1/07/26 at 12:31pm, documents, There are 71 male residents on the 6th floor. On 1/05/26 at 10:48am, upon observation of the sixth-floor men's resident shower room, with V15 (Certified Nursing Assistant/CNA), the following was observed: the shower room door was observed to be secured in an open position using a clear plastic bag, a dark yellow liquid was pooled in the center of the bathroom floor, and a bundled white rag heavily soiled with a brown substance was laying on the bathroom floor next to a toilet. V15 said, All the male residents on this floor (6th floor) use this shower room. The residents always tie the door open with trash bags even though we tell them not to do that. Oh, that puddle looks like water mixed with urine. There's a rag in here? It looks like there's poop on that rag. V15 removed the plastic bag that was securing the bathroom door in open position and disposed of the soiled rag. On 1/07/26 at 1:04pm, V41 (Housekeeping Director) said, Housekeeping staff begin each shift by gathering supplies and cleaning resident rooms. Resident bathrooms are cleaned at the start of the shift and checked throughout the day, to ensure body fluids are not present. Shared bathroom and shower rooms are cleaned daily and monitored during the day. When body fluids are identified, nursing (continued on next page)

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	01/08/2026

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	staff notify housekeeping, and a housekeeper is assigned to clean the area. Housekeeping staff respond when notified. The facility assigns one housekeeping staff member per floor, with one sometimes 2 staff per floor on the first shift. Two housekeeping staff are assigned from 7:00 a.m. to 3:00 p.m., and two staff cover all floors from 3:00 p.m. to 11:00 p.m. There are no housekeeping staff assigned overnight, limiting the facility's ability to promptly address unsanitary conditions after hours. V41 affirmed there should not be soiled rags or liquid puddles of any substance on the bathroom floors. Facility's General Maintenance Policy states: The facility shall maintain all buildings, systems, and equipment in good repair and safe operating condition at all times. Preventive and corrective maintenance shall be performed promptly to ensure compliance with IDPH regulations and to protect resident health, safety, and comfort. Review of pamphlet titled, RESIDENTS' RIGHTS' For People In Long-Term Care facilities, revised date 11/18, documents, Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life. Your facility must provide services to keep your physical and mental health, at their highest practical levels. Your facility must be safe, clean, comfortable, and homelike. Facility's job description for Maintenance Assistant states in #1: 10's and repairs according to established procedures, all electrical and plumbing systems, it's in our cooling units, bathroom fixtures etc. #2: Performs all inspections, documentation, and other duties required under the facility's preventative maintenance plan. Facility job description titled, Housekeeper, undated, documents, the Housekeeper is responsible for cleaning resident rooms and other interior and exterior facility areas and assisting in maintaining a clean and attractive environment for the residents. Cleans and straightens (including vacuuming, wiping, moping, polishing, etc.) rooms, offices, and common areas; polish and remove items; ensure resident's rooms are safe, comfortable and maintained in an attractive manner. Cleans and sanitizes resident bathrooms and common bath areas.

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	01/08/2026

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 0924 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Put firmly secured handrails on each side of hallways. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to secure handrails within hallways used by residents. This failure has the potential to affect all 32 residents that reside on the 3rd floor.Findings include: Facility census (1/5/2025) documents 32 residents reside on the 3rd floor. On 1/5/2026 at 10:15 am, the handrail next to the bathroom and across from room [ROOM NUMBER] was unsecured, loose and able to be displaced over approximately 3 inches up or down. V38 (Licensed Practical Nurse) observed the loose handrail, affirmed it was loose and stated, It needs to be tightened. I'll let maintenance know. V38 explained the purpose of handrails is for safety and to assist residents with gait abnormalities. On 1/7/2026 at 12:13 pm, V8, Maintenance Director, affirmed the facility expectation is that handrails are secured and promptly fixed if there are any repairs needed. V8 stated handrails are affixed to the walls in common areas for resident safety and to assist anyone that may need it. On 1/8/2026 at 11:00 am, the handrail next to the bathroom and across from room [ROOM NUMBER] was unsecured, loose and able to be displaced over approximately 3 inches up or down. Additionally, the handrail across from room [ROOM NUMBER] was observed unsecured, loose and able to be displaced over approximately 3 inches up or down and the handrail outside room [ROOM NUMBER] was unsecured loose and able to be displaced over approximately 5 inches up or down. A screw was observed protruding approximately 1.5 inches from the bracket. V23 (Licensed Practical Nurse) confirmed the observations and affirmed handrails are for resident safety. V23 stated, I'll let maintenance know. Facility preventative maintenance policy (12/11/2025) documents, Inspect all hand rails throughout the facility for loosened fasteners or connectors, sharp edges, paint or stain touch-ups. Make any needed repairs immediately

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	01/08/2026

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on observation, interview, and record review, the facility failed to accurately code Minimum Data Sets (MDS) in accordance with the Resident Assessment Instrument (RAI). This failure affected three residents (R9, R11, R71) reviewed for assessment accuracy in a sample of 59 residents. Findings include: 1.R71's MDS (Minimum Data Set), dated 9/10/2025 and 12/10/2025, item I6000, Schizophrenia, is coded No, indicating R71 does not have an active diagnosis of schizophrenia; R71 is taking antipsychotic medications on a routine basis; and S1200, Primary and Secondary SMI Diagnosis, 7-day look back period schizophrenia is indicated as a secondary diagnosis. R71's MDS (9/10/25) indicates R71 had hallucinations, delusions, Verbal behavioral symptoms directed towards others 1-3 days, Other behavioral symptoms not directed towards others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) occurred daily during the lookback period. R71's MDS (12/10/2025) documents delusions and other behavioral symptoms not directed towards others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) occurred 1-3 days during the lookback. R71 admission record documents an active diagnosis of Schizophrenia (9/3/2025), Schizoaffective Disorder (9/3/2025).R71's physician progress notes, dated 9/17/2025, 10/9/2025, 11/18/2025, 12/22/2025, documents, ALL DIAGNOSIS ACTIVE AND ONGOING AS PER FACESHEET THE DIAGNOSIS ARE APPROVED BY THE ATTENDING PHYSICIAN.R71's Pre-admission Screening and Resident Review (PASSR), dated 9/6/2025, documents, It is recorded you are diagnosed with: Schizophrenia Schizoaffective disorder Major depressive disorder Bipolar disorder You have a hard time sleeping. You sometimes experience feelings of hopelessness and worthlessness. Your behavior might be described as unusual, or unpredictable by other people. You will sometimes choose to stay to yourself and away from others. You believe things are true that other people would not believe to be true. You have experiences that seem real to you but are created by your mind. You need help solving problems and making decisions. You sometimes do not know where you are or what is going on around you. You sometimes do not know the date or time. You typically do not remember what happened a long or short time ago You did not complete the WHO-5 questionnaire. You participated in the Short-Blessed Test, a questionnaire that evaluates your cognitive ability. Your score of (28) reveals signs of cognitive impairment. PASRR Determination Explanation You are diagnosed with: Schizophrenia Schizoaffective disorder Major depressive disorder Bipolar disorder Your behaviors may impact your quality of life. At this time, you meet PASRR criteria for a serious mental illness.On 1/5/202 at 10:28 pm, R71 stated, Santa is real and coming; he's coming to bring you and me gifts next week. He will bring gifts for all of us, I'm so excited. R71 then began having flight of ideas including breaking out of prison, fast food, paranoia of other girls outside, and homeless shelters. On 1/7/2026 at 1:15 pm, V24 (MDS Coordinator, Licensed Practical Nurse) affirmed the facility uses the RAI to code MDS. V27 reviewed R71's MDS and affirmed Schizophrenia was not coded. V27 stated V27 did not code schizophrenia because, we did not have enough documentation to code a schizophrenia diagnosis. To code schizophrenia, we have to have all the parts of the DSM-V that's what the RAI (Resident Assessment Instrument) says.CMS' Resident Assessment Instrument 3.0 Manual (10/2025) coding instructions for I0100-I8000 was reviewed. There is no indication within the RAI the resident must meet DSM-V criteria to code schizophrenia. 2 R9's MDS (10/22/25) documents R9 has unclear speech, is sometimes understood and able to understand others. In C0100, Should Brief Interview for Mental Status (C0200-C0500) be Conducted?, the assessment was not conducted due to R9 being rarely or never understood.On 1/5/2026 at 10:33 am, R9 was observed sitting in the dining room and unable to answer questions. V38 affirmed not being able to understand and answer questions is R9's baseline and R5 is (continued on next page)

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	01/08/2026

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	non-verbal. 3 R11's MDS (11/5/2025) documents B0700. Makes Self Understood R11 is 2. Sometimes understood - ability is limited to making concrete requests (being rarely/never understood is not indicated). In C0100, Should Brief Interview for Mental Status (C0200-C0500) be Conducted?, the assessment was not conducted due to R11 being rarely or never understood. In section A, R11's preferred language is listed as English and that R11 does not need an interpreter to communicate with staff. On 1/5/2026 at 10:41 am, V38 stated that V38 is in the dining room and would not be able to be interviewed. V38 explained R11 does not understand English well and would require V38 to interpret. V38 was unsure how much R11 would be able to respond to be interviewed because R11 is not usually able to communicate much. On 1/5/2026 at 10:43 am, R11 was observed sitting in a wheelchair in the dining room. Surveyor asked how R11 was feeling and R11 was not able to respond. V38 asked the question in Spanish and R11 was observed having difficulty responding but stated bien (good). R11 was unable to answer any further questioning due to cognitive deficits. On 1/5/2026 at 1:18 pm, V24 (MDS Nurse, Licensed Practical Nurse) affirmed the facility should be following the RAI to code MDS. V24 reviewed the MDS for R5, R11 and R9. V24 could not recall a time when R5 could speak any words and affirmed R5's baseline is not able to be understood. V24 affirmed the BIMS (Brief Interview for Mental Status) score should be conducted unless a resident is coded as rarely never understood. V24 affirmed based on the coding, R11 and R9 should have had their BIMS score assessed. V24 was unsure if R11 required a translator. Record review of CMS' Resident Assessment Instrument 3.0 Manual (10/2025) coding instructions for B0600 Speech Clarity: Item Rationale Health-related Quality of Life Unclear speech or absent speech can hinder communication and be very frustrating to an individual. Unclear speech or absent speech can result in physical and psychosocial needs not being met and can contribute to depression and social isolation. Planning for Care If speech is absent or is not clear enough for the resident to make needs known, other methods of communication should be explored. Lack of speech clarity or ability to speak should not be mistaken for cognitive impairment. Steps for Assessment 1. Listen to the resident. 2. Ask primary assigned caregivers about the resident's speech pattern. 3. Review the medical record 4. Determine the quality of the resident's speech, not the content or appropriateness-just words spoken. Coding Instructions Code 0, clear speech: if the resident usually utters distinct, intelligible words. Code 1, unclear speech: if the resident usually utters slurred or mumbled words. Code 2, no speech: if there is an absence of spoken words. B0700 Makes Self Understood Item Rationale Health-related Quality of Life Problems making self understood can be very frustrating for the resident and can contribute to social isolation and mood and behavior disorders. Unaddressed communication problems can be inappropriately mistaken for confusion or cognitive impairment. Planning for Care Ability to make self understood can be optimized by not rushing the resident, breaking longer questions into parts and waiting for reply, and maintaining eye contact (if appropriate). If a resident has difficulty making self understood: - Identify the underlying cause or causes. - Identify the best methods to facilitate communication for that resident. Steps for Assessment 1. Assess using the resident's preferred language or method of communication. 2. Interact with the resident. Be sure they can hear you or have access to their preferred method for communication. If the resident seems unable to communicate, offer alternatives such as writing, pointing, sign language, or using cue cards. 3. Observe their interactions with others in different settings and circumstances. 4. Consult with the primary nurse assistants (over all shifts) and the resident's family and speech-language pathologist. Coding Instructions Code 0, understood: if the resident expresses requests and ideas clearly. Code 1, usually understood: if the resident has difficulty communicating some words or finishing thoughts but is able if prompted or given time. They may have delayed responses or may require some prompting to make self understood. Code 2, sometimes understood: if the resident has limited ability but is able to express concrete requests regarding at least basic needs (e.g., food, drink, sleep, toilet). Code 3, rarely or never understood: if, at best, the resident's understanding is limited to staff interpretation of highly individual, resident-specific sounds or body language (e.g., indicated presence of pain or need to toilet). Coding (continued on next page)

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	01/08/2026

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Tips and Special Populations This item cannot be coded as Rarely/Never Understood if the resident completed any of the resident interviews, as the interviews are conducted during the look-back period for this item and should be factored in when determining the residents' ability to make self understood during the entire 7-day look-back period. While B0700 and the resident interview items are not directly dependent upon one another, inconsistencies in coding among these items should be evaluated. Item Rationale Health-related Quality of Life Inability to understand direct person-to-person communication - Can severely limit association with others. - Can inhibit the individual's ability to follow instructions that can affect health and safety. Planning for Care Thorough assessment to determine underlying cause or causes is critical in order to develop a care plan to address the individual's specific deficits and needs. Every effort should be made by the facility to provide information to the resident in a consistent manner that they understand based on an individualized assessment. Steps for Assessment 1. Assess in the resident's preferred language or preferred method of communication. 2. If the resident uses a hearing aid, hearing device or other communications enhancement device, the resident should use that device during the evaluation of the resident's understanding of person-to-person communication. 3. Interact with the resident and observe their understanding of other's communication. 4. Consult with direct care staff over all shifts, if possible, the resident's family, and speech language pathologist (if involved in care). 5. Review the medical record for indications of how well the resident understands others. Coding Instructions Code 0, understands: if the resident clearly comprehends the message(s) and demonstrates comprehension by words or actions/behaviors. Code 1, usually understands: if the resident misses some part or intent of the message but comprehends most of it. The resident may have periodic difficulties integrating information but generally demonstrates comprehension by responding in words or actions. Code 2, sometimes understands: if the resident demonstrates frequent difficulties integrating information, and responds adequately only to simple and direct questions or instructions. When staff rephrase or simplify the message(s) and/or use gestures, the resident's comprehension is enhanced. Code 3, rarely/never understands: if the resident demonstrates very limited ability to understand communication. Or, if staff have difficulty determining whether or not the resident comprehends messages, based on verbal and nonverbal responses. Or, the resident can hear sounds but does not understand messages .Facility job description titled, MDS (Minimum Data Set) Coordinator, undated, documents, The primary purpose of this position is to coordinate, plan, organize, develop, evaluate and take part in, and to assure the quality of all facility services relating to the HCF A Minimum Data Set Assessment Instrument (MDS) and resident care planning (MDC/Care Planning); to safeguard the health, safety and welfare of all residents of the facility; to assure that all MDS/Care Planning is carried out in accordance with the facility's established policies and procedures, applicable federal and state laws and regulations, and the directions of your supervisors, who include the Administrator, Medical Director, and other members of the facility's management to whom such persons report; to do all things required of an MDS/Care Plan Coordinator; to implement the MDS/Care Planning policies established by, and assist in providing MDS. Conducts periodic review to ensure all documentation is informative and descriptive of nursing care and of the resident's response to that care.

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	01/08/2026

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review, the facility failed to ensure personal/hygiene care was provided to two of 59 dependent residents (R11, R40) in the sample reviewed for ADL care provided to dependent residents.Findings include: 1.R11's Minimum Data Set (11/5/2025) documents a Brief Interview of Mental Status (BIMS) interview should not be completed due to R11 being rarely/never understood, and R11 is dependent of staff for personal hygiene. On 1/5/2025 at 10:43 am, R11 was observed sitting in the dining room. R11's face/beard was covered with brown food particles, and food stains were observed on R11's shirt. R11's nails were long and R11's right thumb nail was approximately 1.5-2 cm long from the tip of the thumb, half the thumb nail was missing to the tip of the thumb and the nail appeared jagged and sharp. V38 (Licensed Practical Nurse) observed R11 and affirmedR11's nails needed to be trimmed and there was food on R11's face. V38 affirmed R11 needs assistance with activities of daily living. 2.R40's (12/22/20) care plan states resident has a self-care deficit. Resident requires supervision to limited assist with ADLS (Activities of Daily Living), assist with dressing as needed. R40's (10/8/25) BIMS (Brief Interview Mental Status) determined a score of 13 (cognition intact). On (1/5/26) at 10:45am, R40's fingernails were notably long and broken. R40 was asked who cuts R40's fingernails. R40 stated, Nobody, I broke 'em (sic) and affirmed his toenails are cut by a provider. R40 was wearing light blue socks, however, the soles of each sock were notably soiled/discolored (black) and appeared wet. R40 was asked if R40's socks were wet. R40 responded, They (staff) mopped the floor; they are wet. The (3/21/23) ADL care policy states maintain nails at a smooth/safe length. The (undated) CNA job description includes Role Responsibilities: assists residents with dressing/undressing as necessary. Assists residents with nail care.

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	01/08/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure alarms were functioning properly, failed to implement fall prevention interventions, and failed to provide supervision for two of 59 residents (R17, R230) in the sample reviewed for safety.Findings include: 1.R17's diagnoses include autistic disorder, developmental disorder of motor function, and lack of coordination. R17's (11/7/25) functional assessment affirms partial to moderate assistance is required for sit to stand and chair/bed to chair transfers. R17's (4/21/25) care plan states resident had actual falls, interventions: self-releasing seat alarm belt. R17's (11/7/25) BIMS (Brief Interview Mental Status) determined a score of 15 (cognition intact). On (1/5/26) at 10:54am, R17 was seated in a wheelchair and an alarm box was observed behind the seat. V13 (Licensed Practical Nurse) asked R17 to stand up from the wheelchair; however, the alarm didn't sound. V13 was asked if R17's chair alarm was working. V13 stated, Nope, it's not working; it looks like it's in his seatbelt. The (undated) CNA (Certified Nursing Assistant) Job Description includes Role Responsibilities – Safety; reports all defective equipment to the charge nurse immediately. The (8/3/17) fall prevention and management program states falls among nursing home residents are usually the consequence of a combination of intrinsic and extrinsic (equipment) risk factors. Risk factors for falls: missing or broken equipment. The fall prevention and management program is designed to address intrinsic, extrinsic and operational risk factors. Identify risk factors. Implement individualized approaches/interventions based upon resident risk. Staff should visually check residents to ensure safety. Interdisciplinary care plan is implemented for residents at risk. 2.R230's face sheet documents an admission date 3/22/2023. R230's face sheet documents diagnoses that include but are not limited to nondisplaced intertrochanteric fracture of right femur (onset date 11/10/25), dementia, schizoaffective disorder, and low back pain. R230's BIMS (Brief Interview for Mental Status) score, dated 11/11/25, is 10, which indicates R230's cognition is moderately impaired. On 1/05/25 at 11:00am, R230 said, I don't know how I fell. Which time? I can't remember. R230's progress note, dated 10/27/25 at 11:46am, per V21 (Registered Nurse/RN), documents, Resident (R230) alert oriented x2 in the dining area sitting in a chair, repeatedly attempting to throw himself out of the chair, staff monitoring area. Will continue plan of care. (continued on next page)

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	01/08/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R230's progress note, dated 10/27/25 at 12:58pm, per V21 (Registered Nurse/RN), documents, Resident (R230) noted sitting in dining area in chair, resident leaped onto floor, resident doesn't know why he threw himself onto floor, Resident assessed. Resident assisted to chair, with staff, monitoring dining area. No enhanced or one-to-one supervision was implemented. R230's progress note, dated 10/28/25 at 10:30am, documents, Resident was observed sitting with the nurses at the nurses' station on the unit. Resident was being redirected not to leave the station at that time. R230's progress note, dated 10/29/25 at 11:08am, documents, Resident was observed with bruises with slight swelling on his left forearm. Resident stated He didn't know how it happened. R230's progress note, dated 10/29/25 at 11:09am, documents, Pain medication administered. R230's progress note, dated 10/30/25 at 7:00am, documents, (R230) Needs constant redirecting from propelling self to his room. His behavior was restless until he went to bed. R230's progress note, dated 10/30/25 at 10:08am, documents, (R230) up in his wheelchair at the dining room repeatedly trying to get out of wheelchair despite redirection. R230's progress note, dated 11/04/25 at 6:31pm, documents, Resident complained of pain rated 4 on a scale of 1-10 to his right-side pain especially to his right hip. MD (medical doctor) called with stat order of x-ray to right hip to r/o fracture. Pain medication Tylenol 650 mg tab administered. R230's progress note, dated 11/08/25 at 5:18am, documents, in part, The resident (R230) was transferred to (Hospital) for possible right hip fracture, awaiting to do CT (computed tomography) of his right hip and right fingers. R230's progress note, dated 11/08/25 at 12:18pm, documents, This RN (Registered Nurse) called (hospital) to f/u on residents' status, resident will be admitted for visualized L (left) displaced rib fractures and non-displaced fractures of the R hip, ortho surgery is on consult, resident is NPO for possible procedure at the moment. R230's hospital records, dated 11/08/25, document, Presented from NH (nursing home) with right hip pain and left arm pain and swelling. Patient states that 5 days ago he was attempting to move from his wheelchair to another chair and fell on his R (right) side. Immediately felt R hip pain. Also hit his right side of his head and left arm. Patient is reported to have tenderness and ecchymoses after fall along the humerus L (left) arm with ecchymosis near medial elbow. R hip/[NAME] internally rotated with resolving ecchymosis. X-rays revealed age indeterminate mildly displaced periprosthetic fracture of greater trochanteric of the right and left displaced rib fractures likely old and healed, plus soft tissue swelling over left humerus. R230's progress note, dated 11/30/25 at 11:54am, documents, Resident was observed with discoloration to his right eyelid during ADL (Activities of Daily Living) care this morning. Resident stated, I scratched my eyelid and left forearm when itching. R230's Fall Risk Review, dated 9/21/25, documents a score of 15, which indicates R230 is at high risk for falls. (continued on next page)

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	01/08/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R230's physician order, ordered date 11/10/2025, documents, Oxycodone HCl Oral Solution 5 MG/5ML (Oxycodone HCl): Give 2.5 ml by mouth every 6 hours as needed for pain. R230's physician order, ordered date 11/11/2025, documents, Lidoderm Patch 5 % (Lidocaine): Apply to right hip topically one time a day related to nondisplaced intertrochanteric fracture of right femur, initial encounter for closed fracture and remove per schedule. R230's care plan, dated 3/23/2023, documents, Falls: (R230) has had actual Falls as evidenced by the following risk factors and potential contributing Diagnosis of Cognitive Impairment, Schizophrenia/Schizoaffective Disorder with mood and/or behavioral issues, with a goal, that documents, (R230) will have a safe environment maintained through next review, and interventions, that document, Place (R230) closest to staff when up and in dining room. R230's care plan, dated 3/23/2023, documents, ADLs (activities of daily living): (R230) has a Self-Care Deficit and I require assistance with ADLs to maintain the highest possible level of functioning AEB (as exhibited by) the following limitations and potential contributing factors: - Schizoaffective disorder, with interventions that document, in part that R230 require extensive assistance and 1 person support for bed mobility, transfer, toileting, eating, bathing and dressing, personal hygiene and oral care, and oral care. R230's care plan, dated 12/27/2023, documents, Mood/behavior distress R230 am challenged by a diagnosis of Dementia, Mental Illness and Psychosis. I experience mood liability, have a poor frustration tolerance and experience restlessness. Symptoms are manifested by agitation/aggression. R230's care plan, dated 11/11/2025, documents, (R230) have a fracture of the: Non displaced fracture of right hip. Problems are manifested by: Impaired mobility., Problems are manifested by: Gain instability., Problems are manifested by: Pain upon movement. On 1/05/26 at 3:14pm, V21 (Registered Nurse/RN) said, I was (R230's) nurse that day (10/27/25). I can't really remember. I don't know what he was going through at the time. He was alert and oriented enough to tell us (staff) that he wants an Ensure or wants to go to bed. Previously, he could walk a little, but he is more wheelchair-bound now. I would say he is impulsive and does keep trying to get up out of the wheelchair. Yeah, he's tried to get up and put himself to the floor before that fall (10/27/25). He was usually up for all meals. At that particular time, we (facility) probably had someone sitting next to him or staying close to him. I didn't see the actual incident, so I don't know what happened afterward. On 1/06/26 at 10:08am, V2 (Director of Nursing/DON) stated, (R230) fell on [DATE] while staff were present when (R230) leaped out of (R230's) wheelchair. The physician ordered (R230) to be sent to the hospital for evaluation. The x-rays were negative and (R230) returned to the facility with no abnormal findings. On 11/04/25, (R230) complained of right hip pain, and a physician order was obtained for a right hip X-ray, which revealed no fracture. On 11/07/25, the resident's left upper arm was noted to be swollen, cause unknown. A Doppler study was ordered and revealed diffuse subcutaneous edema. The physician then ordered (R230) to be sent to the hospital again. While at the hospital, the facility was informed there was a possible right hip fracture, and the resident was transferred to another hospital for further evaluation. An X-ray revealed an age-undetermined fracture. (R230) resided on the sixth floor and there is always an employee to monitor all the residents. V2 indicated approximately one to two hours prior to the incident (fall), R230 was attempting to leap out of R230's wheelchair. V2 stated no reportable incident was completed because the fracture was not (continued on next page)

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	01/08/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	considered acute. V2 also stated V2 was unsure whether R230 had the hip fracture prior to admission to the facility, but confirmed the resident had a history of left hip surgery. On 1/06/26 at 10:52am, V22 (Certified Nursing Assistant/CNA) stated V22 was present when R230 leaped out of his wheelchair (10/27/25). V22 reported V22 and V23 (Licensed Practical Nurse/LPN) were monitoring the dining room and were aware R230 was attempting to stand up from R230's wheelchair. V22 stated neither V22 or V23 were positioned close enough to R230 to intervene and prevent the fall. R230 stood up before V22 could reach R230 and subsequently fell. V22 stated V22 was positioned near the dining room doors, while R230 was seated toward the middle of the dining room. V22 was unable to specify the exact distance but indicated V22 was not directly next to the R230 and it was a little distance. V22 stated R230 is very confused and frequently attempts to stand and acknowledged staff should have been positioned closer to R230 due to this behavior. V22 stated had staff been positioned directly next to R230, yeah, the fall could have been prevented. V22 further stated V22 was responsible for monitoring the entire dining room, which limited V22's ability to provide constant supervision to R230. On 1/06/2026 at 11:27am, V23 (Licensed Practical Nurse/LPN) stated on 10/27/25, V23 was in the dining room passing medications when R230 repeatedly attempted to throw himself out of his (R230) wheelchair. V23 stated by the time V23 reached R230, R230 had already fallen to the ground. V23 said V23 was already assigned to pass medications at the time of R230's fall. V23 stated V23 was present in the dining room when the fall occurred but was not assigned as an additional or one-to-one monitor for R230. V23 stated V23 was positioned near the entrance door of the dining room and was unable to state the exact distance between V23 and R230. V23 stated the staff member that is assigned to monitor the dining room is responsible for monitoring the entire dining room, including multiple residents, and acknowledged R230 was receiving only routine supervision at the time of R230's fall. V23 confirmed no additional or enhanced monitoring was in place despite R230's repeated attempts to exit the wheelchair. 1/07/26 at 11:12am, V2 (Director of Nursing/DON) stated when monitoring is increased, staff have to be directly observing the resident. V2 said R230 was brought from his room to the dining area so a staff member can observe R230. V2 affirmed when the facility increases monitoring for a resident, a single staff member is often assigned to observe multiple residents simultaneously, rather than providing one-to-one supervision. V2 confirmed V22 (Certified Nursing Assistant/CNA) was responsible for monitoring several residents in the dining room and was not assigned to observe R230 exclusively. V2 stated when V2 spoke with V21 (Registered Nurse/RN), R230 was in R230's room and was later brought back to the dining room to be monitored. V2 stated placing R230 in the dining room allowed staff to keep eyes on him; however, R230 was not provided direct or constant supervision. V2 further stated staff place R230 near the nurse's station; however, this also did not include one-to-one monitoring. V2 stated R230 had a history of a prior hip replacement; however, no records were available from R230's previous facility to confirm whether R230's right leg or left ribs were fractured prior to admission. V2 further stated when a resident sustains an injury, the incident is reported to V9, the Chief Nursing Officer and facility risk manager, who determines whether the injury requires reporting to IDPH (Illinois Department of Public Health). V2 affirmed V9 was notified of R230's fall and age undetermined fractures. On 1/07/25 at 11:35am, V9 (Chief Nursing Officer) said, No, he was sent out for his arm and that's when I think the hospital found the old fracture. The fracture was age undetermined fracture where hip surgery was. I don't know typically, with the fracture, we'll (facility) report it, but I did not report it because it wasn't a new fracture, and the level of care didn't change. I don't know anything about rib (continued on next page)

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	01/08/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	fractures. We never receive anything good for documentation from the hospital. Really, we never get anything from the hospital. I don't know, I'd have to pull his admission records to check and see if he had these rib and hip fractures prior to coming here. I'd have to go through all, I mean all, initial records from the hospital. I mean, I'll go and check his initial records as long as I don't keep getting pulled to do stuff. I don't remember him having a hip surgery with us. On 1/07/26 at 1:56pm, V36 (Medical Doctor) stated when residents sustain injuries, the initial X-rays are often negative. V36 said, This has happened multiple times, where the initial imaging does not reveal a fracture, and no immediate intervention is provided. An age indeterminate fracture means that the fracture could be six months, six years, or six days old, and no one can know the exact timing. So, nobody really knows. It's anybody's guess. V36 stated that because of this uncertainty, it is impossible to know whether a specific fall caused a fracture or whether the injury predated the incident. V36 said, The thing is it could have been there way before. Maybe the fall did cause it or maybe it didn't. We're (physicians) human. I'm not sure if (R230) had rib and hip fractures before coming to the facility. Record review of facility policy titled, Fall Prevention and Management Program, undated, documents, his facility is committed to safety and maximizing each resident's physical, mental, and psychosocial well-being. The purpose of our Fall Prevention and Management Program is to: Provide our residents with an interdisciplinary approach to assess risk of falls. Provide appropriate interventions to prevent falls. Ensure that in the event a fall occurs, the fall will be investigated, appropriate emergency treatment will be provided, and additional interventions will be implemented to prevent another fall from occurring as much as possible. The Fall Prevention and Management Program uses clinically accepted guidelines to guide the prevention and management of falls. The program will: identify risk for fall. Decrease the incidence of falls. Decrease the incidence of fall with injuries. Falls are one of the most common and serious problems ill the older adult. Falls are not a normal consequence of aging; rather they are the result of multiple interacting, predisposing, and precipitating factors that put the resident at risk for falls. The consequences may range from no adverse effect to severe, life threatening problems, or even death. Fall related injuries decrease the resident's quality of life and ability to function. Residents who fall without injury may develop a fear of falling that leads to self-imposed limitation of activity. Falls can lead to fractures, traumatic brain injuries, decreased mobility, fear of falling, and increased isolation. While preventing all incidents including falls is not possible, this facility is committed to act in a practical manner to identify those residents at risk for falls, plan for preventative strategies, and facilitate as safe an environment as possible. This is accomplished through the Fall Program. Though an interdisciplinary approach, this facility will provide fall prevention assessment, implement interventions to prevent falls as much as possible, and manage post-fall treatment. This facility will achieve these goals through: An individualized fall risk assessment. Interventions that are implemented based upon the identified risk factors. Immediate response to residents who fall including assessment for any injuries and the emergency management of any injuries. Reassessment of risk after a fall with modification and/or additional interventions as appropriate. Common intrinsic risk factors: Behavioral symptoms and unsafe behaviors. Implement individualized approaches/interventions based upon resident risk. The Fall Prevention Strategies/Interventions list may be used to identify appropriate interventions. Approaches/Interventions should focus of risk factors identified. Record review of facility policy titled, Incidents/Accidents/Falls, undated, documents, If the incident/accident is significant and requires outside emergency intervention/ treatment, the Administrator and DON will be notified immediately that emergency services were called and what the circumstance were that required that intervention. Other required notifications will occur as well. Any (continued on next page)

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	01/08/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	incident/accident/fall that meets the reporting criteria of the state/federal regulations will be reported timely and accurately, to include the initial as well as the follow up report. The CNA information sheet will be updated as indicated to reflect the plan of care. Record review of pamphlet titled, RESIDENTS' RIGHTS' For People In Long-Term Care facilities, revised date 11/18, documents, Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life. Your facility must provide equal access to quality care regardless of diagnosis. You should receive the services and/or items included in the plan of care.

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	01/08/2026

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to dispense the correct medication and failed to dispense the correct medication dose. There were 2 medication errors out of 25 opportunities, resulting in a 8% medication error rate. 1 resident (R24) in the medication administration sample was affected. Findings include:R245's POS (Physician Order Sheets) include (7/19/25) Folic Acid 400mcg (micrograms) one time a day and (10/9/25) Aspirin 81mg (milligrams) one time day (scheduled for 9am administration). On 1/6/26 at 9:12am, V27 (LPN/Licensed Practical Nurse) dispensed (chewable) Aspirin 81mg and Folic Acid (1,000mcg) in a cup and affirmed she was prepared to administer them to R245. V27 was asked about the Aspirin discrepancy. V27 inspected the container and stated, The chewable tablet? V27 was asked if chewable Aspirin was prescribed for R245. V27 responded, No. V27 was asked about the Folic Acid discrepancy. V27 inspected the container and replied, This is 1,000. The (undated) drug administration policy states medications are administered as prescribed, in accordance with good nursing principles and practices. Medications are administered in accordance with written orders of the attending physician. Medications are administered within 60 minutes of scheduled time, except before or after meal orders, which are administered precisely as ordered.

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	01/08/2026

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 0920 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide at least one room set aside to use as a resident dining room and for activities, that is a good size, with good lighting, air flow and furniture. Based on observation, interview, and record review, the facility failed to ensure adequate seating was available for one of 59 residents (R213) in the sample. Findings include:On (1/5/26) at approximately 1:25pm, R213 was served lunch on a tray at the steam table. He proceeded to carry the tray throughout the (4th floor) dining room to find a seat however no chairs were available. R213 stood in the dining room while holding the meal/tray and proceeded to eat half a grilled cheese sandwich before staff provided a chair.On (1/7/26) at 12:20pm, V8, Maintenance Director, was asked if the facility has enough chairs in each dining room V8 (Maintenance Director) stated, I would say yes. V8 was asked why the 4th floor dining room did not have enough chairs available for all the residents (on 1/5/26). V8 responded, Ma'am I couldn't tell you. If anyone needs extra chairs, we just bring extra chairs to the floor. The order of meals served policy (revised April 2022) states dining rooms that have open dining will serve the resident in a timely manner (after) being seated.