STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145914	A. Building B. Wing	04/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Landmark at 95th Rehabilitation and Nursing Center	1010 West 95th Street Chicago, IL 60643

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 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide wound care treatments for two residents R1 and R5, failed to notify the physician when wound worsened for one resident (R1) resulting in R1 being sent to the hospital for wound infection and needing further surgical interventions, failed to assess and treat wounds for one resident (R5) resulting in R5 not receiving wound care for 12 days. These failures affected two residents (R1 and R5) out of 3 residents reviewed for wound care.Findings include:R1's medical diagnoses include but are not limited to dehiscence of amputation stump, bacteremia, sepsis, acquired absence of left leg, pulmonary hypertension, post-traumatic stress disorder, heart failure.R1's Minimum Data Set, dated [DATE] has a Brief Interview for Mental Status score of 12, indicating R1's cognition is moderately impaired.R1's care plan dated 02/28/26 documents in part, Enhanced Barrier Precautions: I am in enhanced barrier precautions for: Wounds or skin opening requiring a dressing. Enhanced precautions will be maintained and I will not exhibit signs of active infection thru next review. Set up isolation per facility protocol. Follow the enhanced precautions guidelines.R1's care plan dated 02/28/26 documents in part, I am at increased risk for impaired skin integrity related to left below knee amputation (BKA), bypass grafts, extremities left leg. I will not develop any skin integrity issues thru next review, unless the disease process causes unavoidable deterioration. Administer wound care treatments per MD (Medical Doctor) orders. Weekly skin checks per facility policy.R1's physician order dated 02/24/26 at 7am documents in part, Paint left BKA with betadine, apply adaptic , calcium alginate and cover with ABD (abdominal) pad, kerlix and tape daily and PRN (as needed). Every day shift. Start 02/24/26.Review of R1's treatment administration record (TAR) has no documentation for treatment on 02/24/26, 02/25/26 and 02/26/26.R1's progress note dated 03/12/26 documents in part, Upon doing rounds, the pt (patient) complained of phantom pain. His wound was assessed and right below knee wound dehiscence was noted. The doctor and NP (Nurse Practitioner) was call and gave orders to send the pt back to the ER (emergency room) for further evaluation.R1's hospital records dated 03/13/26 documents in part, He was sent in from the nursing home because he has had increased drainage for the past week. Left-sided BKA (below knee amputation) wound dehiscence. Concern for infection. Patient reports drainage started occurring one week ago and became increasingly difficult to mange, thus nursing home sent him here.R1's discharge hospital records dated 03/24/26 documents in part, Left BKA wound dehiscence with infection s/p (status post) AKA (above knee amputation) revision by vascular. Right heel stage 2, POA (present on admission). cover with alginate and bordered foam, change daily.On 04/03/26 at 10:27am observed V3 (Wound Care Coordinator/WCC) cleansing R1's right heel wound and apply foam dressing.On 04/03/26 at 10:27am V3 (WCC) stated that she had just discovered the wound to R1's right heel. V3 stated that she would apply a treatment of her recommendation until the wound care doctor sees R1 for wound care.Review of R1's physician orders indicate that R1 had no physician order for right heel wound until 04/03/26, although discharge hospital records dated 03/24/26 documents that R1 had active right heel wound and discharge orders for that wound.R5's medical diagnoses include but are not limited to peripheral vascular disease, venous insufficiency, lymphedema, non-pressure chronic ulcer of other part of right (continued on next page)

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

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	lower leg with unspecified severity.R5's admission date to the facility is dated 02/26/26.R5's progress note dated 02/26/26 at 9:25pm documents in part, Resident has DX (diagnosis) of chronic embolism and thrombosis of lower extremity;non pressure chronic to left lower leg, etc. (etcetera).Physician (V26) notified and order to continue orders. Will continue plan of care.R5's care plan dated 02/26/26 documents in part, I have an alteration in skin integrity: Right lower leg, Left lower leg. I will be free of any additional skin integrity issues, unless the disease process causes further unavoidable deterioration through the next review.Provide treatment as per MD order.Review of R5's physician orders shows that R5's initial wound care orders were not entered until 03/09/26, indicating R5 did not have wound orders from admission on [DATE], a total of 8 days.R5's physician order dated 03/09/26 documents in part, Right lower leg: Cleanse with NSS (Normal Saline Solution), pat dry, apply collagen and cover with ABD, wrap with kerlix and ace wrap every day and prn (as needed) for soiled/dislodged.On 04/03/26 at 11:37am R5 stated that she had been in the facility for over a week without having her wounds changed. R5 stated that she kept asking the nurses to change her wound dressing and they would tell her that there was no one there that could do it.On 04/03/26 at 3:16pm V2 (Director of Nursing/DON) stated that it is the expectation of the facility that nurses document everything that they do. V2 stated that if it is not documented, it looks as though it wasn't done.V2 stated that residents are admitted to the facility with orders from the discharging facility and it is her expectation that the nurse transcribes those orders on admission. V2 stated that a resident should not be in the facility with an open wound with no orders. V2 stated that not treating a resident's wound could cause infection or the wound could deteriorate.On 04/03/26 at 4:21pm V2 (Director of Nursing) stated that the facility does not have a policy for wound care assessments. V2 stated that the admitting nurse is expected to do a wound assessment on admission and document the resident's wounds. V2 stated that wound assessments are done every seven days by the wound care nurse. V2 stated that if there are any changes to an incision, the nurse should notify the resident's physician.Review of R1's records indicate that R1 had a wound assessment done on 02/24/24 and not until 14 days later on 03/10/26. R1 was sent out to the hospital on [DATE] for pain to the wound and admitted with diagnosis of wound infection.On 04/03/26 at 3:51 V26 (Medical Doctor/MD) stated that he was not aware that his residents R1 and R5 had not received wound care treatment. V26 stated that it is his expectation that the nurses follow the physician orders. V26 stated that it is a standard of care and is expected that the physician's orders are carried out. V26 stated that wounds that are not changed can get worse, can lead to infection and even mortality. V26 stated that wounds should be addressed on the day of admission and followed up with the appropriate treatment plan. V26 stated that a newly admitted resident or a resident returning from the hospital should have orders from the discharging facility and those orders should be continued until the resident is seen by the wound care nurse or the wound care doctor. V26 stated that if R1's wounds were not treated as ordered, R1's infection could have come from the facility not treating R1's wounds.Facility's undated policy titled Wound Cleansing and Dressings documents in part, Policy: It is the policy of this facility to perform wound dressing changes as ordered by the physician using clean technique on all chronic or contaminated wounds. A moist wound environment is most favorable for optimal wound healing.Facility's policy titled Guidelines for Observing and Implementing Resident Rights dated 07/12/23 documents in part, Policy: It is the policy of the facility to observe and implement resident rights as dictated by CMA. These rights and protections are mandated by Federal and State laws. These rights and protections are a requirement in edicare and/or Medicaid certified nursing homes. Each resident has the right to be treated with dignity and respect. An interaction between a resident and a staff member, temporary staff member, volunteer, visitor, or any other person must be conducted in such a way as to enhance the resident's self-esteem and self-worth while meeting the resident's needs. The preferences and goals of the resident should be honored as much as possible and the resident's comfort, safety and overall welfare must be promoted, protected, and enhanced at all times. To achieve this staff will 1. Treat each resident with respect and dignity. 2. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Care for each resident in a manner and environment that promotes the maintenance of/or enhances the resident's quality of life. 5. Provide equal access of quality of care.Facility's undated policy titled Physician Orders (Following Physician Orders) documents in part, Policy: It is the policy of the facility to follow the orders of the physician. At the time of admission the facility must have physician orders for the resident's immediate care. The facility will have orders to provide essential care to the resident, consistent with the resident's mental and physical status upon admission. Procedure: 1. The facility must have orders from the physician upon admission for: c. Routine care to maintain or improve the resident's functional abilities until staff can conduct a comprehensive assessment and develop an interdisciplinary care plan. 3. Orders that accompany the resident on admission will be clarified by the physician through action of the nurse who will contact the physician for clarification upon the resident's admission.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and records reviewed the facility failed to ensure medications were securly stored, in accordance with professional standards and not left at the bedside of a visually impaired resident, (R4). This failure has the potential to affected of 1 of 3 residents reviewed for quality of care. Findings include:According to R4's face sheet was admitted to the facility on [DATE]. R4's diagnosis include but are not limited to Multiple Sclerosis, Generalized Anxiety, Insomnia, Chronic Idiopathic Constipation, legal Blindness, Conductive Hearing Loss.On 4/3/26 at 10:27AM the surveyor observed 2 pills at bedside, on bedside table, within easy reach of R4. One pill is white, round, and scored. The second pill is oval, clear, light orange in color. R4 said I can't see well. Surveyor observed hand written notes in large print with black marker. The surveyor showed R4 her identification badge and R4 said I can't see it. R4 asked the surveyor to write her name on a paper, big with a marker because she can't see the writing from a pen.On 4/3/26 at 10:42AM V13, RN, said R4 hasn't taken any pills from me today. The surveyor reported to the nurse 2 pills on the table and asked V13 to accompany her to R4's room. V13 asked R4 what the pills are, R4 said I don't know what they are. V13 took the pills from R4's room. Surveyor and nurse went to the medication cart. R4 compared the pills to what she has in her cart for R4. Orange pill is Lubiprostone 24 mg scheduled for 9:00PM and the white pill is Trazadone 50mg scheduled for 9:00PM. On 4/4/26 at 2:30PM V2, Director of Nursing, said I expect the nurse to administer the medications as prescribed by the doctor. The nurse should let them know what medications they are giving. V2 said the nurse should not set the medication in the cup down and walk away. V2 said the nurse should watch that the medications are taken. V2 said the nurse should not leave the resident before all the medications are taken. V2 said if the nurse leaves before the medication is taken, the resident might not take the medication and someone else may come and take it. V2 said Trazadone is for depression or insomnia. V2 said it is a risk to have a medication in the room. A resident with vision impairment, such as blindness, would not be approved to have self administration of medications.Review of R4's assessments does not include self administration assessment.R4's Order Summary Report 3/1/26-4/30/26 includes an order for Lubiprostone 24mcg capsule two times a day, diagnosis of constipation. Trazadone tablet 50mg at bedtime. Diagnosis Insomnia.Review of R4's medication administration record notes Trazadone scheduled daily at 9:00PM and Lubiprostone scheduled twice daily at 9:00AM and 5:00PM. (The surveyor is unable to identify what day the medication were left at R4's bedside.)R4's care plan include focus for cognitively impaired related to Blind and Hard of Hearing and risk for constipation.According to mayoclinic.org Lubiprostone is used to treat constipation.The facility policy Medication Storage in the Facility dated March 2023 states medications and biologicals are stored safely, securely, and properly.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to wear PPE (Personal Protective Equipment) for one resident (R1) who is on EBP (Enhanced Barrier Precautions) while providing wound care. The facility failed to identify one resident requiring EBP with an indwelling catheter and pressure ulcer. This failure affected two residents (R1 and R4) out of three residents reviewed for infection control.Findings include: R1's medical diagnoses include but are not limited to dehiscence of amputation stump, bacteremia, sepsis, acquired absence of left leg, pulmonary hypertension, post-traumatic stress disorder, heart failure. R1's Minimum Data Set, dated [DATE] has a Brief Interview for Mental Status score of 12, indicating R1's cognition is moderately impaired. R1's care plan with date initiated 12/29/25 documents in part, Enhanced Barrier Precaution: I am in enhanced barrier precautions for: Wounds or skin opening requiring a dressing. Enhanced precautions will be maintained and I will not exhibit signs of active infection thru next review. Reinforce proper handwashing, follow personal equipment protocols and educate me and visitors on protocols as needed. Seet up isolation per facility protocol. Follow the enhanced precautions guidelines. On 04/03/26 at 10:27am observed V3 (Wound Care Coordinator) performing wound care to R1 with no PPE gown on. On 04/03/26 at 10:27am V3 (WCC) stated that she doesn't know what EBP is. V3 stated that she doesn't think that she needs a gown on while performing wound care for R1. On 04/03/26 at 10:59am observed V4 (Infection Preventionist/IP) taping EBP sign outside of R1 bedroom door and placing PPE bin in the hallway next to R1's bedroom. On 04/03/26 at 3:16pm V2 (Director of Nursing/DON) stated that staff should wear PPE when doing wound care to the residents. V2 stated that there should be a sign on the resident's door indicating that the resident is on EBP and PPE should be available outside the resident's room. On 04/03/26 at 3:42pm V4 (IP) stated that R1 should have been on EBP precautions before she placed the signage outside of R1's door. V4 stated that staff should be wearing PPE when caring for R1 to prevent the transfer of germs to R1. V4 stated that if germs are transferred to the resident, they could get an infection and may need antibiotics. Facility's policy titled Guidelines for Enhanced Barrier Precautions (EBP) An extension of Personal Protective Equipment (PPE) Revised 12/2022 documents in part, Policy: It is the policy of the facility to ensure that additional and appropriate PPE is utilized., when indicated, to prevent the spread of Multidrug-resistant Organism also known as MDROs. Enhanced Barrier Precautions (EBP): Enhanced Barrier Precautions are defined as the use of PPE (gowns and gloves) during high-contact resident care activities that generate opportunities for transfer of DROs in the form of blood or body fluids, onto the hands and/or clothing of the rendering caregiver. EBP is to be used when Contact Precautions do not otherwise apply and where there is a diagnosis of a MDRO or a colonized MDRO. Thes precautions are generally in place for the duration of the resident's stay, or until there is (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resolution of the wound or discontinuation of the device that placed the resident at higher risk Who is at High Risk for acquiring or spreading a MDRO? . Resident with wounds regardless of MDRO status. Resident care activities at which time EBP is to be practiced are: Wound care. On 4/3/26 at 10:27AM the surveyor entered R4's room, no precautions identified on the door. Upon entering the room urinary catheter drainage tube visible. R4 said I have this catheter because I was not able to urinate. When they checked my bladder I was holding my urine. Air pump visible on the foot of the bed. R4 said I have a sore on my butt. On 4/3/26 at 10:52AM V2, Director of Nursing, said R4 has been in that room since admission. There is no Enhanced barrier Precautions (EBP) sign on her door (observed with surveyor in the hall). V2 said R4 should have a sign on her door. V2 said the purpose of EBP is to prevent the spread of infection.