

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145914	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/30/2026
NAME OF PROVIDER OR SUPPLIER  Landmark at 95th Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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 0600  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.  **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, that facility failed to ensure that one resident (R1) was free from verbal abuse by a staff member. This failure has affected one (R1) resident from a sample of nine residents reviewed for abuse. Findings include:R1 is a [AGE] year old with diagnosis including but not limited to: End stage renal disease, chronic obstructive pulmonary disease, depression, hypotension and constipation.R1's BIMS (Brief Interview of Mental Status) score is 15, which indicates cognitively intact.On 4/27/26 at 10:00 am, V1 (Administrator) stated the following, I was notified via telephone on yesterday around 1:00 pm about the complaint from R1. The manager on duty (V9/ Restorative Director) called and she stated that V8 CNA (Certified Nurse Assistant) had used profanity with R1.On 4/27/26 at 3:30 pm, R1 stated the following, The other day (4/26/26), V8 placed cream on top of feces on my butt. I asked her to clean me again and I complained to the nurse. After an hour she came into my room and started arguing with me and I reminded her that she was being recorded. She (V8) stated that she does not care about me calling the State (Illinois Department of Public Health). I asked her four times to leave his room. She stated she does not care about this job because she would have another job in no time. She then told me that I would still be crippled in my bed while she works somewhere else. She would not leave my room and just stayed there to argue. I stated that I did not want V8 as my CNA. I just don't want her to take care of me anymore because she is ghetto. I don't want her to get in trouble. I am happy here. I don't want to go to another facility. I feel safe here.At that time, R1 played a video and audio recording of the exchange between he and V8 on 4/26/26 during the night shift. The recording documented the following: R1 asked V8 to leave his room for the second time and reminded her that his camera was recording; V8 started laughing and stated, I'm so scared.; R1 told V8 that she should be scared of losing her job; V8 stated, I could get another job and you would still be lying here in this bed.On 4/28/26 at 10:00 am, V9 (Restorative Director) stated the following, I was manager on duty on Sunday 4/26/26 between 9am -5 pm when R1 asked to speak with me. He had stated that he had an issue with the overnight CNA (V8). He complained that she did not clean him good enough after he had a bowel movement and that they (R1 and V8) had a verbal disagreement. R1 stated that V8 began to use profanity towards him and told him that she did not care that he was recording. He stated that he had asked her to leave his room, and she had refused. R1 no longer wants her (V8) to provide care for him anymore.On 4/28/26 at 2:10 pm V1 (Administrator/ Abuse coordinator), stated the following, It is absolutely not ok for a staff member to go back and forward in a verbal altercation with a resident. The staff member needs to respect the resident and leave the room when asked to. V8 has been suspended pending investigation.On 4/28/26 at 2:30 pm V8 (CNA) stated the following, R1 is on a buddy system, so we (staff) never render care or go to his room alone. On that day (4/26/26) I had cleaned him after he had a bowel movement. He activated his call light around 2 am and complained to the nurse (V3) about not being cleaned properly. I (V8) went and asked him (R1) what the issue was and he started yelling and stating that he was still dirty and smelled feces. I did not take anyone with me to his room at that time. R1 continued yelling at me and stated that I should not be caring for him and that I should not be in the building. I did tell him that I (continued on next page)		

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:  145914	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/30/2026
NAME OF PROVIDER OR SUPPLIER  Landmark at 95th Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>could get another job and that he would still be there (at the facility). I should have left his room when he asked instead of arguing with him, but I was just confused about his allegations. Facility Incident Report dated 4/26/26 at 2:10 pm documents the following, on 4/26/26 R1 asked to speak to the Manager on duty (V9) to report an alleged verbal disagreement with and V8 (CNA). R1 reports feeling safe. Investigation initiated and V8 was sent home pending investigation. Facility policy titled Abuse Prevention Program dated 3/1/21 documents, it is the policy of this facility to prohibit and prevent residents abuse, neglect, exploitation, mistreatment, and misappropriation of resident property and a crime against a resident in the facility; Verbal abuse is any use of oral, written, or gestured language that includes disparaging and derogatory terms to residents or their families, or within their hearing distance, to describe residents, regardless of their age, ability to comprehend or disability.</p>		