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	06/18/2026

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 0600 Level of Harm - 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. Based on interview and record review the facility failed to protect one resident (R2) out of four residents who were reviewed for abuse and the facility failed to report a suspicion of abuse and/or unknown injury to the abuse coordinator. Subsequently the resident sustained multiple bruises and trauma.Findings Include:R2's Progress note dated 06/03/26 19:48 document in part reads: Nursing Progress Note Text: Resident observed with discoloration to the forehead and discoloration to the right side of his face. Further skin assessment revealed discoloration to the right hip area. Attending physician notified and gave orders to send resident to hospital for evaluation.On 06/17/26 at 03:05 PM V21 (Certified Nurse Assistant) stated I did not witness R2 and R24 altercation. After the fact, I prepped R2 to go to the hospital. R2 had a bruise on the forehead over the left eye and a large purplish bruise on the right hip. R24 walks around a lot and requires a lot of redirections.R2's Hospital record dated 06/03/26 document in part reads: Chief Complaint: Assault victim. Visit diagnosis: Intracranial hemorrhage. Presenting after physical assault 2 days ago at the nursing facility. He states that a nursing home resident attacked him after a verbal altercation. He was sitting in a wheelchair during this time as he was punched in the face. Significant bruising and swelling to the right maxilla with bruising extending into the right jaw on the right neck down into the right clavicle area. Small bruise to the left inner knee. Large bruise to the right hip. Right hip series: Pain Trauma with bruising. CT (Computed Tomography) Angio neck with and without contrast: Impression: 2. Right facial and neck soft tissue swelling with right malar soft tissue mass approximately 88 Hounsfield units in density, likely hematoma given history of trauma. CT angiogram of the Extracranial Carotid arteries with infusion and IV contrast with 3-d Rotational Reconstructed Images. Indication: neck trauma. Neck pain and swelling with bruising. There is swelling throughout the neck and face with a rounded 2 - 3 centimeters mildly hyperdense mass in the right malar region. Per EMS (emergency medical services) the nursing home stated that R2 was assaulted. R2 has bruising on the right side from head to hip. R2 is on aspirin and Eliquis. R2 states that he has pain everywhere.R2's Progress note dated 06/04/26 00:01 document in part reads: Nurses Notes Text: Update, the patient has been admitted to Hospital ED (emergency department). The Nurse stated that the patient has been Dx (diagnosis) with bleeding on the brain. Nurse stated that the patient will be transferred to a trauma hospital. R2's Hospital records dated 06/05/26 document in part reads: admission Complaint: Intracranial hemorrhage. Eliquis 5 mg (Milligrams) Twice a day. R2 was brought as a trauma transfer after an assault at his nursing facility. Imaging showed a hypodensity which may reflect a small parenchymal or subarachnoid hemorrhage versus calcification. Physical Exam: Head; Hematoma right lower face. Smaller one on left forehead. Skin: extensive bruising. CT Head without Contrast: There is a right upper lip subcutaneous hematoma. Assessment and Plan: Trauma/assault, Head injury, Right buccal hematoma, Right hip/thigh hematoma.Facility's Initial Abuse Reportable document in part reads: Incident date: 06/03/26. Residents involved R2 and R24. Brief Description of Incident: 06/03/26 11:00 administrator was made aware of R2 having a bruise on his face; alleging an altercation with R24. Immediate Action Taken: Initiated body assessment for both residents. R2 does not feel safe in the facility.Facility's Abuse Reportable Final report document in part: Conclusion: R2 ambulates in a (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145914	A. Building B. Wing	06/18/2026

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 0600 Level of Harm - Actual harm Residents Affected - Few	wheelchair. R2 stated he was struck in the hallway all over after dinner. R2 stated R24 did not like how I was talking to the ladies. R2 stated incident happened on Sunday in the hallway. Administrator noted a bruise on forehead and right cheek. R2 showed administrator bruise on right thigh. R2 stated it was R24. R24 was interviewed by administrator. R24 stated R2 walked behind the ladies. Administrator asked what ladies, R24 stated V13 (Licensed Practical Nurse). R24 stated it occurred a couple days ago after dinner. R24 stated he didn't hit R2 that hard and that it occurred after dinner. R2 was sent to the emergency room and transferred to another hospital due to trauma. Both residents were involuntarily discharged from the facility. 24 hour paper documentation reviewed: the date for 06/01/26 is missing. V12 (Licensed Practical Nurse) on Tuesday (06/02/26) morning admitted seeing the bruise on R2 indicating the incident occurred sometime Monday evening 06/01/26. V12 stated that she did not report to management: if she reported it, she felt she would be retaliated against. R2 stated R24 made contact in the hallway after dinner. Body check completed noted R2 to have a bruise on forehead, right thigh and redness to the right cheek. R24 did make contact lightly with R2's backOn 06/17/23 at 03:48 PM V1 (Administrator) stated I was informed on 06/03/26 at morning meeting from therapy that R2 had a bruise. R2 had a bruise on his forehead, cheek and right thigh. I interviewed R2 and he said that he got jumped by a tall African American. It is R24 and I've had problems with him before. I asked a couple more questions and went to R24. R24 was able to recall the incident, and he said R2 was being mean to the ladies, V13 (Licensed Practical Nurse). R24 only hit R2 once in his back. R2 said it happened in the hallway. R2 uses foul language with the nurse and R24 felt he was protecting them. I feel that is why R24 struck R2. I did not substantiate the allegation of abuse. The definition of abuse is intentional harm. In looking at R24's BIM's score, Medication Administration Record and notes. I did not see any behaviors. I don't believe R24 meant to cause R2 any harm. I feel R24 did not understand the gravity of what could have happened. I did see R2's bruises. R2 ambulates in the wheelchair. If it would have been a fall it should have been reported or it should have been reported because R24 made contact, and the resident was on the floor. Even if it was not witnessed the bruise should have been reported .Both R2 and R24 said it was a couple days ago after dinner on 06/01/26. We narrowed down a day to Monday 06/01/26.The hospital report has R2 was transferred to another hospital because of the suspicion of a hematoma. The bruises should have been reported immediately to V2. Altercations should be reported immediately once the residents are separated and safe. On 06/18/26 at 08:22 AM Per telephone interview V26 (Certified Nurse Assistant) stated I washed R2 on Monday 06/01/26 it was like 5pm after dinner. On Tuesday 06/02/26 afternoon R2 said he was beat up. R24 is violent.On 06/17/26 at 11:25 AM V12 (Licensed Practical Nurse) stated I was not here on 06/01/26. I was here 06/02/26 Tuesday. I did my rounds and noticed R2 had a red mark on the right side of his cheek area. I asked him what the mark was from and R2 said he got into it with another resident. I asked did you tell somebody, and he said I told the nurse. On 06/03/26 Wednesday when I was here therapy came up for R2. R2 did not want to go to physical therapy because he was in pain and did not feel like participating that day. V16 (Contracted Physical Therapist) came to me, and I told V16 what R2 told me prior to that. I did not see any documentation at that time. V16 made his supervisor aware and V1 (Administrator) and V10 (Psychiatric Rehabilitation Service Director) were also made aware. I was the one that did the only documentation and an assessment. The resident-to-resident altercation V1 and V10 did the actual interview. R2 had a red mark to the right cheek and discoloration to the right hip as well. Initially I got orders to do an Xray then it was changed, and the order was to send R2 out. I don't know what happened. No one reported it at shift change, and no one told me anything. He did not mention the other residents name but once interviewed V1 and V10 went directly to R24's room and R24 admitted they had an altercation. R2 was wheelchair bound and was alert and oriented x 2-3. R2 self-propelled himself in the wheelchair and self-transferred from bed and to the toilet. R24 used a rolling walker, was a standby assist.Witness statement dated 06/03/26 document in part: V12 (Licensed Practical Nurse) Statement of Witness: Upon rounds R2 told V12 he had an altercation with another resident after V12 saw a red mark on R2's (continued on next page)

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	06/18/2026

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 0600 Level of Harm - Actual harm Residents Affected - Few	face. R2 stated he reported it to the nurse. Staff made me aware of an alleged allegation with R2 and another resident. On 06/17/26 at 01:58 PM V10 (Psychiatric Rehabilitation Service Director) stated I was not at work when the incident between R2 and R24 happened. There was an altercation between R2 and R24.On 06/17/26 at 02:24 PM Per telephone interview V16 (Contracted Physical Therapist) stated I was told by my boss to assess and evaluate R2. I proceeded to R2's room, introduced myself, and proceeded with the evaluation. R2 demonstrated a decline in function, and he could not move. During my assessment I noted a bruise on R2's forehead and lower part of his right jaw. I asked R2 he had a fall, and he said no. I did range of motion and proceeded to the lower extremity. During the assessment I observed a bruise to R2's right hip area. R2 had pain when I tried to be gentle. R2 said he could not turn, and I reported to V12 (Licensed Practical Nurse) about the bruises on R2's face, right hip and another bruise close to the right ankle near the chin. R2 required extensive assistance. I reported to my boss for her to report it in the morning meeting. The lump on R2's forehead was the size of an egg. On the jaw I could not see the extent, but the redness was the size of my palm.On 06/17/26 at 01:35 PM V15 (Contracted Director of Rehab) stated V16 (Contracted Physical Therapist) reported to me in the morning of 06/03/26. I asked V16 to screen R2 to see if he was appropriate for therapy services. V16 said he went to R2's room and observed R2 with bruises on the face and hip. V16 questioned R2 and he was complaining of a lot of pain with movement. V16 asked what happened and R2 said he had an altercation with another resident. V16 went and informed the nurse, then he came to the gym and told me what was going on. I went to the morning meeting and let V1 (Administrator) know. I did not see R2.On 06/17/26 at 02:50 PM V20 (Certified Nurse Assistant) stated I heard about the altercation between R2 and R24. V16 (Contracted Physical Therapist) asked V12 (Licensed Practical Nurse) about R2 and was he beaten up. V16 took me in the room and R2 said he got into a fight the other day with a tall black guy that walks around. R2 had a knot on his forehead that was turning green. R2's right jaw had a green, purple knot that was small. The green part was big. The bruise on R2's right hip was from the hip to mid-thigh red in color. R2 was in pain when I touched his leg. R2 said that he got pushed down to the ground, it happened in the evening, and a nurse and certified nurse assistant picked him up. On 06/18/26 at 08:54 AM Per telephone interview V18 (Agency Registered Nurse) stated I worked 06/01/26 7am -7pm. I don't recall any bruises on R2's face. R2 was in his room pretty much the whole shift. R2 asked to get in the wheelchair when the 3 pm - 11 pm shift started, and I assisted R2 into the wheelchair.R24 has diagnosis not limited to Cerebral Infarction, Aphasia Following Cerebral Infarction, Transient Cerebral Ischemic Attack, Essential (Primary) Hypertension, Chronic Migraine with Aura, Muscle Wasting and Atrophy, Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side, Dementia in other Diseases Classified Elsewhere, Mild, with Agitation, Dementia in other Diseases Classified Elsewhere, Moderate, with Mood Disturbance, Depression and Anxiety Disorder.Care plan document in part: Focus: R24 have impaired cognition/function or impaired thought process related to diagnosis Cerebral Vascular Accident. Focus: I require psychotropic medication to help manage and alleviate behaviors. Focus: I am at risk for increasing confusion related to diagnosis of dementia.Policy:Titled Abuse Prevention Program revised 03/01/21 document in part: It is the policy of this facility to prohibit and prevent resident abuse, neglect, exploitation, mistreatment, and misappropriation of resident property and a crime against a resident in the facility. III. Orientation and Training of Employees: During orientation of new employees, the facility will cover at least the following topics: Staff obligation to prevent and report abuse, neglect, exploitation, mistreatment, any crime against the residents. What constitutes abuse (physical, mental, sexual, verbal) neglect, exploitation, mistreatment, and misappropriation of resident property. An employee's obligation under the law (Elder Justice Act) for reporting a suspected crime to the facility, the state survey agency, and local law enforcement: the time frames for reporting; and management's obligation to prohibit retaliation against anyone who makes a report. V. Identification of Allegations/Internal Reporting Requirements: Employees are required to immediately report any incident, allegation or suspicion of (continued on next page)

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	06/18/2026

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 0600 Level of Harm - Actual harm Residents Affected - Few	potential abuse they observe, hear about, or suspect to the administrator. The nursing staff is additionally responsible for reporting on a facility incident report the appearance of bruises, or other abnormalities as they occur. Upon report of such occurrences, the Nursing Supervisor is responsible for assessing the resident, reviewing the documentation, and reporting to the Administrator. If the resident complains of physical injuries or if harm is suspected, the resident physician will be contacted for further instructions. If you suspect abuse: Complete an incident Report immediately. Investigation: all incidents, allegations or suspicions of abuse, or a crime against a resident will be documented. Abuse and Crime Reporting: This facility will not tolerate abuse or mistreatment against a resident by anyone, including staff members, other residents and staff of other agencies. All personnel must promptly report any incident or suspected incident of resident abuse. 1. Abuse: the willful infliction of injury resulting physical harm or pain. Willful, as used in this definition of abuse, means individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. 4. Physical Abuse: Hitting, slapping, pinching, kicking etc. Procedure: Any alleged violations involving mistreatment, abuse, neglect or reasonable suspicion of a crime against a resident must be reported to the Administrator or Director of Nursing. Additionally, the person(s) observing an incident of resident abuse or suspected resident abuse must immediately report such incidents to the charge nurse who will immediately report the allegation to the administrator, regardless of the time lapse since the incident occurred. Upon receiving reports of physical abuse, the charge nurse will immediately examine the resident. Findings of the examination must be recorded in a separate incident report and the resident's medical record.Titled Resident Rights Policy and Procedure undated document in part: The facility will protect and promote the rights of each resident.

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	06/18/2026

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility to seek medical attention right away for one resident (R2) who was on anti-coagulant medications after the resident told the nurse he was in an incident with another resident and an injury was noted to his face. Subsequently the resident was not sent to the hospital until a day later after a mark was noted and where resident required hospitalization for a Intracranial Hemorrhage and Hematomas to other parts of his body. Findings Include:R2 has diagnosis not limited to Seizures, Anemias, Transient Ischemic Attack (Tia), and Cerebral Infarction, Abnormalities of Gait and Mobility, Major Depressive Disorder, Epilepsy, Atherosclerotic Heart Disease of Native Coronary Artery, Dementia, Schizophrenia, Bipolar Disorder, Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side, Essential (Primary) Hypertension, Altered Mental Status, Anxiety Disorder, Major Depressive Disorder and Chronic Kidney Disease. R2's MDS (Minimum Data Set) BIMS (Brief Interview for Mental Status) score is 12 indicating intact moderate impairment.On 06/17/26 at 11:25 AM V12 (Licensed Practical Nurse) stated I was not here on 06/01/26. I was here 06/02/26 Tuesday. I did my rounds and noticed R2 had a red mark on the right side of his cheek area. I asked him what the mark was from and R2 said he got into it with another resident. I asked did you tell somebody, and he said I told the nurse. On 06/03/26 Wednesday when I was here therapy came up for R2. R2 did not want to go to physical therapy because he was in pain and did not feel like participating that day. V16 (Contracted Physical Therapist) came to me, and I told V16 that R2 told me prior to that. I did not see any documentation at that time. V16 made his supervisor aware and V1 (Administrator) and V10 (Psychiatric Rehabilitation Service Director) were made aware. I was the one that did the only documentation and an assessment. The resident-to-resident altercation V1 and V10 did the actual interview. R2 had a red mark to the right cheek and discoloration to the right hip as well. Initially I got orders to do an Xray then it was changed, and the order was to send R2 out. I don't know what happened. No one reported it at shift change, and no one told me anything. He did not mention the other resident name but once interviewed V1 and V10 went directly to R24's room and R24 admitted they had an altercation. R2 was wheelchair bound and was alert and oriented x 2-3. R2 self-propelled himself in the wheelchair and self-transferred from bed and to the toilet. R24 used a rolling walker, was a standby assist.On 06/17/26 at 01:35 PM V15 (Contracted Director of Rehab) stated V16 (Contracted Physical Therapist) reported to me in the morning of 06/03/26. I asked V16 to screen R2 to see if he was appropriate for therapy services. V16 said he went to R2's room and observed R2 with bruises on the face and hip. V16 questioned R2 and he was complaining of a lot of pain with movement. V16 asked what happened and R2 said he had an altercation with another resident. V16 went and informed the nurse, then he came to the gym and told me what was going on. I went to the morning meeting and let V1 (Administrator) know. I did not see R2.On 06/17/26 at 02:24 PM Per telephone interview V16 (Contracted Physical Therapist) stated I was told by my boss to assess and evaluate R2. I proceeded to R2's room, introduced myself, and proceeded with the evaluation. R2 demonstrated a decline in function, and he could not move. During my assessment I noted a bruise on R2's forehead and lower part of his right jaw. I asked R2 he had a fall, and he said no. I did range of motion and proceeded to the lower extremity. During the assessment I observed a bruise to R2's right hip area. R2 had pain when I tried to be gentle. R2 said he could not turn, and I reported to V12 (Licensed Practical Nurse) about the bruises on R2's face, right hip and another bruise close to the right ankle near the chin. R2 required extensive assistance. I reported to my boss for her to report it in the morning meeting. The lump on R2's forehead was the size of an egg. On the jaw I could not see the extent, but the redness was the size of my palm.On 06/17/26 at 02:50 PM V20 (Certified Nurse Assistant) stated I heard about the altercation between R2 and R24. I worked Monday morning on 06/01/26. V16 (Contracted Physical Therapist) asked V12 (Licensed Practical Nurse) about R2 and was he beaten up. V16 took (continued on next page)

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	06/18/2026

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 0684 Level of Harm - Actual harm Residents Affected - Few	me in the room and R2 said he got into a fight the other day with a tall black guy that walks around. R2 had a knot on his forehead that was turning green. R2's right jaw had a green, purple knot that was small. The green part was big. The bruise on R2's right hip was from the hip to mid-thigh red in color. R2 was in pain when I touched his leg. R2 said that he got pushed down to the ground, it happened in the evening, and a nurse and certified nurse assistant picked him up. I don't know who it was that picked R2 up, that is the mystery.Progress note dated 06/03/26 19:48 document in part: Nursing Progress Note Text: Resident observed with discoloration to the forehead and discoloration to the right side of his face. Further skin assessment revealed discoloration to the right hip area. Attending physician and gave orders to send resident to for evaluation.Hospital record dated 06/03/26 document in part: Chief Complaint: Assault victim. Visit diagnosis: Intracranial hemorrhage. Presenting after physical assault 2 days ago at the nursing facility. He states that a nursing home resident attacked him after a verbal altercation. He was sitting in a wheelchair during this time as he was punched in the face. Significant bruising and swelling to the right maxilla with bruising extending into the right jaw on the right neck down into the right clavicle area. Small bruise to the left inner knee. Large bruise to the right hip. Right hip series: Pain Trauma with bruising. CT (Computed Tomography) Angio neck with and without contrast: Impression: 2. Right facial and neck soft tissue swelling with right malar soft tissue mass approximately 88 Hounsfield units in density, likely hematoma given history of trauma. CT angiogram of the Extracranial Carotid arteries with infusion and IV contrast with 3-d Rotational Reconstructed Images. Indication: neck trauma. Neck pain and swelling with bruising. There is swelling throughout the neck and face with a rounded 2 - 3 centimeters mildly hyperdense mass in the right malar region. Per EMS (emergency medical services) the nursing home stated that R2 was assaulted. R2 has bruising on the right side from head to hip. R2 is on aspirin and Eliquis. R2 states that he has pain everywhere.Progress note dated 06/04/26 00:01 document in part: Nurses Notes Text: Update, the patient has been admitted to Hospital ED (emergency department). The Nurse stated that the patient has been Dx (diagnosis) with bleeding on the brain. Nurse stated that the patient will be transferred to a trauma hospital.Hospital records dated 06/05/26 document in part: admission Complaint: Intracranial hemorrhage. Eliquis 5 mg (Milligrams) Twice a day. R2 was brought as a trauma transfer after an assault at his nursing facility. Imaging showed a hypodensity which may reflect a small parenchymal or subarachnoid hemorrhage versus calcification. Physical Exam: Head; Hematoma right lower face. Smaller one on left forehead. Skin: extensive bruising. CT Head without Contrast: There is a right upper lip subcutaneous hematoma. Assessment and Plan: Trauma/assault, Head injury, Right buccal hematoma, Right hip/thigh hematoma.Initial Abuse Reportable document in part: Incident date: 06/03/26. Residents involved R2 and R24. Brief Description of Incident: 06/03/26 11:00 administrator was made aware of R2 having a bruise on his face; alleging an altercation with R24. Immediate Action Taken: Initiated body assessment for both residents. R2 does not feel safe in the facility.Abuse Reportable Final report document in part: Conclusion: R2 ambulates in a wheelchair. R2 stated he was struck in the hallway all over after dinner. R2 stated R24 did not like how I was talking to the ladies. R2 stated incident happened on Sunday in the hallway. Administrator noted a bruise on forehead and right cheek. R2 showed administrator bruise on right thigh. R2 stated it was R24. R24 was interviewed by administrator. R24 stated R2 walked behind the ladies. Administrator asked what ladies, R24 stated V13 (Licensed Practical Nurse). R24 stated it occurred a couple days ago after dinner. R24 stated he didn't hit R2 that hard and that it occurred after dinner. R2 was sent to the emergency room and transferred to another hospital due to trauma. Both residents were involuntarily discharged from the facility. 24-hour paper documentation reviewed: the date for 06/01/26 is missing. V12 (Licensed Practical Nurse) on Tuesday (06/02/26) morning admitted seeing the bruise on R2 indicating the incident occurred sometime Monday evening 06/01/26 On 06/17/23 at 03:48 PM V1 (Administrator) stated I was informed on 06/03/26 at morning meeting from therapy that R2 had a bruise. R2 had a bruise on his forehead, cheek and right thigh. I interviewed R2 and he said that he got jumped by a tall (continued on next page)

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	06/18/2026

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 0684 Level of Harm - Actual harm Residents Affected - Few	African American. It is R24 and I've had problems with him before. I asked a couple more questions and went to R24. R24 was able to recall the incident, and he said R2 was being mean to the ladies, V13 (Licensed Practical Nurse). R24 only hit R2 once in his back. Both R2 and R24 said it was a couple days ago after dinner on 06/01/26. We narrowed down a day to Monday 06/01/26. V18 (Agency Registered Nurse), V13 (Licensed Practical Nurse) and two other nurses, none of them recalled. There was no documentation. I interviewed as many certified nurse assistants as I could. A few did not return my call, and no one admitted to it. I in serviced that we are all mandated reporters and it is an injustice if not reported. We never found out exactly what happened. R2 said it happened in the hallway. R2 uses foul language with the nurse and R24 felt he was protecting them. I feel that is why R24 struck R2. I did not substantiate the allegation of abuse. The definition of abuse is intentional harm. In looking at R24's BIM's score, Medication Administration Record and notes. I did not see any behaviors. I don't believe R24 meant to cause R2 any harm. I feel R24 did not understand the gravity of what could have happened. I did see R2's bruises. R2 ambulates in the wheelchair. If R24 hit R2 in the back and R2 had fallen out of the wheelchair he could have fallen on his thigh on the side and hit his face. In my opinion I don't know if he could get back in the wheelchair. If it would have been a fall it should have been reported or it should have been reported because R24 made contact, and the resident was on the floor. Even if it was not witnessed the bruise should have been reported. The hospital report has R2 was transferred to another hospital because of the suspicion of a hematoma. The bruises should have been reported immediately to V2.On 06/18/26 at 08:54 AM Per telephone interview V18 (Agency Registered Nurse) stated I worked 06/01/26 7am -7pm. I don't recall any bruises on R2's face. R2 was in his room pretty much the whole shift. R2 asked to get in the wheelchair when the 3 pm - 11 pm shift started, and I assisted R2 into the wheelchair.On 06/17/26 at 03:05 PM V21 (Certified Nurse Assistant) stated I did not witness R2 and R24 altercation. After the fact, I prepped R2 to go to the hospital. R2 had a bruise on the forehead over the left eye and a large purplish bruise on the right hip. R24 [NAME] around a lot and requires a lot of redirections.On 06/18/26 at 08:22 AM Per telephone interview V26 (Certified Nurse Assistant) stated I washed R2 on Monday 06/01/26 it was like 5pm after dinner. On Tuesday 06/02/26 afternoon R2 said he was beat up. R24 is violent.Witness statement dated 06/03/26 document in part: V12 (Licensed Practical Nurse) Statement of Witness: Upon rounds R2 told V12 he had an altercation with another resident after V12 saw a red mark on R2's face. R2 stated he reported it to the nurse. Staff made me aware of an alleged allegation with R2 and another resident. Policy:Titled Charting and Documentation revised 04/25 document in part: Resident records will be maintained in accordance with regulatory requirements and standards of professional practice. All services provided to the resident, or any changes in the resident's medical or mental condition shall be documented in the resident's medical record. Policy Interpretation and Implementation: 1. All observations, services performed, etc. must be documented in the resident's clinical records. 2. Medical records and documentation in resident records will be complete, accurate and organized. 5. All incidents, accidents or changes in resident's condition must be recorded.Titled Abuse Prevention Program revised 03/01/21 document in part: It is the policy of this facility to prohibit and prevent resident abuse, neglect, exploitation, mistreatment, and misappropriation of resident property and a crime against a resident in the facility. III. Orientation and Training of Employees: During orientation of new employees, the facility will cover at least the following topics: Staff obligation to prevent and report abuse, neglect, exploitation, mistreatment, any crime against the residents. What constitutes abuse (physical, mental, sexual, verbal) neglect, exploitation, mistreatment, and misappropriation of resident property. An employee's obligation under the law (Elder Justice Act) for reporting a suspected crime to the facility, the state survey agency, and local law enforcement: the time frames for reporting; and management's obligation to prohibit retaliation against anyone who makes a report. V. Identification of Allegations/Internal Reporting Requirements: Employees are required to immediately report any incident, allegation or suspicion of potential abuse they observe, hear about, or suspect to the administrator. The nursing staff 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
	145914	A. Building B. Wing	06/18/2026

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 0684 Level of Harm - Actual harm Residents Affected - Few	additionally responsible for reporting on a facility incident report the appearance of bruises, or other abnormalities as they occur. Upon report of such occurrences, the Nursing Supervisor is responsible for assessing the resident, reviewing the documentation, and reporting to the Administrator. If the resident complains of physical injuries or if harm is suspected, the resident physician will be contacted for further instructions. If you suspect abuse: Complete an incident Report immediately. Investigation: all incidents, allegations or suspicions of abuse, or a crime against a resident will be documented. Abuse and Crime Reporting: This facility will not tolerate abuse or mistreatment against a resident by anyone, including staff members, other residents and staff of other agencies. All personnel must promptly report any incident or suspected incident of resident abuse. 1. Abuse: the willful infliction of injury resulting physical harm or pain. Willful, as used in this definition of abuse, means individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. 4. Physical Abuse: Hitting, slapping, pinching, kicking etc. Procedure: Any alleged violations involving mistreatment, abuse, neglect or reasonable suspicion of a crime against a resident must be reported to the Administrator or Director of Nursing. Additionally, the person(s) observing an incident of resident abuse or suspected resident abuse must immediately report such incidents to the charge nurse who will immediately report the allegation to the administrator, regardless of the time lapse since the incident occurred. Upon receiving reports of physical abuse, the charge nurse will immediately examine the resident. Findings of the examination must be recorded in a separate incident report and the resident's medical record.Titled Resident Rights Policy and Procedure undated document in part: The facility will protect and promote the rights of each resident.

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	06/18/2026

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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observations, interviews, and record reviews, the facility failed to provide effective pest control for six [R1, R4, R15, R16, R22, R23] residents in the sample of 25. These failures have the potential to affect all 157 residents residing in the facility. Findings Include, R1's clinical record indicates the following in part: R1's medical diagnosis of schizoaffective disorder, depression, anxiety disorder, movement disorder, type II diabetes, chronic obstructive pulmonary disease, essential hypertension, liver disease, morbid obesity, transient ischemic attack and cerebral infarction, chronic kidney disease, edema, and chronic pain. R1's face-sheet, medical diagnosis, physician order sheets, minimum data set [MDS] Brief Interview Mental Status Score Indicates R1 is cognitively intact, care plans, medication administration record, treatment administration record, and progress notes. On 6/16/26 at 1:15PM, observed R1 resting in bed alert and oriented x3. Observed more than eight flying bugs in R1's room flying around R1 as he ate apple sauce. R1 stated, These gnats flying around for a couple of months are landing on my meal trays, my face, body, and it's very disgusting. I reported all the nets, and the staff see them as well. During the survey dates of 6/16/26 and 6/17/26, Observed gnats flying in R1, R4, R15, R16, R22 and R23 rooms. On 6/16/26 at 2:05 PM, R5 [President of Resident Council] stated, The gnats have been a problem for a few months. The administration is aware, and the exterminator comes out, but the gnats are still here. I think it comes from all the food left lying around. On 1/16/26 at 2:05PM, R22 stated, The gnats are terrible. They fly around all day in my face, food trays and drinks. They have been in my room for a few weeks. On 16/26 at 2:15PM R23 stated, These flying bugs come out when the food trays come out. The bugs just will not leave. On 6/16/26 V6 [Maintenance Director] and surveyor observed many gnats flying around in R15 and R16's room.On 6/16/26 at 3:35 PM, V6 stated, There has been a gnat problem since the spring. The exterminator comes out twice month and treats the drains. If nursing staff do not pick up the food trays from the resident's rooms, then the gnats will keep coming and multiplying. Reviewing the exterminator invoices from March to June, the facility was treated with bio snake for fruit flies, the gnats were not treated. On 6/17/26 at 3:35PM, V5 [Housekeeping Director] stated, The housekeeping department try to keep the rooms clean as possible. The resident hoard food in their rooms. The are two housekeepers on each floor every day from 7AM to 3PM, and a janitor from 3PM to 10PM. The gnats that's; flying around everywhere would clear up if the food trays were not left in the rooms, and residents need to eat in the dining rooms. On 6/16/26 at 1:15PM, V30 [Certified Nurse Assistant], surveyor observed many gnats in R4's room. R4 stated, The gnats have been flying all over me and my food for months. The facility administration has not addressed the bugs. I have not seen any exterminator in my room, this is unsanitary. On 6/16/26 at 1:20PM, V30 stated, These gnats have been here in the facility since the springtime. It's just the season for them to be here. The gnats are all over the facility, from the resident's hording food. On 6/17/26 at 4:10PM, V1 [Administrator] stated, The exterminator comes out twice a month. The gnats are only in rooms where there is leftover food. Staff continue to encourage residents to eat in the dinner rooms. The exterminator will be out to treat the gnats. Reviewed facility's pest control invoices: 3/26 to 6/26. No treatment for the gnat flies noted. 6/8/26: Bio Snake uses to treat the fruit flies. 5/12/26:Kitchen, dish room with food and food related debris have accumulate within the cracks and beneath broken floor tiles. additionally standing water in these areas contributes to the formation of organic waste. These conditions create an ideal environment for fruit flies and other organic waste pests to feed and reproduce. Policy in part:Pest Control PolicyThe purpose of this policy is to ensure a pest free environment within our facility by outlining procedures for the prevention, monitoring, and control of pest infestation.