

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 07/24/2025
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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to organize and participate in resident/family groups in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility has failed to ensure that all residents are aware of the grievance process and that resident's concerns are addressed in a timely manner. This failure has affected two residents (R132 and R143) and has the potential to affect 146 additional residents that reside in the facility. Findings include: R132 is [AGE] year-old with diagnosis including but not limited to: type 2 diabetes mellitus, hypertension, functional quadriplegia, spinal stenosis and limitations of activities due to mobility. R132 has a BIMS (Brief Interview of Mental Status) score of 15, which indicates cognitively intact. R143 is [AGE] year-old with diagnosis including but not limited to: paraplegia, other reduced mobility, type 2 diabetes without complications, pressure ulcer of right buttock stage 4 and other cystostomy status. R143 has a BIMS (Brief Interview of Mental Status) score of 15, which indicates intact. During investigation on 7/23/2025 during resident council meeting at 11:30, R143 (Resident Council President) stated the following, I've been here for nine years, and the food is horrible. I have been complaining about the same thing forever. The problem is that despite all of our complaints, nothing is ever done. We used to have a dietary committee, but we no longer have one and have been asking about it. At that time, R132 stated the following, resident council meetings are a waste of time because nothing is ever done. The only reason that I am attending this meeting today is because a State Surveyor is present, but a lot of us (residents) are not interested in attending resident council because it is a waste of time. We voice our concerns about many different things and nothing changes. During investigation, other residents voiced concerns of not being heard during resident council meeting and that they were not aware of the facility grievance process. The above-mentioned wish to remain unknown. On 7/23/2025 at 12:30 PM, V18 (Dietary Manager) stated that the facility had a food committee in the past in order to address dietary concerns but that no one was running the food committee at this time. On 7/23/2025 at 4:00 PM, V1 (Administrator) stated that all residents should be aware of the grievance process and the all-resident's concerns should be addressed in a timely manner. Facility Resident Council Minutes dated 5/6/2025 documents, General concerns about customer service specifically regarding CNAs (Certified Nurse Assistants) not introducing themselves at the being of their shifts; A resident want to know how to change breakfast preference. Facility Resident Council Minutes dated 6/5/2025 documents, CNAs not providing care in a timely manner. Facility Resident Council Minutes dated 7/8/2025 documents, CNAs need to introduce themselves and let residents know who their CNA is per shift; CNAs need to stop coming in and turning call lights off and leaving back out the room (without providing care); giving food that they (residents) don't eat. Residents stated that they are not getting meal substitutes when requested. Facility policy titled Grievances/ Complaints/ Missing property documents, it is the policy of the facility to see that the residents and their responsible parties are made aware upon admission and as indicated of the resident's right to express a complaint or a grievance orally, or in writing at any time.		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 145914	Facility ID: 145914 If continuation sheet Page 1 of 21

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 07/24/2025
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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, and record review, the facility failed to follow the facility's menu to meet nutritional needs of residents which has the potential to affect the 145 residents receiving oral diets in the facility. Findings include: Facility Week at a Glance menu documents, in part, that on Monday 7/21/2025, the lunch meal is open-faced tuna melt, carrot coins, peach crisp, beverage of choice. On 07/21/2025, during the lunch meal service on all 3 facility floors, the following food items were observed by the survey team being served on residents' meal trays: a scoop of cold tuna salad in between 2 pieces of plain white bread and hot vegetables (green beans on the 1st floor and mixed peas and carrots on the 2nd and 3rd floors). No peach crisp observed being served on all 3 floors on 7/21/2025 during lunch meal service, and on the 1st and 3rd floors, certified nursing assistants handed out graham cracker packets to residents near the end of the lunch meal. Residents' meal tickets read: open-faced tuna melt (1 each), carrot coins (4 ounces), peach crisp (2 ounces) and beverage of choice. On 7/23/2025 at 10:15 AM, V18 stated that the facility utilizes a 4 week cycle menu for the 3 meals a day served to residents and that residents are allowed to choose from the substitution menu if they do not like the main meal being served (which has the same nutritional value). V18 stated, Cooks follow the menu, so residents will receive the proper nutritional content from the menu food being served. During this interview, V18 (Dietary Manager) and V19 (Regional Director of Operations) stated that they are both are not licensed dietitians. On 7/23/2025 at 1:50 PM, V18 (Dietary Manager) and V19 (Regional Director of Operations) were interviewed together. V18 stated that food prepared in the facility kitchen is served per the cycle menu and derived from each food items' recipe. V18 stated that on 7/21/2025 for the facility's lunch meal service, the peach crisp for all residents' dessert was not served due to peaches not being delivered from their food provider. V18 stated that for the 7/21/2025 lunch meal, another dessert was served to the residents. V18 stated that when the kitchen staff has to replace a food item from the pre-determined menu, it must have the equivalence caloric and nutritional value. V18 stated that graham cracker packets are used for snacks for all residents. V18 stated that graham crackers are not a dessert nor a fruit for an equivalent exchange for the peach crisp. V18 stated that tuna salad was served in between 2 pieces of plain white bread for the lunch meal service on 7/21/2025. This surveyor informed V18 that the recipe reviewed for the lunch meal on 7/21/2025 (as listed on the cycle menu) is an open-faced tuna melt which indicates to grill the open-faced tuna melt sandwich with a slice of American cheese on top. V19 stated that the 7/21/2025 lunch meal was modified, with the kitchen staff serving cold tuna salad on 2 pieces of plain white bread, so the kitchen staff did not follow the recipe for the open-faced tuna melt. V18 confirmed that no American cheese slice was served with the cold tuna salad sandwich. V18 stated that when a specific menu item has to be exchanged or altered from the menu posted for the residents, V18 will contact the activities staff to inform them of the change, so activity staff will then inform residents prior to the changed meal being served. V18 stated that on 7/21/2025, V18 called the activities department office, and no one answered. On 7/23/2025 at 10:28 AM, V6 (Activities Aide) stated that on 7/21/2025 in the morning, on the 3rd floor, V6 went to all of the residents receiving oral diets, reading them the lunch menu items, and asking residents if they would like a substitute for the open-face tuna melt. V6 stated that V6 then submitted this information to the kitchen staff. V6 stated that no kitchen staff informed V6 on 7/21/2025 that there was a change in the menu food items, the open-face tuna melt or the peach crisp. V6 stated that V6 would have informed the residents on the 3rd floor to let them know what it is now with the changes. V6 stated that V32 (Activities Director) has not been at work in the facility the past 3 days. On 7/23/2025 at 2:10 PM, V18 stated that despite saying that another dessert was served on 7/21/2025 lunch meal service, no dessert was served. V18 stated that V18 confirmed this with V16 (Dietary Aide) who was behind with work in the kitchen. On 7/23/2025 at 12:58 PM, V34 (Licensed Dietitian Nutritionist) (continued on next page)		

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 07/24/2025
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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	stated that V34 is a contracted licensed dietitian for the facility. V34 stated that each day (3 meals a day) of the facility's food menu is created to ensure that each resident consuming oral diets will receive the proper amount of calories and proper nutrition for the amount of food items such as proteins, fruits, vegetables, grains and dairy. V34 stated that the food service company provides the food items for the kitchen staff to prepare the menu items, and there are corresponding recipes for each menu prepared food item. V34 stated that kitchen staff must follow the recipe to ensure that the caloric and nutritional value is present. V34 stated that when a menu food item needs to be exchanged, V18 (Dietary Manager) can email or call V34 with the food item that needs to be substituted for V34 to ensure that the new food item will meet the caloric and nutritional value for the food item being removed. V34 stated that V34 has not received a phone call or email from V18 within the past week about interchanging food items, omitting food items to be served from the menu or altering the food items from the menu that are being served to residents. This surveyor informed V34 of the lunch menu food items from 7/21/25 and survey teams observations during this lunch meal service: no peach crisp being served to residents on all 3 floors; graham cracker packets served to residents on the 1st and 3rd floors; and open-face tuna melt (recipe to include American cheese slice) was served as a tuna salad sandwich with no cheese. V34 stated that a graham cracker is a grain carbohydrate and not a fruit. V34 stated that a graham cracker is also not a dessert, but a snack. V34 stated that if the peach crisp was not served to residents per the menu, then an alternative to be served should have been in the same category food item that would meet the nutritional value, and some fruit should have been served. V34 stated that kitchen staff omitting the cheese from the tuna salad sandwich lowers the calories of the meal for residents, and also affects the calcium and protein requirements daily needed for residents to consume to meet nutritional standards. Facility Resident List Report dated 7/21/2025 documents, in part, that 148 residents reside in the facility. Facility document provided for all active diets, titled Order Listing Report, documents, in part, 3 residents with nothing by mouth (NPO) listed. On 7/24/2025 at 11:12 AM, V1 (Administrator) confirmed via email that 3 facility residents are NPO status. Therefore, 145 residents are receiving oral diets. Facility recipe, dated 7/21/2025, for Open-Faced Tuna Melt documents, in part, that a slice of American cheese is added to each sandwich. Facility undated policy titled Standardized Recipes documents, in part, Policy: A standardized recipe shall be used for the preparation of each menu item. Procedure: 1. Standardized recipes include volume yield, standard portion size and the number of portions the recipe yields. 4. Standardized recipes are readily available to cooks and production staff. 6. [NAME] or production staff members notify supervisor if they do not have ingredients needed to prepare a recipe. 7. Supervisor procures needed item or assists cooks/production staff with determining if alternative ingredient is available or if menu substitution is necessary.		

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 07/24/2025
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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to store foods at safe temperatures, Label foods with expiration dates, and document freezer and walk-in cooler temperatures on the tracking logs. This failure has the potential to affect 143 residents on oral diets out of 148 residents in the facility. Facility [NAME], [NAME] (51772) - Kitchen Findings include: On 7/21/2025 at 9:26 pm, V36 (Dietary Aide) and surveyor observed the freezer and cooler log missing temperature checks on the temperature tracking log posted on the outside of the freezer and cooler. V36 stated the freezer, refrigerator, and cooler temperatures are supposed to be measured and logged twice a day in the morning and evening. V36 stated not measuring the temperature on the freezer, refrigerator, and cooler can result in food illness. V36 verified the freezer has been broken for 2 days. Freezer tracking log documents the freezers am temperature on 7/19/2025 is Out at 6 o'clock am and Def at 7pm and on 7/20/2025 at 6 o'clock am OUT and at 7pm Def. V36 verified Def is abbreviated for Defrosting. On 7/21/2025 at 9:35 am, V16 was observed mopping water in the freezer. V16 stated the freezer broke down on Saturday. V16 verified the following frozen foods were thawed in the freezer: Ground Beef, [NAME] Turkey, [NAME] Turkey Sausages, Breakfast Sausage, Ice Cream. The thermometer outside the freezer is broken the thermometer in the freezer reads 58 degrees Fahrenheit. The refrigerator temperature reading is 36 degrees and has container of pudding with an expiration date of 7/16/2025. V16 verified 4 bulk packages of ground beef sitting out on a green cart outside the freezer and 1 bulk package of ground beef on the freezer's middle shelf. V16 stated the freezer temperature should read 0 degrees to below 10 degrees Fahrenheit, refrigerator's temperature should read 36 degrees or below, and the cooler temperature should read 36 degrees or below. V16 stated temperatures too low can cause the food to spoil and cause sickness. On 7/21/2025 at 9:45 pm, V36 (Dietary Aide) provided a copy of the cooler and freezer logs with the date of 7/17/2025 at 6 am filled in temperatures of cooler temperatures of 37 degrees and freezer temperatures of -6 degrees. On 7/21/2025 at 9:48 pm, V18 (Dietary Manager) and V36 (Dietary Aide) verified V36 worked that day. V36 stated she (V36) filled the temperature reading in on the 7/17/25 at 6 am because she worked that day in the morning and forgot to record the temperature while V18 (Dietary Manager) was present. V18 stated V36 did work that day. V18 stated the freezer had a power outage. On 7/21/2025 at 9:51 am, V18 (Dietary Manager) stated the freezer has been broken since yesterday and we are trying to salvage the frozen foods by placing them in the cooler. V18 verified the freezer temperature log documents the freezer was out 7/19/2025 and 7/20/2025 and remains inoperable with a temperature of 50 degrees Fahrenheit. V18 stated the reach in refrigerator temperature is 32 degrees. Surveyor observed reach in refrigerator thermometer reading was 48 degrees. V18 measured the temperature of a carton of milk in the reach in refrigerator with a reading of 43 degrees. Surveyor observed salad, pudding, and open sausage within the cooler with no preparation, open, or expiration date. V18 stated The cooks know, if the salad is not used in two days to discard it, and the salad was made today. In the real-world food should have open and expiration dates or discard the food. But I know the salad was prepared today. On 7/21/2025 at 10:18 am, V19 (Regional Director of Operations) stated The frozen meat can be thawed and used within 7 days from the time it is placed in the cooler to thaw, and food can be left out of the refrigerator for 2 hours without any danger to the food. V19 verified the walk-in cooler temperature reads 58 degrees Fahrenheit. V19 measured the ground beef thawing in the walk-in cooler and the reading was 50 degrees. V19 stated all meat in the cooler will be discarded today. On 7/21/2025 at 12:36 pm, observed R6 sitting at a table in the second-floor dining room. R6 served a meal tray by staff, plate on the meal tray included a cheeseburger and vegetables (peas and carrots). Interviewed R6 after he finished eating the meal, R6 stated the cheeseburger was okay, it could have used a little more seasoning. On 7/21/2025 at 1:21 pm, V28 stated he (V28) was informed (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 07/24/2025
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the freezer was not working on yesterday and he called a company named Precision and put in a repair work order today. V28 stated staff should notify him (V28) immediately when the freezer breaks down. V28 stated he does not have the work order on hand yet because it is filled out by the company and will be emailed with the invoice once the work is complete, and the freezer is working. On 7/21/2025 at 1:24 pm, observed repairman from Precision working on the freezer. On 7/21/2025 at 1:27 pm, V19 stated all meat products were discarded, and no meat or meat products were observed in the freezer or walk-in cooler. On 7/21/2025 at 3:13 pm, V19 stated the freezer remains inoperable and the repairman from Precision will bring in the new parts tomorrow to fix the freezer. On 7/22/2025 at 9:15 am, V19 stated the repairman has not arrived at this time and he (V19) received meats and other food products from the facility's food vendor. Receipt for meat and other food products provided. On 7/22/2025 at 2:30 pm, the repairman was working on the freezer. Requested a Kitchen Refrigerator/Freezer/Cooler several times in person and via email from V1 and she (V1) could not provide the policy. Facility's undated policy titled Food Storage documents in part, all food stock and food products are stored in a safe and sanitary manner. All food stock is dated and used on a first in, first out. Facility's Policy titled Labeling and Dating with a reviewal date of 8/12/2023 documents in part, Leftovers and opened foods shall be clearly labeled with date food item is to be discarded. Food items to be labeled and dated include prepared in house and food items that are opened and stored for later use. Facility's Policy titled Freezers and Refrigerators undated documents in part, This facility will ensure safe refrigerator and freezer maintenance, temperatures, and sanitation and, will observe food expiration guidelines. Procedure:1. Acceptable temperatures should be 35 degrees to 41 degrees Fahrenheit and less than 0 degrees Fahrenheit for freezers.2. Monthly tracking sheets for all refrigerators and freezers will be posted to record temperatures. 3. Monthly tracking sheets will include time period, temperature, initials, and action taken. The last column will be completed only if temperatures are not acceptable. 4. Dietary staff must report unacceptable freezer or refrigerator temperatures (s) to the dietary manager immediately.		

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 07/24/2025
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure staff don appropriate PPE (personal protective equipment) prior to performing ADL (Activities of Daily Living) care and prior to administering medications via a g-tube for residents on EBP (enhanced barrier precaution). The facility also failed to ensure soiled linens were contained in plastic bag and tied when transported via laundry chute to prevent the spread of infectious microorganisms. These failures affected 2 (R21 and R102) residents reviewed for infection control and have the potential to affect all 148 residents at the facility. Findings include: The (07/21/2025) facility census was 148. The (07/17/2025) EBP (Enhanced Barrier Precautions) list of residents include R102. On 07/21/2025 at 10:41am, there was an EBP sign posted by R102's door. A PPE (personal protective equipment) bin was outside of the room. V9 (Certified Nursing Assistant) was inside the room touching R102's gown. V9 was not wearing isolation gown or gloves. On 07/21/2025 at 10:44am, V9 stated she came in the room and fixed gown of (R102) that she normally put on isolation gown and gloves and that she is supposed to wear isolation gown and gloves when she (V9) adjusted her (R102) gown to prevent cross contamination and to make sure no germs is transferred to her (R102). That she (R102) is on EBP because she has a g-tube. On 07/22/2025 at 2:15pm, V29 (Infection Preventionist/LPN) stated residents with wounds, indwelling catheter, medical devices, and g-tubes are placed on EBP to protect staff and residents. If staff is going to adjust the gown of a resident, the staff is expected to don appropriate PPE like gown and gloves prior to adjusting the gown. The purpose is to prevent direct skin contact to resident and therefore prevent transfer of pathogens. On 07/21/2025 at 12:32pm, in the Laundry room inside the soiled linen area with V13 (Laundry Aide). V13 opened the door of the laundry chute. Noted a plastic bag with soiled linens not tied and uncontained loose soiled linens. This surveyor pointed out this observation to V13. V13 stated soiled linens should be in a plastic bag and the bag should be tied. Soiled linens come down from the laundry chute like that, not tied. Staff are expected to tie the plastic bag tightly, so they don't come loose to prevent germs from coming out of the bag. On 07/22/2025 at 2:28pm, V29 stated all soiled linens should be placed in a plastic bag and the plastic bag should be tied tightly so no fluids or any microorganism could escape the plastic bag when transported via the laundry chute because soiled linens may contain infectious microorganism. R102's (Active Order as Of: 07/22/2025) Order Summary Report documented, in part Diagnoses: (include but not limited to) nontraumatic cerebral infarction, attention to gastrostomy, and Type 2 Diabetes Mellitus. Order Summary: Enhanced Barrier Precautions Maintain: every day and night shift related to encounter for attention to gastrostomy. R102's (07/10/2025) Minimum Data Set documented, in part Section C. Cognitive Patterns. C0500. BIMS (Brief Interview for Mental Status) Summary Score: 01. Indicating R102's mental status as severely impaired. (continued on next page)		

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 07/24/2025
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R102's (02/13/2025) care plan documented, in part On enhanced barrier precautions for feeding tubes. Enhanced precautions will be maintained. Follow Enhanced Precaution Guidelines when providing care and coming in direct contact with potentially infected material or devices that put me at risk. Direct Care activities include dressing. The (undated) Infection Control/Isolation guidelines documented, in part Objective: To prevent unprotected exposure of residents, visitors and staff to potentially infectious microorganism or diseases and to decrease the spread of in-house or community acquired infections. Enhanced Barrier Precautions & intended to prevent the transmission of multi-drug resistant organisms, which are spread by indirect contact with an intermediate object/person (e.g. environmental surfaces or items in the resident's environment/room). The (undated) Enhanced Barrier Precautions documented, in part Providers and Staff must also: Wear gloves and a gown for the following high Contact Resident Care Activities: Dressing. The (undated) Guidelines For Linen Handling/Storage/Transport documented, in part Policy: It is the policy of the facility to ensure that linens are handled/stored/transported properly to minimize the potential for transmission of pathogens or potentially harmful microorganisms or disease spreading pests. Procedure: 3) Soiled linen should be immediately placed into bags or collection containers able to contain wet and/soiled linen in such a way as to prevent contamination of the environment during collection, transportation, and storage prior to processing (being laundered). Findings include: R21's medical diagnoses include but are not limited to tracheostomy status, dysphagia, cardiac arrest, spinal stenosis cervical region, chronic obstructive pulmonary disease. R21's Minimum Data Set, dated [DATE] has a Brief Interview for Mental Status score of 12, which indicates R1's cognition is moderately impaired. On 07/21/25 at 11:08am V8 (Registered Nurse/ RN) observed administering R21's medication via R21's gastrostomy tube (GT). V8 observed without PPE (Personal Protective Equipment) on during administration of R21's medication. On 07/21/25 at 11:08am V8 (RN) stated that R21 is on EBP (enhanced barrier precautions) because R21 has GT. V8 stated that she knew that she should have had on PPE while administering medication through R21's GT. V8 stated that she was just moving too fast. V8 stated that PPE is to protect the residents from infection. On 07/23/25 at 10:22am V29 (Infection Preventionist/IP) stated that PPE should be worn while giving medication to a resident via GT. V29 stated that PPE is worn to help prevent transmission of pathogens. V29 stated that it could be harmful to the residents if staff do not use PPE when provide care. On 07/23/25 at 11:34am V2 (Assistant Director of Nursing/ADON) stated that PPE is used to protect residents from communicable diseases. V2 stated that gown and gloves should be worn while giving medication through a resident's GT. R21's physician order dated 04/23/25 documents in part, Enhanced Barrier Precautions Maintain: (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 07/24/2025
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Enhanced Barrier Precautions Every Day and Night shift must wear appropriate PPE every shift related to tracheostomy status; gastrostomy status. R21's care plan dated 04/23/25 documents in part, R21 is on enhanced barrier precautions for feeding tube and capped tracheostomy.enhanced precautions will be maintained and I will not exhibit signs of active infection thru next review.follow enhanced barrier precaution guidelines when providing care. Facility's policy titled General Elements of Isolation dated 02/2023 documents in part, Enhanced Barrier Precautions requires use of gloves and a gown if you have contact with the resident or with object in the resident's environment/room.Enhanced Barrier Precautions.A. Used for the following: 2. Indwelling medical devices regardless of MDRO (multidrug resistant organism) status (examples.feeding tube).		

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 07/24/2025
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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to refer seven residents R1, R5,R6,R7,R12, and R88 to the appropriate state designated authority for a Level II PASARR (Preadmission Screening and Annual Resident Review) evaluation and determination after R1,R5,R6,R7,R12,and R88 were all diagnosed with a new mental disorder. This deficient practice affected seven residents (R1, R5, R6,R7,R12,R44and R88) in a total sample size of 64 residents. Findings include: R5's PASSAR dated [DATE] documents in part, PASRR Level II Determination: Level II -Approved No SS &ndash; No SS (Specialized Services within the nursing facility). R5's readmission date to the facility is [DATE]. R5's medical diagnosis includes but are not limited to Bipolar Disorder, Diabetes mellitus, Hyperkalemia, Syncope, Hyperlipidemia, Essential Hypertension, Neuralgia and Neuritis, Anxiety. Facility submitted a document titled Understanding the PASRR Process what each facility needs to know, dated [DATE] documents in part, . 3.If a resident enter the building prior to [DATE] they should still have a valid screen.4.According to Maximus ,if the old screening documents for both Level 1 and Level 2 cannot be located , the person needs to be rescreened.5.Maximus controls the Level 2 process, contractors are typically sent out within 48 hours to complete the screen.The first step is to go to the census in the Path tracker to check if there are expired screens, remember level 2 is needed for residents with MI,ID,DD . On [DATE] at 10:22 am, V25 Business Office manager stated the facility does not accept residents unless they are sent with a PASARR, if a resident is sent without the PASARR being completed the facility will attempt to obtain the PASARR within 24 hours, PASARR 2 should be completed when the resident is assessed that they need it with a new psyche diagnosis if a resident received a new diagnosis in [DATE] there should have been a new PASARR created, an assessment is created and submitted to Maximus and then someone from the agency that handles the PASARR will call and inform the facility when they will be out to facility to complete the assessment, R5 does not have a new PASARR 2 in his chart that was completed after his new diagnosis on [DATE]. On [DATE] at 3:58 pm, V1 Administrator stated All residents should have a PASARR Level I upon admission and a PASARR Level II if mental illness is triggered for specific behaviors. Psyche diagnosis assure proper interventions are in place to care for residents. On [DATE] at 4:13 pm, V31 Social service director stated When corporate receives the PASARR Level 1, they send it to us and mental illness or Developmental Disability will trigger a PASARR Level II, the facility should also make sure the Minimum data Set (MDS) department points out the Level 1 and Level II as needed. R7's Face Sheet does not document a diagnosis of schizoffective disorder. R7's Physician Admission/Follow-Up Schizophrenia Diagnosis date [DATE] documents Initial (continued on next page)		

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 07/24/2025
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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interview for Long-term Resident for Diagnosis Confirmation; Current Diagnosis of Schizoaffective Disorder, Unspecified; and Schizophrenia Diagnosis Findings indicate a comprehensive evaluation validates that the diagnosis of Schizophrenia should be removed from the medical record as it does not meet the DSM-5-TR Criteria. R7's Physician Progress Note Dated Effective Date: [DATE] 23:34 Type: Drug Regimen Review documents in part Quetiapine Fumarate Oral Tablet 50 MG (Quetiapine Fumarate) Give 50 mg by mouth one time a day related to SCHIZOAFFECTIVE DISORDER, UNSPECIFIED (F25.9) R7's Notice of PASARR (Preadmission Screening and Resident Review) dated [DATE], documents PASARR Level I determination: No Level II required. R9's Face Sheet dated [DATE], documents in part, a diagnosis of Major Depressive Disorder Recurrent Severe Without Psychotic Features and Anxiety Disorder Unspecified with an onset date of [DATE]. R9's PASRR (Preadmission Screening and Resident Review) Outcome Explanation- Notice of No PASRR Level II required dated [DATE] documents No mental health diagnosis is known or suspected. R12's Face Sheet documents a diagnosis of but not limited to schizoaffective disorder-Bipolar Type with an onset date of [DATE], Major Depressive Disorder with an onset date of [DATE], anxiety disorder with an onset date of [DATE]. R12 does not have a PASARR (Preadmission Screening and Resident Review) Level I or Level II Screening. R88's Face Sheet dated [DATE] documents a diagnosis of Schizophrenia-Unspecified with an onset date of [DATE] and Major Depressive Disorder- Recurrent with an onset date of [DATE]. R88's PASRR (Preadmission Screening and Resident Review) Level I [DATE] documents in part A Level II evaluation must be conducted. R1's PASSAR dated [DATE] documents in part, PASRR Level I Determination: Refer for Level II Onsite. R1's admission date to the facility is [DATE]. R1's medical diagnosis includes but are not limited to bipolar disorder ([DATE]), unspecified, opioid dependence with other opioid-induced disorder, acute kidney failure, unspecified, chronic obstructive pulmonary disease with (acute) exacerbation, and chronic respiratory failure with hypercapnia. R6's PASSAR dated [DATE] documents in part, PASRR Determination: Short Term Approval without specialized services. Short Term 180 days. R6's admission date to the facility is [DATE]. R6's medical diagnosis includes but are not limited to schizoaffective disorder, bipolar type, ([DATE]) bipolar disorder, unspecified, major depressive disorder, single episode, mild, epilepsy, unspecified, not intractable, without status epilepticus, hyperlipidemia, unspecified, and asthma. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 07/24/2025
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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 10:51am V25(Business Office Manager) stated the admissions department is responsible for completing PASARRs for the residents. V25 stated when a resident receives a psych diagnosis, we are to go into the system to start a new assessment for the resident and this will trigger that the resident requires a Level II PASARR. V25 stated this will let the state agency staff know the resident requires an evaluation because of the psych diagnosis. On [DATE] at 3:25pm V31(Social Service Director) stated a mental health diagnosis will trigger the need for the resident to have a Level II PASARR completed. V31 stated any resident with a mental health diagnosis should have a Level II PASARR.		

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 07/24/2025
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, interviews and record review, the facility failed to ensure that one resident (R45) did not have razors at her bedside; the facility failed to ensure that one resident (R12) did not have a filled sharps container on his bedroom floor; and the facility failed to ensure that five residents (R43, R49, R68, R69, and R105) did not have an overfilled sharps container in their room. This failure has the potential to affect 117 Residents that reside on the second and third floor of the facility. Findings include: R45 is a [AGE] year-old with diagnosis including but not limited to: Tremor, abnormal coagulation profile, polyneuropathy, major depression disorder and hypertension. R45's BIMS (Brief Interview of Mental Status) score is 12, which indicates moderate impairment. During investigation on 7/21/2025 at 11:57 AM, R45 was observed in her room in bed and stated that she planned on shaving later. At that time, a pack of 20 shaving razors were noted on R45's bedside table. On 7/21/2025 at 3:15 PM, V3 (LPN/ Licensed Practical Nurse) stated the following, Residents shouldn't have razors at the bedside because this is the dementia unit and we have wanderers on this floor. Someone could hurt themselves with the razors. I was not aware of the pack of razors being here in her (R45's) room. On 7/23/2025 at 2:53 PM, V2 (ADON/ Assistant Director of Nursing) stated the following, If a person is deemed safe to shave themselves, they should still be supervised by a staff member for safety. Razors should never be left at the bedside of a resident. R45's Care Plan documents, R45 has a 'Self-Care Deficit' and requires assistance with ADLs. Facility Census dated 7/21/2025 documents 117 residents on the second and third floors combined. Facility policy titled Guidelines for Handling Contaminated Sharps documents, it is the intent of the facility to ensure that sharps defined as objects that can penetrate the skin such as needles, scalpels, broken glass, capillary tubes, disposable scissors, razor blades, lancets and the exposed ends of dental wires are handled safely and appropriately. Facility policy titled Guidelines for Handling Contaminated Sharps documents, the sharps container must be replaced routinely and not overfilled; do not fill above the $\frac{3}{4}$ fill line on the container; the closed sharps container will be stored in locked area where bi-hazards are kept until picked up by the facilities contracted bio-hazard waste disposal provider; sharps should never be left at the bedside or unattended on medication cart even for a matter of seconds. On 07/21/2025 at 10:44am entered the room of R43, R49, and R68, observed a sharps container attached to the wall by the door of the room. Observed the sharps container overfilled, the waste in the sharp's container was past the fill line of the container. (continued on next page)		

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 07/24/2025
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/21/2025 at 10:57am entered the room of R105 and R69, observed a sharps container attached to the wall by the door of the room. Observed the sharp's container overfilled, the waste in the sharp's container was past the fill line of the container. On 07/21/2025 at 12:50pm V22(LPN/Licensed Practical Nurse) met this surveyor in R43, R49, and R68's room to observe the sharps container on the wall. V22 stated the sharps container is filled past the fill line, the container is overfilled. V22 stated the nurses are supposed to be changing out the sharp's containers once the waste in the container reaches the fill line. On 07/23/2025 at 10:27am V29(Infection Preventionist/LPN/Licensed Practical Nurse) stated the sharps containers in the resident's rooms should be changed every thirty days and when the sharps container is full. V29 stated the housekeeping staff usually changes out the sharp's containers in the resident's rooms. V29 stated the sharps containers should not be overfilled. V29 stated an overfilled sharps container can cause injury to staff/ puncture wounds from needle sticks and transmission of germs. On 07/23/2024 at 11:29am V2(ADON/Assistant Director of Nursing) stated the sharps containers in the resident's rooms should not be overfilled. V2 stated this can cause the sharps container to not properly seal when changing the container out. V2 stated it is possible that a resident or employee can get poked or pricked by a used needle. V2 stated the nurses are responsible for changing the sharps container out when the container reaches the fill line with waste. On 7/21/2025 at 11:23 am V20 (Certified Nurse Assistant) verified the sharps container should be mounted on the wall in the resident's room. V20 stated the sharps container came off the wall over the weekend and a work order was put in. V20 verified the sharp container was sitting on the floor in R12's room behind the door. V20 stated It is dangerous for a sharps container to be sitting on the floor because needles can fall out and someone can step on them which can cause infection by cross contamination, and it is an infection control issue. On 7/23/2025 at 11:30 am, V29 stated sharps containers are mount in the resident's rooms and on the side of each nursing cart. V29 stated sharps contains should not be on the floor in a resident's room especially on a Dementia unit because someone can get injured of stuck by a needle. On 7/23/2025 at 4:07 pm, V1 stated the sharps container should be on all nursing carts and in the resident's room. V1 stated improper storage of the sharps container can lead to infection or injury.		

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 07/24/2025
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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to discard expired stock medications in two of five medication carts, and failed to ensure the medication refrigerator was checked for appropriate temperature log recordings. These failures affected 3 (R32, R76, and R123) residents and has the potential to affect all residents on the first and third floor. Findings include: The ([DATE]) Resident Listing Report documented that there was a total of 89 residents in the facility on the first and third floor. On [DATE] at 10:35AM during the medication storage and labeling task with V3 Licensed Practical Nurse (LPN) of the third-floor team 1 medication cart and medication storage room, noted the following observations: 1. Magnesium 500mg, 100 tablets dietary supplement house stock medication observed in 3rd floor medication room with expiration date of 6/2025. 2. 3rd floor medication room with two refrigerators 1 black fridge and 1 white fridge no temperature log recording for [DATE]. On [DATE] at 11:08AM during the medication storage and labeling task with V4 Licensed Practical Nurse (LPN) of the second-floor team 1 medication cart, noted the following observations: 1. R32 has 1 bottle of Chlorhexidine Gluconate Solution 0.12% dated [DATE], order reads to give 15 milliliters by mouth two times a day for mouth/throat/dental agents, an expiration date of [DATE] listed on the bottle, medication was in team 1 (2nd floor) cart at time of observation. 2. R123 has 1 bottle of Lactulose Oral Solution 10 gram/15 milliliters (ml) dated [DATE], order reads to give 15 ml orally two times a day for behavior disturbance related to Major Depressive Disorder, an expiration date of [DATE] listed on the bottle, medication was in team 1 (2nd floor) cart at time of observation. On [DATE] at 11:40AM during the medication storage and labeling task with V17 Registered Nurse (RN) of the first -floor team 2 medication cart, noted the following observations: 1. Vitamin B-6 100mg, 100 tablets dietary supplement house stock medication observed in 1st floor medication team 2 cart with expiration date of 7/2024. 2. R76 has 1 Ventolin inhaler device on the medication cart of team 2, 1st floor cart, an expiration date of [DATE] listed on the inhaler, and the medication was in team 2 (1st floor) cart with no labeled open date and not contained in a bag at time of observation. R76 does not have active Albuterol/Ventolin inhaler medication order listed on Physician order sheet dated [DATE]. On [DATE] at 12:53 pm, V3 stated expired medication should not be on the medication cart or in the medication storage room. If a resident takes expired medication, it may not have the desired effect that the medication is supposed to, and the resident can become sick. V3 stated medication storage fridge should be checked and temperature recorded by the nurse and that she did not check fridge this morning. V3 checked the temperature registered on the thermometer and stated temperature is 40F. On [DATE] at 12:49pm, V4 stated if a resident receives expired medication, the medication may not have the desired effectiveness as originally prescribed and it could potentially hurt the resident, and expired medication should not be on the medication cart. On [DATE] at 12:50pm, V17 stated if a resident receives expired medication, it will place the resident at risk and that it is a safety concern that could place the resident life in danger, and expired medication should not be on the cart. On [DATE] at 10:35 am, V2 Assistant Director of Nursing (ADON) stated refrigerator temperature should be kept below 40F to ensure the potency of the medication is maintained and that the medication refrigerator should be checked and signed by the nurse daily. V2 stated she shares the responsibility with the assistance of the nurse managers to clean the medication storage rooms, and it is cleaned and checked on a weekly basis on Wednesdays, if any medications are expired, we remove from rotation and either discharge or send back to pharmacy. If a resident received expired medication there is a possibility that harm, death, or disease could occur. Central supply employee and nurses normally stock the medication rooms. R32's (Active Order as of: [DATE]) Order Summary Report documented, in part Diagnoses: (include but not limited to) Traumatic brain Injury, Essential (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 07/24/2025
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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hypertension, Spinal stenosis, Dysphagia. Chlorhexidine Gluconate Solution 0.12% dated [DATE], order reads to give 15 milliliters by mouth two times a day for mouth/throat/dental agents Order Date: [DATE]. R76's (Active Order as of: [DATE]) Order Summary Report documented, in part Diagnoses: (include but not limited to) Cerebral infarction, Dysphagia, Aphasia, Myopathy, Malignant Neoplasm, Muscle wasting and atrophy, Essential Hypertension. R76 has no active order for Ventolin/Albuterol inhaler. R123's (Active Order as of: [DATE]) Order Summary Report documented, in part Diagnoses: (include but not limited to) Major depressive disorder, Unspecified psychosis, cellulitis of right toe, Hyperlipidemia, anemia, delusional disorders. Lactulose Oral Solution 10 gram/15 milliliters (ml) give 15ml orally two times a day for behavior Disturbance related to Major Depressive disorder dated [DATE], dated [DATE], Order Date: [DATE]. Facility policy The [DATE] month Daily Refrigerator Temperature log documented, in part Acceptable temperature ranges are Medication Storage 36F - 46F for refrigerators. Nurse must check the refrigerator temperature on the night shift daily. The (undated) Policy titled 3.1 Medication Storage in the facility documented, in part, medications and biologicals are stored safely, securely and properly following the manufacture or supplier recommendations.6. Medications labeled for individual residents are stored separately from floor stock medications.11. Medications requiring refrigeration or temperatures between 36 degrees Fahrenheit, and 46 degrees Fahrenheit are kept in a refrigerator. Medications requiring storage in a cool place are refrigerated unless otherwise directed on the label.14. Outdated, contaminated, or deteriorated drugs and those in containers, which are cracked will be immediately withdrawn from stock by the facility. They will be disposed of according to drug disposal procedures, and reordered from the pharmacy if a current order exists.		

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 07/24/2025
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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow the physician's order to conduct a gradual dose reduction(GDR) evaluation as required by the gradual dose reduction order recommendations for unnecessary medication, chemical restraints/psychotropic meds, and medication record review, and discontinue a psychotropic medication for a resident who has a recommendation to discontinue a psychiatric diagnosis. This failure affected 2 residents (R7 and R12) in a sample size of 64. Findings include: R7's face sheet documents a diagnosis of but not limited to NONTRAMATIC INTERCEREBRAL HEMMORRHAGE, UNSPECIFIED, HEMIPLEDIA AND HEMIPARESIS FOLLOWING CEREBRAL INFARCTION AFFECTING RIGHT DOMINANT SIDE, EPILEPSY, UNSPECIFIED, UNSPECIFIED CONVULSIONS, CONSTIPATION, LIMITATION OF ACTIVITIES DUE TO DISABILITY, HYPERLIPEDEMIA, ESSENTIAL HYPERTENSION, ACUTE KIDNEY DISEASE, AND APHASIA. R7's Physician's order sheet documents dated 7/23/2025 documents an active order with a start date of 6/21/2024 at 0600 for Quetiapine Fumarate Oral Tablet 50 mg Give 50 mg by mouth one time a day related to Schizoaffective Disorder, Unspecified (F25.9). R7's Minimum Data Set Section C dated 6/25/2025 documents no BIMS (Brief Interview Mental Status). R7's Minimum Data Set Section D dated 6/25/2025 documents R7 rarely has little interest or pleasure in doing things; feeling or appearing down, depressed, or hopeless; and trouble falling asleep or staying asleep. R7's Physician Admission/Follow-Up Schizophrenia Diagnosis on 5/5/2025 documents Initial interview for Long-term Resident for Diagnosis Confirmation; Current Diagnosis of Schizoaffective Disorder, Unspecified; and Schizophrenia Diagnosis Findings indicate a comprehensive evaluation validates that the diagnosis of Schizophrenia should be removed from the medical record as it does not meet the DSM-5-TR Criteria. R7's Medication Administration Record for the month of May 2025 documents Quetiapine Fumarate Oral Tablet 50 mg by mouth one time a day related to Schizoaffective Disorder, Unspecified was administered on 5/1/2025, 5/2/2025, 5/3/2025, 5/4/2025, 5/5/2025, 5/6/2025, 5/7/2025, 5/8/2025, 5/9/2025, 5/10/2025, 5/11/2025, 5/12/2025, 5/13/2025, 5/14/2025, 5/15/2025, 5/16/2025, 5/17/2025, 5/18/2025, 5/19/2025, 5/20/2025, 5/21/2025, 5/22/2025, 5/24/2025, 5/25/2025, 5/26/2025, 5/27/2025, 5/28/2025, 5/29/2025, 5/30/2025, and 5/31/2025. R7's Medication Administration Record for the month of June 2025 documents Quetiapine Fumarate Oral Tablet 50 mg by mouth one time a day related to Schizoaffective Disorder, Unspecified was administered on 6/1/2025, 6/2/2025, 6/3/2025, 6/4/2025, 6/5/2025, 6/6/2025, 6/7/2025, 6/8/2025, 6/9/2025, 6/10/2025, 6/11/2025, 6/13/2025, 6/14/2025, 6/15/2025, 6/16/2025, 6/17/2025, 6/18/2025, 6/19/2025, 6/20/2025, 6/21/2025, 6/22/2025, 6/24/2025, 6/25/2025, 6/26/2025, 6/27/2025, 6/28/2025, 6/29/2025, 6/30/2025, and 6/31/2025. R7's Medication Administration Record for the month of July 2025 documents Quetiapine Fumarate Oral Tablet 50 mg by mouth one time a day related to Schizoaffective Disorder, Unspecified was administered on 7/1/2025, 7/2/2025, 7/3/2025, 7/4/2025, 7/5/2025, 7/6/2025, 7/7/2025, 7/8/2025, 7/9/2025, 7/10/2025, 7/11/2025, 7/13/2025, and 7/14/2025, 7/15/2025, 7/16/2025, 7/17/2025, 7/18/2025, 7/19/2025, 7/20/2025, 7/21/2025, 7/22/2025, and 7/23/2025. R12's Face Sheet documents a diagnosis of but not limited to Schizoaffective Disorder, Bipolar Type, Major Depressive Disorder, Anxiety Disorder, Alcohol Dependence-In Remission, Hemiplegia and Hemiparesis-Unspecified, Lack of Coordination, Limitation of Activities Due to Disability, and Insomnia. R12's Physician Order Sheet dated 7/23/2025 documents in part, an active order for Seroquel Tablet 100 mg (Quetiapine Fumarate) Give one tablet by mouth in the evening with a start date of 9/16/2022 and an active order Depakote Oral Tablet Delayed Release 500 mg (Divalproex Sodium) Give one tablet by mouth twice a day with a start date of 1/9/2024. R12's Minimum Data Set Section C dated 4/29/2025 documents a BIMS (Brief Interview Mental Status) of 10 which is an indication of moderately impaired cognition. R12's Minimum Data Set (continued on next page)		

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 07/24/2025
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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Section D dated 4/29//2025 documents R12 rarely has little interest or pleasure in doing things; feeling or appearing down, depressed, or hopeless; and trouble falling asleep or staying asleep. R12's Medication Administration Record dated June 2025 documents in part, an active order for Seroquel Tablet 100 mg (Quetiapine Fumarate) Give 1 tablet by mouth every 12 hours for bipolar disorder relate to Schizoaffective Disorder, Bipolar Type with a start date of 9/16/2022 was administered 6/1/2025, 6/2/2025, 6/3/2025, 6/4/2025, 6/5/2025, 6/6/2025, 6/7/2025, 6/8/2025, 6/9/2025, 6/10/2025, 6/11/2025, 6/13/2025, 6/14/2025, 6/15/2025, 6/16/2025, 6/17/2025, 6/18/2025, 6/19/2025, 6/20/2025, 6/21/2025, 6/22/2025, 6/23/2025, 6/24/2025, 6/25/2025, 6/26/2025, 6/27/2025, 6/28/2025, 6/29/2025, 6/30/2025, and 6/31/2025. R12's Medication Administration Record dated May 2025 documents in part, an active order for Seroquel Tablet 100 mg (Quetiapine Fumarate) Give 1 tablet by mouth every 12 hours for bipolar disorder related to Schizoaffective Disorder, Bipolar Type with a start date of 9/16/2022 was administered on 5/1/2025, 5/2/2025, 5/3/2025, 5/4/2025, 5/5/2025, 5/6/2025, 5/7/2025, 5/8/2025, 5/9/2025, 5/10/2025, 5/11/2025, 5/12/2025, 5/13/2025, 5/14/2025, 5/15/2025, 5/16/2025, 5/17/2025, 5/18/2025, 5/19/2025, 5/20/2025, 5/21/2025, 5/22/2025, 5/24/2025, 5/25/2025, 5/26/2025, 5/27/2025, 5/28/2025, 5/29/2025, 5/30/2025, and 5/31/2025. R12's Medication Administration Record dated June 2025 documents in part, an active order for Depakote Oral Tablet Delayed Release 500 mg (Divalproex Sodium) Give 1 tablet two time a day for Bipolar with a start date of 1/9/2025 was administered 6/1/2025, 6/2/2025, 6/3/2025, 6/4/2025, 6/5/2025, 6/6/2025, 6/7/2025, 6/8/2025, 6/9/2025, 6/10/2025, 6/11/2025, 6/13/2025, 6/14/2025, 6/15/2025, 6/16/2025, 6/17/2025, 6/18/2025, 6/19/2025, 6/20/2025, 6/21/2025, 6/22/2025, 6/23/2025, 6/24/2025, 6/25/2025, 6/26/2025, 6/27/2025, 6/28/2025, 6/29/2025, 6/30/2025, and 6/31/2025. On 7/23/2025 at 4:03 pm, V1 (Administrator) stated residents taking psychotropic medications should have a Gradual Dose Reduction (GDR) quarterly. V1 the purpose of the Gradual Dose Reduction is to reduce unnecessary medication for residents that can cause fall, interactions with medication, and disease processes. V1 provided a document for R7 and R12 titled Physician Admission/Follow up Schizophrenia Diagnosis Confirmation Evaluation as R7 and R12's GDR. On 7/24/25 at 12:13 pm, V37 (Pharmacist) was called at [PHONE NUMBER], no answer, voice message left. On 7/24/2025 at 12:50 pm, V37 (Pharmacist) was called at [PHONE NUMBER] no answer and V1 stated she (V1) does not have another phone number to reach the pharmacist, but he (V37) works for United Rx. On 7/24/2025 at 1:26 pm, V38 (Director of Clinical Services) stated any psychotropic medication should have a diagnosis before its use; Gradual Dose Reduction depends on the diagnosis for all residents and a Gradual Dose Reduction should be done 2 times in first year of therapy and when clinically indicated. If a person doesn't have a psychiatric diagnosis and they are prescribed a psychiatric medication, an evaluation by a psychiatrist is needed to determine if the medication is necessary. Facility's Policy titled PAR Meeting Protocol with an effective date of 12/14/2024 documents in part, The facility will ensure that each resident's drug regimen is free of unnecessary psychotropic medication. Unnecessary psychotropics can include excessive dose, excessive duration, inadequate monitoring, inadequate indications for use, or presence of adverse consequences.#3. The Interdisciplinary Team will review the resident's psychotropic drug usage to ensure that the resident has: Diagnosis that substantiated the use of the medication Target Behaviors that support the use of the medication Attempts at reductions as appropriate#5. Gradual Dose Reduction attempts are documented (2 separate attempts the 1st year in 2 separate quarters then annually unless contraindicated with documentation to support the contraindication.		

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 07/24/2025
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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to refer one resident (R105) for rescreening to the state agency for Preadmission Screening and Resident Review (PASRR) before R105's Exempted Hospital Discharge 30 Day Approval expired and failed to complete a Level I Preadmission Screening and Resident Review (PASRR) for one residents (R12) This deficient practice affected two residents (R105,R12) in a total sample size of 64 residents. Findings include: R105's PASRR dated [DATE] documents in part, Level I Outcome: Exempted Hospital Discharge. Rationale: Exempted Hospital Discharge 30 Day Approval-A 30 day or less stay in the NF (Nursing Facility) is authorized. Re-screening must occur by or before the 30th day if the individual is expected to remain in the NF beyond the authorization timeframe. During the survey, the facility was unable to produce a document indicating R105 had a PASRR Level I rescreen. R105's diagnosis includes but are not limited to anxiety disorder, unspecified, bipolar disorder, unspecified, type 2 diabetes mellitus without complications, chronic obstructive pulmonary disease, unspecified, and essential (primary) hypertension. On [DATE] at 10:51am V25(Business Office Manager) stated the admissions department is responsible for completing PASRRs for the residents. V25 stated this is the only screening I see in the system for R105. On [DATE] at 3:25pm V31(Social Service Director) stated every resident should have a PASRR Level I and we are to follow up if the resident requires a rescreen. During the survey, a facility policy regarding PASARRs was requested from V1(Administrator), V1 did not produce a facility policy regarding PASARRs. R12's Face Sheet documents a diagnosis of but not limited to schizoaffective disorder-Bipolar Type with an onset date of [DATE], Major Depressive Disorder with an onset date of [DATE], anxiety disorder with an onset date of [DATE]. R12 does not have a PASARR (Preadmission Screening and Resident Review) Level I or Level II Screening.		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 07/24/2025
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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility failed to ensure that one resident (R118's) with decreased mobility had a properly working Low Air Loss Mattress. This failure resulted in R118 lying on a deflated mattress and verbalizing being uncomfortable. Findings include: R118 is [AGE] year old with diagnosis including but not limited to: Other reduced mobility, weakness, muscle wasting and atrophy, morbid obesity due to excess calories, hypertension and chronic obstructive pulmonary disease. R118 has a BIMS (Brief Interview of Mental Status) score of 14, which indicates cognitively intact. During investigation on 7/21/2025 at 10:45 AM, R118's LALM (Low air low mattress) was noted with a blinking light indicating 'low pressure'. At that time, R118 stated the following, My bed is hard. The mattress is about six years old. You can feel the springs in it. I have pillows under my back to relieve the pressure. I told the medical records staff about my mattress last week because she is the person that orders equipment. I have not heard anything else about the mattress. On 7/21/2025 at 10:53 AM V5 (CNA/Certified Nurse Assistant) stated, the she (V5) noticed R118's spring on her mattress last Friday and made the nurse aware. On 7/21/2025 at 12:09 PM, V4 (LPN/ Licensed Practical Nurse) stated the following, I don't know why the alarm is blinking on the mattress. It is deflated and should not be. In order to prevent pressure ulcers and sores, the mattress should be inflated. On 7/23/2025 at 2:53 PM, ADON (Assistant Director of Nursing) stated the following, The purpose of the LALM (Low air loss mattress) is to prevent skin breakdown. If the low air light is blinking, it should be checked because it is an indication that the air is not being distributed evenly. Subsequently, the mattress will not be effective. R118's Care Plan documents, R118 is at increased risk for alteration in skin integrity related to Impaired Mobility Status; Interventions include low air loss mattress; R118 has an alteration in comfort secondary to pain. Facility policy titled Treatment/ Services to prevent / Heal Pressure and Non- Pressure wounds documents, the facility will ensure that based on the comprehensive assessment of a resident: a resident receives care, consistent with professional standards of practice, to prevent pressure and non-wounds. Facility policy titled Wound Management Program documents, if the sacrum is making contact with the mattress or the bed frame, the device is not providing pressure relief and the devices should be reevaluated.		

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 07/24/2025
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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, the facility failed to ensure the nasal cannula was labeled with the date it was changed. This failure affected 1 (R121) resident reviewed for respiratory care in the total sample of 64 residents. Findings include: On 07/22/2025 at 10:57am, R121's was using a nasal cannula. R121's nasal cannula was not labeled. On 07/22/2025 at 11:00am, V8 (Registered Nurse) checked R121's nasal cannula and stated her nasal cannula is not labeled. Added that (V17-RN) is assigned to her (R121). On 07/22/2025 at 11:02am, V17 stated the nasal cannula should be changed every 72 hours. It should be dated with the date it was changed for the accuracy of when it was changed. It should be changed and labeled to prevent accumulation of mucus in the nasal tubing for infection control. On 07/22/2025 at 2:46pm, V29 (Infection Preventionist/LPN) stated every Sunday during the night shift, nurses have to change the nasal cannula and to label the nasal cannula with the date it was changed for infection control and hygiene. The purpose is to prevent transfer of microorganism; to prevent accumulation of microorganism in the nasal cannula. R121's (Active Order as Of: 07/22/2025) Order Summary Report documented, in part Diagnoses: (include but not limited to) primary hypertension, dependence on supplemental oxygen, and Type 2 Diabetes Mellitus. Order Summary: continuous Oxygen @3L(iters)/NC (nasal cannula) DX: COPD (Chronic Obstructive Pulmonary Disease). R121's (06/19/2025) Minimum Data Set documented, in part Section C. Cognitive Patterns. C0500. BIMS (Brief Interview for Mental Status) Summary Score: 06. Indicating R121's mental status as severely impaired. Section O - Special Treatment, Procedures, and Programs. O0110. Respiratory Treatments. C1. Oxygen therapy. B. While a Resident. R121's (06/20/2025) care plan documented, in part displays complications with gas exchange. Will have adequate gas exchange. Administer O2 (oxygen) as ordered. The (undated) Oxygen Administration documented, in part Policy: It is the policy of this facility to provide oxygen to maintain levels of saturation to residents as needed and as ordered by the attending physician. Orders are entered into the clinical record under medication administration record. 4. Tubing, humidifier bottles, and filters will be changed, cleaned, and maintained no less that (n) weekly and PRN (as needed). Each will be labeled with date, time, and initial by staff completing this service to equipment.		

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 07/24/2025
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 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. Based on observation, interview, and record review the facility failed to label, date, and discard food items in resident 's personal refrigerator in an effort to prevent food borne illness. This failure affected 1 (R36) resident reviewed for personal refrigerator in the total sample of 64 residents. Findings include: On 07/21/2025 at 11:41am, inside R36's personal refrigerator was a black plastic container with translucent lid. The plastic container was not labeled. There is a strong smell coming out of the food container. Inquiring how long the food has been in the refrigerator, R36 stated she did not even know until this surveyor said something about the food in her personal refrigerator. On 07/22/2025 at 10:55am, R36 stated her daughter brought the food. That she could not remember whether it was during her birthday in April or Mother's day in May. On 07/21/2025 at 11:50am, inquiring about the food item in R36's personal refrigerator, V10 (Certified Nursing Assistant) stated housekeeping is in charge of checking the personal refrigerator. V10 took the plastic container out of the refrigerator and stated the food smell old and that she did not see any date or labels on the container, and she did not want to open the food container. V10 stated she was going to throw the food container. On 07/23/2025 at 11:41am, V2 (Assistant Director Of Nursing) stated ultimately the staff who is providing care to the resident should check the resident's personal refrigerator for expired food items, temperature, and cleanliness. That food item should be labeled with the date and time it was kept in the personnel refrigerator, so the next person assigned to the resident knows when to discard the food item. V2 stated, We don't want resident to be sick of food borne pathogen or illness. R36's (Active Order as Of: 07/22/2025) Order Summary Report documented, in part Diagnoses: (include but not limited to) cerebrovascular disease, paralytic syndrome following cerebral infarction, and limitation of activities due to disability. R36's (04/30/2025) Minimum Data Set documented, in part Section C. Cognitive Patterns. C0500. BIMS (Brief Interview for Mental Status) Summary Score: 15. Indicating R36's mental status as cognitively intact. The (undated) Refrigerators In Residents Rooms documented, in part Guideline: Personal refrigerators are permitted to be kept in a resident's room upon request. Resident and/or responsible party will agree to allow periodic safety checks by staff and allow staff to discard outdated food per safety guidelines. Procedure: 4. All food in the refrigerator will be labeled with the common name and used by date. 5. Any food item past its use by date will be discarded by staff or residents. Cooked or prepared meals brought in from home will be discarded after 48 hours.		