

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0055491		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/02/2026	
NAME OF PROVIDER OR SUPPLIER LANDMARK OF RICHTON PARK REHAB & NSG CTR				STREET ADDRESS, CITY, STATE, ZIP CODE 22660 SOUTH CICERO AVENUE , RICHTON PARK, Illinois, 60471			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
S0000	Initial Comments			S0000			
	Complaint Investigation:						
	2693163/2805546 - 300.690 a)b)c)						
S9999	Final Observations			S9999			
	Statement of Licensure Violations:						
	300.690a)						
	300.690b)						
	300.690c)						
	Section 300.690 Incidents and Accidents						
	a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident.						
	b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident.						
	c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence.						
	(Source: Amended at 37 Ill. Reg. 2298, effective February 4, 2013)						

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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S9999	Continued from page 1 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to follow policy and procedure and failed to send a narrative summary of the reportable serious injury incident to the Department within seven days after the occurrence for 1 (R4) of 3 residents reviewed for falls. R4 fell sustaining a laceration to R4's head which required R4 to be sent to the hospital for further evaluation and treatment. Findings include: Facility reported incident, dated 8/29/25, documents, in part, "Initial: Resident (R4) was observed lying on the floor in the bathroom. A laceration was noted to the side of his (R4) left eyebrow. Immediate first aid was initiated. Order given to send to ER (emergency room) for eval/tx. (evaluation and treatment). 911 activated. Paramedics arrived and transported resident (R4) to (hospital) in stable condition. Laceration required sutures." R4's progress note, dated 8/29/25 at 8:45am, documents, in part, "Resident (R4) was observed on the floor, in left lateral position, resident (R4) hit his (R4) head to the floor, noted with generalized weakness and laceration to left side eyebrow. Order received for resident (R4) to be sent out to (hospital). Resident (R4) transferred to (Hospital), due to fall." R4's progress note, dated 8/29/25, documents, in part, "Resident (R4) is admitted for Hypernatremia, AKI (acute kidney injury), and fall." On 4/1/26 at 12:16pm, V2 (Director of Nursing/DON) said, "The initial FRI (facility reported incident for R4's fall with serious injury on 8/29/25) was done, but a final report was not completed according to our (facility) records. It was my (V2) understanding that there were no documented skin injuries requiring closure of with glue or sutures. This is my (V2) assumption because I wasn't here and didn't see R4 when R4 went out. I was not present at the time of the incident and did not observe the resident (R4) being sent out. If I was here, I would have completed a final report." Record review of facility policy titled, "Guidelines For Incidents/Accidents/Falls," dated 6/30/23, documents, in part, "Some occurrences will require a more extensive investigation process. These include but are not limited to falls with serious injury. Any incident/accident/fall that meets the reporting criteria of the state/federal regulations will			S9999			

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S9999	Continued from page 2 be reported timely and accurately, to include the initial as well as the follow up report." Record review of pamphlet titled, "RESIDENTS' RIGHTS' For People In Long-Term Care facilities," revised date 11/18, documents, in part, "... Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life... Your facility must provide equal access to quality care regardless of diagnosis... Your facility must be safe, clean, comfortable, and homelike... You may participate in developing a person-centered care plan which states all the services your facility will provide to you and everything you are expected to do. This plan must include your personal and cultural choices. Your facility must make reasonable arrangements to meet your needs and choices... You should receive the services and/or items included in the plan of care..." (C)			S9999			