STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145507	A. Building B. Wing	12/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clark Manor	7433 North Clark Street Chicago, IL 60626

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. (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

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow its abuse policy and procedure. Facility employees failed to report an abuse allegation to the abuse coordinator. This failure affected one (R1) out of four residents reviewed for abuse. The Findings Include: R1's clinical records show an admission date of 3/25/25. R1's Minimum Data Set, dated [DATE] shows R1's BIMS (Brief Interview for Mental Status) score was 13 (Cognitively Intact).On 12/23/25 at 9:57 AM, R1's lying comfortably in bed noted with forgetfulness. Dry dressing noted on R1's forehead. R1 stated that Friday morning, a CNA [Certified Nursing Assistant] was mad at R1 for pressing the call light too many times, took the bed control remote and hit R1 on the forehead. R1 denied being hit on the stomach or with a wet diaper. R1 stated he called the nurse for help, but the nurse did not believe R1 when he told the nurse what happened. R1 was unable to say the names of the staff involved, but R1 described the CNA and the nurse as both Black heavy-set ladies. R1 said he was sent to the emergency room and had stitches on his forehead. R1 stated he feels safe right now in the facility and no staff is abusing him.On 12/23/25 at 10:44 AM, Surveyor informed V1 (Administrator) and V3 (Assistant Administrator) regarding R1's abuse allegations. Both stated they have not heard of any complaints or allegations from R1 regarding physical abuse. Both stated R1 did not mention any abuse allegation nor did not receive any abuse allegation from the hospital. V1 stated will start abuse reportable and start investigating. Both stated nobody called from the hospital that R1 was alleging abuse. V1 stated that the staff is expected to report to V1 immediately for any abuse allegations and V1 will do initial investigation and reporting to IDPH [Illinois Department of Public Health] within 2 hours. Final is sent within 5 days. V1 said hitting a resident is physical abuse.On 12/23/25 at 12:34 PM, a phone interview was conducted with V9 and stated that she's been coming to work in the facility as agency CNA since 2023. V9 stated, It was Sunday 21st around 6:45 AM I went to his [R1] room to change R1's adult brief. V9 stated I (V9) was doing my rounds. [R1] was awake. I (V9) took the bed remote to bring [R1's] bed up to my height to do incontinence care. [R1] did not want to be changed. [R1] snatched the bed remote from my hand. [R1] pulled the cord forcefully and then it hit his forehead. [R1's] forehead started bleeding, so I called the nurse right away. I called [V10]. [V10] came in the room with me. [R1] was telling [V10] that I hit [R1] with the cord. I did not hit [R1] with the cord. It was an accident. I was there when [R1] was telling [V10] that I hit him. [V10] assessed [R1] and cleaned the wound on [R1's] forehead. It was just me and [V10] went to [R1's] room. I did not report to anybody of [R1's] accusations. It was just the nurse who was there [V10]. After that incident I was not assigned with [R1] again.On 12/23/25 at 1:53 PM, a phone interview was conducted with V10 (Registered Nurse) and stated, It was around 6:45 in the morning. The CNA [V9] was making her incontinence care rounds. I did not witness the incident [V9] told me she went inside the room and started to assist him [R1] to change him but the patient was very resistant while [V9] was holding the bed control to adjust the bed [R1] pulled the cord from [V9's] hand the bed control slipped out of her hand and hit [R1's] forehead. [V9] immediately called me. [R1] is always resistant to morning care. [R1] has a behavior of very resistant every morning. [V9] called me because his [R1] head was bleeding. I went inside [R1's] room I saw that there was bleeding on the forehead, so I put treatment. I cleaned the wound and put pressure dressing. The bleeding was controlled. I asked [R1] what happened, and [R1] said that [V9] was holding the bed control, and [R1] grabbed the remote control slipped from [V9's] hand then hit his [R1] head accidentally. [R1] did not want to be changed. [R1] never told me that the [V9] hit him [R1]. We sent to the hospital [R1] via 911.A review of R1's progress notes dated 12/21/25 at 4:07 PM documented by V8 (R1's Nurse Practitioner) reads in part: [R1] was seen today. A 3-4 cm [centimeters] fresh laceration in the mid of forehand. [R1] reports a confrontation with nurse staff and hit by the remote.On 12/23/25 at 12:20 PM, a follow-up interview was conducted with V1 and V3. Both stated they did not receive any report from V8 (R1's Nurse Practitioner) regarding R1's abuse allegation. R1 said that the expectation is for V8 to report it to V1 immediately for any abuse allegations. They would start the abuse reporting and abuse investigation right away and suspend the staff involve pending investigation if they were informed. Both stated an in-service will be provided right away to V8 about the facility's abuse policy and procedures.On 12/23/25 at 12:23 PM, called V8 and left a message through the answering service, but V8 never returned Surveyor's call.Facility provided V8's in-service on abuse prevention and reporting dated 12/23/25.The facility's Abuse and Neglect policy and procedure dated 6/26/25 documents in part: All allegations and/or suspicions of abuse must be reported to