STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145748	A. Building B. Wing	05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montgomery Place	5550 South Shore Drive Chicago, IL 60637

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interview and record review, the facility failed to ensure that a resident (R1) remain free from physical abuse and verbal abuse. This failure affected R1 who was physically (aggressively bear hugged and pushed) abused by V7 (Registered Nurse, RN) and verbally abused (aggressively yelled at) by V7 out of a sample size of 3. Finding include:R1 had diagnosis of but not limited Cerebral Infarction, Acute Respiratory Failure with Hypoxia, Pneumonia, Aphasia, Chronic Kidney Disease, Stage 4 (Severe), Hypertension, Dementia and Alzheimer's Disease.R1 has a Brief Interview of Mental Status Score of 07 that indicates severe cognition impairment. R1's Care Plan focus titled Altered Neurological Status, dated 4/08/2025, documents, in part, Interventions: Monitor for behavioral changes.R1's Care Plan focus titled Elopement risk/wanderer, dated 4/08/2026, documents, in part, Interventions: Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book.R1's Care Plan focus titled Impaired Cognitive Function/dementia or impaired thought processes r/t (related to) Dementia, Impaired decision making, dated 2/15/2026, that documents, in part, Interventions: Cue, reorient and supervise as needed.Initial Reportable to the state agency, dated 5/18/2026, documents, in part, V7 (RN) came from behind him (R1) and grabbed R1's shoulders and walked R1 to his bed. He (V7) loudly told him (R1) to sit down on the bed and not come back out. On 5/18/2026 at about 1:04pm R1 stated that no one abused him. On 5/18/2026 at 1:40pm V4 (Registered Nurse-RN) said, Yes, I have observed physical abuse from a staff member (V7, RN) to a resident (R1). V4 stated on 5/12/2026 at about 7:30pm she observed V7 pull R1's hands behind R1's back and aggressively pushed R1 into his room. V7 stated that she was waiting for the elevator on the 2nd floor and had a clear sight of the interaction that occurred by the exit door by R1's room, on the right side of the hallway. V7 stated R1 had pushed the exit door, and the alarm was going off and V7 pulled and held R1's hands behind R1's back as he was forcibly pushing R1 into R1's room. V7 stated we should not redirect or guide a resident in this manner. V4 stated that V8 (Certified Nursing Assistant) witnessed the entire incident between V7 and R1.On 5/20/2026 at 8:11am V8 (Certified Nursing Assistant) stated on 5/12/2026 at about 7:30pm or so, V8 observed V7 (RN) aggressively bear hug R1 and pulled R1 back into the hallway from the stairwell. Once V7 had R1 in the hallway, he aggressively pushed R1 to his room and was yelling at him and saying, Don't come out, don't come out. V8 stated that V7 was standing by the door saying what is wrong with this guy (R1), he (R1) is going to make me hit him (R1). Surveyor reviewed email documentation to V1 from V10 (Chief Executive Officer), dated 5/18/2026, that documents, in part, follow up interviews from V8 that states: While still on the landing V7 took over redirecting R1, but V8 indicated that V7 was rough with R1; V7 alleges that V7 put his arms around R1's shoulders from behind in what she described as a bear hug. V8 stated that V7 was upset and yelling, allegedly saying things like What's wrong with this guy and He's going to make me hit him; V8 also alleged that V7 yelled at R1 once back in the room, Don't come out.On 5/18/2026 at 2:05pm V5 (Health Services Executive Assistant) stated V4 called her and reported that V4 witnessed rough housing with R1, and V4 said she was standing at the elevator and saw V7 pull R1's hands behind his back and pushed R1 to his room. On 5/19/2026 at 1:04pm V7 (RN) stated that day (5/12/2026), I (V7) came into work, and the exit door alarm was going (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	off because R1 had pushed the door and was trying to leave. The CNA (V8) was trying to get R1 back into the hallway from the stairwell, so I rushed over to assist. V7 stated he went to help V8 because R1 was being combative and swinging his arms and telling us that he wanted to go home. V7 said, I (V7) did shout at him (R1) and told him (R1) to go back to his room. V7 said, No, I did not put my hands on (R1); I held my hands out in front of me as I guided (R1) as I walked behind him.On 5/20/2026 at 3:08pm V2 (Director of Nursing, DON) stated it is not appropriate to aggressively grab, touch or yell at a resident that has dementia or trying to elope and doing this may startle or make the resident fearful. V2 stated you should gently guide them and talk to them softy to redirect their behavior. On 5/202/2026 at 1:32pm V12 (Physician) stated yes, I (V12) was aware of the abuse allegation (towards R1 from V7) and did see R1 yesterday. R1 has dementia with some behavioral disturbance. V12 stated of course, yelling and being physically aggressive to a resident can create more problems and cause the resident to be fearful, withdraw, and refuse care or food. Abuse Prevention Program with no date documents, in part, this facility affirms the right of our residents to be free from abuse, the purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of mistreatment or abuse of our residents and immediately protecting residents involved in identified reports of possible abuse.Job description titled Staff Nurse with a revision date of November 10, 2020, documents, in part, maintain the physical safety of each resident.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility failed to timely submit an initial abuse report to the state agency within 2 hours which affected one resident (R1) in the sample of 3 residents reviewed for abuseFindings include: On 5/15/26 at 1:50 PM, V4 (Registered Nurse) stated that she has worked at the facility for 11.5 years, and V4's regular work area is R1's floor and hallway. V4 stated that last 5/12/2026 at 7:17 PM that she immediately reported to V5 Health Services Executive Assistant via phone call the abuse incident she witnessed between V7 and R1. V4 stated that V7 pulled R1's arms behind his back and started to push R1 back to the hallway towards R1's bedroom. V4 stated that it is not a form of redirection and V7's voice was loud telling R1 to go back to his room. V4 stated that's the reason the incident was reported immediately due to aggressive actions by V7 towards R1. V4 stated that on the next day, 5/13/26, she reported the incident again to V1 (Administrator), and V4 provided a signed witness statement to V1. On 5/19/2026 at 2:53 PM V1 (Executive Director) stated that when she (V1) was notified about the abuse incident from V7 (Registered Nurse, RN) towards R1 that occurred on 5/12/26, V1 did the investigation but did not report in a timely fashion and that's her fault. V1 stated that she should report any abuse incident to Illinois Department of Public Health (IDPH) within 2 hours and have 5 working days to submit the final report. On 5/19/2026 at 1:04 PM V7 (Registered Nurse) stated they (V1 {Executive Director}, V2 {Interim Director of Nursing} and V11 {Human Resource Manager}) called him on 5/13/2026 and asked me what happened with R1. Facility document dated 5/18/2026 at 3:30 pm, indicates that V1 (Executive Director) submit the preliminary report for R1 to the state agency via fax. The facility document dated 09/05/2024 and titled (Facility) Abuse Prevention Policy and Procedure documents, in part, Purpose: This policy provides guidelines that aims to prevent, protect, and prompt reporting and interventions in response to alleged, suspected or witnessed abuse, neglect, mistreatment, misappropriation of property, or exploitation of any resident. All residents have the right to be free from mental, physical, sexual, and verbal abuse, neglect, mistreatment, misappropriation of property, and exploitation and to be treated with dignity and respect. Responsibility: Facility will not condone the abuse/neglect of any resident by anyone, including, but not limited to, Registered Nurse (RN), Nurse Practitioners (NP), Licensed Practical Nurses (LN), Certified Nursing Assistant (CNA),. Abuse: is the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting physical harm, pain or mental anguish. Mental/Verbal Abuse: The use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation. The facility document undated and titled Reporting Reasonable Suspicion of a Crime in a Long Term Care Facility documents, in part, It is our facility's responsibility to report to IDPH(Illinois Department of Public Health) incidents involving serious physical harm or injury to a resident, in accordance with IDPH licensure requirements Section 300.690 or allegations or reasonable suspicion of abuse, neglect or misappropriation of property, in accordance with licensure regulation 300.3240 and OBRA(Omnibus Budget Reconciliation Act) F326. Facility employees have the obligation to report incidents or (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	suspicion of abuse to the Administrator. If the allegation or suspicion of abuse involved serious bodily injury or sexual abuse, the suspected crime must be reported to IDPH and local law enforcement within two hours of the event. Federal policies make a distinction. Incidents are a facility and facility administrator's responsibility to report to IDPH. The facility document dated 04/29/2026 and titled (Facility) Executive Director of Healthcare Services Job Description documents, in part, Position summary oversees all activities of the nursing home and assisted living business units at Facility in accordance with established policies and federal and state guidelines. Essential duties and responsibilities: Investigates allegations of abuse, neglect and complies with reporting requirements.