

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: 145938	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/24/2025
NAME OF PROVIDER OR SUPPLIER Landmark of Hyde Park Rehabilitation and Nursing C		STREET ADDRESS, CITY, STATE, ZIP CODE 6125 South Kenwood 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 0689 Level of Harm - Actual harm Residents Affected - Few	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 interview, and record review, the facility failed to provide adequate supervision and implement fall prevention interventions for one of six residents (R1) reviewed for high risk for falls. These failures caused R1 to sustain a fall and was sent out to the local hospital with a laceration to the right eyebrow, a large subdural hematoma with mass effect, effacement of the right lateral ventricle, and a right zygomatic facial fracture. Findings include: R1 has a diagnosis of history of falling, weakness, cellulites of right lower limb, unspecified dementia, severity without behavioral disturbance psychotic disturbance mood disturbance and anxiety. R1 has a Brief Interview for mental status dated 10/15/25 with a score of 3 which indicates that R1 has some cognitive impairments. The facility's initial reportable incident to the local state agency dated 10/03/25 at 11:32 pm, documents in part: Upon rounds nurse noted of resident alert and confused period lying on his lateral side on the floor in his room with a skin alteration to his right eyebrow. The facility's final reportable incident to the local state agency dated 10/11/25 at 12:13 am, documents in part: Conclusion the facility completed its investigation through medical review and statements. Based on interviews, the resident sustained an injury to his head due to him jumping up impulsively attempting to ambulate without staff assistance and stumbled through the floor. Staff saw resident approximately 3 to 5 minutes prior to the resident was seated on his bed with his helmet on. The resident was observed next to his bed on the floor with his helmet close by. The resident was sent to the hospital and returned on 10/8/25 on hospice care. The facility's document dated 10/03/25 and titled Falls documents in part: Upon rounds nurse noted of resident alert and confused period lying on his lateral side on the floor in his room with a skin alteration to his right eyebrow. V10 (Registered Nurse, RN) statement documents in part: Resident was observed lying on his right side on the floor in his room. He was immediately assessed and observed with bleeding to his right eye. The helmet was next to his body on the floor. R1's progress note dated 10/03/25 at 10:05 am authored by V10 (Registered Nurse, RN) documents in part: The resident left via ambulance to be transferred to the local hospital related to fall in his room. R1's hospital record dated admission dated 10/03/25 documents, R1 is a [AGE] year-old man with a history of hypertension (HTN), dementia, anemia, heart failure, atrioventricular block (AV), bipolar disorder, who transferred from and outside hospital as a L2 (level 2) trauma activation status post unwitnessed fall from bed at his nursing home. Scan at (local hospital) revealed a large right subdural hematoma with mass effect and effacement of right lateral ventricle. Repeated scan showed right subdural hematoma and . right zygomatic facial fracture. R1's care plan dated initiated 12/07/23. Goal: I will have interventions and place that will help reduce my risk for falls and injury through the next review. Interventions: R1 with low bed . Dysem under floor mat . Apply floor mats to the side of my bed closest to the door; . R1 helmet on at all times as tolerated. R1's care plan dated initiated 12/07/23 documents in part: Focus: I have a Self-Care Deficit and I require assistance with ADL's to maintain the highest possible level of functioning AEB (as evidence by) the following limitation and potential contributing factors: Impaired Cognitive Status with DX (diagnosis) Dementia or Alzheimer's Disease, - (+) (plus) ROM (range of motion) Deficits, - Depressive episodes, - General weakness, HTN (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 145938
		If continuation sheet Page 1 of 3

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145938	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/24/2025
NAME OF PROVIDER OR SUPPLIER Landmark of Hyde Park Rehabilitation and Nursing C		STREET ADDRESS, CITY, STATE, ZIP CODE 6125 South Kenwood 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 0689 Level of Harm - Actual harm Residents Affected - Few	(hypertension), Heart Failure and Anemia. Interventions/Task: . Bed Mobility: I usually requires dependent assist with bed mobility. On 11/19/25 at 2:45 pm, V2 (Director of Nursing, DON, Falls Nurse) stated that V2 is the facility's falls coordinator. V2 then explained that R1 was alert, oriented to name only, high risk for falls due to multiple falls at the facility, used a wheelchair due to his unsteady gait and that R1 was impulsive, easily jumping up from a sitting position due to R1's confusion. V2 further explained that R1 sustained multiple falls at the facility and wore a helmet to prevent R1 from sustaining a fall with injury. V2 explained that R1 required close monitoring by staff due to R1's impulsive manner to jump up from a sitting position. On 11/20/25 at 9:44 am, V10 (Registered Nurse, RN) stated that he worked at the facility since 2012. V10 explained that he was R1's night shift nurse at the facility. V10 then stated that R1 was a resident who was alert to name but not able to follow directions at all times, was high risk for falls due to having multiple falls in the past and required close supervision especially when awake due to R1 attempts to stand and ambulate when awake. V10 then explained that R1 was a one person assist and required a wheelchair for ambulation. V10 also explained that R1 would stay with staff when awake to prevent R1 from falling. V10 also stated that when R1 fell at the facility on 10/03/25 it was around the last hour of the night shift between 5:30 am and 7:00 am. V10 further explained that he was in the hallway at the room next door to R1's room checking his narcotics count when he heard what sounding like a heavy book bag dropping noise coming from R1's room. V10 explained that he went into R1's room and observed R1 laying on the bare floor, on his right side between the dresser and bed, with R1's helmet lying beside R1's head tilted, to the side of R1. V10 stated that R1 was laying on the bare floor and that V10 does not recall where R1's floor mat or R1's floor mat dysem was in the R1's room. V10 explained that R1 had floor mats to each side of R1's bed that should have been in place however, V10 did not observe R1 laying on a floor mat during the time of the fall. V10 stated that R1 was laying on the bare floor, fully dressed, with a laceration above R1's right eyebrow about 2 inches long and about 1-inch-wide, bleeding. V10 then explained R1's bed was not in the lowest position and that R1's bed was slightly raised up to where R1 could sit on the side of the bed with his feet dangling. V10 further stated that R1 was not able to state what happen and was just saying Hey, hey. V10 then stated that when he observed R1 lying on the bare floor in R1's room, he yelled out for V11 (Certified Nursing Assistant, CNA) for help and that V11 came along with two other CNA's came into R1's room to assist with R1 fall. V10 stated that he was able to apply a cold compress and pressure to stop R1's right eyebrow laceration from bleeding. V10 then explained that he has observed R1 remove his helmet in the pass and that he does not think that R1 was wearing his helmet during time of the fall. V10 further explained that the last time he observed R1 prior to his fall on 10/03/25 was between 3:00 am and 4:00 am when R1 was sitting on the edge of the bed nodding off with his eyes closed and R1's head titled wearing his helmet. V10 explained that it is all the staff's responsibility to make sure fall precautions such as the floor mat is next to the residents bed and bed in lowest position to prevent a resident from falling and sustaining a injury. V10 also stated that V10 is given in report who is high risk for falls and V10 then will verbally tell the CNA's who is high risk for falls and what interventions should be in place. V10 explained that he believes that there are documents in place to inform the staff of what residents who are high risk for falls however he is not aware of where the staff can refer to get the information and that he does not use it. V10 stated if a resident who is high risk for falls is not properly supervised and fall interventions are not in place the resident can sustain a fall. On 11/20/25 at 11:07 am, V11 (Certified Nursing Assistant, CNA) stated he has worked at the facility for 2 years. V11 then stated that he recalls R1 at the facility and that R1 was not alert, oriented, required 1 person assist, utilized a wheelchair for ambulation, was high risk for falls and had multiple falls at the facility. V11 explained on 10/03/25 around 5:30 am V11 went into R1's room and observed R1 sitting on the edge of the bed. V11 stated that he dressed R1 and placed R1's helmet on R1's head around 5:30 am. V11 then explained that he went to get R1's some socks from R1's dresser that was along the wall, across from R1's bed in R1's room when he sustained a fall. V11 explained that R1's (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145938	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/24/2025
NAME OF PROVIDER OR SUPPLIER Landmark of Hyde Park Rehabilitation and Nursing C		STREET ADDRESS, CITY, STATE, ZIP CODE 6125 South Kenwood 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 0689 Level of Harm - Actual harm Residents Affected - Few	bed was not at the lowest position when he left R1 sitting on the edge of R1's bed's bed to get R1 some socks because V11 had just finished dressing R1. V11 then explained that R1 fell on a floor mat next to R1's bed facing the door with R1's helmet next to R1 on the floor and that he believes that R1 removed his helmet. V11 then explained that he called out for V10 (RN) (R1's nurse) to come into the room. V11 stated that R1's bed is always at floor level to prevent R1 from falling however V11 raised R1's bed from the floor to dress R1. On 11/20/25 at 11:51 am, V2 (DON, Falls Coordinator) explained that after a fall occurs V2 conducts an investigation, review the risk management form, and collect statements from staff pertaining to the fall. V2 further explained that a fall risk assessment recommendation meeting with the falls team which consist of V2, wound care nurse, social services, therapy department, V1 (Administrator) , Minimum Data Set (MDS) nurse, restorative nurse and activity department is held to discuss the fall plan of care with the interventions. V2 then explained that the restorative nurse is in charge of putting the interventions in place and updating the residents care plan. V2 stated that the nursing staff is responsible for ensuring that the interventions remain in place at all times. V2 explained that there is a binder on each unit that informs the nursing staff of who is high risk for falls and the residents interventions. V2 then explained that R1's fall interventions included R1 being closely supervised, helmet in place, bedside mats in place, bed in the lowest position, ensuring his belongings are near, and R1's call light was to be placed in reach. V2 further explained that if a residents fall intervention are not in place the resident can get injured. On 11/20/25 at 12:30 pm, V12 (R1's Physician) stated that R1 had an extremely advanced dementia, extreme confusion, disoriented, with malnutrition. V12 then stated, R1 was a very high-risk for falls resident, not steady on his feet, who required constantly watching him or R1 would get up and fall because he could not walk properly. V12 explained that every time he saw R1, he was wearing a helmet. V12 also explained that he would observe R1 pulling on his clothing and helmet but never saw R1 remove his helmet. V12 stated that R1's fall interventions included R1 being closely monitored at all times especially when awake, a low bed, floor mats, and R1's room close to nursing station. V12 then stated if R1's falls interventions/preventions are not in place, R1 could sustain an injury. V12 stated that he was called many times regarding R1 falling at the facility . V12 further stated that V12 recalls giving orders to send R1 to the local hospital for a fall where R1 suffered a subdural hematoma (SDH) and that R1 returned to the facility on hospice care. R1's progress note dated 10/03/25 at 5:45 am, authored by V2 (Director of Nursing, DON, Falls Nurse) documents, in part; Upon rounds the nurse noted the resident was alert and confused, lying on his lateral right side on the floor in his room with a skin alteration to his right eye. Head to toe assessment completed, no other injuries noted. First aid rendered. Clean dry dressing applied. Resident assessed for pain, none noted. Range of motion (ROM) to all extremities within normal limits. Medical doctor (MD) notified. Order for hospital evaluation. The facility's document dated 9/18/25 and titled Fall Risk Review shows that R1 has a score of 14 indicating that R1 was high risk for falls. The facility's document dated 10/03/25 and titled Fall Risk Review shows that R1 has a score of 20 indicating that R1 was high risk for falls. The facility's document dated 10/08/25 and titled Fall Risk Review shows that R1 has a score of 13 indicating that R1 was high risk for falls. The facility's document dated 10/15/25 and titled Fall Risk Review shows that R1 has a score of 17 indicating that R1 was high risk for falls. The facility's document dated 05/01/25 through 11/19/25 shows that R1 sustained a fall at the facility on 06/07/25, 10/03/25 and 10/15/25 at the facility. The facility's undated document titled Incident/Accident/Falls documents, in part: It is the policy of the facility to ensure that an incident accident to include falls is Reported immediately to the nurse or appropriate person designated to be in charge . the facility will ensure that incidents and accidents that occur involving residents are identified, reported, investigated, and resolved . This information will be used to implement corrective action to include any needed training to prevent reoccurrences the impossible.		