STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145938	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Landmark of Hyde Park Rehabilitation and Nursing C	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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. Based on interview and record review, the facility failed to implement their policy to inventory the belongings of one (R4) resident of eight reviewed for personal property.Findings include:2/11/26 at 2:00 PM, V2 (Director of Nursing) stated there is no inventory list for R4s belongings.2/13/26 at 11:26 AM, V10 (Certified Nursing Assistant) stated for new admissions, a staff member, usually a CNA (Certified Nursing Assistant), is supposed to record their belongings. There's a form we use to log what the resident has. So, we know what the resident has/come in with. The CNA gives the form to the nurse after filling it out. I believe the resident is supposed to sign the form. We don't log new items that are brought in after admission. We insure there is no contraband. When discharged the belongings should be bagged up by the CNA and taken to a storage area by housekeeping.2/13/26 at 12:42 PM, V1 (Administrator) stated they are supposed to be doing inventory sheets. Everything the resident comes in with is supposed to be noted on the inventory sheet. The sheet is supposed to be uploaded to the system. The purpose is to keep track of what the resident comes in with. To ensure what they have is what they should have in the facility. We do not have an inventory sheet for R4. I am not aware if anyone has come to retrieve R4s belongings. Belongings are packed up when residents go out and put into a storage area then given back when they come back. If they don't come back, the belongings are held for 30 days as we reach out to the family for instruction on what to do with the belongings.2/13/26 at 1:37 PM, V1 (Administrator) located/verified a bag of R4s personal belongings, including a Bible, on the third floor with no name, still in the facility and had not been returned to R4.Facility policy Resident Personal Clothes and Belongings Handling, no date, documents in part: Purpose: To ensure that all clothing/personal belongings are identified/labeled/stored/laundered appropriately. Procedure: (Upon admission and annually the following will be done) Personal belongings are to be listed as well, such as TV/recliner/bookcase etc. The CNA (Certified Nursing Assistant) submits the list of the resident's clothing/belongings to the charge nurse. This list becomes part of the chart.

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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(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to assert the rights of the residents and prevent and protect residents from resident-to-resident abuse. This failure affects two of three residents (R1, R2) reviewed for abuse. Findings include: R1 is no longer in the facility and was reviewed as a closed record. R1's Facesheet documents that R1 has diagnoses not limited to: Schizoaffective disorder, bipolar disorder, current episode manic without psychotic features, cocaine abuse, anxiety disorder, other asthma, depression, schizophrenia, other psychoactive substance abuse, insomnia, adult failure to thrive.R1's progress notes document:10/31/2025 at 10:55AM Resident was physically aggressive towards peer unprovoked. Resident immediately separated and placed on 1:1. Refused PRN (as needed). Order received from psych (psychiatric) team to petition for further psych evaluation. all notifications made.10/31/2025 at 11:07AM Resident is exhibiting aggressive behaviors with increased agitation and is unable to be redirected. NP (Nurse Practitioner) notified, and an order was received to send resident to hospital for psych evaluation.10/31/2025 at 12:28PM Resident left facility in stable condition with ambulance via stretcher on a petition to hospital for psych evaluation. All belongings secured, family and staff notified. Will follow up as needed.R1's aggression assessment dated [DATE] documents that R1 is at moderate risk for aggression, Resident has demonstrated the need for re-evaluating services due to recent behavior.R1's care plan documents in part, R1 presents with signs & symptoms of persistent anger towards self & others related to: Feeling abandoned by support system (which may include family members, friends, physician, God & religion, etc.)., Psychotic symptoms (i.e., delusions, hallucinations, paranoia).R2's progress notes:10/31/2025 at 10:58AM, Resident received physical contact from peer. Residents were immediately separated. Head to toe assessment completed. No visible bruises or injuries noted. Denies pain and discomfort. MD and family made aware. Vital signs stable. All notifications made.On 02/10/2026 at 12:20PM, R2 observed lying in bed in a supine position with an electric wheelchair next to his bed. R2 states this incident occurred so long ago that he does not recall what happened. R2 states R1 was his girlfriend, and she is no longer in the facility.R2's care plan documents in part, R2 will remain safe, will be treated with respect, dignity and reside in the facility free of mistreatment (i.e., abuse/neglect) through next review. Provide a safe environment, free from judgment, especially during the investigation. Provide emotional support to the resident.On 02/10/2026 at 1:22PM, V3 (Nursing Supervisor/RN) states, he is not sure exactly what happened, but he was made aware that R1 hit R2. V3 states R2 is someone that he built a rapport with and talks to frequently. V3 states R2 told him that R1 hit him but R2 did not hit R1 back. V3 states R2 did not complain of pain and stated that he was fine. V3 states he did not speak with R1 regarding the incident, but he has seen R1 upset and aggressive on previous occasions. V3 states he would often calm R1 down by offering her to take a cigarette smoke break because this is the only thing that seemed to calm R1 down when she was not redirectable. V3 states he has even seen R1 become aggressive and verbally abusive towards her own mother. V3 states he would hear R1 curse, get loud, and tell R1's mother I don't want to speak to you, you put me here. On 02/10/2026 at 1:36PM, V1 (Administrator) states she has been the abuse coordinator at the facility since 09/29/2025. V1 states on 10/31/2025, she and other staff members were in a morning meeting, and everyone heard a noise and came running out of the room to see what was happening. V1 states she observed that R1 was having a behavioral episode. V1 states she was trying to tell R1 to calm down and then R1 slapped R2 across the back of his head right in front of V1. V1 states she then told R1 now I have to send you out to the hospital and R1 said I don't care send me out. V1 states R1 and R2 were (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	separated until 911 came and took R1 out to the hospital. V1 states a body assessment was performed for R2 and R2 did not have any bruising or complain of pain. V1 states she observed that R1 did not hit R2 willfully and R1 was just having an episode. V1 states it was not a willful intent to hurt or harm R2. V1 states she also informed R1 that R1 could not return back to the facility.Facility Reported Incident dated 10/31/2025 documents that the facility reported that R1 made physical contact with R2.Facility policy dated 01/2019 titled Abuse Prevention Program documents in part, It is the policy of this facility to prohibit and prevent resident abuse, neglect, exploitation, mistreatment, and misappropriation of resident property and a crime against a resident in the facility. Abuse: The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm or pain or mental anguish or deprivation by an individual,.Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Physical abuse: Hitting, slapping, pinching, kicking, etc.