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	03/24/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to follow their 'Abuse Prevention Policy' and report any alleged violations involving mistreatment, or suspecting resident abuse, to the Administrator for one [R1] of five [R2, R3, R4 R5] residents reviewed for abuse. Findings include: R1 is the subject of the complaint. R2 is the alleged perpetrator [R1's Spouse]. R1's clinical record indicates the following in part: R1 is a forty-eight-year-old admitted on [DATE]. R1's medical diagnosis of major depressive disorder, depression, and schizophrenia. R1's face-sheet, medical diagnosis, physician order sheets, minimum data set [MDS] Brief Interview Mental Status Score indicates R1 is cognitively intact. R1's progress notes in part: 3/19/26 at 6:02 PM V10 [Licensed Practical Nurse] note:R1 returned from out on community pass and was transferred to another room on the second floor. 3/19/2026 6:02 PM, Nursing Progress Note [V10]: Note Text: R1 Returned from OOP (out on pass). R1 was escorted by psych tech to remove her belongings from her room. Transferred to 2nd floor. Resident escorted to 2nd floor by psych tech. Supervisor aware. R1's Trauma Screening dated 1/19/26 indicates in part:R1 said she does not have a history of any abuse; physical, sexual, verbal, emotional, financial, domestic violence or unexplained injuries prior to admission. R1's Care plan notes, in part:Abuse, neglect, exploitation trauma. Interventions: Encourage R1 to verbalize any instances of abuse. Provide a safe environment, free from judgement, especially during the investigation. Provide emotional support. Evaluate R1 response to psychological interventions and support to determine the effectiveness of the treatments provided and expected outcomes. Assure R1 that she is in a safe and secure environment with caring professionals. Offer reassurance. R2's [R1's Spouse] Clinical Record indicated the following in part: R2 is a forty-two-year-old admitted on [DATE]. R2 medical diagnosis of schizoaffective bipolar type disorder, alcohol abuse, alcohol induced acute pancreatitis. R2's face-sheet, medical diagnosis, physician order sheets, minimum data set [MDS] Brief Interview Mental Status Score Indicates R2 is cognitively intact. R2's Progress Note in part: 3/19/2026 10:29 Nursing Progress Note Note Text: R2 left facility on community pass in stable condition, due to return by 2:25 PM. 3/19/2026 9:46PM V10 [Licensed Practical Nurse]Note Text: R2 returned to the facility from community pass. Writer asked R2 if he wanted to take his medication. R2 noted by writer pocketing his medication. Writer informed R2 that if he did not want to take his meds, that is his right but, he had to give writer the meds back. R2 laughed and stated, Shut the f**k up talking to me b-tch! R2 started walking to his room. While walking to his room, R2 continued hollering out profanities. As he opened the door to his room he started hollering Where is my f**king wife at b-tch? I bet you I'll f-ck you up if you don't tell me where my wife is. He continued threatening writer and started walking towards the nurse's station. R2 continued to verbally threaten writer. Psych tech desk called for assistance. Supervisor called. Per supervisor send resident out 911. R2 being monitored off the unit by psych tech until police arrive and medics arrive. Psych on page. 3/19/2026 9:54PM V10 Nursing Progress Note Note Text: discharged out to hospital. Transported via stretcher by [4] 911 medics and 2 police officers. 3/19/2026 22:06 Social Service Note Note Text: R2 was given a Notice of Involuntary Discharge and Opportunity for Hearing for Nursing Home Residents (IVD) (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	form. The form was given by the Administrator and the Social Services Director. The form was completed under the federal proceedings; for the safety of individuals in this facility is endangered. The resident, the resident's representative, the Ombudsman, IDPH and facility attorney were sent a copy of the completed Involuntary Discharge form. The administrator and Social Services Director reviewed the Involuntary Discharge form with the resident, explained the 10-day appeal process, gave the R2 a self-addressed stamped envelope. The physician gave an order to present the R2 with an Involuntary Discharge due to the safety of the individuals in the facility being endangered. Interviews: On 3/21/26 at 10:00 AM, R1 stated, R2 is my legal husband. R2 was admitted to the facility first then I came to the facility. The facility allows R2 and I to share a room because we are married. Before we were admitted to the facility we had several physical altercations in the past. R2 stopped drinking alcohol and smoking marijuana, and we got married in January 2025. Recently R2 started drinking alcohol and smoking marijuana again. R2's behavior was starting to become more aggressive, telling me he was hearing voices. R2 would ask me if he I heard the voices, I told R2 no. I did not report to nursing that R2 was hearing voices. One day, I do not remember the day, R2 got angry and grabbed my wallet and dumped all my cards in the toilet and urinated on everything. R2 made me go in the toilet and take my cards out, then he tore up my social security card. R2 then started calling me b .h- -. On Monday [3/16/26], I went to V4 [Social Worker] office. I told V4 R2 was scaring me and making me feel nervous. I also told V4 R2 dumped out my wallet in the toilet and V4 told me R2 was my spouse, and we need to work it out as a married couple. I did not tell V4 that R2 was physically abusive to me in the past. I think it was the next day, I don't remember the day, R2 was mad at me and told me not to talk about him to anyone, then he punched me on my cheek[face]. This happened in our room with the door closed. I did not yell for help; I just got quiet. I did not report the incident to anyone. My face did not bruise or swell. R2 asked me to go out on community pass with him afterwards, I told him I would lay down. Once R2 left the facility I left out on pass alone and called V3 [External Agency Help Desk] and told V3 that R2 hit me. I called V5 [R1's Friend] and told her about R2 behavior, but I did not tell V3 that R2 hit me. I did not tell anyone at the nursing facility that R2 hit me, I could not remember when R2 hit me. I did not tell V3 that R2 spit on me, I said he looked like he wanted to spit on me. All I needed was a room change. On 3/21/26 at 1:15 PM, V4 [Social Worker] stated, R1 is very quiet and stays to herself. R1 and R2 shared a room as a married couple. R1 came to my office earlier this week, maybe it was on Monday. R1 reported R2 sometimes drinks alcohol. While speaking with me, R1 kept looking out the door and would stop talking if someone walked past. I asked R1 if she was okay, R1 said she was fine. R1 said, R2 don't want me to say nothing to you. R1 said she felt afraid and nervous with him. Soon after, she ended the conversation and left my office. The same day R1 and R2 came to my office and asked for a community past to leave the facility together. R1 did not report that R2 hit her, cursed her, nor made R1 pick her cards out of the toilet. They appeared calm and peaceful; I grated them the pass. Later they both returned calm and peaceful. At that point I was confused, I really did not know what to think. I was going to report this to the administrator, but I wanted to gather my facts first. The information she gave me was so confusing. I received abuse training in December 2025. The abuse coordinator is the administrator. On 3/21/26 at 2:24 PM, V10 [Licensed Practical Nurse] stated, I have been R1 and R2's nurse often. I have not heard or witnessed any abuse between them. R1 has never reported any abuse to me. I have never seen any bruises or marks on R1. R1 has never told me she was afraid or nervous being around R2. If she did, I would have notified the administrator immediately. On 3/19/26, I was notified by V7 [Nurse Supervisor] that R1 would be moving to another floor. Later R2 returned from out on pass and became upset that R1 was not in the room. R2 started yelling at me swearing and walking towards making threats. I called the psych techs, administration, and R2's physician. I received orders to send R2 to the hospital. On 3/22/26 at 6:45 PM, V5 [R1's Friend] stated, R1 came to see me at my job on 3/19/26. R1 told me she was thinking about leaving the nursing facility and not returning because she was tired of R2 and wanted a new start. I told R1 she needs to allow the facility to help her with housing program, and (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medical support. R1 told me R2's behavior has gotten worse over time due to him drinking and smoking and needed to get away from R2. R1 did not tell me that R2 hit her. I called V1 [Administrator], and I explained to V1 that R1 needs her own space and room and needs time away from R2. V1 ensured that she will move R1 out of the room. The same day, when I got off work, I went to the facility and R1 was in a new room on a different floor from R2. On 3/24/26 at 1:40 PM, V1 [Administrator] stated, I was not made aware that R1 was being abused by R2. I was not made aware that R1 felt afraid or nervous being in the room with R2. The moment V5 called me on 3/19/26, I moved R1 out of the room immediately. While speaking with R1, she never told me R2 hit her or anything If so, I would have immediately called the police. Later the same day, R2 returned from community pass and was upset, yelling, swearing and making threats to the nursing staff, 911 was phoned and R2 was petitioned to the hospital. R2 received an involuntary discharge from the facility. R2 is not allowed back on the facility's premises. My expectation is, if any resident tells any staff member, they are afraid or nervous being around another resident or staff member, they should have notified me immediately. I am the facility's abuse coordinator. All new hires receive abuse training in orientation. All staff receive abuse training annually and as needed. The last abuse training was 12/11/25. Policies documented in part:Abuse Prevention Program 1/2019Any alleged violations involving mistreatment, abuse, neglect, exploration, misappropriation of resident property, any injuries of an unknown origin, or reasonable suspicion of a crime against a resident must be reported to the Administrator.Additionally, the persons observing an incident of resident abuse or suspecting resident abuse must immediately report such incidents to the Administrator.This facility will not tolerate residents abuse by anyone including staff members and other residents. All personnel must promptly report any incident or suspect incident of resident abuse.