| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145938 | A. Building<br>B. Wing | 04/03/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Landmark of Hyde Park Rehabilitation and Nursing C | 6125 South Kenwood<br>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<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure four [R1, R4, R5, R13] of eight residents remained free from abuse. This failure resulted in: R2 sustained a closed fractured tooth, human bite, swollen lip and pain. R4 sustained displaced fracture of distal phalanx of right ring finger and displaced fracture of proximal phalanx of right little finger, and pain. R5 sustained forehead altered skin integrity, that required 911 transport for emergency treatment. Findings include: 1. R1's clinical record indicates the following in part: R1 is a fifty-four-year-old with medical diagnosis of: Displaced fracture of lateral Right Fibula, asthma, chronic heart failure, anemia, overactive bladder, schizophrenia, and major depression. R1's minimum data set [MDS] Brief Interview Mental Status Score [15] indicates R1 is cognitively intact.<br><br>R1's progress notes in part:<br><br>On 2/9/26 at 12:34 AM, V21 [Registered Nurse] Note:<br><br>R1 was attacked by her roommate [R2] while sleeping. R1 said the roommate called her a b****, bit her middle finger, scratched her face, and R1's lips were slightly swollen. R1 was sent out for medical evaluation.<br><br>R1's Emergency Department document in part:<br><br>Dated 2/9/26-Reason for visit, Victim of assault, closed fracture of tooth- initial encounter, and human bite-initial encounter. Medications given: Amoxicillin-potassium clavulanate, and tetanus diphtheria injection.<br><br>R2's clinical record indicates in part: R2 is a twenty-eight-year-old with medical diagnosis of schizophrenia, restlessness, agitation, cardiac arrest, respiratory failure, and hemiplegia. R2's minimum data set [MDS] Brief Interview Mental Status Score [15] indicates R2 is cognitively intact.<br><br>R2's Care plan in part:<br><br>R2 displays conflictual difficult behaviors manifest by conflict, anger towards friends and roommates.<br><br>R2's Progress noted in part:<br><br>On 9/2026, at 12:12AM V21 Note [Registered Nurse]<br><br>Note Text: R2 attacked her roommate [R1] while sleeping and bit her [R1] on her right middle finger.<br>(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 |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | There is a finger scratch on her face, and her lips are slightly swollen. The physician was called and ordered R2 to be sent to hospital for Psych -evaluation.<br><br>On 3/31/26 at 1:10 PM, R1 stated, R2 and I were roommates. I was sleeping in bed late at night with a fractured ankle. The nurse helped me in the bed and must have left my wheelchair in the pathway. I was asleep when R2 started calling me b****ches, yelling and screaming at me about my wheelchair blocking the pathway. R2 came over to my bed and started hitting me in the face, head and bit my finger. I could not get up a get away from her due to my fractured ankle. Finally, the nurse came in a pulled R2 off me. My finger was hurting swollen, my mouth was bleeding, and my face had scratches. I was sent to the hospital, and they moved R2 out the room.<br><br>On 3/31/26 at 1:20 PM, R2 stated, I was R1's roommate. R1 used an extra-large wide wheelchair and always blocked the pathway so I could not get to my side of the room. I yelled at R1 and told her I was tired of her leaving the wheelchair in my way. R1 told me to shut the f*** up. R1 and I started arguing then we both started hitting each other. I'm not going to allow anyone to disrespect me. Yes, I hit R2 first, because R1 told me to shut the f*** up. Yes, I bit R1's finger, because she was trying to swing on me. I got R1's finger in my mouth and I bit R1's finger. The nurse came and pulled me off R1. I'm tired of these people disrespecting me.<br><br>On 4/1/26 at 2:00 PM, V22 [Certified Nurse Assistant] stated, I worked on 2/9/26, and was R1 and R2 certified nurse assistant. I was assisting another resident and saw the call light on for R1 and R2's room. I entered the room and saw R2 on top of R1 in R1's bed. I called out for help for another staff member assisted me to get R2 off of R1. I saw R1 bleeding; I was not sure where the blood was coming from. R1 had scratches on her face, her lips were swollen and R1 told me R2 bit her finger, and it was hurting. The nurse came to assess the residents.<br><br>On 4/1/26 at 3:50 PM, V21 [Registered Nurse] stated, I was R1 and R2's nurse the day of the incident. The certified nurse assistant came and got me. R1 said she was attacked while sleeping by R2. R1 was noted with a swollen lip, her finger was bitten, and R1 had some scratches on her face. The two residents were separated and R1 was sent to the emergency room for evaluation. R2 was known to have aggressive behaviors in the past. R1 has not had any aggressive encounters. They are no longer roommates.<br><br>On 4/1/26, V5 [Social Service Director] stated, I started working here 11/24/2025. I assist with investigation abuse related to behaviors. R1 and R2 shared a room together. On 2/9/26 around 12:30 AM, R1's wheelchair was in the pathway. R2 started arguing with R1, when R1 was sleeping in bed. R1 said R2 was hitting her, bit her finger, hit her in the mouth, and scratched her face. R2 was moved to another floor and being monitored closely.<br><br>On 4/2/26 at 2:55PM, V1 [Administrator] stated, I did not substantiate abuse. There was no witness when the residents contacted each other. Their rooms were separated.<br><br>2. R3's clinical record indicates in part: R3 is a forty-three-year-old with medical diagnosis of anxiety disorder, major depression, cannabis abuse, left hand contracture, essential hypertension, embolism and thrombosis of artery. R3's minimum data set [MDS] Brief Interview Mental Status Score [14] indicates R3 is cognitively intact.<br><br>R3's Progress note in part:<br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | V8 [Registered Nurse/Nurse Supervisor]- 1/23/26 at 9:45 PM<br><br>R3 allegedly made contact with another resident [R4]. R3 immediately separated other peer. Body assessment performed no apparent injury noted.<br><br>1/24/26, at 4:59 AM Nurse Note:<br><br>R3 admitted in hospital diagnosis with major depression.<br><br>R4's clinical record indicates in part: R4 is a thirty-four-year-old with medical diagnosis of schizophrenia, psychophysiologic insomnia, displaced fracture of distal phalanx of right ring finger dated 1/28/26, and displaced fracture of proximal phalanx of right little finger dated 1/28/26.<br><br>R4's Progress Note in part:<br><br>V8 [Registered Nurse/Nurse Supervisor] Note-1/23/26 at 9:54PM. Another peer [R3] allegedly made contact with R4. R4 immediately separated from peer. Noted slight swelling and redness to the right hand. MD order Xray to the right hand.<br><br>V29 [Licensed Practical Nurse] Noted: 1/28/26 at 5:22 AM, R4 returned back to the facility with diagnosis of right fourth and fifth metacarpal fractures.<br><br>R4's emergency room document:<br><br>1/28/26: R4 diagnosis with displaced fracture of distal phalanx of right ring finger and displaced fracture of proximal phalanx of right little finger.<br><br>On 3/31/26 at 2:15 PM, R3 stated, R4 and I were roommates. I don't remember why we started to argue. R4 is not his right mind. R4 talks to himself and hears voices. There is nothing wrong with my mind. We were arguing and R4 came over to me. It looked like he had a fork, so I started hitting him with my cane. Yes, I hit R4 first, because I saw something in his hand, I'm not sure what was in his hand. They sent me to the hospital for a psych eval and moved R4 out the room to another floor.<br><br>On 3/31/26 at 2:35 PM, R4 stated, R3 and I were roommates. R3 kept coming over to my side of the room bothering my television. I kept telling him to stop. We got into an argument and R3 drove his electric wheelchair over to my side of the room. Out of nowhere, R3 started hitting me hard with his cane. I was trying to block the hits, but he kept hitting my hand and broke it. Staff came and took the cane from R3 and sent him to the hospital. I wanted a room change, and they moved my room that day. I did not want to go to the hospital; the people came here and took a picture of my hand. My hand still hurts, this my right hand it hurt every time I move it, but it's getting better.<br><br>On 4/3/26 at 1:05 PM, V17 [Certified Nurse Assistant] stated, I was their aide on the day of the incident. Earlier, I did not notice anything different with R3 and R4. All I know is R3 hit R4 with his cane. I did not witness the fight, but I saw R4's hand was swollen.<br><br>On 4/1/26, V5 [Social Service Director] stated, R3 and R4 had an incident on 1/23/26. I learned that R4 was listening to loud rap music on his television and R3 went and turned it down. They both started to argue and R3 hit R4 with the cane on R4's hand as R4 was trying to block the cane. R3's cane was removed, because he used it as a weapon to injury R4's hand. R4 agreed for a room change, (continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | he was moved to a different floor.<br><br>On 4/2/26 at 2:55PM, V1 [Administrator] stated, The allegation of abuse was not substantiated, R3 unintentionally made contact with R4's hand.<br><br>3. R5's clinical record indicates the following in part: R5 is a twenty-three-year-old with medical diagnosis of anxiety disorder, homicidal ideations, stimulant use, and anemia. R5's minimum data set [MDS] Brief Interview Mental Status Score [15] indicates R5 is cognitively intact.<br><br>R5's Notice of Involuntary Transfer or Discharge and Opportunity for Hearing for Nursing Home Residents dated. 1/23/26, document in part:<br><br>Reason for discharge: The safety of individuals in this facility is endangered.<br><br>R5's Care plan in part:<br><br>R5 demonstrates behavior distress. R5 will refrain from verbally or physically abusive behavior following staff intervention.<br><br>R5's Progress notes in part:<br><br>V27 [Licensed Practical Nurse] Note: 1/23/26 at 3:40 PM:<br><br>It was reported that R5 made contact with co-peer [R6] in dining area. Both residents separated immediately. Body assessment completed with noted altered skin integrity. R5 sent out 911.<br><br>[Per Administrator [V1] V27 was currently hospitalized , not available for interview].<br><br>V5 [Social Service Director] Note: 1/23/26 6:27PM:<br><br>R5 was given a Notice of Involuntary Discharge and Opportunity for Hearing for Nursing Home Residents (IVD) form. The form was given by the Administrator and the Social Services Director.<br><br>R6's clinical record indicates the following in part: R6 is a fifty-year-old with medical diagnosis of schizoaffective disorder, glaucoma, essential hypertension, weakness, heart failure, type II diabetes, and chronic obstructive pulmonary disease.<br><br>V27 [Licensed Practical Nurse] Note dated 1/23/26 at 3:33PM in part:<br><br>It was reported R6 made contact with co-peer R5 in dining area. Residents were separated immediately with body assessment completed with no altered skin integrity observed.<br><br>V5 [Social Service Director] Note dated 1/23/2026, at 6:29PM in part:<br><br>R6 was given a Notice of Involuntary Discharge and Opportunity for Hearing for Nursing Home Residents (IVD) form. The form was given by the Administrator and the Social Services Director.<br><br>V27 [Licensed Practical Nurse 1/23/2026, 10:00PM<br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | R6 admitted to hospital with admitting diagnosis of Schizophrenia.<br><br>On 4/2/26 at 2:38PM, V5 [Social Service Director] stated, Per my investigation, R5 and R6 was in the dining room during day shift. R5 threw her cell phone through the dining room door, and R6 told staff what R5 did. Then R5 started hitting R6, then R6 started hitting R5 back. R5 had an injury to her forehead form R6. Both residents exhibit very aggressive behavior and were not easily re-directed. Both received an involuntary discharge.<br><br>On 4/2/26 at 2:55PM, V1 [Administrator] stated, The allegation was not substantiated, because there was no witness. All new hires receive abuse training during orientation, annually and as needed. The last abuse training was in December 2025.<br><br>Policy Documented in part:<br><br>Abuse Policy dated 3/1/2021 in part:<br><br>This facility prohibits and prevents resident abuse, neglect, exploitation, mistreatment, and misappropriation of resident property and a crime against a resident in the facility.<br><br>The facility will not tolerate resident abuse or mistreatment or crimes against a resident by anyone, including staff members, other residents, or family members.<br><br>Abuse: The willful infliction of injury, unreasonable confinement, intimidation or punishment resulting in physical harm, pain, or mental anguish.<br><br>Physical abuse: Hitting, slapping, pinching, kicking etc.<br><br>3. R13 is a [AGE] year-old resident with diagnoses that include but are not limited to fracture of right and left foot; cellulitis of left lower limb; fracture of upper and lower end of right fibula; old myocardial infarction; psychoactive substance abuse; schizoaffective disorder.<br><br>R13 progress note dated 3/6/2026, reads in part: Co-resident (R14) alleged made physical contact with the resident (R13). Staff immediately separated residents, complete body check done, resident (R13) noted with skin alteration to upper right lip.<br><br>R13 MDS (Minimum Data Set), 2/16/2026, BIMS (Brief Interview for Mental Status) score is 15 indicating intact cognition.<br><br>R13 Abuse/Neglect/Exploitation/Trauma care plan, initiated 3/8/2026, documents in part: 3/6 – Incident with peer.<br><br>On 3/31/26 at 1:58 PM, R13 said R14 hit me in the head. R14 stabbed me in the face. I don't know with what. R14 came at me out of the blue. I don't know R14. I was in my wheelchair waiting for the elevator. I fell backwards in the chair and fell to the floor. I had blood coming from my face. I did not go to the hospital.<br><br>R14 is a [AGE] year-old resident with diagnoses that include but are not limited to polyneuropathy; major depressive disorder; anxiety disorder; schizoaffective disorder, bipolar type; psychosis not due to a substance or known physiological condition; delusional disorder; auditory hallucinations; (continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | restlessness and agitation; violent behavior homicidal and suicidal ideations.<br><br>R14 MDS (Minimum Data Set), 2/16/2026, BIMS (Brief Interview for Mental Status) score is 8 indicating moderately impaired cognition.<br><br>R14 progress note, 3/6/2026 16:03, documents in part: Resident (R14) presents with bizarre aggressive behaviors with physical behavior involved towards peer (R13). Resident refuses prn (as needed) medications with resident currently on 1:1 with staff until discharged from facility.<br><br>R14 progress note, 3/6/2026 16:43, documents in part: Writer informed by staff that resident (R14) was involved in an altercation with co peer (R13) with them immediately separated with resident observed with no injuries. Resident refuses prn (as needed) medication with 1:1 initiated until discharge from facility. Writer informed psych doctor of behaviors with orders received to send resident out with petition.<br><br>R14 Ineffective Coping care plan, initiated 8/9/2024, documents in part: R14 has a problem with ineffective coping and has displayed difficulty with managing/responding to stressful situations including lack of acceptance about the realities of current health/psychiatric illnesses and need for services in a structured care setting environment. Additionally, the resident has been noted to present with cognitive deficits, confusion, and behaviors that include forgetting that they have eaten meals/snacks and complaining that they were not provided meals/snacks. Misuse of 911 emergency services to report meal/snack issues, repeated misuse of call light, becoming upset and aggressive with personnel, having repetitive verbalizations and requests despite having all needs regularly and satisfactorily addressed by personnel. On 10/29/2024 resident attempted physical aggression towards staff and was redirected.<br><br>R14 is care planned for demonstrating behavioral distress related to feeling powerless, out of control. Problems are manifested by verbally abusive behavior when agitated, initiated 11/14/2024.<br><br>4/1/26 at 2:20 PM, V33 (Psych Tech) stated they were at the desk at the elevators. They were helping a resident in a wheelchair onto the elevator. The residents were coming in from smoke break. The line was pretty long, at least 15 residents. R13 was against the wall in the line to get onto the elevator. R13 was close in vicinity to the elevator. R14 came from outside smoking. R14 just came from out of nowhere and ran upfront and hit R13. I saw R14 swinging at R13s face. R14 did not have anything in their hands. We grabbed R14 and another Psych Tech escorted R14 to their floor. I don't recall who the other Psych Tech was. I did not notice any scratches, or blood. To keep them separated R13 was sent to the dining area.<br><br>4/1/26 at 3:00 PM, V4 (Assistant Administrator) stated, I was walking past when the residents were coming from smoke break from the patio. They were lined up for the elevator. I assisted a wheelchair into the elevator. R13 never said a word to R14. R14 came from the end of the line. R13 was in their wheelchair at the elevator area. R14 attacked R13 at the elevator area. R14 punched R13 in the face. Maybe it was R14s nails that scratched R13 near the mouth. I grabbed R14 and had a Psych Tech take them upstairs. I took R13 to the dining room. R13's nurse came to do their assessment. R14 was put on 1:1. Afterwards when EMS (Emergency Medical Service) was taking R14 out, R14 said I don't like here. I don't like anybody here. I want to leave now. I don't want to be here. I don't want to come back. R13 told me they (R13 and R14) don't even talk.<br><br>On 4/1/26 at 3:50 PM, V20 (Registered Nurse) stated they was R13's nurse when the incident<br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | happened. They came downstairs to assess R13. R13 was in their wheelchair with no distress, no complaint of pain. V20 stated they saw a little skin tear near R13's mouth/lips. There was no blood. R13's vital signs were stable. R13 was taken upstairs to their room, and a complete body check was done. There were no other marks or injury on the rest of R13's body. V20 notified the physician. R13 took their regular scheduled medication. R13 was in bed when V20 left at the end of the 3pm-11pm shift.<br><br>On 4/1/26 at 4:16 PM, V1 (Administrator) stated I am the Abuse Coordinator. I do trainings for all staff on abuse quarterly and as needed. Types of abuse include physical, mental, sexual, emotional, financial, neglect. I was in my office and heard the code called. R13 was in the dining room yelling to me You owe me money. I received the information from my team. R13 said they didn't know R14. The team told me R14 came out of nowhere from the back of the line. The residents were coming in from outside. I saw R13 had a scratch on their face/mouth area.<br><br>On 4/2/26 at 11:23 AM, V4 (Assistant Administrator) stated R14 was IVD (Involuntarily discharged ) because of aggressive behavior when they attacked R13. R14s baseline was aggressive behavior. There have been other instances of R14 being physically aggressive to other residents, verbally aggressive toward staff. Previously, in 12/24, R14 was petitioned, IVD. R14 has a diagnosis of violent behavior. We (the facility) couldn't guarantee R14s safety and the safety of the other residents with R14 here due to their aggressive behavior. That's why we did the IVD. R14 has a State appointed guardian. We notified the guardian and R14s mom of the IVD. We sent a copy with the petition with R14 to the hospital. We emailed a copy to the Ombudsman and to IDPH (Illinois Department of Public Health).<br><br>R14 Petition for Involuntary/Judicial Admission, 3/6/2026, documents in part: V14 presents with bizarre aggressive behavior, physical aggression towards peer (R13). R14 is in need of immediate hospitalization for psychiatric evaluation to prevent them from harming self and others.<br><br>R14 Notice of Involuntary Transfer or Discharge and Opportunity for Hearing for Nursing Home Residents, 3/6/2026, indicates R14's immediate discharge due to the safety of individuals in the facility is endangered.<br><br>R13 Incident Report, Physical Aggression Received, 3/6/2026, documents in part: Co-resident (R14) allegedly made physical contact with the resident (R13). Staff immediately separate residents, complete body check done, resident noted with skin alteration to upper right lip.<br><br>R14 Incident Report, Physical Aggression Initiated, 3/6/2026, documents in part: Writer informed by staff that resident (R14) was involved in an alleged altercation with co peer (R13) with them immediately separated with resident observed with no injuries. Resident immediately separated with no injuries observed on resident with them offered prn (as needed) medications with them refusing with resident placed on 1:1 with staff with psych doctor aware of behavior. Writer received orders to send resident out to hospital related to behaviors<br><br>Facility Report of Incident, follow-up report, incident date 3/6/2026, involving R13 and R14 documents in part: It is alleged that R1 (R14) allegedly made contact with R2 (R13). Residents separated. Body assessment completed on both residents by nursing. R2 (R13) noted with scratch to right side of the mouth. Police was notified. Medical doctor contacted with order to send R1 (R14) to the hospital for psychiatric evaluation, family and guardian notified appropriately. R1 (R14) was on 1:1 monitoring until discharge to hospital.<br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Facility Abuse Prevention Program Policy, 3/1/21, 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, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental psychosocial well-being. 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. |

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| Landmark of Hyde Park Rehabilitation and Nursing C | 6125 South Kenwood<br>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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow a resident's fall care plan for 1 (R10) of 3 residents reviewed in a total sample of 18.Findings include:R10's clinical records show an initial admission date of 01/13/2026 with listed diagnoses not limited to heart failure, anemia, gastro-esophageal reflux disease, history of falling, dementia, anxiety, bipolar disorder, schizoaffective disorder, major depressive disorder.R10's MDS (minimum data set) with review date of January 30, 2026, documents in part the BIMS (brief interview for mental status) of 10 indicating that R10 has moderate cognitive impairment.Care plan with review date of 03/02/2026 documents in part neuro-checks, Bilateral floor mats, reclining chair, special mattress, Reorder comfort pack, Apply bilateral bed bolters, educate family and care givers about safety reminders and what to do if a fall occurs.R10's progress notes dated on 2/28/2026, documents in part, Nurse was informed by CNA that resident was observed on the floor by the bedside. Nurse assessed resident. Resident was observed with skin alteration to forehead. First aid provided. Nurse and CNA place resident back in bed. ROM WNL. Nurse called 911. Residents do not appear to be in acute distress. Nurse called son in law and Lumina Care. Ambulance arrived via 2 attendees. Resident was taken to University of Chicago. R10's progress notes dated on 3/15/2026, documents in part, Resident was noted on the floor to the right of her bed, safety mattress in place. Resident assessed by writer, and returned to bed via hoyer Lyft, no injuries noted at this time. ADON made me aware. Family member aware, no concerns voiced. Phone numbers listed for MD aren't open for calls at this time. Voice message left on system for MD will endorse to am nurse to f/u/ make MD aware of fall. Neurochecks initiated. BP 132/88 P 81 T 98.3 R 18 O2- 96%ra.R10's progress notes dated on on 03/17/2026, documents in part, Resident attempted to get off bed and rolled to the right side of bed on the floor mat. Resident vitals were taken Bp:126/74 Pulse:72 Temp:97.6 O2:97% on room air. Writer completed A head to toe assessment. Resident is A & O X 2-3 in stable condition no injuries or bruising noted. Md notified , Emergency contact notified no answer, DON notified, Hospice and palliative care made aware. Patient care is ongoing writer will continue to monitor resident.R10's fall risk assessment dated [DATE] R10 is high risk for fall. This fall risk assessment also shows R10 has had 3 or more falls in the past 3 months. R10 has had a fall on 2/28/26, 3/15/26, 3/17/26, 3/27/26.On 03/31/2026 at 12:16 PM, surveyor observed R10 laying down on her bed sleeping. There were bilateral floor mats, one on the left side, the other mat was on the right side. There were 2 wedges in place, one on the left side and the other on the right side. The air mattress was functioning well. Resident was sleeping, however when this surveyor introduced self, R10 opened her eyes, and responded to her name.On 04/01/2026 at 12:10 PM, V2 (Director of Nursing/ DON) stated the resident was sent to the hospital on [DATE]. V2 stated the cause of the fall was due to R10 experiencing anxiety. V2 stated R10 has been experiencing a lot of anxiety and restlessness lately and has had frequent falls. V2 stated the hospice team has been notified for further evaluation. V2 stated some interventions that are taking place are to ensure R10 is up in the dayroom, and she was also moved closer to the nurse's station. Surveyor asked when the last time R10 had a room had changed. V2 stated she was not sure and looked at R10's electronic medical record (EMR). After reviewing R10's EMR, V2 stated there has been no room change yet. V2 stated that it has not been discussed, however it is not a bad idea and considering a room change now. Surveyor asked V2 what can potentially happen if R10 is not being closely monitored, and if she considers R10 a priority to be monitored at all times to prevent frequent falls. V2 stated it is a priority and she will have R10's room change near the nurses station.On 04/02/2026, surveyor reviewed R10's care plan, R10 does not have a room change in her care plan. R10 is currently in room which is not near the nurse's station. On 04/02/2026 at 9:48 AM, V7 (Restorative Nurse) stated the hospice team will evaluate R10 due to her increase level of impulsiveness. Surveyor stated what can<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 145938 | A. Building<br>B. Wing | 04/03/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | potentially happen if a resident who has been more agitative and impulsive causing frequent falls is not being monitored by staff. V7 stated this morning that R10 was moved from room [ROOM NUMBER] to room [ROOM NUMBER], which is now closer to the nurse's station.On 04/03/2026 at 9:15 AM, a phone interview conducted with V26 (License Practical Nurse/ LPN) stated R10 in on hospice, she has been more agitated at times, she moves a lot, and she is at risk for falls. V26 stated R10 requires a lot of supervision. V26 stated R10's room is 208, which is in the middle of the hallway. Surveyor asked V26 if she considered that room to be near the nurse's station. V26 stated the room is in the middle of the hallway and not near the nurse's station. Surveyor asked V26 what can potentially happen to R10 if she is not supervised frequently. V26 stated anything can happen if R10 is not being supervised.On 04/03/2026 at 9:07 AM, a phone interview conducted with V30 (Agency Registered Nurse) stated on the day of the fall, housekeeping walked by R10's room and noted R10 was on the floor. Surveyor asked V30 if R10's room was near the nurse's station. V30 states R10's room was mid hallway; her room was not near the nurse's station. Surveyor asked V30 if she would consider it beneficial if R10's room was near the nurse's station. V30 stated it would be beneficial for R10 to be near the nurse's station because R10 is not able to utilize a call light.On 04/03/2026 at 9:40 AM, V31(License Practical Nurse/ LPN) stated on the day of the fall I was informed by the certified nurse's assistant that R10 had a fall. V31 stated R10 is not alert enough to use a call light, and due to that reason, she would make sure to have R10 up in the dining room or stationed by the nurse's station. V31 stated she did not feel comfortable leaving R10 unsupervised in her room, which is in the middle of the hallway. V31 stated R10 does always require frequent supervision, and with the room being so far down the hallway it made it difficult to keep an eye on R10.Policy title Fall Prevention and Management Program with no review date, documents in part, the facility is committed to safety and maximizing each resident's physical, mental and psychosocial well- being. Through an interdisciplinary approach, this facility will provide fall prevention assessment, implement interventions to prevent falls as much as possible, and manage post fall treatment. Interventions that are implemented based upon the identified risk factors. Reassessment of risk after a fall with modification and/ or additional interventions as appropriate. |