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	05/29/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview and record review, facility failed to follow their policy to ensure residents are allowed to go out on pass individually for one (R8) out of three residents reviewed for community pass in a sample of 20. The facility also failed to replace a voters' registration card after being voiced to staff and documented in a grievance form for one resident (R6) in a total sample 20.Findings Include:1. On 05/27/2026 at 10:57 AM, R8 was in his room. R8 stated that he is not allowed to go out on pass. I am compliant with my medications. I have no physical or mental limitations. R8 stated that his pass was revoked on 04/28/2026 for some reason. They never gave me a reason. Just something that the doctor ordered me a red pass.On 05/27/2026 at 1:16 PM, V8 (Social Service Director) stated that social service does the community skills assessment. V8 stated based on that assessment, it is determined if the resident can go out on pass themselves. V8 stated that she is familiar with R8. V8 stated that R8 does have an independent pass. V8 stated that R8 came in twice late, outside the curfew. V8 stated that he did not notify the facility that R8 was coming in late. V8 stated that the doctor gave the order to suspend his passes for two weeks. Surveyor verified with V8 that there was no documentation about R8 coming back late from being out on pass. V8 stated that she doesn't document the reason but just the fact that R8 was notified that his pass was revoked.On 05/28/2026 at 10:30 AM, V32 (Medical Doctor) stated that he overlooks R8's care. V32 stated that R8 is stable to go out into the community by himself. V32 stated that no staff member have notified him about R8 coming late or his pass being revoked.MDS (minimum data set) with review date of May 6th,2026 documents a BIMS (brief interview of mental status) has a score of 13 indicating R6's cognition is moderate.On 05/26/2026 at 11:34 AM, this surveyor observed R6 wheeling himself in a wheelchair from the dining room to his room. R6 is alert and oriented to person, place and time. R6 appears calm and collected, free from pain. R6 stated he has been in the facility since March 2026, and since then he noticed that his voters registration card is missing. R6 stated he notified V8 (Social Services Director) about it but still does not have his card.On 05/28/2026 at 9:37 AM, V1 (Administrator) stated R6 did make her aware last week of his missing voters registration card. V1 stated there was a concern form that was filled out, in which V8 followed up on. V1 stated she showed V8 how to search if R6 is registered to vote on the website.2. On 05/28/2026 at 9:54 AM, V8 (Social Services Director) stated R6 had a concern with not having his voter's registration card. V8 stated R6 filled out a concern form, where R6 addressed this concern. V8 stated one evening R6 came into her office and shared these concerns with her, that day they both logged in to the voter's registration website. V8 stated she typed in R6's name and date of birth , she then notified R6 that he has never registered to vote, because to register to vote, he needs an identification card. V8 stated there is a form that needs to be filled out for applicants who have no source of income. V8 stated she and R6 are still working on getting his identification card and eventually on the voter's registration card as well. This surveyor asked V8 if she has any record or documentation of the date and time, she assisted R6 in getting him a replacement for his voter's registration card. V8 stated she printed the form as a receipt and has it in her office, she stated she will return and present it to this surveyor.On 05/28/2026 at 10:55 AM, V8 returned to the conference room, and presented to this surveyor a (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	document titled Registration Look up Results with no date and time. After carefully reviewing the document, this surveyor noted the documents stated R6 is actively registered to vote in the state of Illinois. This surveyor asked V8 for clarification as to why she had not simply replaced R6's voters registration card, if he is already registered to vote. V8 appeared to be in denial regarding R6's status on being able to vote, as she originally had stated that R6 did not have a voters registration card when she looked him up on the Illinois Online Voter Application website. V8 had initially stated that R6 was never registered to vote and due to that reason, she was not able to replace R6's voters registration card. This surveyor provided the Registration Look up Results form. After V8 read the form, she confirmed that R6 is already registered to vote in the state of Illinois. V8 angrily approached this surveyor and stated she does not know how to get R6 a replacement voters registration form.Reviewed R8's progress notes. No documentation about notifying V32 (R8's physician), regarding revoking R8's right to go out on pass. Plus, no documentation on the reason for revoking R8's independent community pass.R8's progress note on 04/24/2026 documents in part: Resident out on pass with family. Scheduled to return 04/26/26 by 7:00 PM.R8's progress note on 04/26/2026 at 6:55 PM documents in part: R8 returned from pass in good condition.R8's community skills assessment on 04/27/2026 documents in part: R8 is approved for green pass and able to navigate the community independently.R8's care plan documents in part: The resident requires the support, care and services of a long-term care facility and has been determined by community access assessment to be able to access the community without supervision.Facility's Outside Community Pass Privilege Policy (06/2024) documents in part: The Interdisciplinary team (IDT) will meet on a daily basis to review resident incident reports, behavior forms, nursing notes social services notes, concern forms etc. and place residents on 72-hour restriction, red pass status, yellow pass status or green pass status.Policy and procedure titled, resident rights with no review date, documents in part as a resident of this facility, you have the right to a dignified existence and to communicate with individual and representatives of choice. The facility will protect and promote your rights as designated below. You may voice grievances concerning your care without fear of discrimination or reprisal. You may expect prompt efforts for the resolution of grievances.

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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, facility failed to ensure residents are free from physical abuse for one (R10) out three residents reviewed for abuse in a sample of 21.Findings include:On 05/26/2026 at 12:30 PM, R16 stated that he heard R12 going into R10's room and beating her up. R16 stated that he even heard that R10 was bleeding a little bit but he never saw it. R16 stated that whole floor knows R12 beat up R10. R16 stated that the incident happened around midnight. R16 stated that R12 is known to have behavior problems.On 05/26/2026 at 2:44 PM, V7 (Registered Nurse) stated that he is familiar with R12. V7 stated that he was R12's nurse when R12 had an incident with R10. V7 stated that the incident happened around midnight. V7 stated that he was off the unit. V7 stated that he received report from the CNA of what happened. V7 stated that the CNA mentioned to him that R12 hit R10. V7 stated that R12 was placed on 1:1 and was given Haldol (antipsychotic medication). V7 stated that the police were called, and they came. V7 stated that he doesn't remember who that CNA was. V7 stated that he notified his supervisor.On 05/27/2026 at 10:39 AM, V20 (Assistant Administrator) stated that he is familiar with R12 and R10. V20 stated that he was the person who did the investigation. V20 stated that he interviewed the pysch tech and R16. I think V7 (Licensed Practical Nurse) was the first staff to intervene between R12 and R10's fight. V20 stated that fight happened on 02/21/2026. V20 stated that he is not sure what time it happened. Surveyor verified with V20 that there is no time on the initial report submitted to IDPH. V20 said R10 told him that R12 came to her room and grabbed her arm. V20 stated that R12 came to R10's room. V20 stated that R12 grabbed R10 and fought her. R12 has been doing that for a long time and R10 didn't do anything. V20 stated that he submitted the reportable around 2:00 PM that same day. V20 stated that initial reportables are to be submitted within 2 hours of being notified. V20 stated that he was notified in during day that this incident happened.On 05/26/2026 at 2:00 PM, V18 (Licensed Practical Nurse) stated that she heard from the previous night shift that R12 fought R11. V18 stated that she is not sure of the full details but just the fact that they were separated when the CNA came in.On 05/26/2026 at 1:08 PM, V6 (Social Worker) stated that she has been working in the facility for two years. V6 stated that she is familiar with R12. V6 stated R12 has behavior issues on and off. V6 stated that R12 has become verbally aggressive with residents and staff. V6 stated that R12 had an incident where she was angry and she was slapping staff and throwing water at social services. V6 stated that R12 had a verbal disagreement with R10. V6 stated that she doesn't know if R12 physically hit R10.R16's minimum data sheet (MDS) Section C documents in part: R16 have a Brief Interview of Mental Status (BIMS) score of 15. R16 are cognitively intact.R16's written statement on 02/21/2026 documents in part: R12 went into R10's room and started fighting her.Facility's abuse policy (01/2019) documents in part: Any 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 or Director of Nursing (DON). The Administrator is the Abuse Coordinator of the facility. Additionally, the person(s) observing an incident of resident abuse or suspecting resident abuse must immediately report such incidents to the Charge Nurse who will immediately report the allegation to the Administrator, regardless of the time lapse since the incident occurred. The charge nurse will immediately report the incident to the Administrator or to the DON during the Administrator's absence. This report shall be made immediately, but no later than two hours after the allegation is made. Crimes include but may not be limited to murder, manslaughter, rape, assault and battery, sexual abuse, theft robbery, drug diversion for personal use or gain, identity theft, and fraud and forgery. 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. if you suspect abuse; separate the alleged perpetrator and assure all residents safety. Notify the Administrator and Director of Nursing (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	immediately. If the Administrator or DON are not present in the facility, notify the nursing supervisor who will notify the Administrator/DON immediately. Complete an Incident Report immediately. Do not leave the building until above is completed. Fax report to IDPH immediately. Any incident involving abuse, neglect, exploitation, misappropriation of property, or a crime against a resident will result in an abuse investigation. Any incident that involves crimes or a significant injury to a resident will be reported within 2 hours of the incident. For the purposes of this policy, and to assist staff members in recognizing abuse, the following definitions shall pertain: Physical Abuse: Hitting, slapping, pinching, kicking, etc. It also includes controlling behavior through corporal punishment.

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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 properly report allegation of misappropriation of property for one (R9) out of three residents reviewed for misappropriation of property in a sample of 20. Facility also failed to report abuse within 2 hours of notification of abuse allegation for two (R10, R12) out of three residents reviewed for reporting of abuse allegation in a sample of 20. Findings include:1. R9's minimum data sheet (MDS) Section C documents in part: R9 has a Brief Interview of Mental Status (BIMS) score of 15. R9 is cognitively intact.On 05/26/2026 at 11:00 AM, surveyor observed R9 in her room on her bed. R9 stated that people have been coming into her room and taking her stuff. R9 stated that she has mentioned to CNAs, and nurses. R9 stated that she doesn't remember the names of who she has told. R9 stated that this one black woman would come in and take my money.On 05/26/2026 at 1:08 PM, V6 (Social Worker) stated that she has been working in the facility for two years. V6 stated that she is familiar with R10. V6 stated that she heard from her office about R10 taking people's things. V6 stated that she never reported it because it was never actually reported to her. V6 stated that she is expected to report all allegations of abuse and theft to the administrator. V6 stated that she heard about R10 taking other residents' things from people talking in the halls.On 05/28/2026 at 12:15 PM, V1 (Administrator) stated that all staff are expected to report any theft to her immediately. V1 stated that it doesn't matter if it was reported to them or not. Any time they hear of any allegation of abuse or theft, it to be reported to me immediately. V1 stated that no staff member have reported to her about any allegation of theft. V1 stated that abuse is to be reported to the State Survey Agency within two hours.2. On 05/26/2026 at 12:30 PM, R16 stated that he heard R12 going into R10's room and beating her up. R16 stated that he even heard that R10 was bleeding a little bit but he never saw it. R16 stated that whole floor knows R12 beat up R10. R16 stated that the incident happened around midnight. R16 stated that R12 is known to have behavior problems.On 05/26/2026 at 2:44 PM, V7 (Registered Nurse) stated that he is familiar with R12. V7 stated that he was R12's nurse when R12 had an abuse incident with R10. V7 stated that the incident happened around midnight. V7 stated that he was off the unit. V7 stated that he received report from the CNA of what happened. V7 stated that the CNA mentioned to him that R12 hit R10. V7 stated that R12 was placed on 1:1 and was given Haldol. V7 stated that the police were called, and they came. V7 stated that he doesn't remember who that CNA was. V7 stated that he notified his supervisor.On 05/27/2026 at 10:39 AM, V20 (Assistant Administrator) stated that he is familiar with R12 and R10. V20 stated that he was the person who did the investigation. V20 stated that he interviewed the pysch tech and R16. I think V7 (Licensed Practical Nurse) was the first staff to intervene between R12 and R10's fight. V20 stated that fight happened on 02/21/2026. V20 stated that he is not sure what time it happened. Surveyor verified with V20 that there is no time of the incident on the initial report submitted to IDPH. V20 said R10 told him that R12 came to her room and grabbed her arm. V20 stated that R12 came to R10's room. V20 stated that R12 grabbed R10 and fought her. R12 has been doing that for a long time and R10 didn't do anything. V20 stated that he submitted the reportable around 2:00 PM that same day. V20 stated that initial reportables are to be submitted within 2 hours of being notified. V20 stated that he was notified in during day that this incident happened.R12 and R10 abuse initial reportable submitted to the State Survey Agency on 02/21/2026 at 2:59 PM.Facility's abuse prevention program policy (01/2019) documents in part: Any alleged violation involving mistreatment, abuse, exploration, misappropriation of resident property must be reported to the Administrator or Director of Nursing. The administrator is the abuse coordinator of the facility. The person observing an incident must immediately report such incidents to the charge nurse who will report the allegation to the administrator, regardless of the time lapse since the incident occurred. For the purposes of this policy, and to assist staff members in recognizing abuse, the following definitions shall pertain: Misappropriation of resident property is the (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	deliberate misplacement, exploitation, or wrongful temporary, or permanent, use of a resident's belongings or money without the resident's consent. When an alleged or suspected case of abuse, neglect, exploitation, or crime against a resident is reported to the facility Administrator, the Administrator, or Director of Nursing (DON) in the Administrator's absence, will notify the following persons or agencies of such incident immediately. Any incident that involves crimes or a significant injury to a resident will be reported within 2 hours of the incident. Any incident that involves a resident death will be called to the Illinois Department of Public Health immediately.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, facility failed to ensure necessary post fall interventions, to rule out injury, were completed for one (R11) out of three residents reviewed for falls in a sample of 21.Findings include:R11 is a [AGE] year old male with multiple medical diagnosis such as cerebral infarction, muscle wasting and atrophy, weakness, end stage renal disease, anemia, vitamin D deficiency, hypothyroidism, non-st elevation nstemi) myocardial infarction, atherosclerotic heart disease, systolic (congestive) and diastolic (congestive) heart failure, osteoarthritis of knee, thromboembolism.R11's progress note by physician on 03/28/2026 documents in part: Presents for evaluation post fall. R11 fell at approx. 22:15. Fall was not witnessed. R11 was lying on the bed. The CNA was completing rounds and found R11 on the floor. Per RN, the right leg was caught in the bed rails. The rest of his body was on the floor. Per RN the bed was in a low position. Patient reports hitting his head. R11 is not ambulatory at baseline.R11's progress note on 3/27/2026 documents in part: Patient was observed on the floor by the CNA. R11 was seen to have fell off from the bed with right leg hanging on bed and the upper body on the floor. R11 stated R11 hit his head. Nursing manager on duty was notified. Other staff on floor was called for help to put the patient back to bed using a full mechanical lift. Patient is alerted and oriented at baseline, PERRLA, denies pain, Upper extremities and lower extremities range of motion at baseline. Medical doctor was informed. She recommends following the facility fall precautions and Neuro check per facility guidelines. Family member was informed via phone. Will endorse to night on coming nurse.R11's physician order sheet documents in part: R11 has an order for anticoagulant.On 05/27/2026 at 12:29 PM, V2 (Director of Nursing) stated that she is in charge of investigating all the falls in the facility. V2 stated that she starts the investigation, has statements from staff and put in interventions. V2 stated that restorative help put in interventions. V2 stated that unwitnessed falls, hit the head, injury are reasons to send the resident out to the hospital after a fall. V2 stated that she is somewhat familiar with R11. V2 stated that R11 fell sometime in April. V2 stated that R11 had an unwitnessed fall. V2 stated that the CNA came in and found R11 on the floor. V2 stated that R11 was not sent out to the hospital after the fall. V2 stated that no x-rays or CT scans were ordered. V2 stated that R11 fell on a Friday 3/27/2026 and she only found out on Monday. V2 stated that R11 was placed on neuro checks and 72-hour monitoring. V21 stated that she doesn't think R11 had any injury after his fall.On 05/28/2026 at 10:30 AM, V32 (Medical Doctor) stated that after a fall, it is important to take the residents vitals and do an assessment. V32 stated that it can be an emergency situation if the resident who has fallen, is on anticoagulants and blood thinners. V32 stated that it is very important to send the resident out immediately for a CT scan to rule out bleeding as well monitor for any embolism or clots that may develop. V32 stated that Eliquis is an anticoagulant.Reviewed R11's physician order sheet. No order to be sent out to the hospital and no order for stat x-ray.Facility's Accidents/Fall policy (undated) documents in part: If the incident/accident is significant and requires outside emergency intervention/treatment, the Administrator and DON will be notified immediately that emergency services were called and what the circumstance were that required that intervention. Other required notifications will occur as well.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, facility failed to follow their policy to provide COVID-19 vaccination upon readmission to the facility for one (R6) resident in a sample of 20 residents reviewed.Findings include:R6's MDS (minimum data set) with review date of May 6th, 2026, documents a BIMS (brief interview of mental status) has a score of 13 indicating R6's cognition is moderate.On 05/26/2026 at 11:34 AM, this surveyor observed R6 in a wheelchair. R6 was alert and oriented to person, place and time. R6 appears calm and collected, free from pain. R6 stated he has been in the facility since March 2026. R6 stated when he first arrived in the facility 6 months ago, the facility did not offer the COVID-19 vaccination. R6 stated he requested the vaccine, and V2 (Director of Nursing) told him the vaccine had to be requested from the lab. R6 stated he has not received the vaccine but is still interested in receiving the vaccine.On 05/27/2026 at 10:37 AM, V25 (Infectious Disease Nurse) stated she has been working as an infectious disease nurse since December 1st, 2025. V25 stated her job is to prevent and maintain the spread of infection. V25 stated she is responsible for offering vaccinations and providing education to the residents. V25 stated when she initially took the role she arranged a COVID-19 clinic. V25 stated she attempt to get the number of staff and residents who were interested in the vaccine. V25 stated if there are no vaccines available in the facility, she will order the vaccines from the pharmacy and wait for them to arrive. V25 stated all resident are offered the vaccinations upon admission, readmission, every 6 months after receiving the initial COVID-19 vaccination, or per request. V25 stated R6 was re admitted in early March of this year, but prior to discharging she had offered R6 the COVID-19 vaccination and R6 refused. V25 stated the refusal form was signed and uploaded in the electronic medical record. V25 stated she did not offer the vaccination upon readmission, because since he had refused it on February, she will not ask again if it's within the same season. V25 stated R6 did request the COVID-19 vaccination, but there were no vaccines available at that time. V25 stated she ordered the vaccine for R6. This surveyor asked V25 for a document verifying she had ordered the vaccine for R6.On 05/27/2026, reviewed R6's provider order sheet, a new order for the COVID-19 vaccination was entered on this day.On 05/27/2026 at 11:15 AM, V25 stated R6 confirmed he is interested in receiving the COVID- 19 vaccination, and she has just placed an order for the vaccine through the pharmacy. V25 stated R6 has signed his consent form and will wait for the vaccine to arrive. V25 stated prior to this there were no order or documentation on the electronic medical records because she had not offered the vaccine upon re admission.On 05/28/2026 at 11:21 AM, V2 (Director of Nursing) stated residents are to be offered during admission, readmission and if the resident inquires in receiving the COVID-19 vaccine. V2 stated they are educated on its benefits, it prevents the spread of COVID-19 and keeps the individual as healthy as possible. V2 stated there is a consent form that the resident must sign whether they want to receive or refuse the vaccine. V2 stated if the resident refuses the vaccine the risks and benefits are explained, the provider, family or power of attorney are notified and documented on the electronic medical records. Policy and procedure titled fact sheet for recipients and caregiver about moderna COVID-19 vaccine (2024-2025 formula) which has emergency use authorization (EUA)to prevent coronavirus disease 2019 (COVID-19) in individuals 6 months through [AGE] years of age with no review date.