STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510082	A. BUILDING: _____ B. WING _____	C 05/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HALLMARK	2960 N LAKE SHORE CHICAGO, IL 60657

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comment Facility reported incident: dated 5-3-2026/ IL00201698 Section 295.2050 b) Section 295.9005 a) 3)	A 000		
A2050	Section 295.2050 Incident and Accident Reporting This Regulation is not met as evidenced by: Type 2 Violation Section 295.2050 Incident and Accident Reporting b) The report shall be made by contacting the Department of Public Health Division of Assisted Living via email at DPH.LTCAL@illinois.gov or as requested by the Department within 24 hours after the occurrence of the incident or accident. This requirement was not met as evidenced by: Based on interview and record review, the facility failed to report injuries involving one resident (R1) to the Illinois Department of Public Health (IDPH) within 24 hours. This failure delayed the State's ability to investigate the incident for facility compliance and created a substantial probability of harm to a resident or residents. Findings include: R1 is an 85-year-old female with medical diagnosis that include and are not limited to:	A2050		

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A2050	Continued From page 1 Hypothyroidism, diabetes and major depressive disorder. On 5/23/2026 at 4:00 PM, E8 (Wellness Assistant Director) said, R1 experienced a fall while watering plants in the living room of her apartment. R1 was transported to a local hospital via 911 and was later admitted with a diagnosis of subarachnoid hemorrhage. R1 was transferred to another facility for skilled therapy and returned today. According to Facility Reported Incident (FRI) R1 sustained a fall on 5-3-2026 at 7:30 PM reportable incident was submitted to the Illinois Department of Public Health (IDPH) on 5-5-2026 at 11:04 AM. On 5-23-2026 at 3:20PM E1 (Executive Director) said, our policy for reporting incident aligns with what the regulation reads from IDPH on reporting. In our IDPH reportable form indicates the policy we followed, it reads: instructions: This form should be completed and faxed to the Illinois Department of Public Health, Division of assisted living at 217-557-2432 within 24 hours of the incident or accident. I know the report was sent on 5-5-2026 at 10:36AM. On 5-23-2026 at 4:30 PM E1 (Executive Director) said, E2 (Resident Care Director) is unavailable, on personal time off.	A2050		
A9005	Section 295.9005 Units This Regulation is not met as evidenced by:	A9005		

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A9005	Continued From page 2 Type 2 Violation Section 295.9005 Units a) Each unit in the establishment shall include, at a minimum, the following: 3) An emergency communication response system in place 24 hours each day by which a resident can notify building management, an emergency response vendor, or others able to respond to his or her need for assistance. (Section 10 of the Act) This requirement is Not Met as evidenced by: Based on interviews and record review, the facility failed to ensure that one resident (R1) had access to the call alert device (pendant). This failure to provide accessible life-safety devices has the potential to affect all residents residing in the facility. This failure creates a substantial probability of harm to a resident or residents. Findings include: R1 is an 85-year-old female with medical diagnosis that include and are not limited to: Hypothyroidism, diabetes and major depressive disorder. On 5-23-2026 at 3:20PM R1 was observed to be resting in bed. R1 said, I just came back to my apartment after I was in a rehabilitation center having therapy after I had a fall while I was watering my plants, I missed my step and fell next to the window and the couch, I was not able to call for help because I did not have the pendant. I do not remember why my pendant was not on my neck.	A9005		

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A9005	Continued From page 3 On 5/23/2026 at 2:30 PM, E5 (Licensed Practical Nurse/LPN) said, I was the nurse on duty the day R1 had the fall. R1 returned from an out-on-pass at approximately 7:15 PM. The front desk announced through the internal communication system that R1 had returned to the building. At approximately 7:30 PM, I went to R1's room to check on her and found her lying on the floor. I performed a body assessment and noticed a bump on the back of her head. I immediately called 911. R1 had sustained a head injury, and I recognized it as an emergency requiring transfer to the hospital. R1 was not wearing her pendant. I checked the area near R1 but was unable to locate it initially. The pendant was later found hanging on the closet door, my expectation is for all the residents to have the pendent next to them and available for them to use On 5/23/2026 at 2:45 PM, E7 (Certified Nurse Assistant/C.N.A.) said, I am the regular C.N.A. assigned to R1. On the day of the fall, I was working. E5 (Licensed Practical Nurse (L.P.N.), announced over the internal communication system: 'Code 2 and R1's room number', code 2 is an emergency. I immediately went to R1's room and observed R1 lying on the floor near the window and a chair. R1's walker was beside her; however, she was not wearing her pendant and therefore could not call for help. The pendant is a device residents are required to wear so they can request assistance from staff when needed. When the pendant is activated, all staff are notified through the radio communication system and are expected to respond immediately. On 5/23/2026 at 4:00 PM, E8 (Wellness Assistant Director) said, R1 experienced a fall while watering plants in the living room of her	A9005		

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A9005	Continued From page 4 apartment. R1 was transported to a local hospital via 911 and was later admitted with a diagnosis of subarachnoid hemorrhage. E8 said, I was not aware that R1 was not wearing her pendant at the time of the fall, this as a system failure, my expectation is for all residents to wear a pendant, either as a necklace or wristwatch. The pendant (call light) is necessary for residents to communicate with staff outside of their apartments when they need any help. On 5-23-2026 at 4:30 PM E1 (Executive Director) said, E2 (Resident Care Director) is unavailable, on personal time off. We do not have any policy for the use of the pendant. My expectation is for the residents to have a pendant available for them to use if they need any help. On 5/23/2026 at 4:30 PM, E1 (Executive Director) said, E2 (Resident Care Director) is unavailable due to personal time off. E1 further said, there is no policy regarding the use of the pendant. My expectation is that residents have a pendant available for use if they need any assistance.	A9005		