

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0057992		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/13/2026	
NAME OF PROVIDER OR SUPPLIER MORGAN PARK HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 10935 SOUTH HALSTED STREET , CHICAGO, Illinois, 60628			
(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) COMPLETION DATE	
S0000	Initial Comments Complaint Investigations: 2681278/2731097 2680952/2724170 25811294/2671925 2589919/2641902 2589884/2639745 2589456/2632218	S0000				03/26/2026	
S9999	Final Observations Statement of Licensure Violations: 1 of 2 300.610a) 300.1210b) 300.1210d)3) 300.1210d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of	S9999				03/26/2026	

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These requirements are not met as evidenced by: Based on interview and record review, the facility failed to monitor, supervise, and intervene for seven residents (R1, R3, R7, R19, R20, R21, R22) with known substance use disorders. This failure resulted in the residents engaging in activities suspected of drug use and overdose. R1, R7, R19, and R21 were found unresponsive in the facility. R3 was found unresponsive in the facility and expired with suspicion of drug overdose. The facility also failed to provide supervision and monitoring for residents. As a result of these failures, R4 fell on the floor on 11/02/2025, while located inside the facility and sustained a left femur fracture. The facility also failed to update a fall care plan and follow assessments to prevent 1 out of three residents (R6) from falling. These residents were reviewed for accidents and supervision in a sample of 22. Findings include: R3's face sheet documents R3 is a 60-year-old individual admitted to the facility on 04/10/2025 and discharged on 10/10/2025 (death). R3 has diagnoses not limited to opioid dependence, uncomplicated, anxiety disorder, unspecified, obstructive sleep apnea, and major depressive disorder, recurrent, unspecified.			S9999			03/26/2026

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S9999	Continued from page 2 R3's progress note dated 10/10/2025, at 2:21 PM, documents during rounding, resident observed unresponsive to verbal and tactile stimuli. No respirations or palpable pulse noted. CPR (cardiopulmonary resuscitation) initiated. Code blue and 911 were called. All resuscitation efforts were unsuccessful. Time of death announced at 10:00 AM. Resident was picked up and transported to funeral home. R3's death certificate dated 10/10/2025, documents in part that an autopsy was not performed. On 02/24/2026, at 4:03 PM, R11 was observed in her room, ambulatory, and in no apparent distress. R11 stated that it will be two years in April since she has been residing in this facility. R3's obituary was on R11's bedside dresser. R11 stated "we got along really good, he was like my big brother, unfortunately he OD (overdosed) and died". They found him while passing out breakfast. By the time the CNA (certified nursing assistant) found R3, he already had liquid coming out of his nose. The morning CNA was V30 (Certified Nursing Assistant), and she had her hands full passing out the trays. R11 said she heard V30 say "who is that on the floor?" R11 ran to check, and it was R3, lying flat on his back. His eyes were already black, he (R3) was ice cold, and was stiff. R11 stated R3's room was across from R11's room. Usually, R3 would play music in the morning and was ready by breakfast time. R11 stated when R3 expired, people started telling the truth that R3 had been doing drugs. R11 stated that R3 was not the first resident that has overdosed and died in this place. There were at least five residents. R11 stated another buddy of ours said he was with him (R3), and they did some (illicit drug) at 1:00 AM that night. R11 stated that she will keep the name confidential. R11 stated that it is easy to bring in drugs because staff do not check purses or do searches. R11 stated I (R11) am in school for CNA and denied that she uses any illegal substances. R11 stated that the last OD that she recalls is R21 and it happened about two months ago. R11 stated that during the night shift I (R11) did not see anyone because R11 does not get medications. R11 stated that she thinks the 11:00 PM – 7:00 AM staff didn't check on R3. R11 stated that the 7:00 AM- 3:00 PM staff did not do rounds that morning because it was not until breakfast time that R3 was discovered. R11 stated that R11 remembers that day because no one came to R11's room to announce themselves and say I will be your CNA or nurse. R11's face sheet documents R11 is a 43-year-old			S9999			03/26/2026

Illinois Department of Public Health

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S9999	Continued from page 3 individual admitted to the facility on 04/29/2024. R11's MDS/Minimum Data Set dated 02/06/2026 documents that R11 has a BIMS/Brief Interview for Mental Status score of 15/15, indicating that R11 has intact cognitive response. On 02/25/26, at 12:45 PM V25 (Licensed Practical Nurse) stated that V25 has seen that substance before. Two months ago, V25 was informed that R20 was walking out from another resident's room and it (the same size of baggie with the white loose powdered substance) was dropped on the floor. The housekeeper grabbed it and brought it to V25. It was the same white, dusty, substance that appeared to be cocaine. V25 stated that R20 has tested positive for cocaine. V25 stated that he has addressed this with R20 and R20 confessed to doing cocaine. R20 had just got their pass (outside privilege pass) back from testing positive for cocaine. R20 was upset due to losing their pass again. I (V25) notified whoever was the social worker on the 3rd floor that day. I was the nurse on duty for R20. V25 could not recall the exact date but it was two months ago. V25 admitted that he did not document this incident. V25 stated that he should have documented it because it is important to keep a history on this information. On 02/25/26, at 1:01 PM, V25 (Licensed Practical Nurse) stated regarding R21, there was a recent incident that happened last week on Thursday. V25 stated R21 was passed out and there were five or six of those baggies inside a bigger bag, like a sandwich clear bag in R21's room. V25 said that the baggies were inside the narcotic box. When V39 (certified alcohol and substance abuse counselor) got to work in the morning, V25 gave V39 the substances. V25 stated that V39 did not tell V25 that Narcan was administered to R21. V25 stated that in the past they did drug screens, but he is not sure about now. If the drug screens were positive, the residents were placed on pass restriction. V25 stated I (V25) heard social services say that residents who are repetitive offenders are going to set up outpatient rehab. V25 stated that there is absolutely a substance abuse issue going on in the facility. On 02/25/26, at 1:38 PM, R21 stated that she does not know how the substance in the bag got to R21's room. R21 stated she said she picked it up. I (R21) don't remember her name; it was a nurse. She was kind of short, your height. She asked me what that is. R21 responded that no one asked R21 to do a drug test and just placed R21 on a pass restriction. R21 stated that she had just gotten her pass back and she thinks that someone set her up. R21 stated	S9999				03/26/2026	

Illinois Department of Public Health

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S9999	Continued from page 4 when I (R21) first got here, I was using heroin, but now I am on methadone. We used to go out but now they give it here. It has been about 5-6 months since the last time I overdosed. R21 stated that the staff administered Narcan. I (R21) stayed in the hospital for three days, and it's been so long, I don't know who I got it from. R21 stated I (R21) have no idea how they come. People get drugs in jail, everywhere. R21 stated that she has not attended a group class for a while now because they haven't had them consistently in the last five months. R21's face sheet documents R21 is a 61-year-old individual admitted to the facility on 09/10/2024, with diagnoses not limited to: abuse of other non-psychoactive substances, other psychoactive substance abuse, uncomplicated, opioid abuse, in remission. R21's MDS/Minimum Data Set dated 12/19/2025, documents that R21 has a BIMS/Brief Interview for Mental Status score of 14/15, indicating that R21 has intact cognitive response. R21's social service note dated 2/18/2026, at 3:07 PM, documents in part, resident presented to Counselor/Social Services office to discuss recent incident involving contraband. R21's social service note dated 1/1/2026, at 3:18 PM, documents in part, resident (R21) admitted to substance use and possession of contraband. This is a repeat incident that occurred again today. Counselor and nursing staff met with the resident for counseling, conducted a room search, and confiscated all contraband. The resident was educated on the importance of maintaining sobriety. Community access remains restricted. Due to repeated incidents, the resident will be prompted to admit to an inpatient detox/substance abuse program soon. On 02/25/2026, at 1:58 PM, R20 stated that she cannot remember when R20 tested positive for cocaine but R20 stated that is not her drug of choice. R20 stated that this happened a while ago. R20 stated that she is currently on a 30-minute community pass. R20 stated that she goes out to smoke cigarettes by the parking lot or to the bus stop. R20 denied that she has overdosed or passed out in the facility. R20 denied that staff have had to administer Narcan to R20. R20 stated "that was R21, she was the one, they had to hit her up with the Narcan. It happens with her all the d*** time". R20 stated that the illegal drugs are sold on the second			S9999			03/26/2026

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S9999	Continued from page 5 floor by a resident and R20 won't say the name. R20 stated that they sell crack cocaine and heroin. R20 stated that there is a resident that sells that and another that sells marijuana. The crack cocaine is \$10.00 dollars and the packaging varies; they might have a clear bag or might have a design on it. The heroin bag costs \$10.00 dollars too. R20 stated that the staff are supposed to check the bags, but they do not. R20 stated that R20 does not know where R3 got illicit drug from but R3 always was with R22. R20's face sheet documents R20 is a 61-year-old individual admitted to the facility on 09/26/2024 with diagnoses not limited to: opioid abuse. R20's MDS/Minimum Data Set dated 01/02/2026, documents that R20 has a BIMS/Brief Interview for Mental Status score of 15/15, indicating that R20 has intact cognitive response. R20's social service note dated 1/1/2026, at 2:35 PM, documents in part resident admitted to substance use and possession of contraband. On 02/25/2026 at 2:20 PM, V26 (Certified Nursing Assistant) stated that she has not found illicit substances in residents' rooms herself but V26 was told where they came from. V26 saw the substance in a clear cup when the nurses were discussing it by the nurse's station. V26 stated that the night shift nurse found the substance on R22's bed. V26 stated I (V26) came to work for the 11:00 PM-7:00 AM shift because I work all shifts. The substance was a white, loose, powdered substance in a small clear bag, about one inch by one inch in size. This happened on Saturday night going into the Sunday shift. V26 stated that the nurses said it was heroin, and they ended up having to report it to the nurse supervisor. V26 stated that she heard R3 overdosed but V26 was not here the day R3 expired. V26 stated that she heard R19 overdosed but cannot remember the exact date but V26 thinks it was about a month ago. V26 stated I (V26) noticed R19 wasn't there one day and the next time I saw her, R19 said she (R19) had gotten a hold of a bad drug. V26 stated that she has heard R20 sells drugs and another resident. R22's health status/progress note dated 02/21/2026, at 11:00 PM documents in part, upon coming to the unit and making rounds, it was noticed in resident's (R22) room on his side table a small baggy with a white powdery substance. Resident denies that it is his and doesn't know where it came from. The substance was confiscated. Per protocol, 911 was called.			S9999			03/26/2026

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S9999	Continued from page 6 On 02/26/2026, at 2:32 PM, R19 was sitting on her wheelchair in her room, in no apparent distress. R19 stated that she does have a history of substance abuse. R19 admitted that she had taken something while in the facility. R19 stated that her choice is cocaine. R19 stated I (R19) bought it from a friend about a couple of weeks ago. R19 stated that she overdosed because they gave her Narcan. R19 stated that she cannot recall who the nurse was because there are so many nurses. R19 stated that she bought the cocaine from here and it cost \$5.00. R19's face sheet documents R19 is a 65-year-old individual admitted to the facility on 09/14/2023, with diagnoses not limited to: opioid abuse, uncomplicated, opioid use, and unspecified with withdrawal. R19's MDS/Minimum Data Set dated 01/16/2026, documents that R19 has a BIMS/Brief Interview for Mental Status score of 15/15, indicating that R19 has intact cognitive response. On 02/27/2026, at 10:06 AM, R22 stated that he had known R3 for four to five months because they were roommates initially before R22 transferred to this room. That day, I (R22) got up about 8:30 AM to brush my teeth. A code blue was called, and I rushed into his room. R3 was laid out. R22 stated that R3 did not have a roommate when R3 passed. R3 stated that R3 wanted R22 to move back to R3's room. R22 stated that he was with R3 the other night, but not the night that R3 died. R22 stated that he last saw R3 the night before around 8:30 PM. R22 stated R3 must have passed between 4:00 AM to 8:00 AM. R22 stated usually R3 will be cleaning his room at 7:00 AM, every morning. R22 admitted that R3 was using heroin which was R3's preferred drug of choice. R22 stated that R3 was getting heroin from inside the facility. R3 stated that the guy that sold it is now gone. R22 preferred not to say the name of the seller. R22 stated he (R3) did have some on him that night and it was a clear small bag with white powder. R22 stated he probably snorted it. R22 stated that the heroin costs \$10.00 and some bags have designs. R22 denied that R3 used cocaine and stated R3 wouldn't use cocaine. R22 stated that R3 maybe relapsed about a month before he died because maybe he ran into the wrong person. If someone is restricted, someone can go out for you, it is easy. If you pay someone \$5.00 or \$10.00, they will go get it. R22 denied witnessing anyone overdosing. R22 stated the third floor was overdosing and dying around that time, like October through December 2025. R22 stated that R3 and R22 would use the drug and would share one baggie or			S9999			03/26/2026

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S9999	Continued from page 7 have one each. R22 stated she (R21) is probably on restriction now. I don't mess with her. R21 did overdose but I don't know when. When asked who was in R3's room that morning, R22 stated that R11 was in there because R11 ran over there first and tried to resuscitate him, and as well as the staff that were there. R22 stated that the last time and R3 and R22 used illicit drugs together was the day before R3 expired. R22's face sheet documents R22 is a 58-year-old individual admitted to the facility on 12/10/2024, with diagnoses not limited to: abuse of other non-psychoactive substances. R22's MDS/Minimum Data Set dated 12/17/2025, documents that R22 has a BIMS/Brief Interview for Mental Status score of 15/15, indicating that R22 has intact cognitive response. R22's care plan documents in part the resident have a history of substance abuse/chemical dependency related to abuse of psycho-active substances. R22's care plan documents in part the resident has experienced the death and therefore, the loss of his close friend. Date Initiated: 10/10/2025. On 02/26/26, at 3:25 PM, V29 (Licensed Practical Nurse) stated "I (V29) was running late that morning, I don't remember what time it was, but my shift starts at 7:00 AM. V29 stated that the CNA (certified nursing assistant) found R3. V29 came to get me and I then called the code. V29 stated that the night shift nurse was gone already and had given report to the other nurse that was working on the other side. At this time, I (V29) do not recall who the other nurse was. V29 stated I (V29) didn't get a chance to do rounds; I had literally walked in when this happened. It looked like he had been laying down for quite a while. He was cold and rigid already. V29 stated that R3's eyes were open and completely black. V29 stated residents are supposed to be monitored every 30 minutes, either the nurse or CNA, when I (V29) am there. I can't speak for someone else. V29 stated that R3's health status before his death, as far as last time V29 saw him, was not declining and was still regular (baseline). V29 stated that R3 was alert and oriented. V29 heard that he had drug-seeking behaviors. One time he was in the hospital after he was given Narcan. V29 stated I don't recall when this exactly happened, I was a new nurse in late August, early September. When that happened, I was in the first three weeks of my employment. V29 stated the morning when R3 was found unresponsive, staff moved R3 to bed. R3			S9999			03/26/2026

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S9999	Continued from page 8 had little bit of foam from his mouth. On 02/26/26, at 11:38 AM, V30 (Certified Nursing Assistant) stated, "she was the assigned CNA for R3 the day that she found R3 unresponsive. That day I (V30) was late, at 8:00 AM. V30 stated when I (V30) arrived at the unit, staff started passing trays for breakfast. Breakfast can be between 8:00 AM through 9:00 AM. When I (V30) took his tray in his room, I saw him lying on the floor. He (R3) was closer to the window in the room. He looked deceased. His eyes were kind of dark and open. V30 stated that she ran quickly and got the nurse. V30 stated yes, I've heard about the drug abuse issue in the facility, and I am not sure what is going on with it." On 02/27/2026, at 12:18 PM, V41 (Licensed Practical Nurse) stated R3 was not prescribed any medications for the night shift (11:00 PM-7:00 AM). V41 stated I (V41) usually come at 11:00 PM. R3 was up walking and talking at the nurse's station for some ice. V41 stated that around 4:00 AM or 5:00 AM was the last time V41 saw R3. R3 was in bed and alive. V41 stated that is the time I (V41) usually start my medication pass. V41 stated that R3 was not a check and change patient because R3 was able to go to the restroom on his own. V41 stated that general signs of overdosing could be foaming out of the mouth, nodding, unable to arouse to stimuli, basically unresponsive. V41 stated that some interventions would include administering Narcan and checking vital signs. Narcan cannot be given hours later because of the possibility of organ death and death. On 02/26/2026, at 4:01 PM, V42 (Certified Nursing Assistant) stated, "V42 was not working the day that R3 expired. V42 stated that she came back to work one day or two days after R3 died. I think I (V42) last saw R3 three or two days before he passed. I only work on Wednesday and Friday. He would come out of his room around 1:00 AM-2:00 AM and sweep his room out, listen to music, make himself something to eat, and go back to sleep. V42 stated you wouldn't see him (R3) without (R22). I would come in at 11:00 PM, and they would stay up until about 1:00 AM-2:00 AM." On 02/26/26 at 12:42 PM, V39 (Certified alcohol and substance abuse counselor) stated, "V39 has been working for the facility for three months. V39 stated, "I (V39) did take R21's pass recently because contraband was found in her room. On February 18th, 2026, V25 (Licensed Practical Nurse) found it on R21's dresser and gave it to me. R21 did not tell			S9999			03/26/2026

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S9999	Continued from page 9 me (V39) where she got it from. She denied having contraband. R21 just had gotten her community pass (30-minute pass) the day before. V39 stated that R21's pass was restricted on 2/18/2026. V39 stated I (V39) don't have any in-house drug screens for R21. I (V39) wasn't there when they collected the contraband, I was just getting to work. (V25) gave it to me. He told me he found it the night prior and there was no drug test conducted. If the nurses suspect, whoever suspects, they should drug test that person. V39 stated that the facility's policy is that if there is suspicion of substance abuse, the residents will get drug screened if they accept. If it is positive, their pass is restricted. If they still have contraband, we call the police. A lot of the time the police don't come – I think it's the neighborhood we are in. I'm (V39) not sure why they do not come. We conduct room searches, ask them where they get the drugs from, get them into a program if they are not already in a substance abuse program, take their pass away, if they have guardian or POA (power of attorney) they are notified, document in their files, do an incident report in the computer program under risk management, contact ADON (assistant director of nursing) and DON (director of nursing), notify administration, edit the care plan, and do a substance abuse assessment. I (V39) guess I didn't complete a substance abuse assessment for R21 on 2/18/2026. V39 stated that there is no substance abuse assessment done on 1/1/2026. V39 stated I (V39) think they have the right like everyone else to be free from overdosing. V39 stated that the risk of overdosing is death." On 02/27/2026 at 1:31 PM, V32 (Housekeeping) stated last year around October through December 2025, there were a lot of overdoses. V32 stated that he could not recall the exact names, but this was on the third floor. On 02/27/26, at 1:10 PM, V38 (Licensed Practical Nurse) stated "of course, the residents are doing drugs. We had a few people overdose in here and somebody must be bringing it to them. We still have people that are not on pass restrictions, and we don't know who they are cool with. I (V38) am not sure what they are doing for the residents to overdose. V38 stated yes some of the people (residents) relapse in this building." On 02/27/26, at 1:06 PM, R44 (R3's Physician) stated "if R3 was noted with a bag of white, loose, powdered substance R44 would have suspected R3 of overdosing. R44 stated I (R44) reviewed all my notes, and he (R3) was stable with his chronic conditions. R44 stated if there was foam coming out			S9999			03/26/2026

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0057992		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/13/2026	
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S9999	Continued from page 10 of his nose or mouth that would be an indicator of an overdose." R3's care plan documents in part substance use. Resident has tested positive for opioids. Resident stated relapse has occurred. Date Initiated: 04/24/2025. Revision on: 10/06/2025. No interventions in the substance use care plan regarding monitoring R3 noted. 2. R7 was a 61-year-old resident with diagnoses that include but are not limited to unspecified injury at unspecified level of cervical spinal cord, opioid dependence, neurogenic bowel, spinal stenosis, cervical region, reflex neuropathic bladder, central cord syndrome at C2 and C5 level of cervical spinal cord. R7 has a BIMS (Brief Interview for mental status) score of 15 indicating intact cognition. On 2/25/2026, at 12:40 PM, V25 (Licensed Practical Nurse) stated "R7 had just arrived at the facility like an hour and a half earlier. I did my initial assessment on R7. R7 asked me if I could visit my family. I said yes. R7 informed me that R7's son is coming to visit. Approximately half hour later someone stopped at the nursing station saying they were here to see R7. I escorted them to R7's room and left out of the room so they could visit. I was at the nursing station and approximately ten minutes later the visitor left the room. Approximately 30 to 45 minutes later the CNA (Certified Nursing Assistant) found R7 unresponsive with an unknown bagged substance on R7's chest. I went to assess R7 and called a rapid response. R7's vital signs were normal however R7's respirations were slowed and R7 was unresponsive. I saw the substance (one bag) on R7's chest. I called 911 then administered two to three doses of Narcan (naloxone). I read in R7's history that he had just come from a rehab facility for overdose a couple days before. I used my nursing judgement and administered Narcan. I did sternal rubs and applied a cold compression to R7. Upon pulling R7's sheets back, I observed an additional six to eight bags of the substance. The bags were about a quarter of a quarter, square and clear. The substance inside the bags was white dust, loose powder. V25 stated it must have been a couple minutes after R7 had used the drug before it was caught. V25 stated the incident happened on the 3:00 PM-11:00 PM shift. V25 stated "In my opinion, the substance appeared to be cocaine." R7 did not wake up before leaving the facility. R7 was unresponsive when R7 left the building with 911. R7 returned from the hospital a couple hours later. I asked R7 who the visitor was. R7 would not tell me who it was but R7 said it was not R7's son. R7 was			S9999			03/26/2026

Illinois Department of Public Health

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S9999	Continued from page 11 apologetic as to what happened. Residents should not be using controlled substances in the facility. On 2/26/26, at 12:10 PM, V31 (Medical Health Technician) stated, "I have been a social worker in the facility for one year. I have only encountered R7 once. I want to say it was the 21st of December. I was not in the building when the incident happened. I read about the incident with R7 in a general report that is generated on residents' behaviors, refusals, etc. that have occurred within the current day and day prior. The report said R7 was found to be unresponsive. R7 was given Narcan. R7 was sent out to the hospital and was sent back to the facility. I spoke to R7 about what happened. R7 was hesitant to state what happened. R7 said he had it in his system and it has been in his system. R7 never identified what it was. V31 stated from their understanding it was a possible substance abuse. R7 had substances in their system. V31 stated I went to counsel R7 about substance abuse and maintaining sobriety. I initiated the substance abuse protocol which means I will restrict a community pass for 30 days, document what happened, my encounter with the resident, update the care plan for substance abuse and refer to the resident to the inhouse substance abuse program." On 2/26/26, at 4:30 PM, V2 (Director of Nursing) stated within the first hours of being in the building R7 had to be sent out to the hospital for drug usage/overdose. R7 had a visitor and was found with an unknown powdery substance that we assumed was street drugs. On 2/26/26, at 4:56 PM, V1 (Administrator) stated, "I recall hearing R7 had an illegal substance on them. I don't know what drug it was. The residents should not have illegal drugs in the facility. The residents should not be using illegal drugs in the facility." R7's nursing progress note dated 12/21/2025, at 12:23 AM, reads in part: The resident (R7) arrived at the facility ambulance service via 2 paramedics in stable condition. The writer was notified by the CNA (Certified Nursing Assistant) that the resident (R7) was observed unresponsive in bed. Writer entered the room to assess the resident. Resident is unresponsive, findings of unknown substance on chest. Writer administered Narcan 3 times before emergency response arrived. Resident was transferred to community hospital to follow up for admitting diagnosis. R7 hospital record for hospital admission, dated 12/20/2025, reads in part: Laboratory Tests, dated	S9999				03/26/2026	

Illinois Department of Public Health

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S9999	Continued from page 12 12/20/25, note Urine Opiates Screen – Positive A, Urine Fentanyl Screen – Positive A, Urine Benzodiazepines Screen – Positive A. Labs: Drug screen positive for fentanyl, heroin, and benzos (benzodiazepines). The impression is polysubstance abuse and hypotension (low blood pressure). R7 Social Service Note, 12/21/2025, at 4:57 PM reads in part: Writer received a report that resident (R7) admitted to substance use. R1's current face sheet documents R1's medical conditions to include but are not limited to other secondary parkinsonism, chronic obstructive pulmonary disease, unspecified, transient cerebral ischemic attack, unspecified, cerebral infarction, unspecified. MDS (Minimum Data Set) section C dated Jan 27, 2026, documents R1's Brief Interview for Mental Status (BIMS) as 2/15 indicating R1 has severe cognitive abilities. On 02/24/2026, at 1:13 PM, R1 was observed in the dining room sitting on his wheelchair next to a table. R1 answered simple questions by shaking his head "yes" or "no." R1 was unable to communicate clearly. R1's nursing progress notes dated 9/27/2025, 8:36 AM document: Upon doing rounds, writer noted R1 lying in bed, with the rise and fall of his chest. R1 had nasal flaring. R1 not responding to verbal or painful stimuli. V24 (LPN) called a rapid response and administered 4mg Narcan intranasally. R1 was not responding to 2nd dose of Narcan 4mg administered intranasally. R1 opened eyes, grunting noted. VS (Vital signs) as followed by 123/70 (Blood Pressure), (Pulse) 78, (respirations) 13, (Oxygen saturation) o2 94, BS (Blood Sugar) 159. Supplemental o2 administered 4L (liters) via nasal cannula. Fire department arrived to transport R1 to hospital. R1's Hospital records dated 09/30/2025, document R1 was seen at the hospital for Opiate overdose and UTI (Urinary Tract infection). Hospital physician progress notes dated 09/28/25, document R1 was brought to the ED (Emergency Department) after being found unresponsive at the facility. Per ED, R1 received Naloxone (Narcan) with clinical improvement and is now awake, oriented and hemodynamically stable. Interpretation: Despite a negative USD (Urine Drug Screen), the naloxone response plus history of opioid misuse suggests recent opioid exposure (possible short-acting opioid)			S9999			03/26/2026

Illinois Department of Public Health

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S9999	Continued from page 13 not captured by screen, concentration below cut off, timing and collection, or non-standard analog. On 02/26/2026, at 10:55AM, V28 (Nurse Practitioner-NP) via phone stated she does not remember if she received a call from a nurse notifying her R1 was administered Narcan after being found unresponsive. V28 stated she has given Narcan to residents in the facility on multiple occasions. There is a huge population of residents at the facility with illicit drug use history. V28 stated Narcan is given to a resident if nurses suspect opioid/illicit drug use. If a resident is nonresponsive and illicit drug use is suspected, the nurse administers Narcan to the resident. If the resident has opioid/illicit drug in the system, the resident will start to come around and start responding. On 02/25/2026, at 12:18PM, V24 (Licensed Practical Nurse-LPN) stated via phone that she worked at the facility for a very short time and does not remember R1 or calling code for R1. V24 stated she did not give Narcan to any resident including R1 when she worked at the facility. On 02/25/2026, at 12:35 PM, V25(Licensed Practical Nurse) stated he did not administer Narcan to R1 on 9/27/2025. V25 said he responded to rapid response call for R1who was found unresponsive. V25 went to help V24 (Licensed Practical Nurse). V25 stated he was signed into his work computer on R1's floor and V24 must have charted under his name. V25 stated he was in the middle of administering medications, and he did not have to log off his computer because resident information was hidden and not visible to anyone. V25 said nurses document progress notes under their own names. V24 must have forgotten to sign V25 off when she charted. On 02/25/2026, at 12:58 PM, V2 (Director of Nursing-DON) stated she does not see Narcan in R1's Physician Order Sheet (POS) or on R1's Electronic Medication Administration Record (eMAR) that R1 received Narcan. V22 said the nurse who gets a telephone order from a provider should put the orders in the resident's POS. Once the medication is given, the nurse should document in the eMAR. This will provide better a picture of what medications the resident has received and will aid in better resident care. V2 further stated nurses cannot give medications without a provider's order. The nurse would be working above their scope of practice which could cause harm to the residents. Nurses must follow physician orders. There is a high population of substance abuse in the facility. Nurses were being precautious by giving R1 Narcan. R1			S9999			03/26/2026

Illinois Department of Public Health

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S9999	Continued from page 14 resides on 3N which houses a high number of residents who are known to have a history of using illegal drugs. I don't know if R1 has a history of drug use. V2 stated if Narcan is given in an emergency the nurse notifies the resident's provider and gets an order for Narcan, writes it on the POS and documents in the eMAR when given. V2 stated nurses only chart and document on the work they did. Nurses are not allowed to chart under another nurse's profile. If a nurse leaves the computer open and another nurse charts under their name, the nurse whose name appears on the documentation takes responsibility for the documentation. V2 stated R1's nursing progress note dated 9/27/2025, at 8:36 AM, had V25's name therefore V25 assumes responsibility for writing that nursing progress note. On 02/26/2026, at 3:44PM, V23 (Social Services Director) stated R1 does not have a community pass because he is not capable of taking care of himself while out in the community. Page 31 of Hospital records documents: -R1 chief complaint: Drug overdose. -R1 has history of opioid abuse. R1's Physician Order Sheet (POS) does not document Narcan Order. 3. R6's Face sheet, R6 is a 75-year-old female with a diagnosis of intervertebral disc degeneration, type 2 diabetes mellitus, morbid (severe) obesity, schizophrenia, bipolar disorder, drug induced subacute dyskinesia, hypertension, generalized (osteo)arthritis, muscle weakness, and lack of coordination. On 02/25/2026, at 1:18 PM, V27 (Restorative Nurse/Falls Coordinator) stated, "fall risk assessments are completed after a fall. The only way I would be able to tell the difference between a regular fall risk and a high fall risk is just by looking at their gate. V27 stated that she puts in the fall risk interventions in the care plan. V27 states that she updates a care plan after fall. If a resident falls, the expectation is to update care plans. V27 stated that she is familiar with R6. V27 stated that R6 did have fall in the facility. V27 stated that R6 had a fall during her transfer. V27 stated she completed an investigation for R6's fall. V27 stated that the CNA was transferring R6 from wheelchair to bed and R6's leg gave out. R6 was lowered to the floor. No injuries noted that that time. R27 stated that substantial/maximal assistance only requires one			S9999			03/26/2026

Illinois Department of Public Health

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S9999	Continued from page 15 helper. V27 stated that if a resident is assessed as a dependent assist, they would require two helpers. V27 stated that R6 fell on 1/10/2026 and was transferred to an outside hospital. V27 stated that R27 was readmitted on 1/16/2026. V27 stated that when R6 was readmitted, there were no updated interventions to R6's care plan. V27 stated there should have been new updated interventions to the care plan so that proper interventions can be in place, to protect the residents from falling again. V27 stated that there is no particular reason why V27 did not right a root cause analysis or a progress note on R6's fall. On 02/25/2026, at 3:30 PM, V17 (Assistant Director of Nursing) stated that she is not sure about fall risk assessments. V17 stated that restorative nurse updates care plans after a fall incident. V17 stated that restorative also does the investigation after a resident has a fall. V17 stated that she is familiar with R6. V17 stated that she does not know what happened with R6 that led to her fall. V17 stated that she is not sure if R6 was sent out after the fall. On 02/27/2026, at 12:51 PM, V2 (Director of Nursing) stated that fall risk admissions are done upon admission, quarterly, and after every fall. The restorative nurse is supposed to update care plans with new interventions to prevent a fall from happening again. The restorative nurse does the fall investigations. V2 stated that she is familiar with R6. V2 stated that R6 had a fall in the facility and went to the hospital afterwards. V2 stated that R2 fell during a transfer in R6's room. V2 stated that one CNA was helping the resident transfer and R6's legs gave out. V2 stated that R6's care plan was not updated because R6 was readmitted over the weekend. V2 stated that when a resident is readmitted over the weekend the care plan is not updated because the restorative nurse is not here on the weekend to put in new interventions. V2 stated that when a resident is readmitted anytime during the week, the care plan should be updated appropriately. R6's fall risk management report (1/10/2026) documents in part: Writer summoned to R6's room. Writer was informed upon transferring R6 to bed, her legs buckled, and she lowered R6 to the floor. R6 on the floor laying in a supine position. R6's progress note on 1/10/2026, documents in part: Writer summoned to R6's room and was informed upon transferring patient to bed her legs buckled and she lower the resident to floor. Writer observed resident on the floor laying in a supine			S9999			03/26/2026

Illinois Department of Public Health

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S9999	Continued from page 16 position. The nurse performed a head-to-do observation. R6 was alert and oriented to self with safety precautions in place. Resident transferred to bed by two staff members. ROM (Range of Motion) checked. Patient complained of pain to bilateral legs. Vitals were taken. NP made aware order given for stat x-ray of bilateral lower extremities. All orders carried out. Plan of care is ongoing. MDS section GG (1/17/2026) documents in part: For chair to bed transfer R6 is dependent. For dependent residents, helpers make all the effort. Residents do none of the effort to complete the activity. The assistance of 2 or more helpers is required for the residents to complete the activity. No updated care plan interventions after fall on 01/10/2026. Fall prevention care plan requested on 02/25/2026 at 9:45 AM. Not provided. Requested Fall prevention care plan on 02/26/2026 at 3:30 PM. Not provided. No fall prevention policy was given to surveyors. Facility's care plan policy documents in part: When a significant change occurs in a resident's condition, the MDS coordinator or designee is notified by a member of the interdisciplinary team. The care plan is then reviewed and updated. R4's Face sheet documents that R4 is a 75-year-old male with diagnoses not limited to: legal blindness, muscle wasting and atrophy, malignant neoplasm of prostate, unspecified lack of coordination, unspecified fracture of shaft of left tibia, chronic embolism and thrombosis of unspecified deep veins of lower extremity, bilateral. R4's MDS/Minimum Data Set dated 10/01/2025, documents that R4 has a BIMS/Brief Interview for Mental Status of 11/15, indicating that R4 is mildly cognitively impaired. R4 has impairment to one side of the lower extremity. R4 is dependent on ADL/Activities of Daily Living care. R4 is incontinent bowel and has a urinary catheter for bladder. R4's MDS documents that walking activity for R4 did not occur due to medical conditions and safety. R4 is dependent with mobility including to roll left and right, sit to lying, lying to sitting, sit to stand, chair/bed-to-chair transfer, toilet transfer, and tub/shower transfer. R4 utilizes a manual wheelchair, and the activity of walking 10 feet was not attempted			S9999			03/26/2026

Illinois Department of Public Health

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S9999	Continued from page 17 due to R4's medical condition or safety concerns. On 02/24/2026, at 10:22AM, R4 observed lying in bed with bed bolsters on both sides. R4's wheelchair at his bedside and a fall mat in place. R4 states he fell and broke his hip while walking down the hallway in the facility. R4 states he fell over to his side. R4 states he has been using a wheelchair to ambulate in the facility for the past 6 months. R4 states he also had his foley catheter placed about 6 months ago. On 02/25/2026, at 1:36 PM, V13 (Restorative Nurse) states she is aware that R4 fell in November 2025. V13 states she was made aware that R4 fell out of his wheelchair during transferring. V13 states she cannot recall who made her aware of this information. V13 states she did not determine the root cause of R4's fall and did not perform any documentation about R4's fall. On 02/26/2026, at 8:27 AM, V12 (Registered Nurse/RN) states on 11/02/2025, she worked the 3:00 PM-11:00 PM shift. V12 states upon arriving on her shift, she was informed by the off-going nurse identified as V27 (LPN) that R4 fell and was complaining of pain. V12 states V27 informed her that R4 was sitting in his wheelchair and slid out and fell. V12 states when she arrived at R4's room to assess R4, R4 was sitting in his wheelchair. V12 states when she touched R4's leg, R4 started screaming. V12 states she then asked some of the CNAs/Certified Nursing Assistants to help assist her to put R4 back into his bed. V12 states R4 has some confusion and could not tell her how he fell. V12 states R4 kept saying "I fell" and "I'm hurting." V12 states she called the doctor, and the doctor ordered x-rays for R4. V12 states she was off work for a couple of days. When she returned, R4 was still complaining of pain. She sent R4 out to the hospital that same day. V12 states she informed R4's family that R4 was going to the hospital for evaluation. V12 states she later followed up and received confirmation from the hospital that R4 was admitted and diagnosed with a leg fracture. On 02/26/2026, at 9:44 AM, V27 (LPN) states she has been working at facility for 15 months. V27 states on the day R4 fell, she was the nurse assigned to care for him and was on her way home. V27 states she did rounds prior to leaving and saw R4 on the floor. V27 states when she went inside R4's room, she saw him lying on the floor next to his bed. V27 states R4 was in bed when he fell and not in his wheelchair. V27 states she went to get two CNAs/Certified Nursing Assistants to assist her and		S9999			03/26/2026	

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0057992		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/13/2026	
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S9999	Continued from page 18 is not sure of their names. V27 states she assessed R4 and R4 complained of pain to his leg. V27 states she and the CNAs put R4 back into the bed via a mechanical lift device. V27 states R4 did not tell her how he fell. V27 states R4 is alert and oriented x2-3, he knows his name and can answer questions. V27 states R4 is total care which means he requires help with feeding, brushing his teeth, grooming, and incontinence care. V27 states R4 ambulates via wheelchair, and the staff must do all tasks for R4. V27 states R4 can move one arm and is able to use the call light. V27 states as she was leaving out of R4's room to look for pain medications, she saw the on-coming nurse (V12/RN). She gave the oncoming nurse report about R4's fall. V27 states she paged the doctor before she left and endorsed everything else to V12, who handled the rest. V27 states once she endorsed the report to the oncoming nurse, she is not sure what happened after that because she went home. V27 states she is aware that R4 did go out to the hospital and was admitted for a couple of days. R4's progress note dated 11/02/2025, at 3:30 PM, written by V12 (RN) documents "On 11/2/25 at 3:30 PM, upon arrival at the unit, the morning nurse reported to the writer that R4 fell out of his chair and was assisted back to the chair. Writer, with the help of the afternoon CNA, transferred R4 to bed. head to toe assessment completed, vital signs taken and within normal parameters. Skin assessment performed with no abnormalities noted. Patient complained of pain to the left leg. ROM performed to all extremities well tolerated and WNL (within normal limits). Patient is alert with moderate confusion and is currently resting in bed. Writer notified NP on call for physician. New orders received for X-ray and Initiate Neuro-check. All orders are noted and carried out. Nursing Mgt made aware, and R4's son also notified." R4's progress note dated 11/02/2025, at 6:09PM, written by V12 (RN) documents in part "Writer called and ordered the x-ray and fax number given to the technician. No ETA currently. Will continue to Monitor." R4's progress note dated 11/03/2025, at 2:52 PM, written by V10 (LPN) documents in part, "Writer called x-ray company to get an ETA, operator states they are very busy and will call back when they have a tech available." R4's progress note dated 11/04/2025, at 2:51PM, documents in part, "R4 is noted on 72 hrs. post fall monitoring. R4 is noted to be alert and oriented and			S9999			03/26/2026

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0057992		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/13/2026	
NAME OF PROVIDER OR SUPPLIER MORGAN PARK HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 10935 SOUTH HALSTED STREET , CHICAGO, Illinois, 60628			
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S9999	Continued from page 19 at baseline. No deviation noted during this shift. X-ray was ordered over 48hrs ago and still pending completion. A follow up call was made by writer, and an ETA of 3 hours was given to writer. Anticipating completion which will be endorse to incoming nurse." R4's progress note dated 11/04/2025, at 4:05 PM, documents "Technician here at facility, x-ray completed, waiting for results." R4's progress note dated 11/04/2025, at 7:54 PM, documents in part "R4 discharged to hospital. Reason for transfer: abnormal X-ray. The following people were notified of transfer: physician." R4's progress note dated 11/05/2025, at 6:07AM, written by V12 (RN) documents in part "Writer called hospital for status update and was informed that admitting diagnosis is left femur fracture." R4's fall risk assessment dated 10/20/2025, documents that R4 is at moderate risk for falls with a fall risk score of 5. R4's fall risk assessment dated 11/09/2025, documents that R4 is at moderate risk for falls with a fall risk score of 9. R4's hospital record dated 11/09/2025, documents that R4 experienced a fall and sustained a displaced angulated fracture of the proximal femoral shaft. Per facility reported incident dated 11/05/2025, R4 sustained a fall which resulted in a fracture to R4's left femur while at the facility on 11/02/2025. Policy titled Narcan/ Naloxone Administration Policy, no date, documents: -To administer a life-saving medication that can reverse an overdose of opioids, including prescription opioid medications, heroin and fentanyl. Narcan/Naloxone is to be administered for suspected overdose. Signs of Opioid Overdose: 2. Falling asleep or loss of consciousness. Policy titled: Procedure Physician Orders, dated Jan 2025 documents: Orders must be recorded in the medical record by the licensed nurse authorized to transcribe such	S9999				03/26/2026	

Illinois Department of Public Health

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S9999	Continued from page 20 orders. Physician orders must be documented clearly in the medical record (PCC). The required components of a complete order: Date and time of receipt of order (time stamp PCC) Name of practitioner providing order Name and strength of product Quantity or specific duration Dosage and frequency of administration Route of administration Indication/diagnosis for which product is given Stop date for short term therapy; if applicable Clear and complete orders will be transcribed to the appropriate administration record (MAR/TAR) Policy titled Narcan/Naloxone Administration Policy, no date, documents: Naloxone is to be administered for suspected overdose. Signs of Opioid Overdose: Falling asleep or loss of consciousness Facility document dated 11/2025 titled "Policy and Procedure Alcohol/Substance Use/Abuse Policy" documents in part, it is the policy of the nursing facility to provide a safe and healthy living environment. The facility recognizes that people requiring long-term care present with significant physical and mental health problems. The use of alcohol and other drugs that are not prescribed by the physician are not allowed in this facility or on the facility campus. Facility document dated 07/02/2024, titled "Policy & Procedure Community Pass Policy" documents in part, consenting to be checked at the discretion of supervisory personnel upon return if reasonable suspicion of contraband exists. Facility document dated 11/2025, titled "Policy & Procedure Safety and Supervision of Residents" documents in part, our facility strives to make the	S9999				03/26/2026	

Illinois Department of Public Health

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S9999	Continued from page 21 environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Resident-Oriented Approach to Safety. Our resident-oriented approach to safety addresses safety and accident hazards for individual residents. Staff shall use various sources to identify risk factors for residents, including the information obtained from the medical history, physical exam, observation of the resident, and the MDS (minimum data set). (A) 2 of 2 300.610a) 300.1210b) 300.3210t) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Section 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property.		S9999			03/26/2026	

Illinois Department of Public Health

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S9999	Continued from page 22 These requirements are not met as evidenced by: Based on observation, interview, and record review the facility failed to follow their policy to protect two residents (R13, R14) from abuse in a sample of 22 residents reviewed for abuse. This failure resulted in psychosocial harm to R13 and R14. Findings include: R13 is a 35-year-old resident with diagnoses that include but are not limited to asthma, iron deficiency anemia, osteoarthritis. R13 has a BIMS (Brief Interview for Mental Status) score of 15 indicating intact cognition. R14 is a 56-year-old resident with diagnoses that include but are not limited to asthma, chronic obstructive pulmonary disease, osteoarthritis, anemia, morbid (severe) obesity. R14 has a BIMS score of 15 indicating intact cognition. R16 is a 57-year-old resident with diagnoses that include but are not limited to heart failure, atherosclerotic heart disease of native coronary artery, anemia, osteoarthritis, type 2 diabetes mellitus, cocaine abuse with intoxication. R16 has a BIMS score of 15 indicating intact cognition. On 2/24/26 at 2:48 PM, R13 stated that R13 and R13's mother (R14) resides in the same room. R13 stated that R13 does not feel safe because someone (R16) is being verbally abusive and using foul language towards R13. R13 stated that R16 has called R13 a b**l sucker, and a d**k sucker. R13 stated this happened about two months ago and there were no staff around. R13 stated I never disrespected R16. I've always been cordial, and R16 continues to spread rumors about me and R14. R13 stated that R16 sits in the hallway and says we (R13, R14) stink. R16's room is next door to ours and our rooms share a restroom. R16 does not want R13 and R14 to use the restroom that they share. R13 and R14 have a bedside commode in their room that they use. Writer observed a bedside commode with urine in it inside of R13 and R14's room. R13 stated that they feel the CNAs (Certified Nursing Assistants) and nurses are part of it because R16 has been here for a long time and R16 is favored. R13 stated that R13 and R14 ignore it and try to keep the peace. On 2/24/26 at 3:34 PM, R13 stated that the bullying situation is frustrating and makes them (R13, R14) feel angry. Sometimes I feel that if I say something it will get worse. At this point I feel like I should say	S9999				03/26/2026	

Illinois Department of Public Health

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S9999	Continued from page 23 something because it is getting out of hand. R13 stated that R16 has made fun of R13 and R14 for using the restroom's toilet and said they stink. R13 stated so they (R13, R14) prefer to use the bedside commode, so they don't have to be ridiculed. If we try to use the bathroom, R16 will walk in. It is like their (R16's) territory. I am stressed out and have anxiety because R16 doesn't stop. R14 stated that R14 does not feel safe but R14 is staying in the facility because R14's son is a resident in the facility and R14 wants to stay near him. On 2/24/26 at 3:50 PM, R16 stated they have been in the facility for two years. When questioned if there are any issues between R16 and R13 and R14, R16 stated not that I know of, I barely even see them, we use the bathroom, and I don't have any problems. If they have a problem with me, I don't know about it. R16 denied any verbal altercations. R16 stated that R16 just regularly sits in the hallway and drinks her coffee. R16 stated I used to be really tight with them but one day, R14 said I heard you said something about R13 sucking d**k. I told R14 I never said anything about y'all. I don't say anything to them. R16 stated that R13 still speaks to R16 and says hi and bye and R16's feelings were hurt for a minute. R16 stated that nobody knows them (R13, R14), they keep to themselves. R16 denied ever saying anything about R13 and R14. R16 denied having any altercations with anyone else. R16 said I came to the facility for toe amputation and open-heart surgery. R16 stated there were no staff when R14 came up to R16 and only a couple of other residents. R16 denied telling anyone not to use the restroom. R16 stated that R13 and R14 have one of those porta potties. Writer observed the restroom and noted purple mats and decorations (frames) in the restroom. R16 stated that they decorated the restroom to make it like home. On 2/24/26 at 4:03 PM, R11 stated it will be two years in April since they have been residing in this facility. R11 stated as soon as R16 is mad at you, they (R16) will be ignorant and disrespectful. I never witnessed them (R13, R14, R16) having an argument or disagreement. But I've heard they (R13, R14 and R16) have had differences especially because of the bathroom. I heard R16 said that R13 and R14 left the bathroom dirty, and R16 told them to clean up after themselves. R11 stated that R16 picks at people and if R16 doesn't like you they try to get you off of the floor. R16 thinks they run this floor. R11 stated that a lot of nurses and CNAs (Certified Nursing Assistants) get along well with R16. R16 knows about one of my diagnoses. How does R16 know about it, if not from staff. R16 knows who to pick on			S9999			03/26/2026

Illinois Department of Public Health

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S9999	Continued from page 24 and who not to pick on. We've had our argument, and I told R16 to leave me alone and I'll stay out of their way. I don't like R16s spirit. R11 denied having any issues with R13 and R14. On 2/24/26 at 4:33 PM, V17 (Assistant Director of Nursing) and V18 (Assistant Administrator) were notified that R13 and R14 made allegations of verbal abuse and bullying to IDPH (Illinois Department of Public Health) surveyors. V17 and V18 stated they were going to follow up accordingly. On 2/26/26 at 1:15 PM, V25 (Licensed Practical Nurse) stated I have had abuse training. We have in-services about every three months and if an incident occurs. The Abuse Coordinator is the Administrator. Types of abuse include verbal, physical, and financial. If I witnessed abuse, I would report immediately. Verbal bullying, calling names is abuse. On 2/26/26 at 12:10 PM, V31 (Medical Health Technician) stated I have been a social worker in the facility for one year. I have had abuse in-services. Maybe every two weeks we have one. Types of abuse include physical, mental, emotional, financial, and verbal. The Administrator is the Abuse Coordinator. I would immediately report abuse to the Abuse Coordinator. On 2/26/26 at 3:50 PM, V23 (Social Service Director) stated I have been with the facility for six to seven months. I oversee the other social workers. They notify me of any concerns with the residents. Any abuse witnessed, suspected, or heard about, I would report to the Abuse Coordinator, the Administrator. On 2/27/26 at 9:52 AM, V35 (Wound Care Coordinator) stated I would report abuse to the administrator who is the abuse Coordinator. Verbal bullying is abuse. On 2/27/26 at 10:51 AM, V36 (Certified Nursing Assistant) stated they are familiar with R16 and stated R16 respects V36 and V36 respects R16. V36 denied witnessing any bullying or abuse by any residents. V36 stated that R16 is cordial with other residents. V36 stated the Abuse Coordinator is the Administrator and types of abuse are verbal, physical, financial, mental, and sexual. V36 stated that the last time V36 received abuse training was a couple of months ago. On 2/27/26 at 10:55 AM, V37 (Registered Nurse) stated V37 has worked for the facility for three months. V37 stated R16's demeanor can be	S9999				03/26/2026	

Illinois Department of Public Health

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S9999	Continued from page 25 described as outgoing and outspoken. V37 stated R13 and R14 are both quiet and will come out of their room if they need anything. V37 stated there has not been any incidents or concerns brought up to V37 regarding R13, R14, and R16. V37 stated there has not been any disagreements or incidents regarding their shared restroom brought up to V37. V37 denied witnessing or hearing about any bullying or abuse going on between R13, R14, and R16. V37 stated the Administrator is the Abuse Coordinator and V37 stated bullying is a type of abuse because it could be psychological or intimidating. V37 stated bullying is something they would report immediately including all forms of abuse. R13 Social Service Note, 02/24/2026 19:03, reads in part: Writer received a report that Resident alleged peers made an inappropriate statement towards her. Resident verbalized emotional distress related to the alleged inappropriate comment. R16 progress notes; 07/16/2025, 05/02/2025, 04/19/2025, 02/11/2025 document multiple episodes of verbal altercations, verbal aggression toward peers and facility staff members. Provoking and derogatory name calling. R16 is care planned for verbal aggression; the resident (R16) has a history of manipulative, aggressive, inappropriate, attention-seeking behavior. The history includes: conflicts/altercation with others, threatening behavior, verbal or physical aggression towards peers. Manipulative behaviors; the resident (R16) displays manipulative behavior which is disruptive, insensitive and/or disrespectful to staff and peers. This behavior is related to: anger and depression, symptoms/problems are manifested by: threatening or acting in a verbally and/or physically aggressive manner. Initial Reportable Event, incident date 2/24/2026, involving R13, R14, R16 reads in part: Resident reported inappropriate behavior from co-peer. Facility Policy and Procedure Abuse Prevention Program, 1/24, reads in part: Residents have the right to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish. (B)	S9999				03/26/2026	