

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145764	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/03/2025
NAME OF PROVIDER OR SUPPLIER  Morgan Park Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE  10935 South Halsted Street Chicago, IL 60628	

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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>35432</p> <p>Based on observation, interview, and record review, the facility failed to a.) ensure medications were administered as ordered by the residents' physician, b.) ensure medications were locked and secured while unattended, c.) provide sufficient nursing coverage to ensure adequate resident care and support, and d.) provide care and services that meet professional standards. These failures have the potential to affect 103 residents residing in the facility. The facility also failed to provide timely incontinence brief changing to a resident due to not providing linen to staff. This failure affects one of three residents (R17) reviewed for ADL care in a total sample of 17 residents.</p> <p>Findings include:</p> <p>On 3/01/2025, all the floors were reviewed for staffing. One nurse did not show up for the morning shift on 3/01/2025.</p> <p>On 3/01/2025, at 10:49 AM, V3 (Licensed Practical Nurse) stated, there was one nurse from the night shift that I reported to today. There was a nurse on duty for the night shift last night. At times, there are times I come in and there is no nurse for the night shift. It is not often but it does happen. I work from 7:00 AM until 3:00 PM. Administration will call people and ask them to come in. There are methadone residents that are looking for their methadone on the night shift. But that is not on my side.</p> <p>On 3/01/2025, at 11:10 AM, R17 stated, I have not been changed yet today. I do have sores on my bottom. I need cream for my bottom as well.</p> <p>On 3/01/2025, at 11:41 AM, V5 (Certified Nursing Assistant) stated, I have not changed R17 yet today due to not having any linen. Staff are waiting for linen too long. I am about to change her now.</p> <p>On 3/01/2025, at 12:50 PM, V9 (Assisitant Director of Nursing) stated, the residents say that they did not have a nurse on a Monday morning. If the DON or I are aware, the Director of Nursing or I must come in and cover shifts. I have only been here four months. I have had to do it maybe two or three times.</p> <p>(continued on next page)</p>

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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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 3/01/2025, at 1:11 PM, V8 (Laundry Aide) stated, I am the only one working today for the laundry department. There is not enough linen in the building period. They need to purchase more linen for this building, all linens. There are three shifts for the laundry aides. I am working the 2:00 PM to 11:00 PM shift. The shift before me was 5:00 AM to 2:00 PM. I will build a linen cart for the entire unit around 3:00 PM. The aides will need more linen around 5:00 PM or 6:00 PM. There is a cart at 7:00 AM. After that around 9:00 AM or 10:00 AM, the staff will need more linen. I have brought the concern to my boss. The way it goes, is some kind of chain of command. He will order five cases and they give him one. It is neglect. There is not enough linen to care for the residents. You cannot blame the aides because they are doing the best they can do.</p> <p>On 3/01/2025, V15 (Housekeeping Supervisor) refused to be interviewed by the surveyor during this investigation.</p> <p>On 03/01/2025, at 1:46 PM, V14 (Staffing Coordinator) stated, I was made aware that there was no nurse on 2 south today. She no called no showed. When I am made aware of this I reach out to the person, and I try to replace them. I reach out to the ADON and DON. If no one else can come in they are expected to cover the shift. Usually, I can over the shift with staff. There is always a scheduled nurse. There may be times when someone is running late. There have been one or two nurses that leave before the morning shifts starts. In mid-January there was no night nurse. Then in February the supervisor had to work the cart. I am an aide. When there is a call in or staff running late, I can assist.</p> <p>On 3/01/2025, at 3:53 PM, V10 (DON) stated, it is not true. If there are no nurses, we must come and help. If we are not notified, we will not know what happens. There is always going to be a nurse there on the floor.</p> <p>On 3/01/2025, at 4:07 PM, V18 (Former Administrator) stated, I would try to do as much as I could when I was there. Yes, there were allegations of a nurse not working. I am not going to lie about that.</p> <p>February 20th, 2025, resident council meeting minutes documents there is no linen on night shifts. Resident voiced concerns there has been no nursing on second or third shift. Residents expressed that the overnight shift does not do anything.</p> <p>On 3/01/2025, staffing sheets were provided to the surveyor. On 2/15/2025 and 2/16/2025, there were nurses scheduled for the evening and night shifts. V14 (Staffing Coordinator) was unable to provide the punch documentation to provide the nurses did work their shifts. V14 was unable to provide the documentation sheet that contains staff signatures when they work their shifts.</p> <p>45000</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 03/01/2025 at 10:12 AM, surveyor located on the second floor of the facility with V7 (Licensed Practical Nurse/LPN). V7 states she is currently the only nurse working on the second floor 2 North unit. V7 states she started her shift at approximately 7:00 AM this morning and there is supposed to be another nurse scheduled to work on the 2 North unit with her. V7 states management is aware, and she is awaiting another nurse to arrive to assist with resident care. V7 states she began her medication administration pass at approximately 8:30 AM. V7 states she is only responsible for administering medications to her assigned residents. V7 states she will not be administering medications to all of the residents residing on the 2 North unit. V7 observed with three clear medication cups sitting on top of the medication cart with medications inside of them. V7 states she prepared the medications for 3 different residents at the same time. V7 states she is aware that resident medications should not be prepared all at once because there is potential for medication errors and for residents to receive the wrong medications. V7 states this could be dangerous for the residents.</p> <p>On 03/01/2025, at approximately 10:15 AM, V7 is observed walking away from her medication cart leaving the cart unlocked and unattended. V7 also leaves a residents' electronic medication administration record/eMAR deployed on the computer screen. Staff and residents observed walking past the medication cart and can potentially gain access to residents' medications. Surveyor makes V7 aware of the unlocked medication cart and resident eMAR being visible on the computer while V7 walked away. V7 states she is responsible for the medication cart that is unlocked and unattended and only left the cart temporarily because surveyor was standing there. Surveyor makes V7 aware that surveyor is not responsible for monitoring her medication cart when V7 leaves the cart unlocked and unattended. V7 states if a medication cart is left unlocked and unattended, then residents can gain access and have adverse reactions and possibly overdose. V7 states if a residents' eMAR is left deployed for anyone to see, then resident privacy and HIPAA/Health Insurance Portability and Accountability Act rules are violated.</p> <p>On 3/1/2025, at 11:46 AM, V1 (LPN/Restorative Manager) observed arriving on the second floor 2 North unit and administering medications to residents. V1 states she is not the nurse originally scheduled to work and was recently informed that the scheduled nurse did not arrive to work the shift. V1 states she will not be administering medications to residents that were scheduled at 9:00 AM or this morning. V1 states this is because the facility is allowed the time frame of one hour before and one hour after the scheduled time to administer medications to residents. V1 states she is only administering medications to residents on the 2 North unit that are scheduled for the afternoon time frame. R11 and other residents standing in the medication line verbalizes concerns with not receiving their morning medications stating, it's not our fault.</p> <p>On 03/01/2025, at 12:57 PM, V9 (Assistant Director of Nursing/ADON) states if medications are left unlocked and unattended, then a resident could be harmed by taking the wrong medications and overdosing.</p> <p>R4, R11, R13, and other residents verbalize not receiving their morning medications today on 03/01/2025.</p> <p>Surveyor observes V1's assigned residents' eMARs deployed on the computer on top of the medication cart. Surveyor observes that morning medications scheduled at 9:00 AM are red in color. V1 states the red color on the residents' eMAR indicates that the medications are not signed off and are now late.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Facility census dated 03/01/2025 documents that a total of 103 residents reside on the second floor of the facility.</p> <p>Surveyor requests the facility's HIPAA policy from V9 (ADON) on 03/01/2025 at approximately 1:00 PM. Surveyor inquires with V9 about the facility's HIPAA policy again on 03/01/2025 at approximately 3:15 PM. V9 states she is still awaiting the policy from the corporate office. Facility does not provide surveyor with HIPAA policy during this survey.</p> <p>Surveyor requests the facility's medication audit report dated 03/01/2025, from V2 (Administrator) on 03/01/2025 at approximately 2:00 PM. V2 states she is awaiting the audit report to be sent. Facility does not provide surveyor with the medication audit report dated 03/01/2025, during this survey.</p> <p>Facility policy dated 10/25/2014 titled, Medication Administration documents in part, 2. Medications are administered in accordance with written orders of the prescriber . 4. When medications are administered by mobile cart taken to the residents' location (room, dining area, etc.) medications are administered at the time they are prepared . 12. Medications are administered within 60 minutes of scheduled time . 16. During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide. No medications are kept on top of the cart. The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or others passing by. In addition, privacy is maintained at all times for all resident information (e.g., MAR) [by closing the MAR book/covering the MAR sheet or computer screen] when not in use.</p>