

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 05/01/2025
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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>45001</p> <p>Based on interview, and record review the facility failed to investigate an incident involving a verbal argument and physical contact between a resident and employee to rule out abuse. This failure affected one resident (R1) of three residents reviewed for abuse in a total sample of five residents.</p> <p>Findings include:</p> <p>On 4/29/25, at 2:11 PM, R1 said the incident was on 2/26/25. R1 said R1 felt like V3 (Maintenance Director) was harassing R1 a little bit. R1 and V3 got into an argument. R1 and V3 got into a fight. V3 was calling R1 a fat ass. On the elevator, V3 told R1 to move. V3 got into R1's face downstairs after getting off the elevator. R1 and V3 started swinging on each other. V3 hit R1 a few times on the back of the head and on the right side. R1 was in pain on the right side. R1 said R1 has been on restriction two months for the incident. R1 said V3 does not bother R1. R1 and V3 talk to each other. V3 helped R1 with a fan.</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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/29/25, at 3:12 PM, V3 (Maintenance Director) stated on 2/26/25, I was on the third floor. I noticed and assisted a staff member move a bed onto the elevator. The resident (R1) was in the elevator. CNAs (Certified Nursing Assistants) and nurses were also in the elevator. The resident (R1) was ranting about getting out of here. R1 was on restriction at that time. The nursing staff was trying to calm R1 down. I asked the resident (R1) to move over so I could pull the bed inside and we could all fit. The resident (R1) started to go off on me, cussing. The elevator doors closed, and the resident (R1) continued to rant. We went to level 2. I pushed the bed off the elevator and housekeeping staff got off the elevator with the bed. The elevator went to level one. A resident asked me for a remote control. I went to get the remote control from my office and returned to the third floor about 15 minutes later. The resident (R1) confronted me as I passed on the third floor to deliver the remote control. R1 was saying You looking for me?. Nursing staff came and got R1 out of my face. I took the stairs down to the first floor to avoid R1. By the time I got to my office on the first floor, R1 was coming off the elevator and came straight to me. R1 said come out of the camera so I can beat your a**. R1 swung at me about six to seven times, and one landed on my face. I had a contusion on the inside of my lip. I kept dodging/ducking the swings and pushing R1's elbows away. I was against the wall and had to maneuver out of the corner. I ripped my calf muscle. By that time, staff was coming and took R1 outside to calm down. I reported to human resources, who told me to call an employee hotline for medical attention (x-rays, ultrasound, CAT scan on my leg). I reported it to the Administrator. An investigation was done. I had abuse training the day before the incident. I was trying to deescalate R1. We had been cordial before the incident. R1 is quiet but was going through something that day. I have had normal interactions with R1 since the incident. R1 asked me to put a fan together so I did. The abuse coordinator is the administrator. Forms of abuse include verbal, physical, financial, sexual, neglect.</p> <p>On 4/29/25, at 4:14 PM, V2 (Human Resource/Assistant Administrator) stated I was made aware of the 2/26/25 incident because V3 (Maintenance Director) needed to fill out a workers compensation injury report. I received a call stating V3 needed to report a workplace injury because V3 was beat-up by a resident (R1). I was not in the building. The protocol is to call the injury hotline and gather witness statements. V3 was injured and going back and forth to the medical clinic for visits and therapy.</p> <p>On 4/30/25, at 9:42 AM, V1 (Administrator) stated I did not report the incident on 2/26/25 because it was the resident (R1). R1 became aggressive towards V3 (Maintenance Director). We sent the resident (R1) out to the hospital for the behavior exhibited. It was not reported that V3 was aggressive or initiated any form of violence. R1 actually injured the employee. V3 was hurt pretty bad. The resident (R1) was not injured. I did not investigate the behavior of the resident. V3 asked the resident (R1) to move over while on the elevator, the resident (R1) became verbally threatening and then physical. I did not have a reason to look at it as abuse. The staff that were around stated that the resident became physically aggressive towards the maintenance director. I did not talk to the resident. R1 was separated, placed on a one to one, and then sent to the hospital. I was not in the building when it happened. I went by what the staff present stated to me. I am the abuse coordinator. All types, forms, incidents, allegations, suspicions of abuse should be reported to me. I do abuse training for the staff monthly. Training topics include abuse identification, abuse prevention, and protection of the resident as it pertains to abuse. Types of abuse include mental, verbal, involuntary seclusion, exploitation, physical, sexual, misappropriation of funds. Abuse includes resident to resident and staff to resident. It includes resident to staff. I never report a resident being belligerent or abusive to staff to public health. We do put interventions in place. The resident may be placed on a one to one, prescribed something/medication by the physician, and or sent out to the hospital.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Facility Policy and Procedure Abuse Prevention Program, 1/24, documents in part: Incidents will be reviewed, investigated and documented, whether or not abuse, neglect, exploitation, mistreatment or misappropriation of resident property occurred, was alleged or suspected. Investigation Procedures. The investigator will attempt to interview the person who reported the incident, anyone likely to have direct knowledge of the incident and the resident, if interviewable.</p>		