

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  07/20/2025
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)
F 0600  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.  (continued on next page)

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to keep a resident free of sexual abuse from a resident. This failure affects two of three residents (R1 and R2) in a total sample of three residents. Findings include: This Survey was conducted on-site in the facility from 7/18/25 to 7/20/25. R1 is [AGE] years old and admitted to the facility 10/1/2024 with a diagnosis of chronic kidney disease and is dependent on renal dialysis. Minimum Data Sets (MDS) reviewed on admission [DATE] and most recent of 4/18/2025 indicate that R1 has been assessed to be alert and oriented without cognitive deficit. The MDS also indicates that R1 has not been assessed to exhibit any behavioral or psychotic symptoms. R2 is [AGE] years old and has been a resident of the facility since 2/23/22. R2 has diagnoses that include but are not limited to schizoaffective disorder and Cognitive Communication Deficit. According to R2's MDS dated [DATE] R2 was assessed with mild cognitive impairment. On 7/18/2025 at 7:30pm, R1 was observed independently functioning on their assigned unit, alert, oriented and properly groomed. At 7:40PM, R1 spoke with the Surveyor and expressed concerns regarding several past incidents with another resident (R2) and staff. R1 said that beginning in January of this year, R2, another resident, has come into R1's room several times uninvited, exhibiting sexually inappropriate behavior toward R1; including verbal aggressions and touching R1's genitals. R1 said that he would tell facility staff about these incidents and that no one intervened until one CNA (Certified Nursing Assistant) listened and told the nurse on duty. R1 said a police investigation was conducted and R1 produced a document from the officer who took the report on 4/27/25 that included an allegation of criminal sexual assault. The document included the names of R1 and R2 as well as the police report number associated with the complaint. R1 expressed concerns that the facility's administration is not doing enough to prevent R2 from interacting with R1 as R2 frequently comes to R1's assigned unit and stares at R1 intensely, making R1 feel uncomfortable. R1 also mentioned that there have been some staff nurses who were aware of R1's complaints about R2 and the staff members jokingly dismissed R1's concerns without intervention. R1 said this has made him distrust certain staff and is uncomfortable receiving care from them. On 7/19/25 at 1:19PM R2 was observed participating in activities, alert and oriented to situation. R2 admitted to grabbing R1's genitals while in the hallway listening to music and said that R1 became angry. R2 said they were friends before that incident. R2 said when R1 called the police their friendship ended and R2 was moved to another unit and floor. R2 said that sometimes they try to return to the unit were R1 is assigned but is restricted by the social services department. On 7/19/25 at 1:57pm V3 LPN said they were on duty as the primary nurse for R1 and R2 on 4/27/25. V3 said an unknown CNA notified V3 that R1 alleged R2 was sexually inappropriate with R1. V3 said when speaking to R1 about the incident, R1 said that this had happened multiple times during that week and earlier in the day, and R1 expressed being fed up with it and told the CNA. V3 said when they initially went to speak with R2, R2 did not deny the allegation and immediately apologized. V3 completed a petition for involuntary admission for psychiatric evaluation on 4/27/25. Care plans for R1 and R2 were reviewed and neither included care plans for consensual relationships. On 7/19/25 at 1:47pm V4 PRSD (Psychiatric Rehabilitative Services Director) said that the incident of 4/27/25 occurred prior to V4 working in the facility, however, V4 would expect for consensual relationships to be reported or at least discussed with the Social Services Department. V4 said that this is important to follow-up with residents regarding safe consensual practice should they choose to engage and also notifies that staff of the relationship should any behavior issues arise. Facility reported incident dated 4/27/25 summarized that R1 alleged R2 engaged in inappropriate behavior towards R1. Facility policy and procedure titled Abuse Prevention Program (no revision date) states in part: Residents have the right to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment. This includes but is not limited to corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms. Establishing a Resident Sensitive Environment This facility desires to prevent abuse, neglect, exploitation, mistreatment and misappropriation of resident property by establishing a resident sensitive and resident secure environment. This will be accomplished by a comprehensive quality management approach involving the following: Concern Identification and Follow-up: Resident and family concerns will be recorded, reviewed, addressed, and responded to using the facility's concern identification procedures. Residents and families will be informed of the facility's concern identification procedures. An essential element of customer satisfaction is a timely response back to the family or resident to concerns</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to follow their policy and procedure for reporting an allegation of resident-to-resident abuse. Findings include: This Survey was conducted on-site in the facility from 7/18/25 to 7/20/25. R1 is [AGE] years old and admitted to the facility 10/1/2024 with a diagnosis of chronic kidney disease and is dependent on renal dialysis. Minimum Data Sets (MDS) reviewed on admission [DATE] and most recent of 4/18/2025 indicate that R1 has been assessed to be alert and oriented without cognitive deficit. The MDS also indicates that R1 has not been assessed to exhibit any behavioral or psychotic symptoms. R2 is [AGE] years old and has been a resident of the facility since 2/23/22. R2 has diagnoses that include but are not limited to schizoaffective disorder and Cognitive Communication Deficit. According to R2's MDS dated [DATE] R2 was assessed with mild cognitive impairment. The electronic health record was reviewed for R1 and R2. Progress notes dated 4/27/25 for R1 states: Resident [R1] alleges that co-peer engaged in inappropriate behavior toward him. Residents immediately separated. Co-peer placed on 1:1 monitoring. Body check initiated without findings or complaints of pain. [Medical Doctor], family and police notified. Wellbeing initiated by social services where resident continues to feel safe in the facility. A progress note for R2 on 4/27/25 states: It was alleged that the resident engaged in inappropriate behavior towards co-peer. Residents immediately separated, resident was placed on 1:1 monitoring and will be sent out for an evaluation. MD, family, and police notified. A petition for involuntary admission was completed and signed for R2 on 4/27/25 and included that R2 needed immediate hospitalization to alleged unwanted physical sexual contact to another resident. Facility Incident Report and Investigation were requested from V1 (Administrator) for the alleged incident of 4/27/25. V1 included in the report that both the initial and final investigation were reported to IDPH (Illinois Department of Public Health) on 7/17/25. On 7/19/25 at 2:14PM V1 (Administrator) said that all staff are expected to directly report any allegations of abuse immediately to V1 as they arise as such to begin the investigation and send notification to IDPH. V1 confirmed that this allegation that occurred 4/27/25 is a reportable incident. Facility policy and procedure titled Abuse Prevention Program (no revision date) states in part: 1. Initial Reporting of Allegations - When an allegation of abuse, exploitation, neglect, mistreatment or misappropriation of resident property has occurred, the resident's representative and the Department of Public Health's regional office shall be informed by telephone or fax. Public Health shall be informed that an occurrence of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property has been reported and is being investigated. The report shall include the following information, if known at the time of the report: Name, age, diagnosis and mental status of the resident allegedly abused, neglected, exploited, mistreated or from whom property was misappropriated Type of alleged abuse reported (physical, sexual, neglect, verbal or mental abuse, misappropriation of resident property) Date, time, location and circumstances of the alleged incident Any obvious injuries or complaints of injury Steps the facility has taken to protect the resident This report shall be made immediately, but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse or resulted in serious bodily injury; or not less than 24 hours if the events that cause the allegation do not involve abuse and did not result in serious bodily injury. The resident or resident's representative will also be informed of the report of an occurrence of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property and that an investigation is being conducted. 2. Five-day Final Investigation Report. Within five working days after the report of the occurrence, a complete written report of the conclusion of the investigation, including steps the facility has taken in response to the allegation, will be sent to the Department of Public Health.</p>		