STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145764	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Morgan Park Healthcare	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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145764	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Morgan Park Healthcare	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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and review of records the facility failed to follow their policy to ensure notification of proper parties are done related to discharging 1 out of 5 residents. These failures affected 1 resident (R1) who was discharged after going out of the facility on community pass without required documentation and notification to the proper parties. Findings include:On 11/12/2025 at 10:41 AM, V11 (Law Enforcement Detective) stated that R1 was reported by facility missing on 05/20/2025. V11 stated that she tried contacting facility multiple times via email and phone calls, but facility was not responsive to her communication or correspondence. Per V11 there was lack of cooperation on the part of facility and to do her job she needs cooperation from facility.On 11/12/2025 at 12:38 PM, V1 (Administrator) stated that R1 went out on pass on 05/19/2025 and did not came back in the facility. R1 has a history of not returning to the facility. V1 stated that she did not contact family members listed on the face sheet. And does not know if any of facility staff contacted family members. V1 said, they should have contacted those (family) on the face sheet. V1 stated that R1 current location or status is unknown. V1 said, As for now, I do not know where R1 is. V1 stated that she will check her email to confirm about V11's email. Per V1 (Administrator) there was no physical copy of police report. Only the report number was given by the police. On 11/12/2025 at 01:00 PM, V7 (Director of Nursing) stated that residents that are on independent pass needs to have cognition that are intact and can navigate community safely. V7 stated that there needs to be social service assessment which is community survival skill assessment and doctor's order that the resident was clinically assessed to be independent. When a resident is allowed to go out on pass independently and does not come back it will be treated as discharge against medical advice or [NAME]. Same as in the case of R1 when he left the faciity on [DATE] he was considered as discharge against medical advice or [NAME]. V7 stated that they only contact family member when they are designated as POA / Power of Attorney not when resident is responsible to self as in the case of R1. V7 stated that she was not aware that family was involved with R1's care or police was asking information from facility regarding R1. V7 said, Yes, if it was my family I would like to be informed. Social Service notes dated 04/29/2025 documents that R1's family is involved in his care. On 11/12/2025 at 01:35 PM, V8 (Family of R1) during phone conversation, stated that she was not informed by facility about R1. She only knew about R1 leaving when R1 went from place to place. Currently R1 at V17's (Current Location of R1-another facility.) On 12/03/2025 at 01:14 PM, V1 (Administrator) stated that family and doctor are notified of community and unplanned hospital discharges. When it is discharge against medical advice with resident that are responsible to self, the facility notifies only the physician. V1 does not know if notification is given to State Ombudsman representative during discharge. V1 stated that she is unable to locate Ombudsman notification. Requested to V1 discharge requirements on notification and documentation. V1 submitted discharge planning policy, stated there is no other policy related to discharge.R1's Order Summary Report includes 2 orders for pass 1. May go out for 2 hour independent pass, order date 5/13/25. 2. May go out on 30 min independent pass.R1's progress noted 5/19/25 - 5/21/25 has no notation that the family was notified that R1 has not returned to the facility. Community Pass Policy dated 7/2/24 states Residents who elect not to return to the facility while out on a pass may be considered discharged against medical advice and their physician will be appropriately notified.Discharge Against medical Advice policy dated 7/2024 states call the physician and Administrator to notify them of the pending AMA discharge. Discuss the situation and follow their instructions. If available involve the resident's responsible party (e.g. family). they may be able to talk the resident out of leaving. Use your best judgment as to what must remain confidential. Confidentiality should take second priority to your efforts to assure the resident's continued health and safety. Undated Signing out Against medical Advice (AMA) policy states if the resident refuses to sign the AMA form, the form will be signed by two staff members witnessing the resident's refusal to sign. Notations of the refusal and a description of the discharge will be documented in the resident's clinical record. A trusted staff member should follow the resident to the extent possible while he/she is out of the building.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145764	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Morgan Park Healthcare	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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145764	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Morgan Park Healthcare	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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and review of records the facility failed to follow policy on providing Community Survival Skill Assessment. Failed to follow policy to involve responsible party/family to resident discharged against medical advice ([NAME]). Failed to follow policy in procuring physician order for independent pass and failed to follow community pass and care plan intervention on restriction of resident related to independent pass for 5 out of 11 residents (R1, R2, R3, R4, R11) reviewed for resident safety during community pass. These failures apply to 2 residents (R1 and R11) who was on independent pass and did not return to facility and applies to 3 residents (R2, R3 and R4) that were allowed to go out on independent community pass without physician orders and/or has care plan for restricted pass. Findings include: R1 is [AGE] years old, initially admitted in the facility on 01/06/2025. R1 diagnosis includes Schizophrenia, insomnia, auditory hallucinations, cocaine abuse, extrapyramidal and movement disorder, major depressive disorder and suicidal ideations. R1 cognition is intact has a BIMS score of 15 per MDS assessment dated [DATE]. On 11/12/2025 at 10:41 AM, V11 (Law Enforcement Detective) stated that R1 was reported by facility missing on 05/20/2025. V11 stated that she tried contacting facility multiple times via email and phone calls, but facility was not responsive to her communication or correspondence. Per V11 there was lack of cooperation on the part of facility and to do her job she needs cooperation from facility. On 11/12/2025 at 12:38 PM, V1 (Administrator) stated that R1 went out on pass on 05/19/2025 and did not came back in the facility. R1 has a history of not returning to the facility. V1 stated that she did not contact family members listed on the face sheet and does not know if any of facility staff contacted family members. V1 said, they should have contacted those (family) on the face sheet. V1 stated that R1's current location or status is unknown. V1 said, As for now, I do not know where R1 is. Per V1 (Administrator) there was no physical copy of police report. Only the report number was given by the police. V1 stated that IDPH was not notified because it was not a case of elopement but a discharge against medical advice. On 11/12/2025 at 01:00 PM, V7 (Director of Nursing) stated that residents that are on independent pass needs to have cognition that are intact and can navigate community safely. V7 stated that there needs to be social service assessment which is community survival skill assessment and doctor's order that the resident was clinically assessed to be independent. When a resident is allowed to go out on pass independently and does not come back it will be treated as discharge against medical advice or [NAME]. Same as in the case of R1 when he left the faciity on [DATE] he was considered as discharge against medical advice or [NAME]. V7 stated that they only contact family member when they are designated as POA / Power of Attorney not when resident is responsible to self as in the case of R1. V7 stated that independent pass is based on cognition and not psychiatric diagnosis or mental illness. Resident with mental illness have medication to treat their symptoms. V7 stated that residents that have no access with medication when in the community can go to hospital. V7 stated that since police have been informed, they can help with finding R1 in the community. V7 stated that she was not aware that family was involved with R1's care or police was asking information from facility regarding R1. V7 said, Yes, if it was my family I would like to be informed. Social Service notes dated 04/29/2025 documents that R1's family is involved in his care. On 11/12/2025 at 01:35 PM, V8 (Family of R1) during phone conversation, stated that she was not informed by facility about R1. She only knew about R1 leaving when R1 went from place to place. Currently R1 at V17's (Another Facility-Current Location of R1.) On 11/12/2025 at 2:15 PM, V9 (Former Social Worker/Currently Dietary Aide) who did the Community Survival Skill assessment dated [DATE] stated that supervised pass is when someone accompanies the resident compared to independent pass when resident by himself. V9 stated that family members and police need to be contacted. V9 when asked whether R1 was discharged or eloped? V9 said, I considered both as elopement and discharge. On 11/13/2025 at 11:08 AM, V4 (Licensed Practical Nurse) staff in charge when R1 went out on independent community pass and did not return to facility. V4 stated that there are two (2) kinds of out on passes. Yellow for 30 minutes and green for 4 hours. V4 stated that R1 has yellow or 30 minutes of independent pass. V4 stated that she did not check whether R1 had community survival skill assessment. According to V4 it is the nurse who first received the community survival skill assessment who will call the doctor to get the order for independent community pass. V4 stated that R1 was pretty much to himself or timid. V4 stated that it was around 06:45 PM to 06:50 PM during medication pass when she noticed that R1 cannot be located. V4 said, I notified DON (Director of Nursing), administrator and called the police. V4 stated that she cannot remember calling R1's family. He is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145764	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Morgan Park Healthcare	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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and review of records the facility failed to coordinate with law enforcement agency in providing information related to 1 out of 5 residents (R1) reviewed for independent out on pass. These failures affected 1 resident (R1) who left the facility during community pass did and not return. The facility is unable to report R1's whereabouts and status. Law enforcement agency unable to proceed in finding or knowing resident (R1) status due to lack of cooperation by facility.Findings include:R1 is [AGE] years old, initially admitted in the facility on 01/06/2025. R1'S diagnosis includes Schizophrenia, insomnia, auditory hallucinations, cocaine abuse, extrapyramidal and movement disorder, major depressive disorder and suicidal ideations. R1 cognition is intact has a BIMS score of 15 per MDS assessment dated [DATE].On 11/12/2025 at 10:41 AM, V11 (Law Enforcement Detective) stated that R1 was reported by facility missing on 05/20/2025. V11 stated that she tried contacting facility multiple times via email and phone calls, but facility was not responsive to her communication or correspondence. Per V11 there was lack of cooperation on the part of facility and in order to do her job she needs cooperation from facility. On 11/12/2025 at 12:38 PM, V1 (Administrator) stated that R1 went out on pass on 05/19/2025 and did not came back in the facility. R1 has a history of not returning to the facility. V1 stated that she did not contact family members listed on the face sheet. And does not know if any of facility staff contacted family members. V1 said, they should have contacted those (family) on the face sheet. V1 stated that R1's current location or status is unknown. V1 said, As for now, I do not know where R1 is. V1 stated that she will check her email to confirm about V11's email. Per V1 (Administrator) there was no physical copy of police report. Only report number was given by the police. V1 stated that IDPH was not notified because it was not a case of elopement but a discharge against medical advice. On 11/12/2025 at 01:00 PM, V7 (Director of Nursing) stated that residents that are on independent pass needs to have cognition that are intact and can navigate community safely. V7 stated that there needs to be social service assessment which is community survival skill assessment and doctor's order that the resident was clinically assessed to be independent. When a resident is allowed to go out on pass independently and does not come back it will be treated as discharge against medical advice or [NAME]. Same as in the case of R1 when he left the faciity on [DATE] he was considered as discharge against medical advice or [NAME]. V7 stated that they only contact family member when they are designated as POA / Power of Attorney not when resident is responsible to self as in the case of R1. V7 stated that independent pass is based on cognition and not psychiatric diagnosis or mental illness. Resident with mental illness have medication to treat their symptoms. V7 stated that residents that have no access with medication when in the community can go to hospital. V7 stated that since police have been informed, they can help with finding R1 in the community. V7 stated that she was not aware that family was involved with R1's care or police was asking information from facility regarding R1. Yes, if it was my family I would like to be informed. Social Service notes dated 04/29/2025 documents that R1's family is involved in his care. Per nursing notes dated 05/20/2025 at 01:49 AM, police came in the facility. On 11/12/2025 at 02:04 PM V3 (Medical Records) denies receiving email or call from V11 (Law Enforcement Detective). V3 stated face sheet is allowed to be given to law enforcement agency, and she will address the issue.On 11/13/2025 at 11:50 PM, V2 (Assistant Administrator / Human Resource) denies any email or call from V11 (Law Enforcement Detective). V2 stated that that kind of email will be received by V1 (Administrator). On 11/13/2025 12:49 PM, V1 (Administrator) confirmed that she received email from V11 and has yet to respond. V1 was also informed that besides email, phone calls were also made by V11. V1 stated she will address issue at hand. V1 provided an email dated 10/18/2025 that documents V11 asking information and notifying facility that a call to V3 (Medical Records Manager) was made multiple times.