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	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Morgan Park Healthcare	10935 South Halsted Street Chicago, IL 60628

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. Based on interview and record review, the facility failed to treat a resident's personal belongings with respect and ensure the resident has access to their personal belongings. This failure affects one (R4) resident out of three residents reviewed for resident rights. Findings include: On 02/25/2026 at 9:11AM, surveyor located inside of R4's room and observes a black television/TV measuring approximately 32 inches diagonally. The TV was attached to a portable TV stand, TV observed on and in working condition. On 02/25/2026 at 9:12AM, V11 (CNA) states the TV located inside of R4's room was recently purchased by R4's family because R4's previous TV was broken in the facility. V11 states she heard that a nurse (identified as V12/RN) broke R4's previous TV by bumping it with R4's bathroom door. V11 states R4's family purchased R4's previous TV as well.On 02/26/2026 at 8:27AM, V12 (Licensed Practical Nurse/LPN) states she was located inside of R4's room with three CNAs, who were assisting her with transferring R4 via a mechanical lift. V12 states she cannot remember the names of the CNAs. V12 states R4's TV was sitting on the bedside table and it fell to the floor during transferring R4. V12 states R4's TV did not fall on the floor but, fell on a bag of dirty clothes and one of the CNAs picked it up and placed it back on the bedside table in the same position. V12 states she never looked at R4's TV after it fell and did not know that it was broken. V12 states she went on vacation for one month and when she returned, she heard hearsay that she was the person who broke R4's TV. V12 states she heard that one of the nurses informed V34 (R4's family member) that V12 broke R4's TV. V12 states this hearsay is not true and she did not break R4's TV. V12 states she never addressed the hearsay because she did not want to get into any confrontations.On 02/27/2026 at 10:25AM, V1 (Administrator) states she was also contacted about 2-3 months ago by V34 (R4's family member) regarding R4's broken TV. V1 states R4's previous TV was a TV that R4 had for five years, and the TV just went out and stopped working. V1 states to her knowledge, the facility has replaced R4's TV because the facility replaces residents' TVs all the time. V1 states she is not sure if she has an invoice for R4's TV replacement but she spoke with V22 (Maintenance Director) and informed him to replace R4's TV. V1 states she never went inside of R4's room to verify if R4's TV was broken. On 02/27/2026 at 11:09AM, V22 (Maintenance Director) states several months ago, R4's TV was broken in the facility. V22 states he is not sure how R4's previous TV broke. V22 states R4's family bought R4 another TV. V22 states he is the person who put R4's TV on the TV stand inside of R4's room.Ombudsman Residents' Rights for People in Long-Term Care Facilities dated 11/2018 documents in part, You may keep and use your own property.

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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F 0600 Level of Harm - 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [AGE] 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 [AGE] 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 [AGE] 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 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 (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	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 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 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 (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow its policy and revise a care plan to ensure that the resident's care plan addressed each fall and interventions were changed with each fall for one (R4) out of three residents reviewed for care plans following a fall. Findings include: On 02/25/2026 at 1:36PM, V13 (Restorative Nurse) states she is responsible for inputting fall preventative interventions in the resident's care plan. V13 states residents' care plans should be updated to reflect each fall and the fall care plan interventions should also be updated with different interventions. V13 states if a resident falls multiple times, the fall interventions should not remain the same because this indicates that those interventions are not working to prevent the resident from falling. V13 states this puts the residents at a greater risk of falling when interventions are not changed. V13 deploys R4's care plan dated 11/09/2025 and states she did not update fall interventions for R4 after he fell on [DATE]. V13 states it is important to update the care plan to ensure that residents have the fall prevention intervention and equipment that they need. V13 states the definition of updating the care plan is to add new fall precaution interventions. R4's care plan dated 10/15/2025 was reviewed and documents: R4 is at risk for falls r/t Confusion, Gait/balance problems, Incontinence. Interventions include: Anticipate and meet R4's needs, Date Initiated: 10/04/2023, Assist with proper positioning while in bed, Date Initiated: 06/25/2024, Be sure R4's call light is within reach and encourage R4 to use it for assistance as needed. R4 needs prompt response to all requests for assistance, Date Initiated: 10/04/2023, Bed bolsters to assist with identifying bed perimeter, Date Initiated: 04/08/2024, Educate R4/family/caregivers about safety reminders and what to do if a fall occurs, Date Initiated: 10/04/2023, Ensure that R4 is wearing appropriate footwear when ambulating or mobilizing in w/c, Date Initiated: 10/04/2023, Follow facility fall protocol. Date Initiated: 10/04/2023, Frequent monitoring, Date Initiated: 04/08/2024, Keep commonly used items in reach, Date Initiated: 06/25/2024, Keep resident's immediate environment clutter free, Date Initiated: 06/25/2024, Maintain bed in low position when resident is in bed, Date Initiated: 04/08/2024, Monitor medication side effects and report to MD PRN, Date Initiated: 06/25/2024, R4 has dycem in his wheelchair to prevent sliding, Date Initiated 10/04/2023, R4 provided with a floor mat, Date Initiated: 10/04/2023, R4 will wear hipsters to prevent injury from falls.R4 is at risk for falls R/T History of Falls. Interventions include: Floor mat on side of the bed, Date Initiated: 06/25/2024, frequent Checks, Date Initiated: 04/08/2024, Low bed Date Initiated: 04/08/2024.Record review of R4's care plan dated 11/09/2025 shows that there is no updated care plan to reflect new interventions implemented after R4 fell on [DATE].Facility policy dated 01/2024 titled Care Plan 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.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observations, interviews, and records review, the facility failed to follow their employee handbook policy related to employee cell phone use. This failure has the potential to affect 115 residents residing in the unit.Findings include: On 02/25/2026 at 9:24AM, surveyor exits R4's room and is located on the second-floor north unit nurses' station. Surveyor sees a black phone and hears an audible ringing sound coming from the phone located on a desk at the nurses' station. Surveyor observes V14 (Central Supply Manager/Transportation) standing directly next to the nurses' station phone and is observed talking on her personal cell phone while ignoring the audible rings coming from the nurses' station phone. Surveyor also observes V15 (Restorative CNA/Certified Nursing Assistant) sitting in a chair at the second-floor north nurses' station with his head looking down and personal cell phone in his hand and texting. V15 also observed ignoring the audible rings coming from the nurses' station phone and never looks up from texting on his phone. Once V14 and V15 observes surveyor, V15 stops texting and puts his phone away while V14 puts her cell phone in her pocket and answers the phone at the nurses' station. V14 states she did not hear the nurses' station phone ringing at first because she was talking on her own personal cell phone. V15 states he did not hear the nurses' station phone ringing because he was texting. V15 states it is everyone's responsibility to answer the phone at the nurses' station. V15 states the phone calls are usually for the nurses', so he never answers the phone at the nurses' station anyway. Facility Census dated 02/24/2026 documents that there are a total of 57 residents residing on the second-floor north unit of the facility. Facility document undated, titled Employee Handbook documents in part, Personal Electronic Devices- Cell phone usage while on duty is prohibited. Examples of such devices includes mobile telephones, laptops, tablets hand-held email or texting devices. You may however use such devices, in designated areas, while on break. If you have an emergency situation that must be immediately tended to, please inform your Supervisor. Employees who use personal electronic devices while on duty may be subject to disciplinary action, up to and including termination. Personal cell phones must be left with your personal belongings while in the facility. Consultants and managers must have their cell phones on quiet/vibrate mode and should not talk on their phones in resident care areas. On 02/24/2026 at 1:02 PM-1:10PM, V6 (Certified Nursing Assistant -CNA) was observed sitting in the hallway on 3N with her personal cell phone in her hands scrolling on her phone. V6 stated she is not supposed to be on her personal phone when monitoring hallway for resident safety. If she is on the phone, she might not monitor residents properly which can lead to residents not receiving the care they need. Residents can sustain injuries; residents can get into confrontations. V6 stated staff using personal phones while in the units is not part of her job description. V6 stated she is assigned 20 residents and 3N houses 58 residents' total. On 02/25/2026 at 12:58PM, V2(Director of Nursing-DON) stated Certified Nursing Assistants (CNAs) or nurses are not supposed to use their cell phones on the units. Cell phones are only allowed in the break room when staff are on break. Cell phone use in the units is distracting, can cause HIPAA (Health Insurance Portability and Accountability Act) violations and is unprofessional. If the CNAs and nurses are on their cell phones, they cannot provide proper care to residents. Accidents and injuries can happen to the residents.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE], 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.This was identified as an Immediate Jeopardy began on [DATE]. On [DATE] at 2:35 PM, V1 (Administrator) was notified of the immediate jeopardy.The facility presented an abatement removal plan on [DATE], at 5:01 PM. The plan was not approved. The facility submitted a revised abatement plan on [DATE], at 4:32 PM, [DATE], at 4:16 PM, and [DATE], at 5:25 PM. None of these plans were approved. The facility submitted a revised abatement plan on [DATE], at 4:48 PM. This plan was approved on [DATE].On [DATE], the surveyor confirmed by reviewing the staff in-service list included in the approved abatement Plan, substance abuse prevention competency forms, resident council meeting minutes held on [DATE], residents' care plans regarding substance abuse history, physician order sets, progress notes since [DATE], substance abuse disorder assessments for R1, R19, R20 and R21, observations of a staff member searching belongings upon visitor/resident/staff entering the facility. Also, interviewing R20, R21 and another resident with a history of substance abuse, certified nursing assistant, licensed practical nurse, housekeeper, and social service director, the immediacy was removed on [DATE]. However, the non-compliance remains at level two because additional time is needed to evaluate the implementation and effectiveness of in-services training. Findings include: R3's face sheet documents R3 is a [AGE] year-old individual admitted to the facility on [DATE] and discharged on [DATE] (death). R3 has diagnoses not limited to opioid dependence, uncomplicated, anxiety disorder, unspecified, obstructive sleep apnea, and major depressive disorder, recurrent, unspecified. R3's progress note dated [DATE], 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 [DATE], documents in part that an autopsy was not performed. On [DATE], 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 (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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 [AGE] year-old individual admitted to the facility on [DATE]. R11's MDS/Minimum Data Set, dated [DATE] documents that R11 has a BIMS/Brief Interview for Mental Status score of 15/15, indicating that R11 has intact cognitive response. On [DATE], 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 [DATE], 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 [DATE], 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 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 (continued on next page)

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	145764	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Morgan Park Healthcare	10935 South Halsted Street Chicago, IL 60628

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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 [AGE] year-old individual admitted to the facility on [DATE], 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 [DATE], 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 [DATE], 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 [DATE], 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 [DATE], 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 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 [AGE] year-old individual admitted to the facility on [DATE] with diagnoses not limited to: opioid abuse. R20's MDS/Minimum Data Set, dated [DATE], 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 [DATE], at 2:35 PM, documents in part resident admitted to substance use and possession of contraband. On [DATE] 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 (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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 [DATE], 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. On [DATE], 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 [AGE] year-old individual admitted to the facility on [DATE], with diagnoses not limited to: opioid abuse, uncomplicated, opioid use, and unspecified with withdrawal. R19's MDS/Minimum Data Set, dated [DATE], documents that R19 has a BIMS/Brief Interview for Mental Status score of 15/15, indicating that R19 has intact cognitive response. On [DATE], 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 [DATE]. R22 stated that R3 and R22 would use the drug and would share one baggie or 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 [AGE] year-old individual admitted to the facility on [DATE], (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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 [DATE] 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 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 [DATE]. 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 [DATE]. V39 stated that there is no substance abuse assessment done on [DATE]. 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 [DATE] at 1:31 PM, V32 (Housekeeping) stated last year around October through [DATE], there were a lot of overdoses. V32 stated that he could not recall the exact names, but this was on the third floor. On [DATE], 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 [DATE], 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 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: [DATE]. Revision on: [DATE]. No interventions in the substance use care plan regarding monitoring R3 noted. 2. R7 was a [AGE] 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. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On [DATE], 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 apologetic as to what happened. Residents should not be using controlled substances in the facility. On [DATE], 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 [DATE], 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 [DATE], 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 [DATE], 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. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	R7 hospital record for hospital admission, dated [DATE], reads in part: Laboratory Tests, dated [DATE], 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, [DATE], 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 [DATE], documents R1's Brief Interview for Mental Status (BIMS) as 2/15 indicating R1 has severe cognitive abilities. On [DATE], 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 [DATE], 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 [DATE], document R1 was seen at the hospital for Opiate overdose and UTI (Urinary Tract infection). Hospital physician progress notes dated [DATE], 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) not captured by screen, concentration below cut off, timing and collection, or non-standard analog. On [DATE], 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 [DATE], 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. (continued on next page)

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(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 - Immediate jeopardy to resident health or safety Residents Affected - Some	On [DATE], at 12:35 PM, V25(Licensed Practical Nurse) stated he did not administer Narcan to R1 on [DATE]. 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

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	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure proper indwelling catheter care for two residents (R7, R9) of 22 residents reviewed.Findings include: R9 is a [AGE] year-old individual whose current face sheet documents medical diagnosis to include but not limited to: cardiac arrhythmia, unspecified, gastro-esophageal reflux disease with esophagitis, without bleeding, retention of urine, unspecified, other obstructive and reflux uropathy, disorder of the autonomic nervous system, unspecified. R9's Minimum Data Set (MDS) Section C - Cognitive Patterns dated 02/16/2026 documents R9's Brief Interview for Mental Status 14/15, indicating R9 has intact cognitive abilities. Section GG - functional abilities documents R9 requires supervision or touching assistance with eating and oral hygiene, is dependent on staff for toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear, personal hygiene. On 02/24/2026 at 12:46PM, R9 was observed laying in bed eating lunch, was alert, oriented to person, place, time and situation. R1 was observed with an indwelling urinary catheter. The catheter bag was observed on the floor. R9 stated he cannot see what is placed on the floor and does not know if the urinary bag is on the floor. On 02/24/2026 at 12:48PM, V3(Licensed Practical Nurse-LPN) and surveyor observed R9 lying in bed. R9's urinary catheter was observed to be approximately halfway full. The urinary bag was placed directly on the floor. V3 stated urinary catheter bags are not supposed to be placed on the floor, it should be hooked on the bed frame below the bladder. It is an infection control issue. The floor is dirty. Germs can get into the catheter causing R1 to develop urinary tract infections (UTI). CNAs (certified Nursing Assistants) are supposed to hook it up to the bed frame off the floor. Nurses are supposed to check and make sure the urinary catheter bag is hooked on the bed frame below the kidneys. On 02/27/2026 at 10:48AM V35(Licensed Practical Nurse - LPN) Urinary catheter should be cleaned every day with normal saline then hooked on the bed frame above the kidneys. It cannot be placed on the floor, because it can cause friction and pulling which can cause resident harm. The catheter should never be placed on the floor, which is dirty. It can pick up germs that can cause residents to develop urinary tract infections. It is an infection control issue. On 02/25/2026 at 12:58PM, V2 (Director of Nursing-DON) V2 stated urinary catheters should not be placed on the floor. It should be hung on the side of the bed away from the floor and below the kidneys to prevent back flow and germs from the floor from entering the catheter. Placing the urinary bag on the floor can cause a resident to develop a urinary tract infection. R9's Physician Order Sheet (POS) documents: Catheter: May change urinary drainage bag every 24 hours as needed when unable to observe urine. 2/27/26 at 9:52 AM, V35 (Wound Care Coordinator) stated signs of infection include redness, swelling, puss/sediment to the area, discharge. The catheter area is cleaned daily, and the catheter is (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	changed on order, typically 30 days for infection control or upon doctor's request. We assess the site and clean with normal saline. The catheter bag is placed below the kidneys so the urine can flow downwards with natural gravity on the side of the bed. The urine should not flow backwards so not to risk a UTI (urinary tract infection). The bag should not be on the floor for infection control. R7 catheter care order reads in part: change foley cath (catheter) as needed for blockage, leaking or malfunctioning. R7 is care planned for risk for infection or complications related to catheter use due to neurogenic bladder. R7 Health Status/Progress Note, 01/19/2026 05:45, reads in part: Upon making rounds resident (R7) noted lethargic and slow to respond. Resident noted warm to touch. Vitals taken and were noted at 107/72, 130, 14, 80% on R/A (room air), 103.0. Supplemental 02 (oxygen) administered at 3L/Min (liters/minute) via nasal cannula, 02 increased to 90%. Tylenol administered for temperature. Head of bed maintained elevated. No pain or discomfort noted. On call clinician for MD (medical doctor) phoned, awaiting return call. 911 was called to transport resident to hospital. R7 Nursing Progress Note, 01/19/2026 13:07, reads in part: called and received admitting from hospital diagnosis of hypoxia and sepsis. R7 hospital record for hospital admission 1/19/2026 reads in part: Patient (R7) has indwelling Foley catheter and was reported on non-draining for unknown periods of time with change of urine color to dark brown. Upon arrival to ER (emergency room), temperature was 100.8, HR (heart rate) 122. Activities at onset: other (clogged Foley catheter). Urine appearance: turbid A, Urine leukocyte esterase: Large A, Urine bacteria: many A. Diagnosis: AMS (altered mental status). Hypoxia on BIPAP (Bilevel Positive Airway Pressure), possible postictal, sepsis, hypotension, UTI (urinary tract infection). Ordered change of the Foley catheter which was clogged, and inserted a new Foley catheter which is freely draining. Color of urine is dark brown. Urinalysis: turbid, heavy proteinuria, large leukocyte esterase, many bacteria.