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	06/10/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations, interviews and record review, the facility failed to provide a safe, clean, comfortable, homelike environment by ensuring that the toilets in residents' rooms were functioning for four residents (R4, R11, R21 & R24) and ensuring that one resident's (R4) dresser drawer was not broken with exposed nails. These failures have affected four residents from the sample of 4 residents reviewed for homelike environment.Findings include:R4's admission Record documents R4's diagnoses including opioid dependence, anxiety disorder, major depressive disorder, adverse effect of other opioids, elevated white blood cell count, and pneumonia. R4's admission date to the facility is documented as 1/22/26.R4's Minimum Data Set (MDS) section C showed a BIMS (Brief Interview for Mental Status) score, dated 5/19/26, of 15. R4 is cognitively intact.On 6/8/2026 at 12:22 PM, R4's room was observed with the bedside dresser top drawer broken, and nails are exposed. The toilet appears clogged with a brown substance floating and water overflowing to the floor. Two urinals were noted in the room hanging on the bedside rails, one with a three-fourths amount of yellow liquid that appears to be urine. R4 stated that the toilet has been clogged for a week now and he has to walk a long way to use the public toilet; that's why he uses the urinal for convenience. R4 stated that dresser top drawer was broken and nails exposed since his admission to the facility. On 6/8/2026 at 12:40 PM, R21's room was observed with three urinals noted on the floor. R21 stated that the toilet has been clogged and that he reported it to maintenance many times. R21 stated that he uses a urinal because the toilet is clogged. R1 stated that he needs to walk a long way to use the public toilet. R21 stated that he has a frequency of urination; that's why he uses urinals for convenience. R21 stated that he empties urinals by himself in the public toilet.R21's admission Record documents R21's diagnoses including acute kidney failure, anemia, chronic kidney disease, hypertension, hyperlipidemia, myocardial infraction and inguinal hernia.R21's Minimum Data Set (MDS) section C showed a BIMS (Brief Interview for Mental Status) score, dated 4/13/26, of 15. R21 is cognitively intact.On 6/8/2026 at 12:50 PM, R14's room was observed with two urinals on the floor. R14 stated that the toilet has been clogged for a few days now and he uses the public toilet at the end of the hallway.R14's admission Record documents R14's diagnoses including weight loss, alcohol use, atherosclerotic heart disease, complete loss of teeth, frequency of micturition, nicotine dependence, insomnia, psychoactive substance abuse, unsteadiness on feet.R14's Minimum Data Set (MDS) section C showed a BIMS (Brief Interview for Mental Status) score, dated 4/21/26, of 14. R14 is cognitively intact.On 6/8/2026 at 12:50 PM, R24's room was observed with two urinals on the floor. R24 stated that he doesn't remember when the toilet was clogged; he uses the public toilet at the end of the hallway.R24's admission Record documents R24's diagnoses including hemiplegia and hemiparesis, unsteadiness on feet, atherosclerotic heart disease, insomnia, cerebral infraction, chronic obstructive pulmonary disease, gastro esophageal reflux disease, absence of left and right leg above knee, anxiety disorder, anemia, constipation.R24's Minimum Data Set (MDS) section C showed a BIMS (Brief Interview for Mental Status) score, dated 3/19/26, of 14. R24 is cognitively intact.On 6/9/2026 at 10:10 AM, the surveyor made an observation of R4's room with V11 (Maintenance Director) and noted a urinal with three-fourths urine was in the side rails of R4's bed. Three urinals (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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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	were noted on the floor next to R21's bed, with one urinal half filled with urine. The toilet in R4's room is clogged and covered with a plastic sheet. V11 stated that R4's dresser upper drawer is broken and nails are exposed. V11 stated that it is unsafe for the residents. V11 stated he doesn't do routine rounds and only does repairs by the work order book. V11 stated that R4's room toilet is clogged. V11 stated that residents will report any maintenance issues to the nurse, and they will write it in the work order book. The toilet needed to be rodded.On 6/9/2026 at 10:25 AM, the surveyor made an observation of R4's room with V24 (Licensed Practical Nurse). V24 stated that she noted 3 urinals on the floor of R21's bedside, with one urinal half filled with urine. V24 also stated that she noted a urinal with three-fourths filled with urine in R4's side rails and one empty urinal on the floor. V24 stated that the toilet appears to be clogged; she doesn't know since when it's clogged. V24 stated that R4's dresser top drawer is broken, and nails are visible; it's not safe for the residents. V24 also stated that residents report maintenance complaints to nurses, and they write them in the work order book and report them to the maintenance department.The facility maintenance log was reviewed from May to June 2026. On 6/3/26, an entry of concern is noted that R4's/R21's room toilet is stopped up, and Yes is marked that the area is serviced. On 5/15/26, an entry of concern is noted that R4/R21's toilet is clogged, and Yes is marked that the area is serviced. No further entries of concern are noted for R4/R21's clogged toilet as observed by this surveyor on 6/8/26. No entries are documented for R11/R24's clogged toilet or for R4's broken dresser with nails exposed.The facility document, undated, titled Attachment J: Statement of Resident Rights, noted in part: The resident has a right to a safe, clean, comfortable and homelike environment. Housekeeping and maintenance services to maintain a sanitary, orderly, and comfortable interior.The facility document, dated 10/2024, titled Policy and Procedure: Safe, Clean, Comfortable and Homelike Environment, noted in part: The facility will provide a safe, clean, comfortable and homelike environment to the residents while taking into consideration a person-centered care, where residents' independence is promoted. Purpose: To ensure that the facility remains a pleasant place to live. Procedure: The facility will be kept clean and well-maintained through regular cleaning schedules, a preventive maintenance program, and the repair or enhancement of existing structures, systems, and fixtures.The facility document, dated 7/24, titled Job Description of Maintenance Director, noted in part: Assure the proper maintenance and running condition of all electricity and plumbing in the entire facility including c. the resident's room. Perform all repairs that do not fall under the purview of housekeeping.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 interviews and record review, the facility failed to ensure that: a Fall Risk Assessment was completed for one resident (R12) who sustained a fall in the facility that resulted in a fracture; failed to ensure that an Incident Report was completed for two residents (R12 and R9) post falls; and failed to ensure that Fall Interventions were updated on the Care Plan for (R8, R9 and R12). These failures have affected three of four residents reviewed for falls.Findings include:R12 is [AGE] year old with diagnosis including but not limited to: traumatic arthropathy of right hip, bilateral primary osteoarthritis of knee, anxiety disorder, hypoxemia and essential hypertension. R12's BIMS (Brief Interview of Mental Status) score is 14, which indicates cognitively intact.On 6/8/26 at 11:15 am, R12 stated the following, I broke my ankle here (in facility) on 4/18/26 from a fall. When I fell, I (R12) was in the restroom trying to get up from the toilet. My CNA (Certified Nurse Assistant/ V19)) was busy, so I tried to transfer from the toilet to the wheelchair by myself. I did not want to bother her (V19). When I (R12) started to transfer, I slid to the floor. The next morning, my ankle was swollen, and I was sent to the hospital.On 6/9/26 at 3:12 pm V19 CNA (Certified Nurse Assistant) stated the following, I was assigned to (R12) the day that she fell trying to transfer from the toilet. I (V19) was helping another resident at the time and had told (R12) that I would be back to help her once she was done using the restroom. She was waiting on the toilet, and I had told her that I would be right back. After five to ten minutes, I heard (R12) yelling out my name and went to her bathroom. When I got there, she (R12) was on the floor, and her leg was caught in her chair near the leg rest. It appeared that (R12) twisted her leg trying to transfer before she fell. I notified the nurse.Facility document titled State Report (Facility Reported Incident) dated 4/21/26 documents the following, on 4/20/26 (corrected date of 4/18/26 confirmed by V2/ADON, Assistant Director of Nursing) R12 reported left foot pain. Upon assessment, R12's foot and ankle were noted to be swollen. The Physician was notified and gave orders for a STAT (immediate) x-ray of the left foot and ankle. X-ray results revealed a fracture to the left lateral malleolus. R12 was transported to the local hospital and returned with cast to the left ankle. Facility document titled Witness Statement and dated 4/18/26 documents the following signed statement from V19 (CNA), As I entered the resident's bathroom (R12) upon hearing her (R12) call me, I noticed her foot caught in her chair and reported it to the nurse.R12's Section GG-Functional Abilities assessment dated [DATE] documents, R12 uses a wheelchair; R12 requires maximal assistance with toilet transfers.R12's Hospital Patient Report dated 4/19/26 documents, Left ankle x-ray reveals acute nondisplaced fracture of the lateral malleolus. R12's Care Plan dated 4/13/26 documents, R12 is at risk for falls related to limited mobility due to Cardiopulmonary insufficiency. R12's Fall Care Plan documents no new fall intervention was added after R12's 4/18/26 fall occurrence.R12's EMR (Electronic Medical Record) excludes any Fall Risk Assessment after R12's 4/18/26 fall occurrence. R12's EMR excludes a Fall Incident Report regarding R12's 4/18/26 fall occurrence. R9 is [AGE] year old with diagnosis including but not limited to: gout, malignant neoplasm of prostate, aphasia, hemiplegia and hemiparesis following cerebral infarction.R9's BIMS (Brief Interview of Mental Status) score is zero, which indicates severe cognitive impairment. On 6/8/26 at 12:50 pm, V13 (LPN/ Licensed Practical Nurse) stated, R9 has been discharged . He had fallen out of bed on 3/16/26 and somehow hit the back of his head. He was assessed and sent to the hospital where he received sutures. I'm not sure how he fell out of the bed, but his bed was in the lowest position. I can't remember if there were floor mats by his bed. I'm not sure if he had fallen in the past. After each fall we (nurses) complete incident report, fall assessment and update care plan. The purpose of the incident report and the fall assessment is to capture what occurred and assess the possible cause. I believe the fall nurse (V18) is the person that updates the care plan interventions.Facility document titled State Report (Facility Reported Incident) dated 3/17/26 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documents the following: On 3/14/26, R9 was observed on the floor next to his bed. R9 was immediately assessed and noted with an open area to the back of the head. Area cleansed and a pressure dressing was applied. R9's Medical Doctor and family were made aware and an order to transport to the local hospital was received. R9 returned with staples to the back of his head.R9's Fall Risk Review completed by V13 LPN on 3/16/26 documents: R9 has balance issues; R9 uses an assistive device.R9's EMR excludes a Fall Incident Report for R9's 3/14/26 fall occurrence. R9's Fall Care Plan dated 1/29/26 documents no new fall intervention was added after R9's 3/14/26 fall occurrence.Facility Census Report dated 6/8/26 excludes R9 as an active resident of the facility. R8 is [AGE] year old with diagnosis including but not limited to: repeated falls, unsteadiness on feet, other lack of coordination, and muscle weakness.R8's BIMS (Brief Interview of Mental Status) score is blank, which indicates that R8 is rarely/never understood. Facility document titled State Report (Facility Reported Incident) dated 11/20/25 for the initial reportable sent to the State agency documents the following: On 11/19/25, R8 was observed on the floor next to his bed. The staff nurse immediately assessed the resident and he was noted to have an open area to the forehead. R8's family and physician were made aware. New orders were received to transport R8 to the hospital. R8 returned with sutures to the forehead. Facility document titled State Report (Facility Reported Incident) dated 11/26/25 for the final reportable sent to the State agency documents the following: The residents' care plan and assessments were updated accordingly.R8's Fall Care Plan dated (initial date) 1/15/25 documents no updated fall interventions after R8's 11/19/25 fall occurrence to 11/26/25, as the final State Report indicates.R8's Fall Incident Report dated 11/19/25 and reported by V32 (LPN) documents the following: Nurse (V32) was alerted by a noise from R8's room and immediately went to observe R8. R8 observed to by laying on left side near the front of his bed. R8 unable to give a description; R8 sustained a laceration to the face; R8's bed was in the lowest position; R8's call light was within reach. R8's Fall Risk Review dated 11/19/25 documents: R9 had at least one fall within the past three months.Facility Census Report dated 6/8/26 excludes R8 as an active resident of the facility. On 6/9/26 at 12:34 pm V2 (ADON/ Assistant Director of Nursing) stated the following, I'm not sure what happened with (R12's) fall. She did sustain a fracture, and it was reported to IDPH (Illinois Department of Public Health). Incident reports and post-fall assessments are done after each fall to investigate the fall, to assess the well-being of the resident and prevent future falls. I'm honestly not sure if the assigned nurse or the fall nurse is responsible for the fall assessment. The incident report should be done by the assigned nurse. Incident reports are completed in the risk management system (electronic charting system). I can't locate an Incident report or fall assessment for (R12's) fall on 4/18/26. I only have the report sent to IDPH about the incident. The fall occurred on 4/18/26, but the incident was reported to IDPH on 4/21/26 after (R12) was hospitalized and we were made aware of the fracture. On 6/9/26 at 1:19 pm V18 (Fall/ Restorative nurse) stated the following, After a resident falls, I complete an incident report in risk management to find out the root cause of the fall. I investigate the fall by getting statements from the staff and the resident regarding the fall and I update the care plan with interventions to prevent a possible fall again. (R12) stated that she tried transferring herself because she did not want to bother her CNA. (R8 and R9) were both observed right before their falls by the assigned nurses. Their (R8 and R9) beds were in the lowest position and they hadn't fallen from the bed in the past. I don't do a fall assessment after the fall. I think the assigned nurse does that, but I'm not sure. It is important to document fall incidents in our system so that we can track the falls and again, prevent the falls from happening again.Facility policy titled Fall Prevention Program dated 2/28/26 documents: The program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized necessary; A Fall Risk Assessment will be performed at least quarterly and with each significant change in mental or functional condition and after any fall incident; Accident/Incident Reports involving falls will be reviewed by the Director of Nursing and the IDT (Interdisciplinary (continued on next page)

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