(X6) DATE

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BUILDING.			
		IL6003958	l		1	0/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MORGA	N PARK HEALTHCAR	F	UTH HALST , IL 60628	ED STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
S 000	Initial Comments		S 000			
	Complaint Investiga	ation				
	2487182/IL177721 2487585/IL178272					
S9999	Final Observations		S9999			
	Statement of Licens	sure Violations:				
	300.610a) 300.1010i) 300.1210b) 300.1210c) 300.1210d)3) 300.1210d)6)					
	Section 300.610 R	esident Care Policies				
	a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.					
	i) At the time of immediate treatment	Medical Care Policies of an accident or injury, nt shall be provided by n first aid procedures. (B)				

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

10/17/24 **Electronically Signed**

TITLE

Illinois Department of Public Health

AND DIAN OF CORRECTION \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		` ′			SURVEY PLETED
		7. Sollbino.			,
	IL6003958	B. WING			0/2024
PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MORGAN PARK HEALTHCARE			ED STREET		
(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	ULD BE	(X5) COMPLETE DATE
Section 300.1210 Nursing and Person b) The facility care and services to practicable physical well-being of the releach resident's complan. Adequate and care and personal cresident to meet the care needs of the releach resident to meet the care needs of the releach direct and be knowledged respective resident. c) Each direct and be knowledged respective resident. d) Pursuant to nursing care shall in following and shall seven-day-a-week. 3) Objective or resident's condition emotional changes determining care refurther medical evaluate by nursing stresident's medical in as free of accident nursing personnel stresident in and assistance to provide the condition of	General Requirements for nal Care shall provide the necessary o attain or maintain the highest all, mental, and psychological sident, in accordance with imprehensive resident care disproperly supervised nursing care shall be provided to each the total nursing and personal esident. care-giving staff shall review able about his or her residents' care plan. subsection (a), general include, at a minimum, the be practiced on a 24-hour, basis: bservations of changes in a main including mental and mental and mental and mental and mental and mental including mental including and recorded in the measurement shall be taken esidents' environment remains hazards as possible. All shall evaluate residents to see receives adequate supervision prevent accidents.	S9999			
Based on record re	eview and interview the facility				
	PROVIDER OR SUPPLIER N PARK HEALTHCAR SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa Section 300.1210 Nursing and Person b) The facility care and services to practicable physical well-being of the releach resident's complan. Adequate and care and personal resident to meet the care needs of the releach resident to meet the care needs of the releach resident to meet the care needs of the releach resident to meet the care needs of the releach resident to meet the care needs of the releach resident to mursing care shall in following and shall seven-day-a-week 3) Objective or resident's condition emotional changes determining care refurther medical evaluate by nursing stresident's medical evaluate and surresident in a sfree of accident nursing personnel stresident in and assistance to put these requirements.	PROVIDER OR SUPPLIER N PARK HEALTHCARE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.	PROVIDER OR SUPPLIER IL6003958 STREET ADDRESS, CITY, STREET, ADDRESS, CIT	PROVIDER OR SUPPLIER ILEGO3958 **REST ADDRESS, CITY, STATE, ZIP CODE 1935 SOUTH HALSTED STREET CHICAGO, IL. 60628 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 6) All necessary precautions shall be taken to assure that the resident's environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These requirements are not met as evidenced by:	OF CORRECTION IL6003958 B. WING

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Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
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	IL6003958	B. WING		09/3	30/2024	
NAME OF PROVIDER OR SUPPLIER			STATE, ZIP CODE			
MORGAN PARK HEALTHCARE		UTH HALST), IL 60628	ED STREET			
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to conduct a physical vital signs, failed to de Practitioner, failed to the unit when EMS (Services) arrived, fail orders, and/or failed three of three reside change in condition. R2 sustaining abdorn bowel obstruction and shock with multi orgation. R2 sustaining abdorn bowel. In addition, R2 pain" due to pulmonate Findings include: 1. On 9/19/24, IDPH Health) received allesto send a resident to care) in a timely mare R2's diagnoses inclused in a timely mare required fective disorrhabdomyolysis, CKI hemiplegia and heminon-traumatic intractileft side. R2's (10/2/23) function supervision or touch eating and partial mare required for toileting. R2's care plan including and report any signs discomfort, fever, and discomfort.	care plan interventions, failed al assessment, failed to obtain contact the Physician/Nurse of ensure that a Nurse was on Emergency Medical filed to follow Physician to provide timely care to ents (R2, R3, R4) reviewed for These failures resulted in: minal pain secondary to small and death caused by septic an failure likely from ischemic as sustained "excruciating ary embolism. I (Illinois Department of Public regations that the facility failed of the hospital (for emergency nner. Inde but not limited to reder, dementia, D (Chronic Kidney Disease), hiparesis following erebral hemorrhage affecting for oderate assistance is required for oderate assistance is required for oderate assistance is at siency related to history of olysis. Intervention: monitor	S9999	DEL IGIENCI			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
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		IL6003958	B. WING			30/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MORGA	N PARK HEALTHCAR	'E	UTH HALST), IL 60628	ED STREET		
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	include anti-psychoclosely for significa of appetite, and contimes side effect no physician notification. R2's (10/2/23) programmed Chief complaint: reparted but can a Claims to feel sad a week ago. No no recent passing. Appleeling sad. 9:12pm family member (V5 phoned 911 for respecting well. Unit sure (Primary Care Physical Appropriate papers) (Emergency Medic	S (Physician Order Sheets) of the medication use: observe not side effects, sedation, loss instipation. Enter the number of office (requires progress note of on for each occurrence). I press notes state 12:29pm, view of depression symptoms. In the symptoms of the sympt				
	(10/2/23) SBAR (Si Assessment Recor condition report (which is the condition of the conditi	pm, surveyor requested R2's ituation Background mmendation) and/or change in nich include vital signs at time er neither were received during				
	(Family) about R2's V5 stated, "I (V5) w mother (R2) looked (R2) wasn't asking to eat. She (R2) sa hadn't eaten in a w	pm, surveyor inquired from V5 is (10/2/23) change in condition. Went up there (facility) and my is like her normal self, but she for food, and she usually likes id that she was nauseated and hile, so I (V5) told the Nurse, med a little lax about it. My				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
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	OLIMANA DV. OTA		, IL 60628	DDOVIDEDIO DI ANI OF GODDECTI	201	0.4=>
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	and said she (R2) s (V6) to call 911. Wh	p there around 9:00 at night still didn't eat so I (V5) told him nen the EMT's got there they				
		o on the floor to give them any (V5) got to the hospital, I				
	found out she (R2)	hadn't pooped for 2 weeks, me she threw up her bowels				
	in the CT (Compute	ed Tomography) scan. She				
	, ,	bstruction that led to sepsis. was supposed to be recording				
	her bowel moveme	nts and her eating. If they that there was a problem				
	ahead of time, why	did the family have to get her				
		acility). Nurses are supposed nat something is wrong and be				
		ut and output. It's basically a e passed away October 4th,				
		om, surveyor requested R2's				
	(including bowel mo	r (2023) input and output ovements) documentation				
	however neither we	ere received during this survey.				
	R2's (10/2/23) char	2am, surveyor inquired about nge in condition, V8 ctical Nurse) stated "I (V8)				
	was not taking care called downstairs b	of her (R2) that day. I was y the CNA (Certified Nursing				
		are of some paperwork for her as out on a lunch break to my				
	understanding. The	family was at the bedside and				
	hospital. I printed of	ner (R2) sent out to the out the face sheet and the				
		ne necessary documents when y out" [SBAR and/or change in				
	condition report we	re excluded]. Surveyor				
		ssed R2 prior to transfer, V8 e was already on the gurney to				
		n I came down." Surveyor				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
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		IL6003958	B. WING		09/3	30/2024
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MORGA	N PARK HEALTHCAR	E 10935 SOI CHICAGO		ED STREET		
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\$9999	inquired if V8 obtain transfer, V8 replied gurney for transfer. covers the unit whill stated "The other N made aware when y cover for you." Surv. Nurse manager on don't recall." Survey (evening shift) Nurse V8 replied "There's inquired if any Nurse during change in costated "Not on that R2's (10/2/23) histopresented to the ED with abdominal pair obtained from EMS non- nursing floor a providers on the flo vomiting profusely of quadrant abdominated Tomography) scan bowel obstruction. Van episode of emes aspirated because slightly more hypox the patient and place with brownish output patient's clinical state increasingly hypoxic patient has a contrapersistent vomiting intubate for this hypelevated creatinine lactate 6.5 and slight the ER, blood press	ge 5 ned R2's vital signs prior to "No, she was already on the " Surveyor inquired who e the Nurse goes on break, V8 urses are supposed to be you go on break so they can reyor inquired if there was a duty that day, V8 responded "I ror inquired how many ses are assigned to each floor, 2 on each unit." Surveyor es were present on R2's unit andition and/or transfer, V8 unit when I arrived, no." Ty & physical states resident of (Emergency Department) of and vomiting. Report states that patient was on a t her nursing home with no or when she was found complaining of left lower I pain. CT (Computed was obtained with signs of While in CT scan patient had sis which was presumed to be afterwards, she became ic. General surgery evaluated sed an NG (Nasogastric) tube ut. After placement of NG tube tus deteriorated becoming c and tachycardic and as the andication to BiPAP with the a decision was made to oxia. Notable labs include from baseline, elevated nt leukocytosis 13.7. While in sures were difficult to obtain y available pressure reading	S9999			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED	
		IL6003958	B. WING		l l	C 30/2024
	PROVIDER OR SUPPLIER N PARK HEALTHCAR	F 10935 SO	DRESS, CITY, ST UTH HALSTE 1, IL 60628			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
\$9999	80/auscultation. Sh (vasoconstrictor us blood pressure) at to max dose. R2's (10/3/23) surg presented from nur abdominal pain and reports she had 2 vno bowel movemer gas. CT abdomen a for small bowel obstruction with two weeks. Patient bowel obstruction vHowever, patient's required intubation patient started to vostarted on IV Zosyr (Antibiotic) for aspir R2's (10/4/23) discipled life-sustaining in became PEA (Pulsitime of death pronouncement started to vostarted on IV Zosyr (Antibiotic) for aspir R2's (10/4/23) discipled life-sustaining in became PEA (Pulsitime of death pronouncement started to vostarted on IV Zosyr (Antibiotic) for aspir R2's (10/4/23) discipled life-sustaining in became PEA (Pulsitime of death pronouncement started bowed on 9/30/24 at 12:43 the expectation of Nexperience a change Director) stated "The minimum getting virobvious history of the physician." Survey not had a bowel more started to work and a bowel more started to work and the proposed life in the pr	e was started on Levophed ed to treat life-threatening low that time and quickly escalated ery consult states patient sing home with 2 weeks of d poor oral intake. Patient weeks of abdominal pain, and ats though continues to pass and pelvis finding concerning struction. To present illness states to ER from nursing home due with vomiting. Per notes, for was revealed to have a small with an NG tube placed. condition worsened and due to hypoxia which the omit fecal material. Patient was a (Antibiotic) and Doxycycline ration pneumonia. The present gradually eless Electrical Activity) and bunced at 11:00am. Cause of with multi organ failure likely	S9999			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
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NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
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\$9999	pain, decreased app Surveyor inquired if what's the potential there's a lot of potential there's a lot of potential pneumonia or uppe but I think the bigge pneumonia." 2. R3's diagnoses in Obstructive Pulmonial R3's (6/14/24) care potential for impaired COPD. Intervention signs/symptoms of with treatment to make a survey of the composition with treatment to make a survey of the composition of the resident for shortnes interventions as orday. R3's POS includes every 4 hours as not (7/1/24) stat left rib R3's progress notes resident complained inhalation causing halo breathing deeply. In Practitioner who gas the left rib. Order not scheduled x-ray with to provide an ETA (18:30pm, [8 hours late pain to exterior left informed nursing state of the composition of th	ad to fecal impaction, horrible petite, or a bowel obstruction." a resident vomits feces harm, V7 replied "I think ntial for harm, they can have r GI (Gastrointestinal) pain, est thing would be aspiration include COPD (Chronic lary Disease). plan states resident has the ed gas exchange related to monitor and report respiratory distress unrelieved edical doctor. Monitor ss of breath and implement lered if needed. (6/14/24) oxycodone 5mg eeded for moderate pain and	\$9999			

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	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
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NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MORGAI	N PARK HEALTHCAR	F		ED STREET		
		CHICAGO	, IL 60628			1
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				DEFICIENCY)		
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00000	·		00000			
		e 5mg (milligrams) per orders.				
		dmitted to ICU (Intensive Care				
	Unit) diagnosis pulr	nonary embolism.				
	R3'e (0/20/24) RIM9	S determined a score of 15				
	(cognition intact).	o determined a score or 15				
	(oogimion maor).					
	On 9/25/24 at 3:36p	om, surveyor inquired about				
	R3's (7/1/24) chang	ge in condition. R3 stated				
		the blood clot. I had to call and				
		he pain was too bad for me to				
		around." Surveyor inquired				
		mented when they were made				
		ge in condition R3 responded d someone, and they				
		nding someone to do some				
		er showed up. When it came to				
		in excruciating pain. I had				
		to call the doctor, but they kept				
	saying what the oth	er shift did, so I had to call 911				
	myself. The doctor	said I had a blood clot."				
		5am, surveyor inquired about				
		ge in condition, V10 (LPN)				
	` ,	s complaining about chest when he breathed in deep, he				
		p pain. So, I (V10) listened to				
		ds, lung sounds everything				
		his oxygen saturation was				
		ctor and let her (doctor) know				
		she (doctor) ordered a stat				
		d to schedule the x-ray and				
		ay provider) was unable to				
		urveyor inquired if V10				
		or to report that the x-ray				
		e to provide an ETA for R3's				
	x-ray (wnich was or "No."	dered stat), V10 responded				
	INU.					
	On 9/30/24 at 12:48	B, surveyor inquired if a				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
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NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	09/-	30/2024
		10935 SO		ED STREET		
MORGA	N PARK HEALTHCAR	CHICAGO	, IL 60628			
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\$9999	procedure is ordered turnaround time, V7 would say like 2 hoor get an x-ray becasomebody to come inquired if an x-ray provider is unable to done, V7 responde patient go to the hocare." Surveyor incepain upon inspiration what's the potential potential causes cobe a pulmonary empulmonary empulmo	ed stat what's the expected 7 (Medical Director) stated "I urs for someone to draw blood ause we need to call and do that." Surveyor is ordered stat and the o do it stat what should be d "I would recommend the spital to get more immediate quired if a resident has chest on and difficulty breathing cause, V7 replied "Two ould be a heart attack or could bolism." Surveyor inquired if a m is not treated timely what's V7 stated "death."	S9999			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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S9999	Continued From pa	age 10	S9999			
		omen x-ray results affirm it was d at 8:03pm [x-ray performed				
	R4's (7/12/24) BIMS rarely/never unders	S affirms resident is stood.				
	On 9/24/24 at 2:39pm, surveyor spoke to R4 however received no verbal response. On 9/30/24 at 10:28am, V10 (LPN) stated "Whenever there's any change in condition you will do an SBAR." Surveyor inquired when R4's (7/21/24) KUB was obtained, V10 stated "I scheduled a stat KUB, and they (x-ray provider) gave an ETA of 4 to 6 hours." Surveyor inquired about stat turnaround time, V10 responded "I believe it's between 2 to 4 hours." Surveyor inquired if V10 contacted the Nurse Practitioner to report that the x-ray providers ETA was going to be 4 to 6 hours (therefore not stat), V10 replied "No, I should have called the doctor." Surveyor inquired when R4's (7/21/24) KUB was obtained, V10 stated "I'm not sure but it says I relayed the results at 10:25pm [roughly 12 hours after orders were received]. I'm not exactly sure what time they (x-ray provider) came."					
	(reviewed 11/2023) resident's physician there is significant or physical, mental or deemed necessary interest of the resident and their rephysician/NP will be	dent's condition policy states Nursing will notify the nor nurse practitioner when: change in the resident's emotional status. It is or appropriate in the best lent. Communication with the esponsible party as well as the e documented in the resident's other appropriate documents.				

Illinois Department of Public Health STATE FORM

PRINTED: 11/20/2024 FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _____ С B. WING _ IL6003958 09/30/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 10935 SOUTH HALSTED STREET **MORGAN PARK HEALTHCARE** CHICAGO, IL 60628 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) S9999 S9999 Continued From page 11 (AA)

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