Illinois D	enartment of Public	Health			FORM	APPROVE
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	R: A. BUILDING:		(X3) DATE SURVEY COMPLETED C	
		IL6003958	B. WING		11/0	07/2024
NAME OF F	ROVIDER OR SUPPLIER			STATE, ZIP CODE		
MORGAN	I PARK HEALTHCAR	F	OUTH HALST O, IL 60628	EDSTREET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE
S 000	Initial Comments		S 000			
	Complaint Investigation					
	2488425/IL179415	- 300.661 cited				
\$9999	Final Observations		S9999			
	Statement of Licensure Violations:					
	300.661					
	Section 300.661 H Background Check					
	Worker Backgroun	bly with the Health Care d Check Act and the Health ground Check Code.				
	This requirement w by:	as NOT MET as evidenced				
	failed to conduct he history background employment for two	and record review, the facility ealth care worker criminal checks before the start of employees. This failure has ct all the residents residing in				
	Findings include:					
	Assistant/CNA) sta	4pm, V9 (Certified Nursing ted that she worked for the 1 until 01/2024 and the facility on the registry.				
	Resource Director) background check	22pm, V8 (Corporate Human stated that the facility did a and placed V9 (CNA) on the I. V8 stated that V9 had not				
	tment_of Public Health ′ DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	GNATURE	TITLE		(X6) DATE
	cally Signed					11/18/24
ATE FORM	Λ		6899 L	.1MR11	lf continu	ation sheet 1

Illinois Department of Public He STATEMENT OF DEFICIENCIES (X* AND PLAN OF CORRECTION (X*		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED C		
	IL6003958		B. WING			11/07/2024	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE			
MORGA	N PARK HEALTHCAR		OUTH HALSTE O, IL 60628	D STREET			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
S9999	had a background of stated that employed done for the safety not doing backgrour residents and staff Review of V4's (Psy Services Coordinati files shows that V4' was 10/07/24. V4's 11/04/24. On 11/06/24 at 9:50 that the facility ran a 11/04/24 when they one done. On 11/06/24 at 3:35 checks are importa employees are safe and won't hurt or ta in any kind of way. not done prior to hin for potential harm." Facility's job descrip "Human Resources "Essential Duties ar employee backgrou our facility's establis Facility's policy date Prevention Program Procedure" docume screening of potent will not knowingly h action in effect again licensing body that	check done by the facility. V8 ee background checks are of the residents and staff and nd checks could put the at risk. ychiatric Rehabilitation or/PRSC) human resource s date of hire to the facility background check dated Dam V1 (Administrator) stated a background check for V4 on realized that he didn't have 5pm, V1 stated "Background nt to assure that the e to work with the residents ke advantage of the residents When a background check is re it puts the residents at risk ption dated 03/23/17, titled " documents in part, nd ResponsibilitiesConduct and checks in accordance with					

L1MR11

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORPECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		IL6003958	B. WING			C 07/2024
AME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
IORGAN	I PARK HEALTHCAR			ED STREET		
(X4) ID	SUMMARY STA		O, IL 60628	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	COMPLET DATE
S9999	Continued From page 2		S9999			
	facility will:check Worker Registry or prior reports of abu misappropriation of fingerprint check re website links on the State Police Livesc	f resident property, previous esults, and the sex offender e registry; and initiate an Illinois an fingerprint check for any al being hired without a				