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	01/31/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 45111 Based on interviews and record review the facility failed to keep seven residents, (R1, R2, R3, R4, R5, R6, R7) free from abuse for seven residents reviewed for abuse. Findings include: R1 is a [AGE] year-old individual with medical diagnosis that include but not limited to: violent behavior, schizoaffective disorder, bipolar type, schizophrenia, unspecified, bipolar disorder, current episode manic without psychotic features, moderate, major depressive disorder, recurrent, severe with psychotic symptoms. MDS (Minimum Data Set) section C dated [DATE], documents R1's Brief Interview for Mental Status (BIMS) as 15/15 indicating R1 has intact cognitive abilities. On 01/29/2025, 11:08AM, R1 stated he did not want to talk about the incidence with R2 that happened on 12/24/2024 because he would get mad talking about it. R1's progress notes dated 12/24/2024 document R1 had physical altercation with R2(roommate) in their room and peers (No names documented) witnessed it. R1's Social Service progress noted 12/26/2024 document R1displayed agitation while recalling the incident where he and R2 (roommate) were involved in a physical altercation. R2 is a [AGE] year-old individual with medical diagnosis that includes but not limited to: conversion disorder with seizures or convulsions, cerebral palsy, unspecified. MDS (Minimum Data Set) section C dated [DATE], documents R2's Brief Interview for Mental Status (BIMS) is not scored, and R2 requires substantial/maximal assistance with Activities of Daily Living (ADL) care. R2's progress notes dated 12/24/2024 documents document R2 had physical altercation with R1 (roommate) and R2 called 911. R3 is a [AGE] year-old individual with medical diagnosis that include but not limited to hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, alcohol use, unspecified with alcohol-induced persisting dementia. MDS (Minimum Data Set) section C [DATE], dated documents R3's Brief Interview for Mental Status (BIMS) as 9/15 indicating R3 has moderate cognitive impairment. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R3's Social Services progress notes dated 12/31/2024 document's R4 was involved in an altercation with another resident (R4) and was witnessed by V6 (Activity Aide), and further documents R4 was cutting the line during smoking time on the patio. R3 told R4 to wait and let the women residents go first, but R4 got mad and hit R3 who didn't like being hit by R4 and pushed back. R4 is a [AGE] year-old individual with medical diagnosis that include but not limited to: schizophrenia, unspecified, chronic obstructive pulmonary disease, unspecified. MDS (Minimum Data Set) section C dated [DATE], documents R4's Brief Interview for Mental Status (BIMS) as 7/15 indicating R4 has severe cognitive impairment. On 01/28/2025, at 3:22 PM, V6 (Activity Aide) stated during smoking break, (does not remember the date) at 3:00PM, V6 and residents were standing at the smoke door located at the rear of the building, and residents were waiting for V6 to open the door so they can go to the smoke patio to smoke. V6 stated R3 was at the door and R4 come on the side of R3 and pushed R3 after R3 told R4 that the lady residents are going out first. R3 told R4 not to push him anymore. V6 stated R4 pushed R3 again and R3 pushed R4 hard. R4 fell backwards on the floor, headfirst right next to the smoking door and stated man, why did you push me? and R3 replied because you pushed me. V6 stated there were about 10 or 15 residents by the door waiting to go to smoke who witnessed R3 and R4 push each other, and she was the only staff taking the residents out for their smoking break. V6 stated she tried to separate R3 and R4 but when she was unable to separate them, she went to V7 (Social Services Director) office which is next to the smoking door. V6 told V7 R3 pushed R4 down. V6 stated V7 got other staff (no names provided) to help, and the nurse came down and assessed R4. V6 wrote statements and R4 was ok. V6 stated some of the residents witnessed it and wrote statements of what they saw. On 01/30/2025, at 12:17PM, V19 (Certified Nursing Assistant -CNA) via phone stated she was in another resident's room giving care when she heard a commotion and went to see what was going on and found R1 and R2 arguing. R1 was closer to R2's bed on his knees, and R2 was on his wheelchair. R2 stated he had to defend himself because R1 came at him. V19 stated she heard R1 making threats to R2 and telling R2 not to go to bed tonight because R1 would do something bad to R2 at night. V19 asked R2 to come out of the room and go speak to the nurse (no name provided). Facility reported Incident Report resident witness statements dated 12/31/2024, document R5, R9, R10 witnessed R3 and R4 get into a physical confrontation during afternoon smoke break. On 01/29/2025, R5, R9, R10 stated they witnessed R3 and R4 get into a physical confrontation during afternoon smoke break on 12/31/2024. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/30/2025, at 10:31AM, R12 stated on 12/24/2024 during the 3:00 PM-11:00 PM shift, she was in her in room with the door closed when she heard commotion in the room across from her that belonged to R1 and R2. She heard R1 telling R2 to get the F . out of his room, and R2 was telling R1 to leave him alone because it was his room too. R12 stated she then heard hitting going on and went outside her room and saw and R1 throwing punches randomly towards R2 because R1 is blind and cannot see, and R1 was hitting R2 on the left side of the shoulder. R12 stated R2 kept telling R1 to leave him alone, but R1 kept swinging his arms towards R2. R12 stated R2 got fed up and got up and put R1 in a head lock. That's when R12 started shouting to V8 (Registered Nurse-RN) they are fighting, they are fighting R12 stated V8 was at her medication cart, came and asked what had happened, and R12 had already separated R1 and R2. R12 stated there was no staff around when this happened and that is why she had to yell for help. R12 stated R1 and R2 are both in wheelchairs and R1 can stand but R2 cannot walk. R12 stated she was worried for both residents fighting and stated she feels a little safe in the facility because R1 keeps fighting with other residents, but R1 is no longer on the same floor as R12. R4's progress notes dated 12/31/2024 document's R4 was involved in an altercation with another resident (R3) in the main dining room and R4 fell . R1's care plan dated 09/30/2024, documents R1 presents with Physical Aggressive Behavior with deficits in his behavior patterns as he presents as combative, antisocial, and angry towards others almost daily. R3's care plan dated 03/30/2020 documents R3 demonstrates Verbal/Physical Aggressive Behavior. R4's care plan dated 02/01/2023 documents R4 has ineffective coping mechanisms; physically abusive behavior when agitated r/t (related to) poor impulse control. R1 and R2's Facility Reported Incident Report dated 12/24/2024 documents: -Writer (facility staff) made aware of alleged resident to resident altercation. Residents immediately separated. R3 and R4's Facility Reported Incident Report dated 12/31/2024 documents: -Alleged resident to resident, during smoking break time. One resident stated he accidentally pushed resident as they were going out the door. Policy titled Abuse Prevention Program, Facility Policy and Procedure dated 1/4/18 documents: -Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. 45001 On 1/28/25, at 2:03 PM, R7 said a CNA (Certified Nursing Assistant), V9, took R7 to the toilet. R7 said R7 had a incontience brief on and asked to get the brief off so R7 could go to the toilet. R7 said V9 was taking too long and R7 started peeing before R7 got onto the toilet. R7 said the pee got on V9's shoe. R7 said V9 slammed R7's back and R7's back hit the back of the toilet. R7 said this happened in the evening about a month ago. R7 said R7 was sent to the hospital. R7 told the hospital that R7 was abused. The hospital called the police. V9 has not worked with R7 since then. R7 has seen V9 in the building. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/28/25, at 2:20 PM, R5 said R5 pushed another resident (R6). R5 said R6 kept coming into R5's room. R6 is blind. R6 was in the room next to mine. R5 said R5 lost their temper. R5 was going into their room. R6 was blocking the way. R5 said R5 pushed R6 pretty hard. R5 got frustrated with the whole situation of R6 banging on the wall at 5:00 AM, coming out of the room butt naked, and coming into R5's room butt naked. R5 said the facility needs to take care of the situation. R5 reported to staff about doing something about R6 coming into R5's room. That invades R5's privacy. R5 feels safe in the facility. R5 said R5 has to learn to control their temper. R5 is going to anger management classes and NA (Narcotics Anonymous) meetings. On 1/28/25, at 3:10 PM, V9 (Certified Nursing Assistant) stated I have worked here since September 2024. I work second shift, 3:00 PM-11:00 PM. I work on 3 North now. I asked them to put me there because a patient (R7) almost got me fired. I have only had R7 as a resident once. I don't remember when this happened, maybe December. R7 needed someone to transfer them to the toilet. I went in with another coworker, V16 (Certified Nursing Assistant). We both transferred R7 to the toilet. Nothing unusual happened. R7 wears an adult brief. R7 pulled the brief down on their own. I helped R7 sit on the toilet. I was not rough handling R7 on 12/30/24. I did not push R7 back against the back of the toilet. R7 is one-person assist. V16 assisted because R7 is big and heavy. R7 did not pee on my shoe. R7 peed on herself. R7 was peeing at the time R7 was taking the brief down. No urine got on me or V16. I have had abuse training. Types of abuse include emotional, financial, physical. I'm not sure who is the abuse coordinator. If I witness abuse, I would let the nurse know. On 1/29/25, at 2:04 PM, upon record review of V9 (Certified Nursing Assistant) time punch dated 12/30/24, V1 (Administrator) stated V9 (Certified Nursing Assistant) is stealing time. On 1/29/25, at 2:05 PM, V10 (Staffing Coordinator/Scheduler) stated I was asked to provide the schedule for 12/30/2024. I did not make a copy of my original schedule. I retyped the schedule from 12/30/2024. In the process of retyping the schedule, I skipped over some names. I didn't thoroughly do a good job of line by line typing the names. On my original, V9 (Certified Nursing Assistant) did work on 12/30/2024. V9's name is not on the schedule submitted to IDPH (Illinois Department of Health) surveyor because I didn't check for correctness when retyping. I wanted to kill two birds with one stone by inputting the schedule into the computer and then submitting to IDPH. I did have the option to photocopy my hardcopy original of the schedule. My hardcopy is the final version of the schedule. On 1/30/25, at 10:47 AM, V16 (Certified Nursing Assistant) stated V9 (Certified Nursing Assistant) was toileting R7. Afterwards, I came into the room. I assisted V9 to get R7 out of their wheelchair to the bed. We did a two-man transfer. Once R7 was in bed I left out of the room. I was not in the room while they were in the bathroom. R7 was complaining that V9 slammed R7 down onto the toilet or V9 yanked R7 up from the toilet. I don't remember which. R7 was saying R7 was going to report V9 and get V9 fired. R7 was saying R7 was going to sue the facility. R7 said R7 already has a suit against the facility. R7 is a manipulator and liar. R7 embellishes the truth. R7 has been known to lie on the CNA's/staff/nurses. I am not familiar with V9. I have not had complaints against V9 from residents or staff members. I've been here for a year. I have had abuse training. I don't know who the abuse coordinator is. They have in-serviced on abuse. Verbal, physical, financial, mental are types of abuse. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/30/25, at 3:26 PM, V1 (Administrator) stated usually I have social service to investigate allegations, and I write and submit the report. Social Service investigated R5 and R6's incident and the R7 incident. R6 is blind and stands across from the nursing station most of the day. My understanding is R6 was blocking R5's way and R5 apparently pushed R6. Social Service did the behavior assessments and completed well-being checks and the nurse did physical assessment and separated them immediately. Social Service continued to monitor and make them feel safe. My understanding is later-on R5 apologized to R6. Police and family were contacted. The incident was substantiated, it did happen. Staff is automatically suspended until the investigation is finished. V9 (Certified Nursing Assistant) was suspended until the investigation was finished. She did return to the facility. I know R7 will fabricate things. R7 never told me that V9 did what R7 said V9 did. We have the type of relationship where R7 would tell me. The incident was not substantiated due to R7 not validating with me that staff person did anything. We could not prove anything. We have abuse training for staff, usually quarterly and sometimes immediately after an incident. I am the abuse coordinator. I expect staff to contact me immediately in case of abuse. I expect they make sure the residents are out of harm's way, contact the doctor, family, and police if necessary. We make sure to update care plans and do re-assessments as needed. We either monitor or send out to the hospital per doctor's orders. On 1/31/25, at 12:03 PM, V18 (Licensed Practical Nurse) stated I witnessed the incident with R5 and R6. R5 and R6 rooms were side by side. R5 was trying to get to R5's room and R6 was in the way. R5 told R6 to move and R6 did not. R5 asked R6 a second time to move but R6 did not. R5 stood up out of R5's wheelchair and pushed R6 into the wall out of the way. They were immediately separated. I assessed R6 for injury. I notified the abuse coordinator, the police, and families for both residents and the doctor on call. R5 nor R6 had injury. R5 was sent out to the hospital for psychiatric evaluation. Record review of R5's Facesheet, MDS (Minimum Data Set) and care plan provided by facility on 1/30/25 indicates R5 is [AGE] years of age with diagnoses that include but are not limited to encephalopathy, chronic obstructive pulmonary disease, alcohol dependence with withdrawal, bipolar disorder, hypertensive heart disease with heart failure and spinal stenosis lumbar region with neurogenic claudication. R5 BIMS (Brief Interview for mental status) score is 13 indicating intact cognition. R5 is care planned for aggressive behaviors presenting as combative, antisocial, and angry toward others. R5 has been observed being physically aggressive towards peers and staff. Record review of R5 progress note dated 1/4/25, timed 20:02, reads in part: The resident (R5) was trying to get to room while another blind resident (R6) was in the way. The resident (R5) got impatient and got up and pushed the other resident (R6) to the wall out of the way. Record review of R6's Facesheet, MDS, and care plan provided by facility on 1/30/25 indicates R6 is [AGE] years of age with diagnoses that include but are not limited to chronic obstructive pulmonary disease, Alzheimer's disease, encephalopathy, bipolar disorder, legal blindness, schizophrenia, and major depressive disorder. R6 BIMS score is 5 indicating severe cognitive impairment. R6 is care planned for demonstrating behavior symptoms concerning inappropriate personal boundaries due to diagnosis of severe mental illness, cognitive impairment secondary to Alzheimer's disease or a related dementia. Record review of R6 progress note dated 1/4/25, timed 19:20, reads in part: The resident (R6) was standing in the hallway while another resident (R5) was trying to get in the room beside them. The other resident (R5) got impatient and got up and pushed R6 forcefully into the wall out of the way. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Police report for incident: battery simple filed 1/4/2025 with R6 named as victim. Record review of R7 facesheet, MDS, and care plan provided by facility on 1/30/25 indicates R7 is [AGE] years of age with diagnoses that include but are not limited to chronic obstructive pulmonary disease, heart failure, paranoid schizophrenia, type 1 diabetes mellitus, dementia, schizoaffective disorder, bipolar disorder, major depressive disorder, generalized anxiety disorder, and spinal stenosis, thoracic region. R7 BIMS score is 15 indicating intact cognition. R7 requires substantial/maximal assistance with toilet transfer and toilet hygiene. R7 uses a wheelchair. Police report for incident: simple battery filed 12/31/2024 with R7 named as victim. Record review of facility investigation including witness statements, and State Report Reportable Event, incident date 12/31/24, provided by facility, reveals the facility is not able to provide witness statements for the two Certified Nursing Assistants named in the abuse incident of R7. Record review census and facility staffing schedule for 12/30/2024 reveals V9 (Certified Nursing Assistant was scheduled to work R7's unit. Facility policy Abuse Prevention Program Facility Policy and Procedure, 1/4/2018 documents in part: Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45111 Based on interviews and records review, the facility failed to thoroughly investigate abuse allegations for three residents, (R1, R2, R7) of seven residents reviewed. Findings include: On 01/29/2025, at 1:45PM, V1 (Administrator) stated R1 and R2's Facility Reported Incident report (FRI) was not properly investigated because V8's (Registered Nurse) progress dated 12/24/2024, documented Certified Nursing Assistant (CNA) and residents as witnesses to R1 and R2's physical altercation on 12/24/2024, and the CNA and residents were not interviewed during the abuse allegation investigation for their statements. V1 stated she is the abuse coordinator and did a sloppy job regarding R1 and R2's investigation. V1 further stated she asks social services to investigate and give her the investigations then she writes the report and sends it to IDPH (Illinois Department of Public Health). V1 stated a complete and thorough investigation is necessary to make sure no details are left out and to get to the root of the issue so that interventions can be put in place. V1 stated this can prevent residents from hurting each other. V1 stated if an abuse allegation is not properly investigated, there is potential for re-occurrence and care plan might not be updated, therefore proper interventions might not be put in place. On 01/30/2025, at 12:17PM, V19 (Certified Nursing Assistant -CNA) stated she was not asked any questions, nor did she write any statement regarding R1 and R2's altercation. On 01/30/2025, at 10:31AM, R12 said she was not asked any other questions, or asked for a statement regarding R1 and R2's altercation. 45001 On 1/28/25, at 2:03 PM, R7 said a CNA (Certified Nursing Assistant), V9, took R7 to the toilet. R7 said R7 had a brief on and asked to get the brief off so R7 could go to the toilet. R7 said V9 was taking too long and R7 started peeing before R7 got onto the toilet. R7 said the pee got on V9's shoe. R7 said V9 slammed R7 back and R7s back hit the back of the toilet. R7 said this happened in the evening about a month ago. R7 said R7 was sent to the hospital. R7 told the hospital that R7 was abused. The hospital called the police. V9 has not worked with R7 since then. R7 has seen V9 in the building. Record review of R7's Facesheet, MDS, and care plan provided by facility on 1/30/25 indicates R7 is [AGE] years of age with diagnoses that include but are not limited to chronic obstructive pulmonary disease, heart failure, paranoid schizophrenia, type 1 diabetes mellitus, dementia, schizoaffective disorder, bipolar disorder, major depressive disorder, generalized anxiety disorder, and spinal stenosis, thoracic region. R7's BIMS score is 15 indicating intact cognition. R7 requires substantial/maximal assistance with toilet transfer and toilet hygiene. R7 uses a wheelchair. Police report for incident: simple battery filed 12/31/2024, with R7 named as victim. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility investigation including witness statements, and State Report Reportable Event, incident date 12/31/24, provided by facility, reveals the facility is not able to provide witness statements for the two Certified Nursing Assistants named in the abuse incident of R7. Facility policy Abuse Prevention Program Facility Policy and Procedure, 1/4/2018 documents in part: Incidents or allegations involving abuse, neglect, exploitation, mistreatment or misappropriation of resident property will be reviewed by administration and shall be investigated, as indicated and appropriate. The investigator will attempt to interview the person who reported the incident, anyone likely to have direct knowledge of the incident and the resident, if interviewable.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45000 Based on observation, interview, and record review, the facility failed to a.) provide adequate supervision and monitoring for residents, and b.) revise a care plan for one (R8) out of three residents reviewed for resident injuries. These failures have the potential to affect 45 residents residing in the facility. Findings include: On 01/29/2025, at 1:20PM, R8 observed sleeping in his bed. R8 observed with a floor mat on the right side of his bed, bed in a low position, and a bolster underneath his legs. On 01/29/2025, at 1:22PM, V12 (Licensed Practical Nurse/LPN) states she was the nurse assigned to care for R8 on 01/14/2025. V12 states it was brought to her attention by the restorative team that R8 did not get up to walk when the restorative aides went in to weigh him. V12 states R8 usually ambulates in the facility without assistive devices so she went to assess R8. V12 states she also asked R8 to get up out of bed and R8 declined. V12 states R8 has a history of injuring himself and not reporting it to staff members. V12 states although R8 told her he was fine, she noticed facial grimacing and decided to further assess R8. V12 states she assessed R8s' vitals, called the doctor, and administered pain medications to R8. V12 states R8 was ordered an x-ray which showed that R8 had a leg fracture. V12 states R8 was sent to the hospital and returned with staples to his leg. V12 states R8s' staples were removed today on 01/29/25 and R8s' leg wound is healing well. V12 locates a yellow binder titled Fall Binder and states R8 is at risk for falls and his fall interventions are located inside the yellow binder. R8s' fall interventions sheet dated 01/23/2025, documents that R8s' fall interventions are as follows: low bed, floor mat. V12 then deploys R8s' fall care plan on the computer and surveyor observes that low bed and floor mat interventions are not included on R8s' fall care plan. Nursing progress note dated 01/14/2025, at 2:41 PM documents R8 was observed with assigned aide and restorative team holding left knee and left thigh. Writer informed and head to toe assessment performed, writer observed some facial grimacing when touching left thigh, R8 stated I'm fine no pain girl. Vitals are stable. NP/nurse practitioner made aware and new order was given for stat x-ray to left knee and left femur. Emergency contact phoned no answer. R8 currently in room alert and oriented per normal baseline. Plan of care is ongoing. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/29/2025, at 1:39 PM, surveyor enters the third-floor dining room and announces surveyors' presence. Surveyor observes multiple residents located inside the dining room sitting in wheelchairs and geri chairs. Surveyor observes V13 (Certified Nursing Assistant/CNA) sitting in a chair with a white ear bud in her right ear and her phone in her hand with a social media video playing on her phone screen. Surveyor is now located standing directly next to V13 and V13 does not notice surveyor standing there. V13 then looks up to see surveyor and turns her phone screen off. V13 states she is responsible for monitoring the residents in the dining room at the current moment. V13 states the CNAs take turns monitoring the residents in the dining room at 30-minute intervals. V13 states she monitors the residents to make sure they do not fall or injure themselves. Surveyor asks V13 is it possible to effectively monitor the residents if she is utilizing her phone device to watch social media videos. V13 then agrees that she is unable to effectively monitor the residents in the dining room since she was looking at social media videos on her phone. V13 states residents have the potential to fall and injure themselves if they are not properly monitored. V13 states she was the CNA assigned to care for R8 on 01/14/2025. V13 states she provided incontinence care for R8 that day and R8 did not get up out of bed. V13 states later, she was informed that R8 was complaining of pain from two of the restorative aides. V13 states she entered R8s' room to try to get him to stand up and R8 could not stand up. V13 states she then informed the nurse and the nurse assessed R8. V13 state she was later informed that R8 had a fractured leg. On 01/30/2025, at 1:10 PM, V14 (Restorative Aide/CNA) states she has been working at the facility for [AGE] years. V14 states R8 resides on the locked dementia unit on the third floor of the facility. V14 states herself and a co-worker (identified as V15/Restorative Aide/CNA) entered R8s' room sometime after 1:00 PM on 01/14/2025, to obtain a current weight for R8. V14 states when she arrived to R8s' room, R8 was lying in bed on his back with the covers pulled up over his waist. V14 states she went to help R8 get up to stand and obtain his weight and R8 yelled out in pain. V14 states she pulled the covers back and saw that R8s' left leg was swollen. V14 states she went to get R8s' CNA (identified as V13) and V13 came to R8s' room and was made aware of R8s' status. V14 states that V13 told her that V13 was not aware of what happened to R8 or why R8 was complaining of pain. V14 states she then informed the nurse V12 (LPN) who went to R8s' room to assess R8. V14 states during V12s' range of motion assessment, V14 saw that R8 could not lift his left leg. V14 states she was later informed that R8 had a broken leg. V14 states she is not sure what happened to R8s' leg but R8s' leg could have become broken due to a possible fall. On 01/30/2025, at 1:23 PM V15 (Restorative Aide/CNA) states she's been working at the facility since 2021. V15 states on 01/14/2025, herself and V14 (Restorative Aide/CNA) went to R8's room to obtain a weight for R8. V15 states she noticed R8 with facial grimacing and holding his left leg. V15 states she notified V13 (CNA) and V12 (LPN) of R8s' status, who were both assigned to care for R8 that day. V15 states she is unsure of what may have happened to R8s' leg. R8s' Facesheet documents that R8 has diagnoses not limited to: heart failure, displaced intertrochanteric fracture of left femur, dementia, history of falling, hypertension, osteoarthritis, and paroxysmal atrial fibrillation. R8s' MDS/Minimum Data Set, dated dated dated [DATE] documents that R8 has a BIMS/Brief Interview for Mental Status of 03/15, indicating that R8 is cognitively impaired. R8s' care plan documents that R8 is care planned for risk for falls, cognitive impairment, fracture of left femur, hospice care, communication barrier, risk for pain, and active range of motion. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145764	A. Building B. Wing	01/31/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Facility reported incident dated 01/14/2025, documents that R8 sustained an injury of unknown origin while in the facility. R8s' fall risk assessment dated [DATE], documents that R8 is at high risk for falls with a fall risk score of 11. Facility CNA assignment sheet dated 01/14/2025, documents that V13 was assigned to care for R8. Facility CNA assignment sheet dated 01/29/2025, documents that V13 is responsible for monitoring the dining room starting at 1:30 PM. Facility census dated 01/28/2025, documents that a total of 45 residents reside on 3-south (identified as the locked dementia care unit) of the facility. Facility policy undated, titled Fall Prevention Program documents in part, 10. Care plan incorporates: a. Identification of all risk/issue, b. Interventions are changed with each fall, as appropriate, c. Preventative measures. Facility policy undated, titled Care Plan documents in part, All residents will have comprehensive assessments and an individualized plan of care developed to assist them in achieving and maintaining their optimal status. 8. b. When a change occurs in a residents' condition, the Care Plan Coordinator is notified by a member of the Interdisciplinary Team. The care plan is then reviewed and updated. Facility policy undated, titled Supervision and Safety documents in part, 1. Our facility-oriented approach to safety addresses risks for groups of residents such as wanderers, behaviors, aggressiveness, confusion, etc. 4. Resident supervision is a core component to resident safety. 9. Staff to decrease safety risk factors as much as possible. Facility document undated, titled Personal Electronic Devices documents in part, Cell phone usage while on duty is prohibited.