

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145764	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2025
NAME OF PROVIDER OR SUPPLIER Morgan Park Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41356</p> <p>Based on observation, interviews, and record reviews, the facility failed to ensure a resident was transferred as per assessment, care plan, and proper procedure/use of equipment (Hoyer lift) for 1 (R1) out of 3 residents reviewed for the right of every resident to be safe and free of accidents. These failures affected 1 resident (R1) resulting in R1 sustaining a fractured left leg and undergoing surgery on the left leg (left leg nailing procedure) with three (3) separate incisions with staples.</p> <p>Findings include:</p> <p>R1 is [AGE] years old initially admitted in the facility on 02/14/2024. R1 diagnosis includes Alzheimer's Disease, anxiety disorder, left below the knee amputation, and more recent sustained fracture of lower end of left femur. R1 has an intact cognition with a score of 12 on her Brief Interview of Mental Status (BIMS) dated 02/10/2025.</p> <p>On 03/18/2025 at 12:01 PM, R1 was seen on her bed in her room. R1 able to express thoughts well within topic during conversation. R1 stated she had a fracture on her left leg. R1 took off the sheet that covers her left leg with below the knee amputation. R1 has three incisions on her left leg. R1 stated that when she came back from dialysis, the staff that help her lost her balance. R1 said, I guess, I am too heavy for her. R1 stated that the staff that helped her did not use a gait belt. And both the staff and her (R1) hit the floor. R1 stated that she was sitting on a dialysis chair (Geri chair) when she was transferred to the bed and fell . R1 stated that it takes two (2) people to transfer her. But when she fell it was only us (her and the staff) because the staff cannot find anybody. R1 said, Sometimes they use equipment (Hoyer lift) if it is available. But sometimes it just disappears. It is from another unit. R1 stated that she knows that she needs Hoyer lift or at least two (2) people when she transfers. R1 stated that she weighs two hundred forty-three pounds (243 LBS.). R1 said, I think it's safer if I use the lift. It is safer if two people help me that is how I see it. R1 stated that somedays they have don't have CNAs (Certified Nursing Assistants). And there are times they only have one (1) CNA, but they do not come inside her room. When asked why only one (1) staff helped her. R1 said, I really don't know why she was the only one who helped me.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 03/18/2025 at 12:22 PM, V4 (Licensed Practical Nurse) stated that she was informed by V5 (Certified Nursing Assistant) that R1 slide to the fall mat. And that V5 was transferring R1 from chair to bed. V4 stated that V5 was by herself when she transferred R1. V4 stated that R1 needs Hoyer lift because the facility does not use lifting of resident by staff. V4 said, There is no lifting of residents by staff policy in facility. V4 stated that she did not remember if she asked V5 why she was not using a Hoyer lift. And stated that it may be that someone else was using the Hoyer lift that time.</p> <p>On 03/18/2025 at 12:39 PM, V5 (Certified Nursing Assistant) stated that she was the staff that transferred R1 when she fell . V5 stated that it was nighttime and time for R1 to go back to bed, V5 stated that she went to look for the Hoyer lift and it was not working at that time. She looked for another staff to help her transfer R1 but was not able to find anyone. V5 stated that she transferred R1 by herself. V5 said, I was gonna pivot her (R1) to slide her over to the bed because I cannot lift her. And you are not supposed to lift her. I did it myself. I tried to slide her, and she ended up sliding from the chair and slide on the mat. V5 stated that all of facility's Hoyer lifts were not working or not charged. V5 said, I know that I should have made safety the first priority and will not transfer her again by myself.</p> <p>On 03/19/2025 at 10:24 AM, V6 (Restorative Manager / Fall Prevention Coordinator / Licensed Practical Nurse) stated that R1 is a total assist and needs to be transfered with the Hoyer Lift in and out of her wheelchair or dialysis chair (Geri chair). V6 said, R1 is an amputee, and her transfer ability is not strong, and it is not safe to transfer when not using Hoyer lift. V6 confirmed that under MDS (Minimum Data Set) assessment sit to stand was not done during assessment because of R1's medical conditions and safety concerns. V6 stated that facility has a Safe Lifting Policy as part of nursing staff education. And the same policy needs to be signed before starting to work with residents or new hires. V6 said, Staff needs to follow the policy.</p> <p>On 03/19/2025 at 11:47 AM, with V2 (Director of Nursing) and V7 (Nurse Consultant). V7 stated that probably R1 needs to be with mechanical lift during transfers. V2 stated that she did not do the investigation. And that she does not know anything about it. V2 stated that during that time she was the Assistant Director of Nursing (ADON).</p> <p>R1's MDS (Minimum Data Set) assessment dated [DATE] on functional abilities sit to stand: the ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed. Assessed as 88 that means not attempted due to medical condition or safety concerns.</p> <p>R1's Care Plan for activities of daily living (ADL) and mobility dated 02/15/2024 is to transfer with mechanical lift (Hoyer) with two (2) persons.</p> <p>R1's notes documents history of falls on 08/30/2024, V8 (Registered Nurse) clinical notes reads that R1 slide out of her bed while CNA (Certified Nursing Assistant) providing care. On 12/14/2024 V8's (Registered Nurse) note reads that R1 fell in the dining room.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 03/19/2025 at 01:09 PM, with V9 (Certified Nurse Assistant) the facility was found to have only one (1) mechanical (Hoyer) lift available to use on the floor. V9 cannot locate the second mechanical lift. Per V9 the facility has only two (2) mechanical lifts for all the residents. V9 stated that she is assigned to nine (9) residents and two (2) of the residents needs a lift. V9 said, the 2nd floor alone has around eighty (80) to ninety (90) residents. V9 was asked if with only one (1) lift available would that be enough for residents to use? V9 replied, That would be a problem.</p> <p>At 01:50 PM, V6 (Restorative Manager / Fall Prevention Coordinator / Licensed Practical Nurse) stated an estimated thirty (30) residents need a Hoyer lift for transfer. Per facility's census dated 03/18/2025, facility has three hundred (300) available beds. Two hundred eleven (211) are occupied by residents.</p> <p>R1's X-Ray result dated 2/11/2025 reads: Fracture on the left leg. (Acute, mildly comminuted nondisplaced distal femoral fracture).</p> <p>R1's hospital record dated 02/11/2025 documents as follows: Description: R1 status post left below knee amputation fell while being helped from a wheelchair bringing down facility staff too. R1 sustained left femur (leg) fracture. Admitting diagnosis, mechanical fall at the nursing home resulting in left femoral fracture. Under pain assessment, R1 screams and yells in pain upon therapist application to left lower extremities. Procedure or surgery done due to left femur fracture: Intermedullary nailing left distal femur fracture (femoral nailing).</p> <p>Safe Lifting Policy for all employees in nursing department reads: The Safe Lifting Policy exists to ensure a safe working environment for resident handlers. The policy is to be reviewed and signed by all staff that performs or may perform resident handling. The safety committee will review this policy annually with changes made accordingly. Under process and procedure: Total Lift Transfers needs Hoyer type of lift with 2 or more caregivers.</p> <p>Fall Prevention Policy dated 02/18/2014, reads: It is the policy of this facility to have a Fall Prevention Program to assure the safety of all residents in the facility, when possible. 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 as necessary.</p> <p>Transfer conveyances shall be used to transfer residents in accordance with the plan of care. Per R1's care plan she needs Hoyer lift with two (2) persons assisting with the transfer.</p> <p>Centers for Disease Control and Prevention on Safe Lifting and Movement of Nursing Home Resident dated February 2006 reads: Safe resident lifting programs that incorporate mechanical lifting equipment can protect workers from injury, reduce workers' compensation costs, and improve the quality of care delivered to residents.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41356</p> <p>Based on interviews and record reviews, the facility failed to accurately record the fall incident of 1 (R1) out of 3 residents reviewed for incident record. This failure affected the accuracy of 1 resident's (R1) record, with inaccurate documentation of the chronological occurrence of the incident, impacting the credibility of facility staff documentation on resident's record.</p> <p>Findings include:</p> <p>R1 is a [AGE] year old resident in facility. R1 initially admitted in the facility on 02/14/2024. R1's diagnosis includes Alzheimer's disease, anxiety disorder, left below the knee amputation, and more recent sustained fracture of lower end of left femur/leg. R1 has an intact cognition with a score of 12 on her Brief Interview of Mental Status (BIMS) dated 02/10/2025.</p> <p>On 03/18/2025 at 12:01 PM, R1 was seen on her bed in her room. R1 able to express thoughts well within topic during conversation. R1 stated she had a fracture on her left leg. R1 took off the sheet that covers her left leg with below the knee amputation. R1 has three incisions on her left leg. With eleven (11) staples, five (5) and four (4) staples. R1 stated that when she came back from dialysis, the staff that help her lost her balance. R1 said, I guess, I am too heavy for her. R1 stated that the staff that helped her did not use a gait belt. And both the staff and her (R1) hit the floor. R1 stated that she was sitting on a dialysis chair (Geri chair) when she was transferred to the bed and fell . R1 stated that it takes two (2) people to transfer her. But when she fell it was only us (her and the staff) because the staff cannot find anybody else. R1 said, Sometimes they use equipment (Hoyer lift) if it is available. But sometimes it just disappears. It is from another unit. R1 stated that she knows that she needs Hoyer lift or at least two (2) people when she transfers. R1 stated that she weighs two hundred forty-three pounds (243 LBS.). R1 said, I think it's safer if I use the lift. It is safer if two people help me. That is how I see it. R1 stated that somedays they have don't have CNAs (Certified Nursing Assistants). And there are times they only have one (1) CNA, but they do not come inside her room. When asked why only one (1) staff helped her. R1 said, I really don't know why she was the only one who helped me.</p> <p>On 03/18/2025 at 12:22 PM, V4 (Licensed Practical Nurse) stated that she was informed by V5 (Certified Nursing Assistant) that R1 fell on [DATE] and was informed by V5 around nine (9) o'clock PM about the fall. V4 stated that she documented the day after. V4 read her notes on electronic health records and was asked if her notes dated 02/11/2025 was accurate. V4 said, I might be confused with somebody else. She (R1) fell on the 11th not 10th.</p> <p>On 03/18/2025 at 12:39 PM, V5 (Certified Nursing Assistant) stated that she was the staff that transferred R1 when she fell . V5 was asked what day the incident happened. V5 said, I did not work on the 11th, I worked on the 10th. I did a double morning and evening on the 10th.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 03/19/2025 at 11:47 AM, with V2 (Director of Nursing) and V7 (Nurse Consultant). Both V2 and V7 were asked about documentation inaccuracy for R1's incident report and clinical notes dated the incident of the fall on 02/11/2025; staff statements (V4 and V5) saying it happened on 02/10/2025; and nursing schedule also reads that V5 worked on 02/10/2025 not 02/11/2025. V2 and V7 stated they will look into it. V1 (Administrator), emailed V5's time sheet that reads V5 worked double on 02/10/2025 and did not work on 02/11/2025. V1 was emailed to clarify when R1's fall happened (02/10/2025 or 02/11/2025). V1 did not reply to the email.</p> <p>During review, inconsistencies of resident record were also identified. Facility's incident report dated occurrence of incident on 02/11/2025. Report also documents that V5 (Certified Nursing Assistant) was the facility staff that transferred R1 during the fall. R1's clinical notes by V4 (Licensed Practical Nurse) documents that incident happened on 02/11/2025. Facility nursing schedule and V5's time sheet documents that V5 did not worked on 02/11/2025. V1 (Administrator) and V2 (Director of Nursing) were asked to clarify the inconsistencies but were not able to provide information.</p>		