

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  08/01/2025
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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>Based on observation, interview, and record review, facility failed to follow their policy to accommodate resident's needs by ensuring call light is within reach for 4 (R2, R127, R156, R203) out of 8 residents reviewed for call lights as well as provide an adequately sized wheelchair for 1 (R92) resident out of 8 reviewed for appropriate wheelchairs in a sample of 37. R203 has diagnosis not limited to Unspecified Dementia, Severe Protein-Calorie Malnutrition, Encephalopathy, Adult Failure to Thrive, Alcohol Dependence with Unspecified Alcohol-Induced Disorder, Essential (Primary) Hypertension, Anemia, Muscle Wasting and Atrophy, Vitamin D Deficiency, Polyneuropathy, Abnormal Weight Gain, Restlessness and Agitation and Gastro-Esophageal Reflux Disease. R203's MDS (Minimum Data Set) BIMS (Brief Interview for Mental Status) score is 03 indicating severe cognitive impact.</p> <p>R203's Care plan document in part: Focus: R203 is (low) risk for falls related to weakness. Interventions: Be sure R203's call light is within reach and encourage the resident to use it for assistance as needed. Focus: R203 has a self-care deficit (ADLs (Activities of Daily Living/Mobility) generalized weakness. Interventions: Call light within reach; encourage resident to use prior to attempting self-care.</p> <p>On 07/29/25 at 11:06 AM R203 was observed lying in bed in a low position with the call light laying on the left side of the bed on the floor mat out of reach. V31 (Certified Nurse Assistant) was observed sitting in the hallway. V31 stated "R203 is alert and oriented x 1-2 depending on the time of day." Surveyor asked V31 is R203 able to use the call light. V31 responded, "I don't think so, I am not sure." When asked if she (V31) could tell the surveyor where R203 call light was located V31 responded "I don't have that room. The call light should be next to the resident in bed and in a place that they can reach it. It is supposed to be two call lights in that room and there is only one call light in the room."</p> <p>On 07/29/25 at 11:12 AM surveyor asked V15 (Licensed Practical Nurse) the location of R203's call light. V15 proceeded to pick R203's call light up from the floor mat. V15 responded, "it doesn't look like R203 have one." V15 then placed the call light on the bed next to R203. V15 stated "the call light should be placed on the bed in R203's hand or next to her so that she can call us. R203 is alert and oriented x 1 and unable to use the call light. We check R203 frequently, other than that we can get R203 up. R203 has no history of falls. There are not two call lights, maintenance must have taken it out and did not tell us. The policy is if the resident is in the room the call light should be in reach." Two beds were observed in the room with bed 2 call light observed to be missing. The light on the outside of R203's room was illuminated and flashing.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 145764
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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 07/29/25 at 11:18 AM a staff member instructed V31 (Certified Nurse Assistant) to answer the call light in R203's room and V31 said the call light is not working.</p> <p>On 07/29/25 at 11:59 AM the illuminated call light located above R203's door continues to flash with no sound.</p> <p>On 07/31/25 at 08:12 AM R156 was observed lying in bed with the call light located at the foot of the bed. Surveyor asked R156 did he know the location of his call light. R156 responded, I don't know where my call light is at.</p> <p>On 07/31/25 at 08:19 AM surveyor entered R156's room and observed the call light at the foot of the bed. Surveyor asked R156 did he know where his call light was located. R156 looked around and said "no";</p> <p>On 07/31/25 at 08:21 AM V15 (Licensed Practical Nurse) entered R156's room with the surveyor and when asked the location of R156's call light, V15 looked and pulled at a cord on the left side between the R156's bed and the wall. V15 walked toward the foot of R156's bed, picked it up then said R156's call light was at the foot of the bed.</p> <p>On 07/31/25 at 10:11 AM V3 (Director of Nursing/Registered Nurse) stated "the call light should be answered in a timely manner and the placement should be within reach. The call light should be within reach because someone could be in distress and cannot call for help. If a resident is unable to use the call light everyone should be rounding every hour."</p> <p>Policy Titled "Call Light" dated 09/19 document in part: Equipment: Functioning Nurse Call System. 1. All residents shall have the nurse call light system available and within easy accessibility to the resident at the bedside or other reasonable accessible location. 6. Call bell system defects will be reported promptly to the Maintenance Department. 8. Check room frequently until system is repaired, per management guidance. Request repair promptly.</p> <p>Policy Titled "Preventive Maintenance Program" dated 11/22 document in part: Purpose: To conduct regular environmental tours/safety audits to identify areas of concern within the facility. 3. Preventive Maintenance Program will review the following areas during random rounds: 10. The call light system is in working condition.</p> <p>On 07/29/2025 at 11:22 AM, surveyor observed R127's call light was on the floor and not within reach of the resident. R127 had no idea where his call light was. Surveyor asked V13 (Certified Nursing Assistant) to come into the room. V13 stated R127's call light should be clipped to his bed so he can make his needs known. V13 stated if R127's call light is not within reach he cannot call for help. Surveyor observed V13 place R127's call light on his bed.</p> <p>07/29/2025 12:56 PM Surveyor observed R2 in her room. R2's call light was lodged underneath her bed between the wall and the wheel. Surveyor asked V14 (Certified Nursing Assistant) to come into the room and find R2's call light. V14 saw R2's call light lodged underneath her bed. V14 unlocked R2's bed and moved it to dislodge the call light and place it on R2's bed. V14 stated that R2's call light should be on her bed.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 07/31/2025 at 9:50 AM, V3 (Director of Nursing) stated that call lights are expected to be within reach. V2 stated that if call light is not within reach, the residents cannot call for help if they need assistance. Which is a risk for falls.</p> <p>R127's fall care plan (1/15/2024) documents in part: Be sure R127's call light is within reach and encourage R127 to use it for assistance as needed.</p> <p>R2's care plan (9/12/2023) documents in part: Be sure R2's call light is within reach and encourage R2 to use it for assistance as needed.</p> <p>On 7/29/2025 at 11:40 AM, R92 was sitting up in a wheelchair in [R92's] room. R92 stated the wheelchair was uncomfortable and wanted a wider one. R92 stated asking staff for at least a month to locate a bigger wheelchair for [R92] but have not provided one. R92 stated the wheelchair was rubbing on [R92's] thighs on both sides. R92 lifted the hospital gown to show surveyor. R92's bilateral hips and thighs were snug against the wheelchair. R92 stated already having a pressure sore to the right posterior thigh and didn't want any further skin breakdown.</p> <p>R92's Weights and Vitals Summary document a weight of 267 pounds on 6/05/2025.</p> <p>R92's Care Plan Report documents in part that R92 is at increased risk for alteration in skin integrity (revision 2/24/2025). Interventions include to follow facility policies/protocols for the prevention of skin breakdown (revision 2/24/2025).</p> <p>On 7/30/2025 at 10:56 AM, V3 (Director of Nursing) stated a proper fitted wheelchair for someone is one that fits comfortable within the wheelchair. V3 stated if a resident's sides are rubbing on both sides of the wheelchair, it's not comfortable or proper fitting.</p> <p>On 7/30/2025 at 11:49 AM, V20 (Nurse) went into R92's room with surveyor. R92 was sitting up in a wheelchair. V20 checked R92's sides and stated the wheelchair was small for R92.</p> <p>Facility provided survey team with a copy of the Illinois Long-Term Care Ombudsman Program "Residents' Rights for People in Long-Term Care Facilities" document (Rev. 11/18). It documents in part: "Your facility must be safe, clean, comfortable and homelike."</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>Based on observation, interview and record review the facility failed to provide a resident's tube feeding in accordance with the physician's order for 1 of 1 resident (R44) reviewed for tube feeding in a sample of 37. Findings Include:R44 has diagnosis not limited to Gastrostomy, Asthma, Essential (Primary) Hypertension, Seizures, Encephalopathy, Chronic Pain, Tachycardia, Dysphagia, Cognitive Social or Emotional Deficit Following Unspecified Cerebrovascular Disease and Abdominal Pain, Vascular Dementia. MDS (Minimum Data Set) BIMS (Brief Interview for Mental Status) score is 03 indicating severe cognitive impact. Care Plan document in part: Focus: The resident is receiving a tube feeding and it has been determined medically necessary. Focus: The resident may be at risk for weight loss related to NPO (Nothing by Mouth) diet. Interventions: Prepare/serve the resident's nutritional diet as ordered.On 07/30/25 at 11:24 R44 was observed in bed with a feeding pump at the bedside turned off. A bottle of Jevity 1.2 was hanging on the feeding pump with the tubing connected to R44.On 07/30/25 at 11:32 surveyor asked V6 (Registered Nurse) to enter R44's room. Surveyor asked V6 was the feeding pump on. V6 proceed to the feeding pump then began pushing buttons on the feeding pump. The feeding pump then displayed 55 ml/hr. (milliliters/hour) and volume infused 1025 on the feeding pump screen. Surveyor asked was the feeding pump turned off. V6 responded yes. The feeding is ongoing for my shift and runs 24 hours ongoing. The feeding tube is flushed with water every 4 hours and I flushed it at 10:00 AM. I think when the certified nurse assistant was doing patient care they turned it off. They usually call me to pause the feeding pump so that R44 will not aspirate and when we entered R44's room the feeding pump was off. If the feeding pump is off that means R44 is not getting the right amount of calories and volume.On 07/31/25 at 10:11 AM V3 (Director of Nursing/Registered Nurse) stated If a resident has a gastric tube feeding, care should be provided every shift, the feeding should be hung as ordered with the head of the bed elevated. The feeding pump is turned off for therapy and ADL (Activities of Daily Living) care. Once the ADL care or therapy is completed the feeding pump should be turned back on. The nurse on the unit is responsible for turning the feeding pump on and off. The staff should come get the nurse once care is completed. If the tube feeding pump is turned off when the feeding should be infusing, there is a potential that the resident is not getting the scheduled feeding.</p>		