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	04/19/2026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to update the care plan for one (R1) of 6 (R1, R3, R4, R5, R6, R7) residents reviewed for falls.Findings Include:R1 was admitted to the facility on [DATE] with diagnosis not limited to Hypertensive Heart and Chronic Kidney Disease with Heart Failure and With Stage 5 Chronic Kidney Disease, Chronic Obstructive Pulmonary Disease, Major Depressive Disorder, Anxiety Disorder, End Stage Renal Disease, Dependence on Renal Dialysis, Dementia, Epilepsy, Acute Pain, Presence of Automatic (Implantable) Cardiac Defibrillator, Seizures, Alzheimer's Disease and Diabetic Retinopathy with Macular Edema. R1's MDS (Minimum Data Set) BIMS (Brief Interview for Mental Status) score is 07 indicating severe cognitive impact.R1's Initial reportable dated 03/23/26 document in part: R1 was observed on the floor next to the bed. R1 was assessed and noted an open area to the back of the head. R1 was transported to the hospital and returned with staples to the back of the head.R1's final reportable dated 03/27/26 document in part: R1 attempted to reposition himself in bed and subsequently fell from the side of the bed onto the floor. Staff assessed R1 and noted a laceration to the back of his head, an order was obtained to transfer R1 to the hospital for further evaluation. R1 returned to the facility with sutures to the back of his head. Upon R1's return to the facility, interventions were implemented including a low bed and floor mats. R1's care plan was updated to reflect the same changes.R1's care plan document in part: Focus: Resident is at risk for falls R/T (related/to) cardiorespiratory conditions and comorbidities Revision on: 12/09/25. Interventions: Be sure call light is within reach and encourage the resident to use it for assistance as needed. Staff to respond promptly to all requests for assistance. Date Initiated: 12/08/25. Anticipate and meet individual needs of the resident. Date Initiated: 12/08/25. Focus: R1 has impaired cognitive function/dementia or impaired thought processes r/t Dementia.On 04/18/26 at 12:50 PM per telephone interview V11 (Licensed Practical Nurse) stated I came off lunch and was doing rounds when I observed R1 on the floor next to his bed. I assessed R1 and observed bleeding from the back of his head. The doctor ordered to send R1 out to the hospital. R1 came back with 4 staples to his head. The fall interventions R1 had in place: R1 had a helmet for seizures, bed low to the floor and I am not sure if R1 had mats on the floor. R1 was a high fall risk and a total care x 1 assist.On 04/18/26 at 01:03 PM Per telephone interview V14 (Certified Nurse Assistant) stated On 03/22/26 I was checking on R1 like every 5 - 10 minutes because he likes to get up. R1 was a total assist, alert and oriented x1 and was confused. At 9 pm I was across from R1's room charting. V11 (Licensed Practical Nurse) did rounds again and that is when R1 fell and hurt himself. R1 did not have a floor mat but was in a low bed and the call light was in reach clipped to his pillow. R1 would not use the call light.On 04/18/26 at 09:49 AM V6 (Licensed Practical Nurse) stated R1 has had falls in the past and he is a fall risk. R1 had a hematoma and some staples to the back of his head.On 04/18/26 at 09:52 AM V7 (Licensed Practical Nurse) stated R1 was a fall risk and was monitored in the dining room, bed lowest position and no skid socks.On 04/18/26 at 01:18 PM Per telephone interview V16 (Director of Nursing) stated R1 had a fall in the facility. There is an interdisciplinary approach, and I am not the fall nurse. V11 (Licensed Practical Nurse) called me and said that she (V11) was doing (continued on next page)

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

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	rounds and found R1 on the floor. R1 had an open area to the back of his head and was sent to the hospital. R1 came back from the hospital with staples. We did a review of the medications that he was taking, root cause analysis. The initial intervention when the fall first happened was to send R1 to the hospital. The new interventions were floor matt and the low bed. I am not sure why the care plan was not updated.On 04/19/26 at 01:00 PM Per telephone interview V15 (Restorative Nurse) stated I don't remember R1's exact fall but I remember he was a resident. I am responsible for entering the fall interventions and it should be entered within 24 hours. If it is not entered in the care plan I must not have updated the care plan properly.Policy:Titled Policy and Procedure Care Plan revised 01/24 document 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. Purpose: To promote continuity of care and communication among staff, increase resident safety and safeguard against adverse events. Procedure: 4. Members of the interdisciplinary team participate at care conferences. b. The interdisciplinary team develops a comprehensive, individualized care plan based on interdisciplinary team assessments and comprehensive assessment of the resident prior to the care conference. 5. Care plans are reviewed and discussed individually. a. Concerns, problems, needs, and/or strengths are listed based on residents' individual needs. Physicians' orders and personal care and nursing needs are also listed based upon comprehensive assessments. c. Goals are resident oriented, specific problem-oriented goals relative to medical and nursing diagnosis, realistic, measurable, and directed towards increased functional levels. 7. Care conferences for review and revision of resident's care plan are scheduled at a conducive time for residents and their families. a. Skilled and intermediate residents every 90 days and PRN (as needed). b. When a significant change occurs in a resident's condition, the MDS coordinator or designee is notified by a member of the interdisciplinary team. The care plan is then reviewed and updated. 8. The MDS coordinator or designee has responsibility for each resident's care plan. a. The MDS coordinator or designee is responsible for coordinating each resident's care plan and for ensuring that the appropriate information is available to all staff and is transmitted at time of discharge or transfer. b. The interdisciplinary team is responsible for the implementation of resident care management. 9. All interdisciplinary team departments are responsible for charting that reflects the care plan concerns, problems, needs and /or strengths, approaches, progress of lack of progress with possible reasons for and any new problems. 10. The MDS coordinator or designee is responsible for in-service training for all departments and shifts to ensure understanding of the care plan process and each person's responsibility and participation in the care plan.