

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 07/16/2026
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)		
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that a resident (R6) who depends on staff's assistance for their ADL (Activities of Daily Living) care received incontinence care. This failure affected one residents R6 out of six residents reviewed for ADL care. Findings include: R6's face sheet shows that R6 has a diagnosis of lack of coordination, weakness, hemiplegia, and hemiparesis following cerebral infarction affecting non dominant side. R6's Brief Interview for Mental Status (BIMS) dated 6/12/26 with a score of 13 which indicates that R6 is cognitively intact. R6's Minimum Data Set (MDS) dated [DATE] shows that R6 is dependent for Activities of Daily Living (ADL) care, toileting, and personal hygiene. On 7/13/26 at 12:40 pm, surveyor toured the facility's 2 North unit, and a strong pungent odor consistent with urine and feces was detected upon leaving the elevator and entering R6's room from the hallway. Surveyor observed R6 from the doorway lying in bed gesturing for the surveyor to enter R6's room. R6 was asked if her continence brief needed to be changed, R6 nodded her head up and down signaling yes however, R6 was not able to say how long R6 had been for staff to provide her with incontinence care. On 7/13/26 at 12:45 pm, Surveyor requested V11 (Certified Nursing Assistant, CNA) to perform an incontinence check with R6. R6 was observed lying in bed with a large amount of soft brown stool present on the front of R6's, incontinence brief, abdomen extending through R6's perineal area, back and bed linens. A strong urine odor was present, and the bed linens was saturated in urine. The odor was sufficiently strong that it was detectable from the hallway outside the residents room. V11 stated that her shift started at 7:00 am and 12:45 pm was the first time she provided incontinence care to R6 for the day. On 7/15/26 at 10:13 am, V3 (Assistant Director of Nursing, ADON) stated that the nursing staff should be rounding on residents every two hours, prn (as needed) and after each meal by the Certified Nursing Assistants (CNA's) to ensure that the residents are taking care of properly and adequately. V3 stated if a resident is soiled in urine and feces that can cause the resident to acquire bedsores, pressure ulcers, excoriations, and the facility to have an odor of urine and feces. The facility's undated document titled Activities of daily Living (ADLS) document, in part: Purpose: To preserve ADL function, promote independence and increase self-esteem and dignity.		

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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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure physician-ordered physical therapy, occupational therapy and speech therapy screening upon admission was completed for one resident (R2). This failure affected one of six residents reviewed for specialized rehabilitative services. Findings include: R2's face sheet shows that R2 has a diagnosis of dysphagia, nontraumatic subarachnoid hemorrhage from anterior communicating artery, obstructive hydrocephalus and cerebral infarction due to unspecified occlusion or stenosis of left posterior cerebral artery. R2 was admitted to the facility on [DATE] and discharged from the facility on 6/24/26. R2's electronic medical record chart does not show a Brief Interview for Mental Status (BIMS) during R2's stay at the facility. R2's Physician Order Sheet (POS) dated 6/16/26 shows orders for PT (physical therapy), OT (occupational therapy), ST (speech therapy) screen on admit, readmit, and/or as needed. May eval (evaluate) and tx (treat) if applicable. R2's care plan dated 6/17/26 documents in part: Dysphagia: Interventions: Speech therapy as ordered to eval (evaluate) and treat as indicated. R2's hospital record dated 6/16/26 documents, in part: Assessment: Discharge needs based on today's assessment: Therapy needs at discharge: Intensive daily therapy . therapy five or more times per week. On 7/13/26 at 12:04 pm, V6 (Certified Occupational Therapy Assistant, COTA, Therapy Manager) stated that she is the therapy manager for the facility. V6 explained that the therapy department PT (Physical therapy), OT (occupational therapy), SLP/ST (speech language pathologist) did not evaluate R2 when R2 resided at the facility. V6 then explained that she is not sure why R2 was not seen by the therapy department and that the therapy department may have been backed up with evaluating residents. V6 then explained that all residents are screened for therapy services upon admission to the facility and that residents who are admitted with dysphagia, a gastrostomy tube (Gtube), and an oral diet should be evaluated by the speech therapist upon admission due to the risk of aspiration. V6 also explained that she coordinates the new admission resident screenings and relay them to PT, OT, SLP/ST to perform a screening and evaluation on the resident upon their admission to the facility. V6 stated, I don't recall why she was not seen. I swear I don't know how I missed her (referring to R2). V6 stated if a resident who has orders to be seen by PT, OT and SLP/ST upon admission is not seen the resident can decline and the facility can be in trouble. On 7/14/26 at 11:36 am, V19 (Dietitian) explained that she was informed that R2 was not tolerating her diet and that R2 would only have G tube feeding orders. V19 also stated she will usually review the residents speech therapy notes however she did not recall R2 having any ST/SLP notes. On 7/15/26 at 10:40 am, V20 (Speech Language Pathologist, SLP/ST) stated that she recalls R2's name on the communication board in therapy room. V20 explained that the communication board is written by V6 (Therapy Manager, Certified Occupational Therapy Assistant, COTA) as a means of communication and is utilized in the therapy department to notify therapy staff regarding incoming residents, new admissions, and evaluations request for residents. V20 then explained that she recalls R2's name written on the board to perform a screening and swallow evaluation. V20 then explained once she attempted to access R2's medical chart in her electronic medical record at the facility she was not able to pull up R2's name in the facility's computer on June 23, 2026, and she then asked the floor nurse regarding R2's status and was informed that R2 had discharged from the facility. V20 stated that she is at the facility two days a week usually on Tuesdays and Thursdays however the days can vary. V20 then explained that she was not sure how long R2 was at the facility prior to V20 attempting to evaluate R2. V20 also explained that she is not made aware of how long new admissions are at the facility prior to the days that V20 is scheduled (continued on next page)		

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care for residents at the facility. V20 explained that whenever she is scheduled at the facility is when V20 will check the communication board and evaluate residents who require SLP/ST services. The facility's policy dated 2025 and titled Resident/Patient admission to Rehab Program documents in part: Purpose: To design a formal standardized process and criteria for residents/patient admission into the rehabilitation program. Policy: In accordance with OBRA (Omnibus Budget Reconciliation Act) state Guidelines, resident/patient will have access to rehabilitation services based on appropriate clinical need, outcome of the assessment and the ability of the rehabilitation department to provide the needed services and interventions. Resident/patients will not be discriminated against based on their diagnosis, age, gender, sexual orientation, payer source, financial, physical, status or cognitive status. Procedure: 1. The therapist will screen resident/patients by reviewing the medical record and admission information to predetermine the resident/patience the need for rehabilitation services. Hospital records of therapy services and doctors recommendations are helpful to review. 2. This therapist will screen all new admits, readmitted resident/patients, referrals, and resident/patients annually, according to the screening policy. 3. Any evaluation is indicated, discontinue the screen and request evaluation orders. It is not to perform any evaluation without doctor's orders. 4. Perform the evaluation and request clarification treatment orders, when indicated, based on resident/patients clinical needs. Ensure that the medical director clarification orders are documented in the resident/patients chart . 6. If any evaluation is not appropriate, complete the screen as indicated . 11. Specialized therapist (PT, OT, ST) shall be included in the preadmission process in order to ensure timely assessments are performed and services offered. It is the responsibility of the therapist to contact the hospital or other provider regarding specialized therapy services to be initiated upon admission to the facility. The facility's undated policy titled Specialized Rehabilitative Services Policy documents, in part: Definition: Specialized rehabilitative services include but are not limited to physical therapy, speech/language and audiology, pathology, respiratory therapy patient off therapy. Such services are utilized to restore, maintain, or improve the residence optimal level of functioning, self-care, independence, and quality of life. Purpose: to ensure appropriate rehabilitative services are available to the residents and outline the responsibilities of therapy providers as well facility staff. Policy: it is the policy of this facility to provide specialized and supportive rehabilitative services either directly or through arrangements with services provider. Services shall be provided in accordance with the assessment results, the written comprehend plan of care in accordance with physicians orders. Standards: 1. The coordinator is responsible to oversee the provision of therapy services for physical, occupational and speech/audiology to arrange for contract services when facility employed staff are not available . 3. Rehabilitative services shall be provided to all residents whose physician has determined a new and the resident or their legal representative consents to the service. 4. A qualified therapist evaluates the resident and develop a plan of care includes the amount, frequency and duration therapy as ordered by the physician. 5. Therapists are responsible to communicate in writing to the nursing department recommendations for restorative programs which reinforce skills wired door therapy.		