STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003958	A. BUILDING: _____ B. WING _____	C 09/08/2023

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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S 000	Initial Comments Facility Reported Incident of 08/20/2023/ IL163542	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210b) 300.1210d)6) Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These requirements are not met as evidenced by: Based on interview and records review, the	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 facility failed to provide adequate and sufficient care for one resident (R1) of 3 reviewed for two person-assist for bed mobility. This failure resulted in R1 falling out of bed and sustaining a subdural hematoma. Findings include: R1's Face Sheet documents resident is a 67-year-old with diagnoses including but not limited to: Chronic Myeloid Leukemia, BCR/ABL-Positive, Not Having Achieved Remission, Unspecified Dementia, Unspecified Severity, Without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, And Anxiety, Muscle Wasting and Atrophy, Not Elsewhere Classified, Multiple Site, Other Specified Symptoms and Signs Involving the Digestive System And Abdomen, Pain in the Right Knee. Facility Incident Investigation Report (dated 08/23/2023) regarding R1 documents in part: Resident has impaired mobility and cognition requiring total staff assistance with mobility and transfers. Resident is able to move in bed but requires staff assistance for safety. MD notified of fall and injury with orders to send resident to the hospital for further evaluation. Resident was admitted to the hospital with a diagnosis of Subdural Hemorrhage. Minimum Data Set Section G (MDS) (dated 05/31/2023) scored R1 as (3) requiring 2-to-3-person physical assistance for bed mobility. MDS section C (dated 05/15/2023) scores R1 as having a BIMS score of 4, indicating that R1's cognition is impaired. R1's Fall Care plan (dated 01/17/2023)	S9999		

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S9999	Continued From page 2	S9999		

documents that R1 is at risk for falls r/t poor safety awareness, poor balance, unsteady gait. R1's fall care plan documents that R1 exhibits impaired bed mobility r/t CVA and R1 is not able to position/ reposition self when in bed or sitting.

Fall Risk Assessment (dated 05/26/2023) prior to fall incident on 08/20/2023 scored R1 as (14) a moderate risk for falls.

Fall Prevention Program (dated 02/28/2014) states: 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 risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary.

On 08/29/2023 at 12:38pm V4 CNA (Certified Nursing Assistant) stated, "On 08/20/2023 I was going to change R1, and all her care items were gathered at her bedside table. R1 was in the bed with R1's top half of her body centered in bed, and R1's legs were more near the edge. I was on R1's left side of the bed. I turned to grab the items that were needed to provide the care for the resident. I had to step away to be able to reach them, and that's when R1 fell out of the bed. R1 requires a two-person assistance for ADL care, and at the time R1 fell, I did not have any other staff member in the room with me. I did not reposition R1 before I stepped away to grab the care items. That day, there were several CNAs scheduled to work on that unit, however, there were multiple call offs. I was the only CNA who was working the 3-south unit and there was not enough staff to help me. For the 3rd floor/3 south

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unit, there should have been 4 certified nursing assistants, but it was only me and the restorative aide. R1 requires the assistance of 2 staff members, and we were short that day, so I had to change R1 by myself. R1 requires 2 CNAs because R1 moves a lot and it is unsafe, but I was the only on the floor, so I had to change the resident by myself."

On 08/29/2023 at 1:01pm V3 RN (Registered Nurse) stated," On 08/20/203, the last time I saw R1 was when I administered R1 her morning medications. The CNA on duty came to inform me that R1 fell. I was at the nurse's station when V4 came to inform me of the fall. We were working short that day because we had multiple call offs from CNAs who were scheduled to work on the 3-south unit. V4 and a restorative aide were the only ones who were working on the unit, so it was really hard for the two of them to care for all these residents. V4 was the only CNA at the bedside doing R1's care because there was no other CNA to assist V4 with changing R1. R1 requires the assistance of 2 CNAs for ADL care. R1 slid out of the bed and after the fall, I saw that R1 had a knot on her forehead. I notified R1's physician and family and I sent the resident out to the hospital, after initiating neuro-checks. R1 sustained a subdural hematoma from the fall."

On 08/30/2023 at 11:37am, V5 (Staffing Coordinator) stated, "On 08/20/2023, for the unit of 3 south, there were 5 certified nursing assistants scheduled and we had 4 call offs. On that shift there was only a total of 1 CNA working the 3-south unit during the 7am-3pm shift. A restorative aide was pulled to work the 3-south unit. We are not utilizing a staffing agency. The new company that owns the building does not want to utilize a staffing agency. Sometimes a

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staffing agency is needed during times where there are a lot of call offs. The facility is attempting to hire more staff, both nurses and CNAs."

On 08/30/2023 at 12:10pm, V7 (Restorative Director) stated, "R1 does not walk. R1 is chair bound and requires total staff assistance of 2 people for transfers. R1 requires a 2 person assist for bed mobility. R1 requires the assistance of 2 CNAs when being changed."

On 08/31/2023 at 9:54am V2 (Director of Nursing) stated, "The facility has an issue with employee call offs. There are a lot of call offs. The staffing coordinator will have the schedule filled appropriately and all of a sudden, we will have many call offs. The facility does not use a staffing agency because the corporate office decided not to use the agency. We do a good job covering the shifts by offering bonuses and the corporate office feels like a staffing agency is not needed."

On 09/05/2023 at 2:33pm V15 (Nurse Practitioner) stated, "I am aware that R1 had a fall on 08/20/2023. R1's fall could have been avoided. R1 moves and scoots all over in bed. I know the resident really well. R1 has leukemia. R1 scoots all over the bed and R1 does not walk. If there were 2 staff members the fall could have been avoided potentially because when R1 is changed, she definitely needs the assistance of two CNAs. R1 shifts her weight a lot. It is not safe for one CNA to provide ADL care. R1 is not appropriate for one staff member for ADL care and changing the resident. One CNA can wash the resident's face or provide assistance with feeding the resident, however, when R1 is being changed, the resident requires the assistance of

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S9999	Continued From page 5 2 CNAs." R1's Progress Note (dated 08/20/2023) documents, "Nurse alerted to residents' room, resident laying on her back on floor. CNA stated, Resident rolled from bed during ADL care, head to toe observation done and resident alert per usual mental status, large hematoma to left side of forehead with no bleeding, cold compress applied, pain level evaluated, denies pain and discomfort, ROM preformed, resident able to move all extremities, resident sent to ER. Family and MD made aware." Progress Note (dated 08/20/2023) documents, "Call placed to ER to get updated status on resident, was made aware that resident was transferred to Community ER. Call placed to Community ER x3 to get updated status; each attempt was unsuccessful, due to no one answering the ER phone. Endorsed to oncoming nurse to follow up with status." Progress Note (dated 08/20/2023) documents, "Report from Community ER stated that the Resident has been admitted after evaluation. DX subdural hematoma." Review of the schedule 3 south 7am-3pm (dated 08/20/2023) indicated that there was only one certified nursing assistant working and one restorative aide. (A)	S9999		