STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001523	A. BUILDING _____ B. WING _____	C 07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER HOME HISPANIC ELDERLY	1401 NORTH CALIFORNIA CHICAGO, IL 60622

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S 000	Initial Comments Complaint Investigations: 2384488\IL160423	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210a) 300.1210b)5) 300.1210d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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. Restorative measures shall include, at a minimum, the following procedures: 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. 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	S9999		

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S9999	Continued From page 2 nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These requirements were not met as evidenced by: Based on interview and record review, the facility failed to provide adequate supervision to R1. This failure resulted in R1 sustaining four falls requiring emergency room evaluations and R1 sustaining a right arm humerus fracture, scalp hematoma in the left parieto-occipital region with soft tissue swelling and a head laceration with one staple to R1's head. This failure affects one of four residents reviewed for falls on the sample list of five. Findings include: R1's diagnosis include but are not limited to encounter for other orthopedic aftercare, unspecified fracture of upper end of left humerus subsequent encounter for fracture with routine healing, unspecified fall subsequent encounter, laceration without foreign body of scalp subsequent encounter, and history of falling. R1's Brief Interview of Mental Status (BIMS) dated 04/11/23 documents that R1 has a BIMS of 07 which indicates some cognitive impairments. On 07/25/23 at 11:28 am, V6, Licensed Practical Nurse (LPN) stated, R1 was ambulatory and recalls R1 falling at the facility twice within one month. V6 stated R1 went out to the local hospital on 04/15/23 and 05/25/23 after a falling and sustaining injuries. V6 stated that when R1 fell on 05/25/23, V6 was told by an unknown CNA staff	S9999		

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S9999	Continued From page 3 that R1 fell in the sunroom. V6 stated the unknown CNA's back was turned to R1 when R1 fell on 05/25/23. After R1's fall on 05/25/23, R1 complained of right arm pain and sent R1 to the local hospital for evaluation. V6 was informed the next day that R1's right arm was placed in a sling due to R1 having a right arm fracture. On 07/25/23 at 1:59 pm, V11 (R1's Physician) stated that V11 was informed of R1 having multiple falls with injuries at the facility. V11 stated every time V11 was informed that R1 had a fall, R1 was sent to the local hospital for an evaluation of R1's injuries. V11 explained that R1 was a confused resident with dementia and high risk for falls due to R1's condition. V11 also stated that staff should monitor residents who are high risk for falls and have a history of multiple falls with injuries more closely. When V11 was asked what could happen if a resident who is high risk for falls is not closely monitored and sustains a fall, hitting their head or falls on their arm and V11 stated that the resident would have to go to the emergency room to rule out brain bleeds, fractures, and treatment of any injuries. V11 also stated, "R1 should have been supervised closely every shift by staff due to R1's dementia." On 07/26/23 at 1:02 pm, V2 (Director of Nursing, DON) stated that R1 was high risk for falls and had multiple falls with injuries at the facility from April 2023 through May 2023. When V2 was asked regarding R1's how often was R1 being monitored, V2 stated that staff cannot watch all the residents all the time. When V2 was asked if R1 was ever placed on a one-to-one monitoring due to R1 having multiple falls in one-month V2 stated, "No." When V2 was asked in V2 professional opinion was R1 closely supervised V2 stated, "No. It is impossible for the facility to	S9999		

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S9999	Continued From page 4	S9999		

prevent every fall. There is always room to improve supervision." When V2 was asked what could happen if a resident who is high risk for falls and sustains a fall is not supervised, V2 stated that the probability of the resident falling increases and the resident could get injured from the fall.

On 07/27/23 at 11:11 am, V10 RN (R1 nurse on 04/18/23) observed (R1) on the floor after falling on 04/18/23. V10 could not recall when the last time V10 was seen prior to R1's fall on 04/18/23. V10 stated R1 was trying to go to the bathroom and fell. R1 had a large hematoma on the back of R1's head that R1 had from a previous fall a few days prior to 04/18/23. R1 was sent to the hospital to evaluate R1's hematoma. V10 recalls R1 having at least three falls while at the facility.

The facility's Reportable Incident to local State Agency dated 04/15/23 at 8:53 am, documents R1 fell on the floor with blood next to R1's head. R1 was sent to local hospital. R1 returned with one staple to the back of R1's head.

The facility's Reportable Incident to local State Agency dated 05/26/2 at 4:52 pm, documents R1 was observed in a supine position, with arms by R1's side and legs extended. R1 with minor superficial abrasion to right elbow. R1 complained of pain six out of ten to right arm with limited range of motion. R1 was sent to the local hospital for treatment and evaluation. R1 returned to facility with right arm sling related to hairline humorous fracture.

R1's local hospital records dated 04/15/23 documents R1 was sent to the local hospital for scalp laceration, staple care, and skin avulsion. R1's CT (Computed Axal Tomography) shows no

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S9999	Continued From page 5 evidence of acute intracranial hemorrhage, mass effect or shift. There is extensive scalp hematoma in the left parieto-occipital region. There is extensive soft tissue swelling and hematoma measured approximately 4.4 by 1.2 cm (centimeter). R1's local hospital records dated 04/18/23 documents R1 was sent to the local hospital for laceration of scalp. R1 with a 3 (cm) laceration to the left parieto-occipital area. 1 staple in place inferior aspect of the laceration. R1's local hospital records dated 04/19/23 documents R1 was sent to the local hospital for fall with posterior head laceration. CT of head without intravenous contrast findings: soft tissues: Left occipital scalp soft tissue swelling and small soft tissue gas are seen. No intracranial bleed is identified. R1 had a fall on 04/16/23 resulting in hematoma in the occiput, dried blood with one staple in place. On 07/24/23 surveyor requested and was unable to obtain R1's hospital records dated 05/25/23. R1's progress noted dated 04/15/23 at 8:50 am, by V6 (Licensed Practical Nurse, LPN) documents V6 was made aware that R1 was on the floor with blood next to R1's head. R1 stated that R1 was walking out of R1's room got dizzy and fell backwards and hit R1's head. V6 assess R1 and called 911. R1's progress noted dated 04/15/23 at 7:50 pm, by V8 LPN documents R1 returned to the facility from the local hospital with 1 staple and prescription for Bacitracin ointment twice a day for seven days.	S9999		

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S9999	Continued From page 6 R1's progress not dated 05/22/23 at 11:50 pm, by V9 (Registered Nurse, RN) documents V9 rushed to the second floor and noted R1 lying on R1's back with R1's upper body on the floor and R1's lower body on the safety mat. V9 documents that R1 reached for R1's bedside commode but loss balance and fell on the floor. R1's progress noted dated 05/25/23 at 4:52 pm, by V6 LPN documents R1 was seen lying face down on the floor in the sunroom by activity aide. V6 observed R1 lying on R1's back. R1 complained of pain to R1's right arm/elbow. R1's practitioner was called and R1 was sent to the local hospital. R1's progress noted dated 05/26/23 at 3:21 pm, by V13 LPN documents R1 returned to the facility from the local hospital with a proximal humerus fracture (break in the top of R1's upper arm bone). R1's care plan dated 02/08/21 documents R1 has is at risk for falls related to (R/T) history of falls, DJD (Degenerative Joint Disease), side effects of medication, limitations in ROM (Range of Motion) to BUE (bilateral upper extremity) and has flaccid RUE (right upper extremity) .... Focus ... Anticipate and meet individual needs of the resident. R1's fall risk review dated 05/25/23 documents R1 has had three or more falls within the last six months and that R1 is high risk for falls. The facility's document/policy dated 06/14 and titled "Falls" documents, in part: "Falling Star Program: Resident is at risk for falls based on Fall Risk assessment. Resident has had a least two (2) falls within a thirty (30) day period.	S9999		

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S9999	Continued From page 7 The facility's document dated 03/15 and titled "Supervision and Safety" documents, in part: " Policy: Our policy strives to make the environment as free from hazards as possible. Resident safety and supervision are the facility-wide priorities. 1. Our facility-oriented approach to safety addresses risk for groups of residents such as wanderers, behaviors, aggressiveness, confusion, etc. ... 4. Resident supervision is a core component to resident safety ... 10. Staff to make visual rounds on residents minimally every two hours and more often, if necessary, based on residents' assessment needs." (B)	S9999		