Illinois D	epartment of Public	Health				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		(X3) DATE COMP	SURVEY LETED
		IL6001523	B. WING		(12/1) 7/2024
	PROVIDER OR SUPPLIER			STATE, ZIP CODE	<u>. </u>	-
	- NOVIDEN ON SUFFEIEN					
CENTER	HOME HISPANIC EL	DERLY CHICAGO	, IL 60622			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
S 000	Initial Comments		S 000			
	Complaint Investiga	ation 2489497/IL181237				
S9999	Final Observations		S9999			
	Statement of Licens	sure Violations:				
	300.610a) 300.1210a)					
	300.1210b) 300.1210d)2)5)					
	Section 300.610 R	esident Care Policies				
	procedures governi facility. The written be formulated by a Committee consisti administrator, the a medical advisory co of nursing and othe policies shall compl The written policies the facility and shal	dvisory physician or the ommittee, and representatives r services in the facility. The ly with the Act and this Part. shall be followed in operating l be reviewed at least annually documented by written, signed				
	Section 300.1210 (Nursing and Persor	General Requirements for nal Care				
	facility, with the part the resident's guard applicable, must de comprehensive car includes measurabl meet the resident's and psychosocial n	sive Resident Care Plan. A ticipation of the resident and dian or representative, as evelop and implement a e plan for each resident that le objectives and timetables to medical, nursing, and mental eeds that are identified in the				
ABORATOR	tment of Public Health Y DIRECTOR'S OR PROVID ically Signed	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 12/27/24

If continuation sheet 1 of 9

STATEMEN	Pepartment of Public	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
and plan	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		C 12/17/2024	
		IL6001523	B. WING			
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
CENTER	HOME HISPANIC ELI	DERLY	RTH CALIFOR D, IL 60622	NIA		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 1	S9999		,	
	allow the resident to practicable level of provide for discharg restrictive setting ba needs. The assess the active participat resident's guardian applicable. (Section b) The facility s care and services to practicable physical well-being of the resident's com plan. Adequate and care and personal of resident to meet the care needs of the resident to					
	nursing care shall in	subsection (a), general nclude, at a minimum, the be practiced on a 24-hour, basis:				
		nts and procedures shall be dered by the physician.				
	pressure sores, hea breakdown shall be seven-day-a-week l enters the facility wi develop pressure so clinical condition de sores were unavoid pressure sores sha services to promote	ogram to prevent and treat at rashes or other skin practiced on a 24-hour, basis so that a resident who ithout pressure sores does not ores unless the individual's monstrates that the pressure lable. A resident having Il receive treatment and healing, prevent infection, ressure sores from developing.				

If continuation sheet 2 of 9

TATEMEN	epartment of Public IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		A. 1		A. BUILDING.			<u>_</u>
		IL6001523	B. WING			C 17/2024	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
ENTER	HOME HISPANIC EL	DERLY	RTH CALIFOR O, IL 60622	NIA			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLET DATE	
S9999	Continued From pa	ge 2	S9999				
	These regulations were not met as evidenced by:						
	review the facility fa Wound Care Nurse resident needs, fail incontinence care, it treatments, failed to of required LALM (I settings and failed to on the correct settin (R1, R2, R3) review These failures resu acquired) sacrum p exposure/fracture a osteomyelitis, R2 st acquired) pressure stage 3 (facility acq Findings include:	ion, interview, and record ailed to ensure that sufficient es are available to meet ed to provide timely failed to administer prescribed o ensure that staff are aware Low Air Loss Mattress) to ensure that the LALM was ng for three of three residents wed for pressure ulcers. Ited in R1 sustaining a (facility pressure ulcer with tailbone and radiographic suggestion of ustained a stage 3 (facility ulcer, and R3 sustained a uired) pressure ulcer.					
	sacrum pressure ul 1) R1's diagnoses i	tained (facility acquired) icers. nclude dementia, multiple scular dysfunction of bladder,					
		llitus, (Stage 4) pressure ulcer miplegia, and hemiparesis.					
		ctional assessment affirms ubstantial/maximal assistance right.					
		assessment for potential skin t determined a score of 13					
		alteration assessment quired) sacrum (stage 2)					

If continuation sheet 3 of 9

STATEMEN	Pepartment of Public IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COMI	E SURVEY PLETED
		IL6001523	B. WING		C 12/17/20	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
CENTER	HOME HISPANIC EL	DERIV	RTH CALIFOR O, IL 60622	NIA		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
S9999	Continued From pa	ige 3	S9999			
	pressure injury 1.3	x 1.3 x 0.3cm (centimeters).				
	alteration in skin int additional and/or we related to incontine Intervention: Air los R1's (1/8/24) POS include pressure re R1's (12/5/24) weig On 12/9/24 at 2:03 LALM was set on a when R1 was place	(Physician Order Sheets)				
	bit after 10am" (rou subsequently remo (as requested) a lai adhered to the skin lower back. Survey skin V4 (CNA) repli	Ighly 4 hours prior). V5 ved R1's incontinence brief rge bowel movement was between the buttocks and yor inquired what was on R1's ied "Poop." Bowel movement n R1's sacrum dressing dated				
	Administration Rec physician orders: a Castor Oil daily how documented for 11/	924) TAR (Treatment ord) includes the following pply to sacrum Balsam Peru vever "9" (see nurses note) is /3, 11/9, 11/15, 11/16, 11/18, , 11/22, 11/23, 11/26 and 11/27				
		/15, 11/16, 11/18, 11/19, 11/20 , 11/26 and 11/27 2024) lude wound care	,			
nois Depar	On 12/11/24 at 1:12 tment of Public Health	2pm, surveyor inquired what a				

If continuation sheet 4 of 9

STATEMEN	Department of Public NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:			E SURVEY PLETED
		IL6001523	B. WING		C 12/17/2024	
AME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
		1401 NO	RTH CALIFOR	NIA		
JENIER	HOME HISPANIC EL	CHICAG	O, IL 60622			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC ¹	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
S9999	Continued From pa	ge 4	S9999			
	Care Nurse) stated what weight that is. that don't got no we between setting. I d leave mid-Novembe since I got back." S sacrum wound and responded "Current Her wound looks re little area. It's heali (Collagen) schedule PRN (as needed).	on the LALM. V11 (Wound "I don't know, I don't know We got 2 of them (LALM) sight on it and it may be the in came back from maternity er and I haven't checked them urveyor inquired about R1's current treatments. V11 tly she has collagen to the site eally good, its open in just a ng very well. We have it ed every other day unless its				
	Pelvis (obtained 2 c worsening deep sat tissue infection and Findings: there is n over the distal verte sacrum transitions associated focal sa fracture of the dista osteomyelitis. Impr 4.8cm skin and soft the tailbone beginn transitions to the co	(Computed Tomography) days later) states indication: cral wound. Check for soft underlying osteomyelitis. o skin or subcutaneous tissue abral column where the to the coccyx. There is crococcygeal sclerosis and l bone concerning for ression: penetrating 4.7 x t tissue defect (ulcer) exposes ing where the sacrum pocyx, complicated by stion of osteomyelitis.				
	potential harm to a are not administere Director) stated "Its Surveyor inquired a	Bpm, surveyor inquired about resident if wound treatments d as ordered. V18 (Medical gonna get worse and worse." bout potential harm to a exposure. V18 responded sepsis."				
		nclude dementia, type 2 nd stage 3 chronic kidney				

Illinois Department of Public Healt STATE FORM

Illinois D	epartment of Public	Health			FORM	APPROVED
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		IL6001523	B. WING			C 17/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
CENTER	HOME HISPANIC EL	NERIV	RTH CALIFOR	NIA		
		CHICAGO	D, IL 60622			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC)	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 5	S9999			
		tional assessment affirms artial/moderate assistance with				
		assessment for potential skin t determined a score of 16				
	includes (facility ac pressure injury 3.2	I skin alteration assessment quired) sacrum (stage 3) x 5.8 x 0.2cm. What is the cause of the skin alteration? tinence.				
	increased risk for a related to periphera mellitus and inconti	plan states resident is at Iteration in skin integrity Il vascular disease, diabetes nence. Interventions: vention of Pressure Ulcers will d peri care.				
	R2's POS includes mattress.	(2/5/24) pressure reduction				
	LALM, and the sett Surveyor inquired a LALM V4 (RN/Regi deal with this. I thir restorative if I'm no brief had a blue line was wet). V6 (CNA	om, R2 was lying atop of a ing was on 160 (pounds). about the settings on R2's stered Nurse) stated "I don't ak who deals with this is t mistaken." R2's incontinence e present (indicating the brief A) removed R2's brief (as as soiled with urine.				
inois Depa	weighs 160# (lbs). ' stated "I don't think electronic medical r	Bpm, surveyor inquired if R2 V11 (Wound Care Nurse) so" then reviewed R2's records and affirmed "It's 12/6/24." Surveyor inquired				

linois Department of Publi		-			APPROVE
TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	IL6001523	B. WING			C 17/2024
AME OF PROVIDER OR SUPPLIE	R STREET AI	DRESS, CITY, ST	ATE, ZIP CODE		
ENTER HOME HISPANIC E		RTH CALIFOR D, IL 60622	NIA		
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
responded "I don' setting's suppose about R2's curren "He gets Medihom inquired who's res V11 stated "I do th sign them off. Too the Nurses are re affirmed that she's employed by the f R2's (December 2 physician orders: cover with borden treatment was no is blank). 3) R3's diagnose mellitus. R3's (9/10/24) fun- requires substant rolling left and righ R3's (9/10/24) risk integrity impairme (moderate risk). R3's (2/2/24) care potential/actual im Intervention: Keep R3's (10/31/24) im includes (facility a pressure injury. 1	es is supposed to be set on. V11 t know. I'm not sure what the d to be." Surveyor inquired t sacrum treatment. V11 replied ey to the sacrum." Surveyor sponsible for dressing changes. hem every time I'm here and day I'm working on the floor, so sponsible for wound care" and s the only Wound Care Nurse acility. 2024) TAR includes the following apply to sacrum Medihoney and ed foam daily however the documented on 12/8 (the entry s include type 2 diabetes ctional assessment affirms R3 al/maximal assistance for nt. c assessment for potential skin int determined a score of 14 plan states resident has ipairment to skin integrity. o skin clean and dry. itial skin alteration assessment cquired) sacrum (stage 3)				

Illinois Department of STATEMENT OF DEFICIENC AND PLAN OF CORRECTION	IES (X1) PI	ROVIDER/SUPPLIER/CLIA ENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		СОМ	E SURVEY PLETED
		L6001523	B. WING			17/2024
NAME OF PROVIDER OR SU	PPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
CENTER HOME HISPA	NIC ELDERLY		RTH CALIFOR O, IL 60622	NIA		
PREFIX (EACH DE	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
LALM. Surv R3's LALM V with the air s R3's LALM s however R3 weight. [R3 therefore the Surveyor ind was last che "Around lund R3's brief (a soiled with u On 12/11/24 responsible (Wound Car around may Surveyor ind (on 12/9/24) cause I'm nd should not h weighs 350 she's not big current sacr just has beta R3's (Decen Administration physician or time a day h The (8/23) L low air loss a who are high developmen pressure ad pressure lev	at 1:49pm, R3 eyor inquired /4 (RN) replie ettings." V5 etting was or appeared to b s 12/6/24 wei e LALM was o uired when R cked and/or o ch, she may b s requested) a rine. at 1:09pm, su for the facility e Nurse) state be once a mo uired why R3 V11 respond to really sure v ave been." S bounds. V11 r at all." Surve um treatment done to the si ober 2024) TA on Record) ind ders: apply Be bowever on 12 ow Air Loss M nattresses m or risk for presi t. Operating i ust knob to se el from soft to	was lying atop of a about the settings on d "I am not too familiar (CNA) affirmed that "#8 (350 pounds)" be less than half that ght was 138.0 pounds n the incorrect setting]. 3's incontinence brief changed V5 responded. e wet." V5 removed and affirmed it was urveyor inquired who's LALM settings. V11 ed "I set them, and I go nth to check on them." 's LALM was set on #8 led "I can't answer that vhy that was set on 8. I urveyor inquired if R3 replied "She does not, eyor inquired about R3's . V11 stated "She (R3) te." AR (Treatment cludes the following etadine to sacrum one /8/24 the entry is blank. Mattress policy states ay be used for residents sure ulcer/injury nstructions: turn the et a comfortable o firm. [required settings weights are excluded	t			

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		IL6001523	B. WING			C 17/2024
IAME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
ENTER	HOME HISPANIC EL		ORTH CALIFOR 60, IL 60622	NIA		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
S9999	Continued From pa	age 8	S9999			
	(B)					