

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6001523	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/31/2025
NAME OF PROVIDER OR SUPPLIER CENTER HOME HISPANIC ELDERLY		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 NORTH CALIFORNIA CHICAGO, IL 60622		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Facility Reported Incident of 12/30/2024/IL184755	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.3240a) 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 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These regulations were not met as evidenced by: Based on interview and record review, the facility failed to ensure that a resident remained free from mental abuse for one (R5) of three residents reviewed for abuse. This failure resulted in V4 (Former Certified Nursing Assistant/CNA) taking	S9999		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

02/11/25

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S9999	Continued From page 1 inappropriate photos of R5 and sending them in a text to her peers. A reasonable person who had inappropriate photos taken of them and shared with others would have felt sad, humiliated, and angry. Findings include: Facility's final incident report of 1/3/2025, documents on 12/30/2024, it was reported that (V4 Former CNA) took some inappropriate photos of (R5) and sent them to a CNA group text. An investigation has been immediately initiated and completed. Upon investigation, it is noted that V4 took photos and posted in CNA group. Face sheet indicates R5 is a 65-year-old female admitted to the facility on 9/28/2024, with diagnoses including but not limited to: Cerebral Infarction (stroke), Occlusion and Stenosis of Right Carotid Artery, Coronary Angioplasty Status, Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side (paralysis and weakness on one side of body following stroke), Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side, Dysphagia (difficulty swallowing), and Sepsis (body's extreme reaction to infection). MDS (Minimum Data Set) assessment dated 1/3/2025 indicates R5 has severely impaired cognition. 1/28/2025, at 3:05 PM, V2 (DON-Director of Nursing) said V4 (Former CNA) was terminated on 12/31/2024, for HIPPA (Health Insurance Portability and Accountability Act) and resident rights violations by posting photos of a resident (R5) to CNA chat group members.	S9999		

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S9999	Continued From page 2 1/28/2025, at 4:24 PM, V6 (Certified Nursing Administrator) said she received pictures of R5 via group text from V4 (Former CNA). 1/29/2025, at 11:06 AM, via telephone, V9 (Scheduler) said she received a text from V4 (former CNA) at approximately 10:30 PM on 12/30/2024. Included in the text were two pictures of R5 (V9's aunt). R5's face was visible, diaper open and soiled with feces, buttocks visible. V9 said she was upset V4 sent pictures of R5 to her in a CNA group. V9 said V4 responded, "it's not right what's going on, everyone needs to know." V9 reported the incident to V2 (DON) and V11 (Human Resources Director). V2 followed up with all CNAs included in the group text to ensure that pictures were deleted from their phones and not forwarded. R5's family was informed of the incident. 1/31/2025, at 9:02 AM, via telephone, V4 (Former CNA) Spanish speaking states, that day I went to start my night shift, I got to the floor, there were no nurses or CNAs, nobody was on the floor. When I got there, I find R5, hanging from the side rail, full of stool/wet and R5 is a fall risk. V4 continues to state I got scared and how could they leave her like that. My first reaction was that it was not fair to leave a person like that. I took a picture of the status she was in, they always left her like that. V4 reports that they wouldn't keep her safe, they didn't have anyone watching her, on top of that they would close her door because she would yell out. V4 reports that she was added to the group chat via text that was made for support. V4 states that she took one picture of R5 and sent the same picture twice in the group text. V4 states that she doesn't know how many CNAs were in the group chat. V4 continued to state that she did not receive any abuse training in the	S9999			

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S9999	Continued From page 3 facility. I'm told to sign things, I don't know what I'm signing. V4 states that she completed her CNA training outside of the facility and she did struggle during the CNA training due to her language barrier. V4 reports that she feels sorry about what she did, but she continues to state she (V4) didn't know she shouldn't send the picture. V4 reports that other CNAs had sent other residents' pictures of bruises in the group chat. 1/30/2025, at 7:49 PM, via telephone, V25 (R5's Daughter) said she was informed by V2 (DON) that a CNA (Certified Nursing Assistant) took pictures of R5 and posted them to other staff via a group chat. V25 said R5 "is not in her right mind" and could not have given consent for the pictures to be taken. The pictures showed R5's face, she was completely nude. I was very heated, my concern was if R5's picture was posted on social media. V25 said she did not tell R5 about the pictures. V25 added, R5 would have felt sad, humiliated, and angry because it was an invasion of R5's privacy. CNAs Group Text list documents there were 19 CNAs included in the text. Abuse Prevention Program Facility Policy and Procedure (reviewed 1/4/2018) page 6 Photographing and Recording Residents documents in part, staff photographing or recording residents or their private space for other than medical or facility purposes is strictly prohibited. Staff posting or sending a photo or recording on social media or otherwise keeping or sending a photo or record through multimedia messaging other than for facility purposes is also strictly prohibited. Staff taking or using a photograph or recording of a resident in a manner	S9999		

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S9999	Continued From page 4 that demeans or humiliates a resident, regardless of the resident's cognitive status or whether the resident consented, is strictly prohibited and will be handled as an allegation of abuse. "Photographing or recording" includes taking photographs or recordings from any type of device, including smart phones. Screening Assessment to Determine the Presence of Trauma Factors Including Abuse and/or Neglect Policy Protocol (undated) documents Mental Abuse includes, but is not limited to humiliation, harassment, threats of punishment, deprivation, or offensive physical contact. This includes abuse that is facilitated or enabled through the use of technology. (B)	S9999		