STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0050989	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/02/2025

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

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S0000	Initial Comments Complaint Investigation 2586769/2568230	S0000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210a) 300.1210b) 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 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	S9999		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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S9999	Continued from page 1 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. 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 were not met as evidenced by: Based on interviews and record review, the facility failed to provide adequate supervision during provision of ADL (Activities of Daily Living) care for 1 (R2) resident out of 3 residents reviewed for falls. This failure resulted with R2 falling while at the facility on 06/24/2025 and sustaining a facial laceration requiring sutures. Findings include: R2's Admission Record documented that R2's diagnoses (include but not limited to) Type 2 Diabetes Mellitus, repeated falls, Alzheimer's disease, dementia, and laceration part of head (Onset Date: 06/25/2025). R2's (05/13/2025) Minimum Data Set documented, in part "Section C. Cognitive Patterns. C0500. BIMS (Brief Interview for Mental Status) Summary Score: no entry. C0700. Short-Term memory Ok: 1 memory problem. C0800. Long-Term Memory Ok: 1. Memory Problem. C1000.	S9999		

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S9999	Continued from page 2 Cognitive Skills for daily decision making: 3 severely impaired. Section GG – Functional Abilities. GG0130. Self-Care. E. Shower/bathe self: 02 – substantial/maximal assistance – Helper does more than half of the effort. Helper lifts or holds trunk or limbs and provides more than half of the effort." R2's (Revision Date: 05/24/2025) care plan documented, in part "Focus: has a "Self-Care Deficit" and requires assistance with ADL's to maintain the highest possible level of functioning. Goal: will maintain their current level of ADL functioning without a significant decline. Interventions: Provide assistance with all ADL's as required per the residents need dependence: Bathing." R2's (Revision on: 06/22/2023) care plan documented, in part "Focus: is at risk for falls R/T (related to) Cognitive Impairments, Dementia. Goal: will remain free of injuries. Interventions: Staff to redirect resident when they see her bending over picking up anything off the floor (initiated: 09/13/2021). Anticipate and meet individual needs of the resident. (Date Initiated: 05/02/2017)." R2's (06/24/2025) Fall documented, in part "Person Preparing Report: V3 (Licensed Practice Nurse). Nursing Description: This writer was called by the CNA (Certified Nurse's Assistant) to the west side shower room, pt (patient) found lying on the floor leaning toward the left side, noted 2 lacerations on the left forehead above the left eye, bleeding, pressure dressing applied. 911 call was made, ambulance here to take pt to ER via stretcher. Predisposing Physiological Factors: confused, decreased safety awareness, and decreased strength." R2's (06/24/2025) CT Scan report documented, in part "FINDINGS: Soft tissues: Swelling and laceration of the frontal scalp on the left side extending into the left periorbital area." R2's (06/30/2025) Final Reportable documented, in part "Summary of Investigative Findings: While being showered by CNA (V4), the resident leaned forward, slipped off the shower chair, and fell, hitting her face on the floor. Resident has poor trunk control causing her to fall and sustain head injury, resident was sent out 911 and returned within 24 hours from ER (Emergency Room) with sutures." On 08/01/2025 at 10:32am with V17 (Licensed Practice Nurse) at the facility's first floor dining/activity room, R2 was seated on a wheelchair. R2 was leaning forward and V17 has to touch and guide R2's chin to	S9999		

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S9999	Continued from page 3 show R2's face to the surveyor. R2 was observed with approximately 1mm x 2mm, 2mm x 2mm, and 3mm x 3mm scabbing above the corner of R2's left eyebrow. R2 was making noises, clenching her teeth. R2 failed to interact with the surveyor. V17 stated that she (R2) needs extensive assistance with bathing. That there should be 2 persons assisting her. That sometimes she (R2) is not redirectable and will not bear her weight. V17 stated, "We need 2 people to safely give her a bath." On 08/01/2025 at 2:10pm, V4 (Certified Nursing Assistant) stated that if a resident is maximum assist with shower, there should be 2-person assisting the resident, that she (V4) took her (R2) to the shower; it was just her during that time and she did not ask other CNAs for assistance. V4 was in front of R2 while she was bathing her. V4 stated R2 tends to lean forward, and she (R2) leaned on her left side, and she (V4) tried to catch her. V4 stated R2 was too heavy for her and she grabbed her (R2) body, trying to protect her (R2) head from the impact but her head still hit the floor. V4 stated that even with the arm rest on both sides of the shower chair and positioned herself (V4) in front of her (R2), she still fell. V4 stated even before the incident on 06/24/2025, she (R2) always leans forward, and she (V4) should have asked for assistance when she gave her (R2) a shower to prevent her from falling. On 08/01/2025 at 12:03pm, V3 (Licensed Practice Nurse) stated that (R2) was being showered and fell; V4 tried to catch her but was unable to do so. That while in the shower room, she (V3) observed R2 with a laceration on the left side above her eyebrow. There were no other staff was present. V3 stated R2 is dependent on everything including shower and that R2 did normally well, but her (R2) trunk control was declining. R2 had poor trunk control prior to the incident. V3 added that there should be 2-person assisting R2 during shower to prevent falls. On 08/01/2025 at 12:31pm, V16 (Restorative Nurse/LPN) stated (R2) is coded substantial/Maximum assist with shower/bathing; that there should be up to 2 people assisting her with shower. R2 is alert only to herself and has a poor safety awareness and for safety, there should be 2 people assisting her with showers. On 08/01/2025 at 2:59pm, V9 (Therapy Director/Speech) stated for safety, she (V9) would recommend 2-person assist with shower. She (R2) has a very poor safety awareness and severe cognitive impairment. The likelihood of her falling could have been minimized.	S9999		

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S9999	Continued from page 4 There is still a possibility she will fall with 2-person assist, but the incident of falls will be minimized. She has poor spatial awareness. She does not recognize leaning forward could cause her to fall. On 08/01/2025 at 1:22pm, V2 (Director of Nursing) stated V4 was disciplined for working in unsafe manner and R2 is 2-person assist with shower. V2 stated if a resident's MDS is coded 2 for Maximum Assist, ADL care should be performed with two people. V2 sated V4 did not follow the 2- person assist and if only she followed the 2-person assist, (R2) would have not fallen. V4's (06/25/2025) Corrective Action documented, in part "Employee Name: (V4). Supervisor: (V2) Suspension. Reason for warning: No work shall be performed in an unsafe manner. The employee (V4) failed to follow safety precautions while giving a shower to a resident (R2) who was identified as a fall risk. Although the resident required the assistance of two caregivers, the CNA took the resident to the shower alone and did not ask for help. Disregard the company protocol led to the resident falling and sustaining an injury." The (06/25/2025) Inservice/Training Sheet documented, in part "Topic: Resident that requires 2 (person) assist should always have 2 people/CNA present in the shower room. Presenter: V2 (Director of Nursing)." The (undated) Residents' Rights for People in Long-Term Care Facilities documented, in part "As a long-term care facility resident in the State, you are guaranteed certain privileges according to rights, protections and State and Federal laws. You have the right to safety and good care. Your facility must provide services to keep you physical health." (B)	S9999		