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 08/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER HOME HISPANIC ELDERLY	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 Complaint Investigations: 2185303/IL136393 2185994/IL137230	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 a) 300.1210 b) 300.1210 d)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	S9999	**Attachment A** **Statement of Licensure Violations**	

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 08/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER HOME HISPANIC ELDERLY	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
S9999	Continued From page 1 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. 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. There requirements are not met as evidenced by: Deficiencies at this level require more than 1 Deficient Practice Statement (DPS): A. Based on observation, interview, and record review, the facility failed to ensure two residents (R1 and R9) at risk for falls were monitored to prevent falls and injuries in a sample of 8	S9999		

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 08/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER HOME HISPANIC ELDERLY	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
S9999	Continued From page 2 residents reviewed for falls. This failure resulted in R1 falling sustaining acute rib fractures and requiring hospitalization, and R9 falling and sustaining a fracture of the right femur requiring surgical repair. B. Based on observation, interview, and record review the facility failed to implement fall interventions for six residents (R2, R3, R4, R5, R6, and R7), in a sample of eight residents reviewed for falls. Findings include: A.1. R1 is 94 years old with diagnosis including, but not limited to, Atrial Fibrillation, Hypertension, Diabetes, Asthma, Osteoarthritis, Dementia, Anxiety, and Urinary Incontinence. R1's cognitive assessment, dated 6/8/21, notes R1 is cognitively impaired with a score of 3. R1's Fall Risk Review, dated 6/04/21, notes R1 is determined to be high risk for falls. Review of R1's care plan, date initiated 3/05/21, notes at risk for falls related to cognitive impairments. R1's cognitive care plan, date initiated 3/12/21, notes R1 is disoriented to time and place. Review of R1's Monthly Summary, dated 7/02/21, notes R1 is at risk for falls. Review of R1's CT of the chest, abdomen, and pelvis, approval date 7/25/21, notes in an Addendum: fractures of the right sixth through eleventh ribs. Fractures of the tenth and eleventh ribs may be chronic, but the remainder appear acute.	S9999		

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 08/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER HOME HISPANIC ELDERLY	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
S9999	Continued From page 3	S9999		

Review of R1's 7/25/21 hospital admission record notes Chief Complaint: fall with rib fractures on right side.

The facility's initial investigation report for R1, dated 7/26/21, notes R1 has rib fractures of ribs 6-11.

The facility final investigation report, dated 7/30/21, notes R1 received report from hospital of rib fracture.

On 8/17/21 at 12:21PM, V9, CNA, said she assisted R1 with her cares and toileting. V9 said for night shift, R1 was incontinent of urine, but on day shift she would toilet R1 every 2 hours. V9 said if she did not assist R1, R1 would try to get up and go to the bathroom, unassisted. V9 said she knew R1 had fallen in the past.

During a phone interview on 8/17/21 at 1:04PM, V4, Registered Nurse (RN), said she was on duty the evening of 7/24/21 on the evening shift, prior to R1's fall. V4 said R1 was "always a fall risk."

On 8/17/21 at 1:26PM, V3, RN, said R1 was confused and forgetful at baseline. V3 said, "I saw (R1) about 11:00PM and 1:00AM. (R1) was in the second bed in the room and had one other roommate located in the bed near the door. On the night of 7/24/21, when (V3) checked her at 11:00PM, (R1) was drifting to sleep, and at 1:00AM (R1) was sleeping." V3 said, "(R3) is incontinent of urine and we just change her, we don't get her up to use the bathroom. While in another room (V3) heard a noise "boom," it sounded like something fell." V3 said, "When I approached (R1's) room I saw the call light was on. I opened the door to the room, and saw (R1)

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 08/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER HOME HISPANIC ELDERLY	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
S9999	Continued From page 4	S9999		

laying on the floor behind the door." V3 said all R1 said was she was going to her "casa" (home). V3 said when she was turning R1 on her left side, R1 said "leg pain." V3 said R1 was wearing a brief and a gown and the floor was wet from R1 being incontinent of urine. V3 said R1 was "a known fall risk." V3 said before the fall R1's "door was closed because R1's roommate wants it closed." V3 said 911 was called, and R1 was taken to the hospital and did not return on her shift.

On 8/17/21 at 2:00PM, V2, Director of Nursing (DON), said he investigated R1's fall. V2 said R1 woke up during the night, was confused, and verbalized she wanted to go home. V2 said he was told V3 and V5, Certified Nursing Assistants (CNAs), said they heard a sound and went to R1's room and saw her on the floor. V2 said he was told R1 was observed sleeping 30 minutes before the fall. V2 said he was not told when R1's incontinent brief was last changed. V2 said before the fall, R1 was not able to safely stand, transfer, or walk independently. V2 said R1 was at risk for falls. V2 said the door to R1's room should not be closed when staff is not in the room.

On 8/17/21 at 2:25PM, during a phone interview, V7, R1's family, said at 2:30AM (07/25/21), V26, R1's son, received a call R1 had fallen and was sent to the hospital. V7 said V26 told V7 that R1 had 6 broken ribs.

On 8/17/21 at 3:43PM, V21, CNA, said R1 would try to get up unassisted. V21 said the door to R1's room was kept closed because R8 wanted it closed.

On 8/18/21 at 10:37AM, V2 said he did not collect a written statement from V5, CNA, working when

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 08/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER HOME HISPANIC ELDERLY	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
S9999	Continued From page 5 R1 fell. V2 said, "I don't recall speaking to him (V5)" about R1's fall. On 8/18/21 at 10:41AM, V12, CNA, said on 7/24/21 she changed R1 into a nightgown and assisted her with toileting around 8:00PM. V12 said she placed a new brief on R1, transferred R1 into bed, and covered her with blankets. V12 said R1 was "drifting to sleep" when V12 left the room. V12 said she closed the door to R1's room when she left the room. V12 said R1 had a history of trying to get up unassisted and R1 was not safe to get up unassisted. V12 said R1 did not know how to use the call light to call for assistance. V12 said she last checked R1 "about 9:30PM" before she ended her shift. V12 said R1 was sleeping and clean, and V12 did not wake R1 up. V12 said after checking R1, she closed the door to R1's room and left the room. On 8/18/21 at 12:00PM, V17, Physician, said after her fall, R1 was taken to the trauma hospital on 7/25/21. V17 said R1 had a history of Cervical #7 and #8 fractures from multiple falls in the community. V17 said before her fall, R1 was stable and at baseline on 7/25/21, alert and oriented times one, and was confused. V17 said R1's diagnoses included Dementia, Atrial Fibrillation, and Incontinence. V17 said R1 had cognitive impairments and walked unsteady. V17 said he expected R1's room door to be open to see if she has any changes because her "mentation is disorganized." V17 said if R1 got up unassisted in her room "she would not be able to navigate her surroundings." A.2. R9 is a 77 year old with diagnoses including but not limited to: Diabetes, Repeated Falls, Dementia, and Weakness	S9999		

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 08/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER HOME HISPANIC ELDERLY	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
S9999	Continued From page 6	S9999		

Review of R9's care plan, revised on 3/24/21, notes R9 has weakness and will have active range of motion exercises to left and right upper extremities and right and left lower extremities for strengthening.

Fall Risk Assessments, dated 6/20/21 and 6/32/21, notes R9 is determined to be high risk for falls.

On 7/11/21, R9 suffered a fall at the nursing home requiring hospitalization due to right leg pain. X-Ray of the right hip, performed on 7/11/21, notes a comminuted intertrochanteric fracture involving the right femur.

Review of R9's hospital records include an X-Ray of the right hip, performed on 7/11/21, note "Comminuted intertrochanteric fracture involving the right femur."

Review of R9's Functional Status assessment, dated 7/7/21, notes R9 required extensive assistance of two persons to provide weight bearing support to transfer between surfaces. R9 required extensive assistance from one staff person to provide weight bearing support with toilet use. Mobility devices used indicate only a wheelchair. The bowel and urinary continence assessment, dated 7/7/21, for R9 notes he was frequently incontinent of bowel and bladder.

Review of R9's care plan, revised on 7/8/21, notes R9 has self care deficit and requires assistance due to Dementia and weakness and requires limited to extensive assistance with most activities of daily living. Intervention, dated 6/24/21, notes wheelchair for weakness.

Review of R9's Progress Notes, dated 7/16/21,

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 08/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER HOME HISPANIC ELDERLY	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
S9999	Continued From page 7 note right hip surgery site is covered with gauze. On 8/20/21 at 10:35AM, R9 was observed sitting up in wheelchair in the dining room being supervised by activity staff. R9 did not give details when surveyor asked him why he is in wheelchair. On 8/24/21 at 12:58PM, V21, CNA, said R9 had a walker in the bathroom, but R9 should not be walking alone into the bathroom. V21 said R9 is known to get up unassisted, because he does not like staff needs to help him. V21 said R9 was in his bed in his room about 30 minutes before she saw him in the bathroom. V21 said R9 would have walked out of his room and past two doors to get into the bathroom. V21 said R9 was in an area not visible from the nurses' station. On 8/24/21 at 2:11PM, V19, Restorative Nurse, said R9 began to use a wheelchair on 6/24/21. V19 said R9 was unable to walk when she assessed R9 on 6/24/21. V19 said on 7/11/21, R9 still required the use of a wheelchair because he was unsteady, unsafe, had weakness, and was not able to ambulate. V19 said R9 was unable to use a walker safely at this time. On 8/24/21 at 2:47PM, V4, Registered Nurse (RN), she said she was working when R9 fell while using a walker and trying to get to the bathroom. V4 said when she entered the bathroom to assess R9 she saw he had been incontinent of urine and loose bowel movement, and bowel movement was on R9 and on the floor. V4 said on 7/11/21, R9 was not able to safely ambulate in the hallway using a walker independently. V4 said she saw R9's right leg was shorter than the left, and it appeared like a fracture. V4 said the ambulance was called to	S9999		

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 08/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER HOME HISPANIC ELDERLY	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
S9999	Continued From page 8 send R9 for evaluation at the hospital. On 8/25/21 at 9:44AM, V2, Director of Nursing, said R9 fell on 6/19/21. V2 said R9 got up from his bed unassisted and fell in his room. V2 said R9 was sent to the hospital following the fall, and when he was readmitted to the facility R9 was in a wheelchair and no longer able to ambulate independently. V2 said R9 got up unassisted on 7/11/21, and was walking using a walker into the bathroom. V2 said R9 was not supposed to have been walking using a walker independently. V2 said R9 did not have a bathroom in his room and had to walk into the hallway to use the bathroom. V2 said the expectation for staff is that they meet the resident needs during rounds. V2 said R9 had been incontinent when he was observed on the floor in the bathroom on 7/11/21. V2 said he was notified verbally by the hospital that R9 suffered a fracture following the fall on 7/11/21. B.1. R2 is 66 years old with diagnoses including, but not limited to Atherosclerotic Heart Disease, Syncope and Collapse, Osteoarthritis, Dementia, Alzheimer's Disease, Delusional Disorder, and History of Falling. R2's Fall Risk Review, dated 8/17/21, notes R2 has been determined to be high risk for falls. Review of the facility Floor Safety Rounds includes following residents and interventions: R2: Call light, floor mat, and bed/wheelchair alarm On 8/17/21 at 11:41AM, surveyor toured with V15, Licensed Practical Nurse (LPN), into R2's room where R2 was sitting in his wheelchair. Surveyor asked V15 if R2 has a chair alarm. V15	S9999		

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 08/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER HOME HISPANIC ELDERLY	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
S9999	Continued From page 9 checked the alarm attached to R2's wheelchair. Surveyor observed with V15 that the clip was not attached to R2 or his clothing, and when she tested the alarm it did not make a sound. B.2. R3 is 90 years old with diagnoses including, but not limited to Adult Failure to Thrive, Repeated Falls, Unsteady on Feet, and Dementia. R3's care plan, date initiated 3/04/20, notes R3 is at risk for falls related to history of falls, cognitive impairments, and unsteadiness on feet. Interventions include "floor mat." Review of the facility Floor Safety Rounds includes following residents and interventions: R3: Floor mat, call light On 8/17/21 at 11:32AM, surveyor observed R3 in his bed and no floor mat observed. On 8/17/21 at 11:41AM, surveyor observed R3 in his bed and no floor mat observed. On 8/17/21 at 12:00PM, surveyor was in R3's room with V16, and asked about floor mats. V16 said R3 should have a floor mat. Surveyor observed a floor mat against the wall in the room. B.3. R4 is 97 years old with diagnoses including, but not limited to of Atherosclerotic Heart Disease, Atrial Fibrillation, Hypertension, Diabetes, Weakness, and Dementia. R4's care plan, revision dated on 10/04/19, indicates R4 is at risk for falls related to cognitive impairments, side effects of medication, unsteadiness on feet. R4's Fall Risk Review	S9999		

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 08/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER HOME HISPANIC ELDERLY	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
S9999	Continued From page 10 notes R4 is at high risk for falls. Review of the facility Floor Safety Rounds includes following residents and interventions R4: Call light On 8/17/21 at 12:01PM, surveyor observed R4's room door closed. Surveyor knocked on door and entered. R4 was sitting in a wheelchair with nothing on her feet, near the window and air conditioning unit. The call light was not visible on the bed. R4 had no call light in reach. R4 was not wearing shoes, slippers, or any foot covering. V16 delivered R4's meal tray and was asked where her (R4's) shoes were. R4 did not answer, and then V16 left the room. V16 did not put any shoes on R4. On 8/18/21 at 2:30PM, V19, Restorative Nurse, said she expects staff to follow the fall prevention interventions. V19 said the floor safety rounds sheet is used so staff can identify who is at risk for falls and what interventions need to be in place to keep them safe. V19 said R4 is at risk for falls and in the falling star program. While reviewing R4's medical record with the surveyor, V19 said R4 had a fall on 5/06/21 and 6/11/21. V19 said R4 should have her call light in reach when she is in her room. V19 said R4 should have shoes on her feet when she is in her wheelchair and she would not be safe to stand without shoes. V19 said R4's room door should not be closed so she can be visualized often by staff in the hall. B.4. R5 is 79 years old with diagnoses including, but not limited to Chronic Obstructive Pulmonary Disease, Diabetes, Rheumatoid Arthritis,	S9999		

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 08/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER HOME HISPANIC ELDERLY	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
S9999	Continued From page 11 Osteoarthritis, Weakness, and History of Falling. R5's care plan, revised on 8/19/19, notes R5 is at risk for falls related to history of falls, weakness, and subsequent fall. R5's Fall Risk Review, dated 7/19/21, notes R5 is at high risk for falls. Review of the facility Floor Safety Rounds includes following residents and interventions R5: Floor mat (X2), call light On 8/17/21 at 11:42AM, surveyor toured with V15 to R5's rooms. R5 in her bed with floor mat under her bed and R5's call light was not in reach. V15 said the mats are not protecting R5 from injury under the bed while V15 placed R5's call light in her reach. On 8/18/21 at 9:55AM, surveyor observed R5 in a wheelchair with the call light not in reach. B.5. R6 is 83 years old with diagnoses including, but not limited to Atherosclerotic Heart Disease, Atrial Fibrillation, Hypertension, Weakness, Dementia, and Alzheimer's Disease. R6's care plan, revised on 12/29/20, notes R6 is at risk for falls related to cognitive impairments. R6's Fall Risk review, dated 6/30/21 notes, R6 is at high risk for falls. Review of the facility Floor Safety Rounds includes following residents and interventions R6: Floor mat, call light, bed/wheelchair alarm On 8/17/21 at 11:49AM, V16, Certified Nursing	S9999		

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 08/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER HOME HISPANIC ELDERLY	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
S9999	Continued From page 12 Assistant, (CNA), toured R6's room with surveyor. R6 was in her bed. V16 said, "I don't know where (R6's) floor mat is." V16 said, "(R6) has no alarm or call light in reach. (R6) is at risk for falls and tries to get up unassisted." V16 called out in hallway that R6 needs a floor mat. V16 then began passing meal trays in the hallway. On 8/18/21 at 9:52AM, surveyor observed R6 in her bed without an alarm and the call light located on the night stand, out of R6's reach. B.6. R7 is 88 years old and with diagnoses including, but not limited to Osteoarthritis of knee, Unsteady on Feet, and Weakness. R7's Fall Risk Review, dated 5/21/21, notes R7 is at high risk for falls. R7's care plan notes she has cognitive impairments, and care plan, revised on 7/13/21, notes R7 is at risk for falls related to history of falls On 8/17/21 at 12:17PM, surveyor observed the shared door to R7's and R8's room closed. R8 was R1's roommate on 7/25/21. On 8/18/21 at 1:10PM, surveyor observed R8's (and R7's) room door closed. Surveyor knocked on the door and entered. R8 acknowledged surveyor and pointed to her ears and gestured for surveyor to go. R8 was R1's roommate and surveyor was attempting to interview R8 regarding R1's fall on 7/25/21. R7 is now R8's roommate, and R7 said R8 wants the door to be kept closed. R7 said if the door is not closed then R8 begins to yell "door, door" until someone closes the door. On 8-18-21 at 2:30 PM, V19 said R8 likes to have her room door closed. V19 said R8 was R1's	S9999		

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 08/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER HOME HISPANIC ELDERLY	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
S9999	Continued From page 13 roommate and is now R7's roommate. V19 said R7 is at risk for falls. The facility's undated Fall Prevention Program notes: 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 the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary. 16. All nursing personnel will be informed of residents who are at risk of falling. 17. Residents at risk of falling will be assisted with toileting needs. 19. Footwear will be monitored to ensure the resident has proper fitting shoes or footwear is non skid. (A)	S9999		