Illinois Department of Public Health

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 09/24/2022

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 Investigation 2287582/IL151471	S 000		
S9999	Final Observations Statement of Licensure Violation 300.610a) 300.1210a) 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	S9999	Attachment A Statement of Licensure Violations	

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

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S9999	Continued From page 1	S9999		

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)

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 regulations were not met as evidenced by:

Based on interview and record review, the facility failed to update a residents care plan and failed to ensure that residents remain free from abuse for one of three residents (R1) reviewed for abuse in the sample of three. This failure resulted in R2, a resident with known aggressive behavior, pushing R1 and causing R1 to strike their head before falling on the floor. R1 was sent to the hospital for evaluation and treatment of a bump to R1's head.

Findings include:

R1's medical record (Face Sheet, Minimum Data

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S9999	Continued From page 2 Set) notes R1 is a moderately cognitively impaired 94-year-old admitted to the facility on 8//10/2022 with diagnoses including but not limited to: Heart Failure, Vascular Dementia, Atherosclerosis of Renal Artery, and Type 2 Diabetes Mellitus. R2's medical record (Face Sheet, Minimum Data Set) notes R2 is a severely cognitively impaired 74-year-old admitted to the facility on 9/23/2020 with diagnoses including but not limited to: Atherosclerotic Heart Disease, Paranoid Schizophrenia, Psychosis, Dementia, and Bipolar Disorder. Facility's final incident report (9/24/2022) notes in part, R1 allegedly had a physical encounter with co-peer R2, which caused alleged victim, R1, to lose balance and fall. R1 alleged that "esa vieja me empujo", (that old lady pushed me). R1 was sent out to the hospital for medical evaluation and R2 was sent out to hospital for psych evaluation. R1's Progress Notes, on 9/16/2022 at 10:45 AM, notes in part, "@Approximately 10:45am Resident Allegedly receive Physical Contact from Peer. Immediately Complete Body assessment done Lump observed to Left side back of the Head." R2's Progress Notes, on 9/16/2022 at 7:00 AM, note in part, At approximately 6:50 am resident allegedly had physical contact with peer. Resident was immediately Separate and place on 1:1 monitoring. Resident refused body assessment and vital signs to be taken. Spoke to NP give orders for Resident be sent out to (local hospital) for Psych elevation. At 5:59 PM, writer contacted sister and POA(Power of Attorney) of (R2) and informed her that an Involuntary Discharge Notice	S9999		

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S9999	Continued From page 3	S9999		

has been issued to (R2). (Sister) verbalized understanding and thanked me and facility for taking care of (R2) all these years. She voiced that she knows that it's difficult to take care of (R2) when (R2) doesn't want to take (R2's) medication.

R2's "Low Frustration Tolerance" care plan, initiated 7/30/2018, revised 11/20/2018, notes in part, "R1 may become physical with others". There are no additional interventions to address R2's aggressive behavior of 9/6/2022.

V1 (Administrator) on 9/24/2022 at 12:50 PM said, V3 (Assistant Administrator) reported they heard a yell, ran, and saw R1 on the floor. V1 said they reviewed video of incident. R2 was in their room, R1 was walking down the hallway. R2 is seen coming out of their room, R2 can be seen pushing R1. R1 is seen falling backwards on the floor, apparently hitting their back on handrail before landing on floor. V1 said R2 has a history of prior unwitnessed physical altercations in the past with other residents where R2 was the aggressor. There was a previous incident with R1 and R2 this month, it was reported to IDPH (Illinois Department of Public Health). Surveyor asked V1 what interventions were in place to address R2's aggressive behavior, V1 responded, re-direction, if that didn't work, call PCP, look at medications,
refer to psych.

V3 (Assistant Administrator) on 9/24/2022 at 1:29 PM said, R1 allegedly had an incident with R2 but we didn't know what it was, it was just hearsay. R1 reported, earlier this month, that R2 smacked R1. There were no witnesses, we did investigate, but were unable prove anything.

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S9999	Continued From page 4 R1, on 9/24/2022 at 2:12 PM said, "R2 pushed me. I didn't say anything to R2 (before R2 pushed R1). R1 said R2 could hurt me. I hit my head before I fell on the floor". R2 was not available for interview. V5, (Certified Nursing Assistant) on9/24/2022 at 2:32 PM said, "I heard someone scream. I ran around the corner, that's when R2 came past me, and I saw R1 on the floor. R2 didn't say anything to me, they just walked by real fast. R1 said "R2 pushed me". V5 said, R2 paced around and talked to herself, I'm not aware of any incidents of physical abuse (where R2 was the aggressor). Facility's Abuse Prevention Policy (effective November 22, 2017) notes in part, Residents have the right to be free from abuse ...Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means ...Abuse is the infliction of injury on a resident that occurs other than by accidental means and that requires medical attention. B	S9999		