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 10/27/2023

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

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S 000	Initial Comments Complaint Investigation: 2387641/IL00164361 Investigation of Facility Reported Incident of 9-11-2023/IL165240	S 000		
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	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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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)

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 requirments were not met as evidenced by:

Based on observation, interview and review of records, the facility failed as follows: Failed to supervise and monitor an elopement risk resident

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with behavioral needs. Failed to maintain the right of a resident to be safe related to accessing facility area (stairwell). Failed to complete a comprehensive assessment for a newly admitted resident. Failed to follow individualized care plan policy in addressing hip precaution or safety measures on the plan of care for a resident that had undergone hip surgery. Failed to investigate an incident for a hip prosthesis dislocation. These failures affected 2 (R1, R2) out of 3 residents reviewed for safety, hazards, and incidents on a total sample of 5 residents. This failure resulted in (R2) sustaining a left hip fracture after a fall.

Findings include:

1. R2 was 83 years old, initially admitted on 8/7/2020 with diagnosis of dementia, psychotic disturbance, mood disturbance, and anxiety. Progress notes of R2 dated 9/11/2023 by V3 (Licensed Practical Nurse) documents that R2 was sitting in an upright position on the stairs. R2 was sent to the hospital. Notes of V2 (Former Director of Nursing) documents that hospital diagnosis was left hip fracture.

On 10/24/2023 at 1:35 PM, V1 (Administrator) stated during the incident that happened night of 9/11/2023. She (V1) was the staff that first saw R2 on the stairwell. Per V1, R2 used the elevator to go from first floor to ground floor. R2 then went to the door and pushed the button to get into the stairwell. R2 was found on the stairwell east side. V1 stated when R2 was asked, R2 stated, "I (R2) rode the elevator down to go to work. I go (sic) back up and lost my balance and fell. " V1 presented a written statement that reads as follows: R2 was noted sitting on the ground floor stairwell on the east side, on 9/11/2023. When I

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(V1) asked R2 what happened. R2 stated that he rode the elevator down to go to work. And I go (sic) back up and lost my balance and fell.

On 10/24/23 at 1:57 PM, V16 (Restorative Nurse / Licensed Practical Nurse) stated that R2 was an elopement risk and needs monitoring and supervision. R2 sometimes goes down to the ground floor from first floor. V16 stated that residents are not allowed to go to the stairwell.

On 10/24/23 at 2:42 PM, V2 (Former Director of Nursing) stated that he received a call regarding fall incident of R2. V2 stated that R2 needs to be monitored and preventative measures because R2 was an elopement risk. V2 said that residents are not allowed in the stairwell. And that alarm will go off upon entering the stairwell.

On an earlier note, by V17 (Registered Nurse) dated 9/11/2023, before R2 fell on the stairwell it was documented. R2 had two episodes of agitation and confusion at about 1:30 AM and 3:00 AM, insisting he has to go to work. R2 has multiple attempts to leave the facility. R2 needs frequent monitoring and one on one supervision.

On 10/24/23 at 3:23 PM, with V12 (Maintenance Director) checked both doors going into the stairwells located at the ground floor. Both doors when entering going to the stairwells does have a doorbell-like button. Once pressed and upon opening the door, the alarm does not sound. Inside the stairwells there was the pad where the code needs to be entered before going out of the stairwells. V12 stated that once the doorbell-like button is pressed it disables the alarm for 5 seconds. Once the door is open it disables the alarm for 10 more seconds. The person then is able to enter the stairwell without the alarm

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sounding. If R2 was able to enter without sounding the alarm, I think it would be a good idea to place the code pad outside the stairwell. Because every time someone goes inside the stairwell, they need to put the code first. Earlier at 10:39 AM, upper floors (first, second, and third) were seen with keypads that a code was needed before entering the stairwell. Unlike on the ground floor where keypad was located inside the stairwell for code to be used when exiting the stairwell.

Care plan of R2 documents that R2 is a fall and elopement risk. Under elopement intervention: R2 needs preventative intervention strategies that includes make rounds and room checks per facility protocol to minimize chance of unauthorized leave.

Unusual Occurrence Report Form dated 9/12/2023 initial report documents, that R2 was sent to ER (Emergency Room) in the hospital. X-ray was done, there is evidence of injury bruising to left eye and with left lower extremity pain. Report obtained from (local hospital), resident admitted with diagnosis of left hip fracture.

On 10/26/2023 at 11:45 AM. V3 (Licensed Practical Nurse) upon hearing the name of R2 stated, "I am a nurse not a babysitter. "V3 stated that R2 has dementia and was wandering a lot that day. Proximity of time the incident happened was about 8:00 PM. R2 was trying to escape all day. V3 said, "I do med pass, watch residents, and do patient care. I cannot do all those things."

Elopement Risk Assessment policy dated 5/14, reads: the purpose is to identify residents who may be potentially at risk for elopement and at

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risk for harm. To use a baseline to maintain a secure resident environment. The Social Service Department will notify facility staff and initiate interventions necessary to protect the resident. Intervention include one-on-one observation.

2. R1 was 71 years old, initially admitted in the facility on 8/23/2023 and was discharged on 8/26/2023. R1 was admitted in the facility for orthopedic aftercare due to left artificial hip joint. R1's progress notes dated 8/25/2023 by V2 (Former Director of Nursing) documents erythema to left hip was observed and an order for total left hip x-ray. X-ray result dated 8/25/2023 documents R1 has dislocated hip prosthesis. Progress notes dated 8/26/2023 by V14 (Licensed Practical Nurse) documents that R1 was sent to hospital.

On 10/24/2023 at 1:34 PM, V15 (Minimum Data Set / Licensed Practical Nurse) stated that she works on the floor, so she knows what nurses use as an assessment tool. V15 stated that the assessment form that needs to be filled up on every admission is called Admission/Readmission Screener. This assessment has everything in itself to familiarize with the resident. It covers head-to-toe assessment, vital signs, skin assessment, ADLs (Activity of Daily Living) or how much assistance the resident needs. R1's Admission/Readmission Screener dated 8/23/2023 was not completed, almost all sections were not filled up except for allergies and vital signs. R1 does not have any full assessment during admission on record. V15 stated I noticed that it was not done. R1's care plan also does not address hip precautions. V15 stated, "I cannot find anything that addresses proper transfer (technique) for R1's hip replacement. "V15 was

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asked to present an incident report related to R1's dislocated hip. V15 stated that V1 (Administrator) informed her that a report was not done. At 2:20 PM, there was no incident report that was done when R1's X-ray was taken and R1 was sent to the hospital.

On 10/24/2023 at 2:42 PM, V2 (Former Director of Nursing) stated that R1 needs hip precaution. And stated that he (V2) was the first person to notice irregularities of R1's left hip. None of the staff informed him. V2 said that incident report and investigation is needed when there is a change of condition. But he (V2) cannot remember if he made an incident report. What he can remember was that he spoke to V13 (Certified Nursing Assistant) about the incident. V2 said he cannot remember the nurse.

On 10/26/2023 at 10:15 AM, V14 (Licensed Practical Nurse) stated that she cannot remember R1 because a lot of residents needed attention. After informing V14 that R1's family member spoke to her multiple times about R1 hip after therapy during transfer from wheelchair to bed. V14 stated, "Now I remember. " V14 stated that either R1's son or daughter told her that a staff moved or transferred R1 and caused hip redness and pain. V14 said, "R1's family was here almost every day. "V14 stated that she explained to either the son or daughter that when R1 was moved or transferred it happened on a previous shift. V14 stated, "I do remember a staff transferred R1, but I forgot the name of the staff. "When asked to elaborate V14 also said that she forgot how the transfer happened. Then V14 said, V2 was covering the floor before she (V14) arrived. And that she (V14) only covered the floor due to original nurse that was scheduled did not arrive. V14 stated that x-ray was followed up the

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next day and the result was dislocation of hip.

On 10/26/2023 at 11:39 AM, V18 (Physical Therapy Director) stated that he (V18) did the exercise with R1 on 8/25/2023 and it was in the morning time. But V18 cannot remember the exact time. V18 stated that after therapy, R1 was endorsed to a CNA (Certified Nursing Assistant) but he cannot remember who, or if it was a male or female CNA. V18 said that there was no problem with the wheelchair R1 used. Nursing staff that was working in the morning shift on 8/25/2023 were interviewed (V22/Licensed Practical Nurse, V13/Certified Nursing Assistant) both denied transferring R1 the whole shift.

On 10/26/23 at 1:20 PM, V20 (Restorative Aide) stated that R1 was using the wheelchair of her roommate who was in the hospital during that time. The wheelchair was a little big for R1's size. And that therapy was on the process of getting R1 her wheelchair.

Admission of Resident Policy dated 4/14, reads:

The purpose is to facilitate smooth transition into a health care environment. To gather comprehensive information as a basis for planning individualized therapeutic care. To ensure adherence to facility policies. Equipment during admission of residents includes assessment tool. Conduct head-to-toe nursing assessment of body system, parts, and surfaces identifying functional status abilities, needs, or problem. Complete other admission forms within 72 hours and begin resident care plan. Under care plan policy with the same date, reads: All residents will have comprehensive assessments and individualized plan of care developed to assist them in achieving and maintaining their

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