STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146062	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center Home Hispanic Elderly	1401 North California Chicago, IL 60622

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. 45346 Based on interview and record review the facility failed to follow their policy on involuntary transfer by failing to send the appropriate paperwork with one resident (R2) who required involuntary transfer to the hospital and as a result R2 returned to the facility without treatment and had to wait for the paperwork to be send out to emergency again for treatment. This failure has the potential to affect one of three residents (R2) reviewed for transfer/discharge on the total sample of 23. Findings include: On 04/10/2024 at 12:06pm V11 (LPN/Licensed Practical Nurse) stated on 3/26/2024 I sent R2 out to the hospital. V11 stated R2 started saying that, we all have the devil in us. V11 stated R2 was making cat like noises. V11 stated R2 seemed as if she was possessed. V11 stated I called R2's psychiatrist and R2's doctor regarding the behaviors R2 was exhibiting and both doctors stated to send R2 out to the hospital for evaluation. V11 stated I called 911 and 911 came to the facility to take R2 to the hospital. V11 stated R2 returned from the hospital during my shift. V11 stated R2 was exhibiting the same behaviors and I told the emergency medical technicians I was not accepting R2 back into the facility. V11 stated I did not receive the hospital paperwork from the emergency medical technician when R2 returned from the hospital. V11 stated R2 remained on the stretcher and V17 (Social Services Director) completed the petition to send R2 back to the hospital. V11 stated the emergency medical technicians took R2 back to the hospital. V11 stated I did not send an involuntary petition to the hospital with R2. V11 stated I now know a petition is required when sending a resident to the hospital for evaluation for psychiatric behaviors. On 4/10/2024 at 2:44pm V1 (Administrator) stated on 3/26/2024 R2 went out to the hospital for behaviors. V1 stated every shift has a staff person who can complete the petition when a resident needs to be sent to the hospital due to behaviors. V1 stated the hospital did not admit R2 the first time R2 was sent to the hospital on 3/26/2024. I do not know why R2 was not admitted to the hospital. V1 stated when R2 returned to this facility a petition was prepared and R2 went back out with the same emergency technicians who brought R2 to the facility, to the same hospital. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/10/2024 at 3:15pm V3 (DON/Director of Nursing) stated the social worker is responsible for completing the paperwork for a petition when a resident needs to go to the hospital due to behaviors. V3 stated the nurses are to complete the petition paperwork after hours and when the social worker is not in the facility. V3 stated it is my expectation that all nurses working in the facility are able to complete the petition paperwork when the resident needs to be sent to the hospital due to behaviors. On 4/10/2024 at 3:45pm V15 (RN/Registered Nurse) stated R2 went out to the hospital on 3/26/2024 but returned to the facility a few hours later. V15 stated when R2 returned from the hospital R2 was still cursing at facility staff. V15 stated petition paperwork is supposed to go with the resident when the resident goes to the hospital due to behaviors. V15 stated I still don't know the complete process for completing the paperwork for a petition. V15 stated the social worker does not always have to complete the petition paperwork. On 4/11/2024 at 10:24am V17 (Social Service Director) stated if there is no doctor on-site to complete a petition when a resident needs to be sent to the hospital due to behaviors then the nurses or social services staff can complete the petition. V17 stated the DON did tell me that there are some nurses at the facility who do not know how to complete the petition and I was asked by the DON to do an in-service with those nurses. The facility's undated policy titled Involuntary Discharge or Transfer documents in part, A. Policy: The facility will provide proper procedure and notification of an involuntary transfer or discharge pursuant to the regulations of the Health Care Financing Administration for States and long-term care facilities, 42 CFR 438. 12(federal regulations); and State rules and regulations. Procedure: Reasons for transfer or discharge a. the resident's welfare cannot be met at the facility. c. the health and /or safety of individuals in the facility are endangered. R2's Petition for Involuntary/Judicial Admission was completed by V17(Social Services Director) on 3/26/2024 at 2:20pm. The facility's undated LPN (Licensed Practical Nurse) job description documents in part, Essential Duties and Responsibilities: 4. Perform administrative duties such as completing medical forms, charting, reports, etc. 9. Admit, discharge and transfer residents as required. 40. Other duties as assigned that fall within scope of nursing practice. The facility's undated RN (Registered Nurse) job description documents in part, Essential Duties and Responsibilities: 4. Perform administrative duties such as completing medical forms, charting, reports, etc. 9. Admit, discharge and transfer residents as required. 40. Other duties as assigned that fall within scope of nursing practice.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41611 Based on interview and record review the facility failed to ensure the nurses provided care, in accordance with professional standards of care for one (R3) of four residents who was experiencing a reduction in oxygenation and a delay in receiving emergency medical attention reviewed for change in condition on the total sample of 23. Findings include: R3 has a diagnosis of but not limited to Orthopedic Aftercare, Displaced Fracture of Medial Malleolus of Left Tibia, Subsequent Encounter for Closed Fracture With Routine Healing, Contusion of Unspecified Part of Head, Subsequent Encounter, Malaise, Osteoarthritis, Gastro-Esophageal Reflux Disease Without Esophagitis, Chronic Kidney Disease Stage 3 And Age-Related Osteoporosis Without Current Pathological Fracture. R3's Minimum Data Set (MDS) dated [DATE] documents, in part, a Brief Interview of Mental Status score of 08 that suggests moderate cognitive impairment. Local hospital record dated [DATE] reads, in part, R3's arrival time 9:28am with diagnosis of Sepsis, unspecified Organism and Acute Respiratory Failure with Hypoxia, Respiratory Insufficiency, Septic Shock. R3's hospital records also reads, in part, R3's discharge information that reads discharge date /time [DATE] at 11:30am and discharge disposition expired. Progress note dated [DATE] at 6:08am by V24 reads, in part, R3 was noted pale. Progress note dated [DATE] at 6:20am by V5 (Licensed Practical Nurse-LPN) reads: at approximately 3:20 am V5 (LPN) went to check on the R3 during rounds and R3's hands were cool to touch with a SPo2 (peripheral Capillary Oxygen Saturation) of 84%. At 6 AM during rounds and med pass R3 SPo2 went to 82%. R3 DNR (Do Not Resuscitate) will continue to monitor. DON (Director of Nursing) aware. V8 (Medical Doctor) notified. BP ,d+[DATE] T 96.7 SPo2 82% RA (room air). Progress note dated [DATE] at 6:57am by V6 (LPN) reads: received R3 in bed lethargic and SOB (shortness of breath) sating at 87% O2 at 4l/nc (nasal cannula) skin cool to touch R3 able to respond to tactile stimuli. HOB (head of the bed) elevated 45 degrees. b/p (blood pressure) ,d+[DATE]-,d+[DATE].5. R3 DNR will continue to monitor. DON aware. On [DATE] at about 1:00pm Surveyor reviewed progress notes for [DATE] and there were no progress notes for the 1st (6:00am-2:30pm) or 2nd shift (2:00pm-10:30pm) regarding R3's medical status. Surveyor also reviewed R3's progress notes for [DATE] and V5 (LPN) does not document giving R3 oxygen when R3's oxygenation levels were 84% (3:20am) and 82% (6:00am) on [DATE]. On [DATE] at about 3:00pm surveyor reviewed R3's weights/vitals in Point Click Care software (PCC) and there were no vitals listed for [DATE]. Surveyor also reviewed progress notes for [DATE] and there were partial vitals listed at 6:20am (BP ,d+[DATE] T 96.7 SPo2 82% RA) by V5 and at 6:57am (at 87% O2 at 4l/nc {nasal cannula}, ,d+[DATE]-,d+[DATE].5) by V6. (continued on next page)

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Center Home Hispanic Elderly	1401 North California Chicago, IL 60622

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 12:10pm V5 (LPN) stated R3's oxygenation level was 84% at about 3:20am on [DATE] and that she (V5) did not place oxygen on R3 until V6 (LPN) came in, which was at about 5:55am, because she (V6) assisted her (V5) with placing oxygen on R3. V5 (LPN) stated in interview if a person has a DNR there are no interventions that should be provided. R3 had a code status of DNR (DO NOT RESUSCTATE) and I (V5) kept R3 cleaned and comfortable. V5 stated that she (V5) monitored R3 (kept clean and comfortable) frequently, every thirty minutes or so, but did not chart what interventions were done. V5 stated that she attempted to contact the doctor, nurse practitioner and the Director of Nursing and no one answered the phone. On [DATE] at 2:06pm V8 (Medical Doctor-MD) stated if a resident is having shortness of breath and oxygenation is 92% or below you will place oxygen at 2 liters nasal cannula and call 911. V8 also stated that the nurse can use her nursing judgement to send a resident to the hospital if they are having issues with breathing and their oxygenation levels are below normal. On [DATE] at 12:34pm by V6 (Licensed Practical Nurse) stated that R3 did not have oxygen on when she arrived at 5:50am on [DATE] and her skin was cool to touch and R3 was responding to me by opening her eyes. V6 said V5 told her (V6) that R3 was not doing good and that R3 was not breathing well and I (V6) asked V5 did she (V5) give R3 oxygen and V5 said no because V5 could not find it. V6 said she placed an oxygen mask on R3 but R3 kept trying to pull it off so I switched it over to a nasal cannula and opened it all the way up. I put her on 4 liters of oxygen and R3 oxygen was at 87%. V6 (LPN) stated that V5 (LPN) told her that she spoke with V3 (DON) who asked her about R3's code status, which was DNR, and V3 (DON) told V5 (LPN) to monitor R3. V6 (LPN) stated from the time, she (V6) placed the oxygen on R3 her oxygen levels began to fluctuate. V6 (LPN) stated R3 was responding to the oxygen therapy and the treatment nurse was doing her treatment and that is the reason why she was still in the building. The CNA (certified nursing assistant) got R3 out of the bed to eat and I told her that R3 can't eat and to put R3 back in the bed. On [DATE] at 9:27am V8 (MD) stated that he did review R3's chart briefly and that he had missed a call from the facility at around 3:30am on [DATE] but spoke with someone briefly early that morning around 7:00am and told them (V6) to apply oxygen and to monitor R3. V8 stated he (V8) would expect for them (the nurses) to monitor R3 at least every 15 minutes to 30 minutes depending on how she (R3) is doing. V8 also stated that R3's DNR status and co morbidities does not change his answer that the nurse should have applied oxygen (2-Liters nasal cannula) and send R3 to the hospital via 911. R3's POLST (dated [DATE] reads, in part, A: Do Not Attempt Resuscitation/DNR, B: Selective Treatment: Primary goal of treating medical conditions with selected medical measures. In addition to treatment described in Comfort-Focused Treatment (relieve pain and suffering through the use of medication by any route as needed; use oxygen), use medical treatment, IV (Intravenous) fluids and IV medications as medically appropriate and consistent with patient preference. Undated job description titled LPN Job Description reads, in part, the primary purpose of your job position is to provide direct nursing care to the residents, 2. Ensure that resident care procedures are followed in rendering nursing care, 4. Perform administrative duties as charting, 12. Chart nursing progress notes in an informative and descriptive manner that reflects the care provided to the residents as well as the resident's response, and 23. Make independent decisions concerning nursing care. (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	Policy titled Physician Orders dated ,d+[DATE] reads, in part, these guidelines are to ensure that 1. Changes in resident status/condition are assessed and physician notification is based on assessment findings and is to be documented in the medical record and 2. Any orders given by Physician are carried out. Policy titled Change in Condition Physician Notification Overview Guidelines dated ,d+[DATE], documents, in part, 3. Medical care emergency problems are communicated to attending physician and family immediately (generally within two (2) hours or sooner), A. Any calls to or from physician will be documented in the nurse's notes indicating information conveyed and received and E. The nurse shall indicate in the nurses notes ongoing conversations with the physician regarding response to notification (phone calls) of changes in condition.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41611 Based on interview and record review the facility failed to provide emergency treatment and care for a resident (R3) with a low oxygen level, in accordance with professional standards of care, and failed to immediately contact 911 for an acute change in condition for R3 based on R3's code status of Do Not Resuscitate. This failure resulted in R3 not receiving timely care and treatment until 6 hours after the change in condition requiring hospitalization with admission diagnosis of Acute Respiratory Failure with Hypoxia (Deficiency In The Amount Of Oxygen Reaching The Tissues), Sepsis, Metabolic Encephalopathy, Severe Sepsis with Septic Shock, Urinary Tract Infection, Acidosis, and Coagulation Defect, and subsequently expiring at the hospital. This failure affected one (R3) of four residents reviewed for change in condition on the total sample list of 23. This was identified as an Immediate Jeopardy that began on [DATE]. R3's progress notes dated [DATE] at 6:20am by V5 (LPN) documents that at approximately 3:20 am V5 went to check on the R3 during rounds and R3's hands were cool to touch with a SPo2 of 84% (blood oxygen level of 84% measured with a pulse oximeter) and at 6 AM during rounds and med pass R3's SPo2 went to 82%. Progress notes reads: R3 DNR will continue to monitor. V5 does not document providing oxygen to R3 for oxygen saturation levels of 84% (3:20am) or 82% 6:00am). R3's POLST (Physician Orders for Life Sustaining Treatment) dated [DATE] documents A: Do Not Attempt Resuscitation/DNR, B: Selective Treatment: Primary goal of treating medical conditions with selected medical measures. In addition to treatment described in Comfort-Focused Treatment (relieve pain and suffering through the use of medication by any route as needed; use oxygen), use medical treatment, IV (Intravenous) fluids and IV medications as medically appropriate and consistent with patient preference. V1 (Administrator), V2 (Assistant Administrator), V3 (Director of Nursing) and V4 (Regional Nurse Consultant) were notified of the immediate jeopardy on [DATE] at 10:12am. The surveyor confirmed by interview and record review that the Immediate Jeopardy was removed on [DATE], but noncompliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of their Removal plan and Quality Assurance monitoring. Findings include: R3's Face sheet documents that R3 has a diagnosis of, but not limited to, Orthopedic Aftercare, Displaced Fracture of Medial Malleolus of Left Tibia, Subsequent Encounter for Closed Fracture With Routine Healing, Contusion of Unspecified Part of Head, Subsequent Encounter, Malaise, Osteoarthritis, Gastro-Esophageal Reflux Disease Without Esophagitis, Chronic Kidney Disease Stage 3 And Age-Related Osteoporosis Without Current Pathological Fracture. R3's Minimum Data Set (MDS) dated [DATE] documents, in part, a Brief Interview of Mental Status score of 08 that suggests moderate cognitive impairment. Progress note dated [DATE] at 6:08am by V24 reads, in part, R3 was noted pale. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Surveyor reviewed progress notes for [DATE] and there were no progress notes from V25 (LPN) on the 1st shift (6:00am-2:30pm) and V15 (Registered Nurse-RN) on the 2nd shift (2:00pm-10:30pm) regarding R3's change in condition. 24-hour Shift Report dated [DATE] does not have any documentation about R3's change in condition on the 1st, 2nd or 3rd shift. Progress note dated [DATE] at 6:20am by V5 (Licensed Practical Nurse-LPN) reads at approximately 3:20 am V5 went to check on the R3 during rounds and R3's hands were cool to touch with a SPo2 of 84%. At 6 AM during rounds and med pass R3 SPo2 went to 82%. R3 DNR will continue to monitor. DON aware. V8 (Physician) notified. BP ,d+[DATE] T 96.7 SPo2 82% RA. On [DATE] at about 1:00pm surveyor reviewed the Nursing Daily Staffing Sheet that documents, in part, on [DATE] there was no Registered Nurse (RN) that was scheduled or worked the 10:00pm-6:30am shift. Surveyor reviewed progress notes for [DATE] and there were no progress notes for the 1st (6:00am-2:30pm) or 2nd shift (2:00pm-10:30pm) regarding R3's medical status. Surveyor also reviewed R3's progress notes for [DATE] and V5 (LPN) does not document giving R3 oxygen when R3's oxygenation levels were 84% (3:20am) and 82% (6:00am) on [DATE]. Progress note dated [DATE] at 6:57am by V6 (Registered Nurse-RN) reads received R3 in bed lethargic and SOB (shortness of breath) sating at 87% O2 at 4l/nc (nasal cannula) skin cool to touch R3 able to respond to tactile stimuli. HOB (head of the bed) elevated 45 degrees. b/p (blood pressure) ,d+[DATE]-,d+[DATE].5. R3 DNR will continue to monitor. DON (Director of Nursing) aware. Progress note dated [DATE] at 9:04am by V6 reads R3's vitals declining NP (Nurse Practitioner) notified with orders to send R3 to hospital. 911 called. Progress noted dated [DATE] at 9:11am V6 reads 911 Arrives R3 in route to nearest hospital. Local hospital record dated [DATE] reads, in part, R3's arrival time 9:28am with diagnosis of Sepsis, unspecified Organism and Acute Respiratory Failure with Hypoxia, Respiratory Insufficiency, Septic Shock. R3's hospital records also reads, in part, R3's discharge information that reads discharge date /time [DATE] at 11:30am and discharge disposition expired. Local hospital record dated [DATE] reads, R3 presents to Emergency Department (ED) for respiratory distress and hypotension and EMS (Emergency Medical Services) reports that nursing home states that approximately 3 AM they noticed her breathing was labored and her oxygen was low. On arrival of EMS patient was still hypoxic and was hypotensive. She (R3) was placed on a nonrebreather. Diagnoses this visit reads, in part, Respiratory Insufficiency (when the lungs cannot get enough oxygen into the blood). R3's hospital laboratory values at 9:51am reads [NAME] Blood Cells (WBC) 24.8 (H: higher than normal levels), Platelets 146 (L: lower than normal levels), RBC (Red Blood Cells) 3.20 (L), (Hemoglobin 10.6 (L) and Lactic Acid level of 4.9 (HH). Red blood cells measure the number of oxygen-carrying blood cells in your body. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Article titled Hemoglobin Test on website mayclinic.org documents, in part, Hemoglobin measures the amount of a protein in red blood cells. Hemoglobin carries oxygen to the body's organs and tissues when you breath in and then it carries waste gas carbon dioxide back to the lungs to be breathed out. Article titled Lactic Acid Blood Test: What Your Levels mean from website www.webmd.com documents, in part, lactic acid is made in muscle cells and red blood cells. It forms when your body turns food into energy. (Your body relies on this energy when its oxygen levels are low). Local hospital record dated [DATE] also reads, in part, leukocytosis present, lactic acid is severely elevated, and R3 has severe metabolic acidosis (the chemical balance of acids and bases in your blood get thrown off. This can happen when your body: is making too much acid, isn't getting rid of enough acid and doesn't have enough base to offset a normal amount of acid.) On [DATE] at about 3:00pm surveyor reviewed R3's weights/vitals in Point Click Care software (PCC) and there were no vitals listed for [DATE]. Surveyor also reviewed progress notes for [DATE] and there were partial vitals listed at 6:20am (BP ,d+[DATE] T 96.7 SPo2 82% RA) and at 6:57am (at 87% O2 at 4l/nc {nasal canula}, ,d+[DATE]-,d+[DATE].5). On [DATE] at 12:10pm V5 (Licensed Practical Nurse-LPN) stated in interview if a person has a DNR there are no interventions that should be provided and with a DNR you should keep the R3 cleaned and comfortable. V5 stated R3's oxygenation level was 84% at about 3:20am on [DATE] and that she (V5) did not place oxygen on R3 until V6 came in, which was at about 5:55am, because she (V6) assisted her (V5) with placing oxygen on R3. V5 stated that she (V5) monitored R3 (kept clean and comfortable) frequently, every thirty minutes or so, but did not chart what interventions were done. On [DATE] at 2:06pm V8 (Medical Doctor-MD) stated if a patient is having shortness of breath and oxygenation is 92% or below you will place oxygen at 2 liters nasal cannula and call 911. V8 stated that care should be provided to a resident regardless of their code status (DNR or not) and timely care is necessary. V8 also stated that the nurse can use her nursing judgement to send a resident to the hospital if they are having issues with breathing and their oxygenation levels are below normal. On [DATE] at 2:31pm V3 (Director of Nursing-DON) stated if they (residents) are a DNR and they are declining, the nurses are still expected to provide care to the residents. DNR does not mean that a nurse does not provide care and care still needs to be provided. V3 also stated there is a standing order to give 2 Liter of oxygen via nasal canula and keep them (the resident) comfortable for someone who is having trouble breathing and I (V6) would expect for them (nurses)to use their nursing judgement and send the resident out via 911 and then the staff can call the MD, DON and the family. The nurse should be looking to see if they have labored breathing or panting, use of accessory muscles and use a pulse oximeter to determine the oxygenation level. If the oxygenation readings are in the 80's you would definitely start to give the resident oxygen 2liters via nasal cannula. It is expected for the nurse to call 911, raise head of bed, and use any measure to assist with opening the airway and not giving them water or fluids. Surveyor asked if they should wait to send resident out and V6 stated No, I would expect for them to place the resident on oxygen and immediately contact 911. The resident will continue to decline, and death could occur if oxygen is not given, and the resident is not sent to the hospital. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at about 3:41pm surveyor reviewed hospital records from [DATE] that reads R3 was admitted with diagnosis of acute respiratory failure with hypoxia, sepsis, metabolic encephalopathy, severe sepsis with septic shock, urinary tract infection, acidosis, and coagulation defect. R3's hospital records reads: discharge disposition expired on [DATE] at 11:30am. On [DATE] at 12:34pm by V6 (Licensed Practical Nurse) stated that R3 did not have oxygen on when she arrived at 5:50am on [DATE] and her skin was cool to touch and R3 was responding to me by opening her eyes. V6 (LPN) stated that V5 (LPN) told her that she spoke with V3 (DON) who asked her about R3's code status, which was DNR, and V3 (DON) told V5 (LPN) to monitor R3. V6 (LPN) stated that V5 (LPN) did not know where the oxygen was and from the time, she (V6) placed the oxygen on R3 her oxygen levels began to fluctuate. V6 stated she (V6) placed an oxygen mask on R3 but R3 kept trying to pull it off, so I switched it over to a nasal canula and opened it all the way up (give 4 liters of oxygen). I had the CNA (Certified Nursing Assistant) to put R3 back in the bed and I checked her oxygen levels again, which were fluctuating, and decided it was time to send to the hospital because the levels were not approaching the normal limits. V6 stated that she thought she charted what R3's saturation levels were. Surveyor did not see a progress note from V6 indicating R3's saturation levels after V6 placed R3 on 4 liters of oxygen. On [DATE] at 3:36pm V15 (Registered Nurse-RN) stated R3 was pale and requested to be put in bed early on [DATE] during her (V15's) shift (2:00pm-10:30pm) and R3 was not really drinking the supplements and she only consumed 50% of the supplement and I (V15) offered it twice on my shift. V15 stated there was no issues with R3's blood pressure and R3 was ok at that time and her temperature was a bit cold, I took R3's temperature and it was on the lower end of normal, so I gave her a blanket. V15 said I did not check her oxygenation status because I did not have my pulse oximeter. On [DATE] at 9:27am V8 (MD) stated that he did review R3's chart briefly and that he had missed a call from the facility at around 3:30am on [DATE] but spoke with someone briefly early that morning around 7:00am. Stated that he spoke to the facility that morning, but he does not recall the details of the conversation, but I (V8) told them to apply oxygen and to monitor R3. Stated he did not hear back from the facility regarding R3. V8 stated he (V8) would expect for them (the nurses) to monitor R3 at least every 15 minutes to 30 minutes depending on how she (R3) is doing. V8 also stated that R3's DNR status and co morbidities does not change his answer that the nurse should apply oxygen (2Liters nasal cannula) and send R3 to the hospital via 911. V8 also stated that R3 had a change in condition quickly (oxygen saturation) and that it was not something he was treating her for. On [DATE] at 10:24am V3 (DON) stated after the orientation is done the new nurse shadows with an experienced nurse and are shown everything that needs to be done when they are working and some of other things that are explained are the med pass and the knowledge of the medicine that is given, the code status and the process if someone is found unresponsive and they are a DNR that you really don't do anything, but you notify the provider, DON and family. On [DATE] at 10:50am-V3 (DON) stated she (V3) believed did receive a call from V5 and it was at 3:23am, but it was a missed call. V3 stated I spoke with the nurse (V5) at 6:14am and the conversation was about the R3's oxygen saturation, she read the vitals to me, and I advised V5 to put the R3 on oxygen and call 911. V3 stated I do remember asking V5 if she put R3 on oxygen and was told No, and when I asked why I was told that she (R3) was a DNR. Nurse said that she did not put her oxygen because she did not have an order and she is a DNR. V3 continues, I expect them to follow the standing order and for oxygen it's 2liters via NC (nasal canula) and also call 911. (continued on next page)

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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R3's POLST (dated [DATE] reads, in part, A: Do Not Attempt Resuscitation/DNR, B: Selective Treatment: Primary goal of treating medical conditions with selected medical measures. In addition to treatment described in Comfort-Focused Treatment (relieve pain and suffering through the use of medication by any route as needed; use oxygen), use medical treatment, IV (Intravenous) fluids and IV medications as medically appropriate and consistent with patient preference. Undated policy titled Do Not Resuscitate reads, in part, 4. When faced with a possible DNR order situation: If the order is valid and the physician does not order otherwise, follow the terms of the DNR Order, thoroughly document the circumstances following the use of the DNR Order. Policy titled Respiratory Distress: Emergency Procedure date ,d+[DATE] reads, in part, Residents exhibiting signs of respiratory distress will be assessed and treated immediately, 1. Elevate HOB, 2. Oxygen ,d+[DATE] L per nasal cannula, 3. Take and record vital signs, 8 Notify physician and 9. Call paramedic and transfer to hospital if indicated. Policy titled Physician Orders dated ,d+[DATE] reads, in part, these guidelines are to ensure that 1. Changes in resident status/condition are assessed and physician notification is based on assessment findings and is to be documented in the medical record and 2. Any orders given by Physician are carried out. Policy titled Change in Condition Physician Notification Overview Guidelines dated ,d+[DATE], documents, in part, 3. Medical care emergency problems are communicated to attending physician and family immediately (generally within two (2) hours or sooner), A. Any calls to or from physician will be documented in the nurse's notes indicating information conveyed and received and E. The nurse shall indicate in the nurses notes ongoing conversations with the physician regarding response to notification (phone calls) of changes in condition. Undated job description titled LPN Job Description reads, in part, the primary purpose of your job position is to provide direct nursing care to the residents, 2. Ensure that resident care procedures are followed in rendering nursing care, 4. Perform administrative duties as charting, 12. Chart nursing progress notes in an informative and descriptive manner that reflects the care provided to the residents as well as the resident's response, and 23. Make independent decisions concerning nursing care. The Immediate Jeopardy that began on [DATE] was removed and the deficient practice corrected on [DATE] when the facility took the following actions remove the immediacy and correct the noncompliance: On [DATE], at 11:00am re-education began with Facility Nurses and CNAs with focus on: This will be ongoing until all Nurses and CNAs are re-educated by [DATE]. Facility roster of all Nurses and CNAs was printed and being used for Staff signage as they are educated on process to ensure all is educated. Facility will ensure new hires are educated during the first 3 days of orientation period for Understanding DNR and Understanding Change in Condition: o Understanding DNR Meaning no CPR or heroic measures in case of complete cardiac arrest (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Do not mean no treatment or hospitalization for acute symptoms o Understanding Change in Condition Vitals and thorough assessment must be done Must notify Physician/NP immediately or as soon as possible Must notify Family immediately or as soon as possible Must initiate nursing interventions based on assessment findings Closely monitor Resident until transported to ER Document, document, document May initiate oxygen as needed without Dr's order Call 911 and transfer to ER as warranted prior to Dr's order Solicit assistance from Co-Workers as needed If unable to contact Physician/NP, contact Medical Director Once Physician/NP is contacted, give thorough assessment findings and follow his/her instructions Nursing Management will evaluate the training by giving reminders and/or asking questions at Morning Standup Meetings with Nurses which is currently being held daily and by doing chart audits/reviews. Administrator will be responsible for overall compliance to plan of correction in conjunction with DON to ensure all Nursing Staff are re-educated on the process. The Quality Assurance Quality Improvement Team meets monthly. This event will also be brought to the next monthly QAQI meeting for discussion and re-evaluation of interventions. If further interventions are needed at that time, they will be implemented accordingly. The facility presented a removal plan on [DATE] at 1:51pm and it was not approved. A revised abatement plan was submitted on [DATE] at 3:06pm and it was not approved. A revised abatement plan was submitted on [DATE] at 5:53pm it was not approved. A revised abatement plan was submitted on [DATE] at 12:18pm and it was not approved. A revised abatement plan was submitted on [DATE] at 1:22pm and it was approved at 1:28pm.

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F 0726 Level of Harm - Actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41611 Based on interview and record review the facility failed to provide sufficient nursing staff with the appropriate competencies and skill sets to provide nursing services to ensure residents safety and to maintain the highest practicable physical, mental and psychosocial well-being for the residents. This failure resulted in a delay in care for R3 being sent out 911 and interventions not being implemented for respiratory distress and has the potential to affect all the residents residing in the facility. Findings include: R3 has a diagnosis of but not limited to Orthopedic Aftercare, Displaced Fracture of Medial Malleolus of Left Tibia, Subsequent Encounter for Closed Fracture with Routine Healing, Contusion of Unspecified Part of Head, Subsequent Encounter, Malaise, Osteoarthritis, Gastro-Esophageal Reflux Disease Without Esophagitis, Chronic Kidney Disease Stage 3 And Age-Related Osteoporosis Without Current Pathological Fracture. R3's Minimum Data Set (MDS) dated [DATE] documents, in part, a Brief Interview of Mental Status score of 08 that suggests moderate cognitive impairment. Progress note dated [DATE] at 6:08am by V24 reads, in part, R3 was noted pale. Surveyor reviewed progress notes for [DATE] and there were no progress notes for the 1st (6:00am-2:30pm) or 2nd shift (2:00pm-10:30pm) regarding R3's medical status. Progress note dated [DATE] at 6:20am by V5 (Licensed Practical Nurse-LPN) reads: at approximately 3:20 am V5 (LPN) went to check on the R3 during rounds and R3's hands were cool to touch with a SPo2 (peripheral Capillary Oxygen Saturation) of 84%. At 6 AM during rounds and med pass R3 SPo2 went to 82%. R3 DNR (Do Not Resuscitate) will continue to monitor. DON (Director of Nursing) aware. V8 (Physician) notified. BP ,d+[DATE] T 96.7 SPo2 82% RA (room air). Progress note dated [DATE] at 6:57am by V6 (Registered Nurse-RN) reads: received R3 in bed lethargic and SOB (shortness of breath) sating at 87% O2 at 4l/nc (nasal cannula) skin cool to touch R3 able to respond to tactile stimuli. HOB (head of the bed) elevated 45 degrees. b/p (blood pressure) ,d+[DATE]-, d+[DATE].5. R3 DNR will continue to monitor. DON aware. Progress note dated [DATE] at 9:04am by V6 reads R3's vitals declining NP (Nurse Practitioner) notified with orders to send R3 to hospital. 911 called. Progress note dated [DATE] at 9:11am by V6 reads 911 Arrives R3 in route to nearest hospital. Local hospital record dated [DATE] reads, in part, R3's arrival time 9:28am with diagnosis of Sepsis, unspecified Organism and Acute Respiratory Failure with Hypoxia, Respiratory Insufficiency, Septic Shock. R3's hospital records also document, in part, R3's discharge information that reads discharge date /time [DATE] at 11:30am and discharge disposition expired. (continued on next page)

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F 0726 Level of Harm - Actual harm Residents Affected - Many	On [DATE] at about 1:00pm surveyor reviewed the Nursing Daily Staffing Sheet that documents, in part, on [DATE] there was no Registered Nurse (RN) that was scheduled or worked the 10:00pm-6:30am shift. Surveyor reviewed progress notes for [DATE] and there were no progress notes for the 1st (6:00am-2:30pm) or 2nd shift (2:00pm-10:30pm) regarding R3's medical status. On [DATE] at about 1:10pm surveyor reviewed R3's progress notes for [DATE] and V5 does not document giving R3 oxygen when R3's oxygenation levels were 84% (3:20am) and 82% (6:00am) on [DATE]. On [DATE] at 12:10pm V5 (LPN) stated that she (V5) only received 4 days of orientation and that was orienting to each floor plus an additional day of orientation. V5 stated she worked at the facility as Certified Nursing Assistant (CNA) initially, and then became an LPN and started working as a new nurse in December of 2023. On [DATE] at 2:31pm V3 (Director of Nursing-DON) stated if they (residents) are a DNR and they are declining, the nurses are still expected to provide care to the residents. DNR does not mean that a nurse does not provide care and care still needs to be provided. V3 also stated there is a standing order to give 2 Liter of oxygen via nasal canula and keep them (the resident) comfortable for someone who is having trouble breathing and I (V3) would expect for them (nurses) to use their nursing judgement and send the resident out via 911 and then the staff can call the MD, DON and the family. On [DATE] at 3:36pm V15 (Registered Nurse-RN) stated R3 was pale and requested to be put in bed early on [DATE] during her (V15's) shift (2:00pm-10:30pm) and R3 was not really drinking the supplements and she only consumed 50% of the supplement and I (V15) offered it twice on my shift. V15 stated there was no issues with R3's blood pressure and R3 was ok at that time and her temperature was a bit cold, I took R3's temperature and it was on the lower end of normal, so I gave her a blanket. V15 said I did not check her oxygenation status because I did not have my pulse oximeter. This change of condition was not documented on the 24-hour Shift Report and there was no progress note in regards to R3's change of condition by V15 (RN). On [DATE] at 12:06pm surveyor reviewed V5's employee file and V5 had an undated Nursing Skills Check List that confirms her orientation with V6 (LPN). Surveyor reviewed V5's General Orientation Checklist for All New Employees that is partially completed. Instructions state to initial beside each area when completed. Have manager to sign each. V5's did not initial any areas. V5 did not have a Self-Competency Packet in her (V5's) employee file. (continued on next page)

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F 0726 Level of Harm - Actual harm Residents Affected - Many	On [DATE] at 10:24am V3 (DON) stated she provides orientation to each nurse on each floor for a least 5 days on everything that falls under their job description and onboarding which is computer training, on abuse, nursing care and other topics. V3 stated that ideally the nurse will get a total of 5 days of orientation and more if needed. After this orientation is done the new nurse shadows with an experienced nurse and are shown everything that needs to be done when they are working and some of other things that are explained are the med pass and the knowledge of the medicine that is given, the code status and the process if someone is found unresponsive and they are a DNR that you really don't do anything, but you notify the provider, DON and family. V3 also stated that there is another Nursing Skills Orientation Checklist that is given to the new employee and that the checklist that I have (V5's checklist) is for (workforce education training) and that the employee must initial the boxes and have the supervisor signs off from each department and the form has to be completed before the floor orientation starts. V3 said, No, we don't have charge nurses for each shift and if it is after hours they can call me and they know to ask for help from other experienced nurses and the RN's who are always in the building on the third shift (10:00pm-6:30am). On [DATE] at 11:15am surveyor reviewed V22's (LPN) employee file and there were a Self-Competency Packet that was incomplete. Surveyor reviewed V23's (LPN) employee file and did not find a Self-Competency Packet or Nursing Skills Orientation Checklist. On [DATE] at about 12:15pm V3 stated that the facility did not have any other Self Competency Packets or Nursing Skills Orientation checklist for V5, V22 or V23 if it was not in their (V5, V22 and V23) employee file. On [DATE] at 12:44pm V23 (LPN) stated that she was hired about the end of [DATE] and had about 6 weeks of orientation. V23 stated I did have another nurse that was available for questions, but I had to pass meds by myself on one side of the hall and the nurse I was shadowing was passing meds on the other side of the hall. V23 stated on about the 3rd or 4th day of orientation I had to work by myself, while still in orientation, but she (V23) did not take the other side of residents. V23 stated she was questioned why, and she told administration that she (V23) did not feel comfortable taking care of 40 residents by herself. V23 stated that she had been scheduled to work by herself, while in orientation, on more than one occasion and that was the reason she (V23) left that job. V23 stated that she did not have to complete a Nursing Skills Orientation checklist or anything like that and she did not have to submit anything to the Director of Nursing. On [DATE] at 1:40pm V6 (LPN) said I was V5's preceptor when she first started and I only precepted her one shift on the first floor sometime in December of 2023 and I did complete R5's orientation checklist for the one time I precepted R5. On [DATE] at 6:31pm via email V1 (Administrator) stated No, we do not have a policy on training/orientation of nurses. On [DATE] at 11:55am by V3 (DON) via email that reads a new nurse with previous nursing experience gets a minimal 2 days classroom orientation doing paper work, being in-serviced on various topics and watching educational videos and then a minimal 3 days orientation shadowing with another facility Nurse and a new grad nurse will typically get a minimal of 2 weeks of shadowing another Nurse and same 2 days of classroom orientation. V3 also stated no new Nurse is to be scheduled solo (to work alone) to work a floor and be responsible for a group of residents during the above listed orientation period. (continued on next page)

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F 0726 Level of Harm - Actual harm Residents Affected - Many	Undated job description titled LPN Job Description reads, in part, the primary purpose of your job position is to provide direct nursing care to the residents, 2. Ensure that resident care procedures are followed in rendering nursing care, 4. Perform administrative duties as charting, 12. Chart nursing progress notes in an informative and descriptive manner that reflects the care provided to the residents as well as the resident's response, and 23. Make independent decisions concerning nursing care. Policy titled Physician Orders dated ,d+[DATE] reads, in part, these guidelines are to ensure that 1. Changes in resident status/condition are assessed and physician notification is based on assessment findings and is to be documented in the medical record and 2. Any orders given by Physician are carried out. Policy titled Change in Condition Physician Notification Overview Guidelines dated ,d+[DATE], documents, in part, 3. Medical care emergency problems are communicated to attending physician and family immediately (generally within two (2) hours or sooner), A. Any calls to or from physician will be documented in the nurse's notes indicating information conveyed and received and E. The nurse shall indicate in the nurses notes ongoing conversations with the physician regarding response to notification (phone calls) of changes in condition.

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. 45346 Based on interview and record review the facility failed to send the appropriate paperwork with one resident who required involuntary transfer to the hospital and notify a resident's power of attorney that a psychotropic medication was discontinued. This failure had the potential to affect all three residents (R2, R5 and R6) reviewed for facility's policy and procedures. Findings include: On 04/10/2024 at 12:06pm V11(LPN/Licensed Practical Nurse) stated on 3/26/2024 I sent R2 out to the hospital. V11 stated R2 started saying that, we all have the devil in us. V11 stated R2 was making cat like noises. V11 stated R2 seemed as if she was possessed. V11 stated I called R2's psychiatrist and R2's doctor regarding the behaviors R2 was exhibiting and both doctors stated to send R2 out to the hospital for evaluation. V11 stated I called 911 and 911 came to the facility to take R2 to the hospital. V11 stated R2 returned from the hospital during my shift. V11 stated R2 was exhibiting the same behaviors and I told the emergency medical technicians I was not accepting R2 back into the facility. V11 stated I did not receive the hospital paperwork from the emergency medical technician when R2 returned from the hospital. V11 stated R2 remained on the stretcher and V17(Social Services Director) completed the petition to send R2 back to the hospital. V11 stated the emergency medical technicians took R2 back to the hospital. V11 stated I did not send a involuntary petition to the hospital with R2. V11 stated I now know a petition is required when sending a resident to the hospital for evaluation for psychiatric behaviors. On 4/10/2024 at 2:44pm V1(Administrator) stated in January 2024 R2 was taken off psychotropic medications. I am not sure if R2's power of attorney was notified that R2's psychotropic medication was discontinued. V1 stated according to R2's POA (power of attorney) she was not notified of R2 being discontinued off psychotropic medications. V1 stated on 3/26/2024 R2 went out to the hospital for behaviors. V1 stated every shift has a staff person who can complete the petition when a resident needs to be sent to the hospital due to behaviors. V1 stated the hospital did not admit R2 the first time R2 was sent to the hospital on 3/26/2024, I do not know why R2 was not admitted to the hospital. V1 stated when R2 returned to this facility a petition was prepared and R2 went back out with the same emergency technicians who brought R2 to the facility, to the same hospital. On 4/10/2024 at 3:15pm V3 (DON/Director of Nursing) stated the social worker is responsible for completing the paperwork for a petition when a resident needs to go to the hospital due to behaviors. V3 stated the nurses are to complete the petition paperwork after hours and when the social worker is not in the facility. V3 stated it is my expectation that all nurses working in the facility are able to complete the petition paperwork when the resident needs to be sent to the hospital due to behaviors. V3 stated the power of attorney should be notified if a long-term psychotropic medication is being discontinued for a resident. (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/10/2024 at 3:45pm V15(RN/Registered Nurse) stated R2 went out to the hospital on 3/26/2024 but returned to the facility a few hours later. V15 stated when R2 returned from the hospital R2 was still cursing at facility staff. V15 stated petition paperwork is supposed to go with the resident when the resident goes to the hospital due to behaviors. V15 stated I still don't know the complete process for completing the paperwork for a petition. V15 stated the social worker does not always have to complete the petition paperwork. V15 stated I must notify the resident's power of attorney if a psychotropic medication is discontinued for the resident. On 4/11/2024 at 10:24am V17(Social Service Director) stated if there is no doctor on-site to complete a petition when a resident needs to be sent to the hospital due to behaviors then the nurses or social services staff can complete the petition. V17 stated the Director of Nursing did tell me that there are some nurses at the facility who do not know how to complete the petition and I was asked by the Director of Nursing to do an in-service with those nurses. V17 stated I am familiar with R2. V17 stated R2 had a reduction of the psychotropic medications to see if R2 could go without the medications. V17 stated R2's power of attorney stated she was not notified of the psychotropic medication changes for R2. V17 stated I would think the power of attorney should be notified for discontinuation of psychotropic medications. The facility's undated policy titled Involuntary Discharge or Transfer documents in part, A. Policy: The facility will provide proper procedure and notification of an involuntary transfer or discharge pursuant to the regulations of the Health Care Financing Administration for States and long-term care facilities, 42 CFR 438. 12(federal regulations); and State rules and regulations. Procedure: Reasons for transfer or discharge a. the resident's welfare cannot be met at the facility. c. the health and /or safety of individuals in the facility are endangered. R2's Petition for Involuntary/Judicial Admission was completed by V17(Social Services Director) on 3/26/2024 at 2:20pm. The facility's undated LPN (Licensed Practical Nurse) job description documents in part, Essential Duties and Responsibilities: 4. Perform administrative duties such as completing medical forms, charting, reports, etc. 9. Admit, discharge and transfer residents as required. 40. Other duties as assigned that fall within scope of nursing practice. The facility's undated RN (Registered Nurse) job description documents in part, Essential Duties and Responsibilities: 4. Perform administrative duties such as completing medical forms, charting, reports, etc. 9. Admit, discharge and transfer residents as required. 40. Other duties as assigned that fall within scope of nursing practice.