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	05/03/2024

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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41356 Based on review of records and interviews, the facility failed to provide bed hold notification when transferring to another facility, for 1 resident (R3) in a total sample of 3 residents reviewed. This failure affected 1 resident (R3) who was not afforded notification on the option to return to the facility after discharge. Findings include: R3 is [AGE] years old, initially admitted on [DATE] with depressive disorder. R3 cognition has impaired cognition based on his brief interview of mental status dated 3/22/2024 scoring at 3. Per R3's progress notes resident was discharge to hospital on 4/13/2024. Progress notes: Dated 4/13/2024 by V3 (Licensed Practical Nurse/LPN) documents that R3 was trying to set his clothes on fire. R3 was placed under involuntary petition for being danger to self and others. On 4/30/2024 at 12:41 PM, V3 (LPN) stated that she was the nurse in-charge of R3 during the time R3 was involuntarily transferred to the hospital on 4/13/2024. On 5/1/2024 at 10:45 AM, V2 (Director of Nursing/DON) stated R3 was involuntarily discharged or petition. And it was V3 (Licensed Practical Nurse) who sent R3 out to the hospital. Bed hold notice was not given because facility does not have any intention for R3 to come back. V2 also pointed out that it was an error that MDS (Minimum Data Set) place discharge return anticipated. Because during R3's transfer there was no intention for R3 to return to the facility. On 5/2/2024 at 1:34 PM V1 (Administrator) stated that R3 was accepted in another nursing home. And the reason why R3 was not accepted back in the facility was due to the behavior that happened when R3 transferred to the hospital (4/13/2024). V1 stated that it was Saturday and by Monday facility decided not to take R3 back. V2 (DON) stated that there was no decision at the time when R3 was transferred to the hospital because it was Saturday (4/13/2024). V2 added, By Monday we decided not to take him back. Discharge / Transfer of Resident Policy dated 11/18, reads: (continued on next page)

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

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Send copy of Bed Reserve Policy Notification with transfer form. Document in the progress note that policy was sent. Facility Bed Reserve Policy Notification dated 11/18, reads: This Bed Reserve Policy will be given to the you (resident/R3) at the time of admission and a copy will be given to you each time you are transferred from the facility. The Nursing Home Care Act requires a nursing facility to hold a bed for a period of ten days when you (resident/R3) are hospitalized .

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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 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41356 Based on review of records and interviews the facility failed to determine current status of resident before denial of re-admission for 1 resident (R3) in a total sample of 3 residents reviewed. This failure affected 1 resident (R3) that was not accepted and therefore did not receive services in the facility after discharge. Findings include: R3 is [AGE] years old, initially admitted on [DATE] with depressive disorder. R3 cognition has impaired cognition based on his brief interview of mental status dated 3/22/2024 scoring at 3. Per R3's progress notes resident was discharged to hospital on 4/13/2024. Progress notes: Dated 4/13/2024 by V3 (Licensed Practical Nurse) documents that R3 was trying to set his clothes on fire. R3 was placed under involuntary petition for being danger to self and others. On 4/30/2024 at 12:41 PM, V3 (Licensed Practical Nurse) stated that she was the nurse in-charge of R3 during the time R3 started fire on his clothes. V3 said, When I told him what are you doing? He (R3) said I don't want to live. V3 stated that R3 has a lot of behavioral concerns including fighting with other residents, taking off his clothes and sleeping on the hallway, refusing medication, following a certain nurse the whole day. V3 stated that she thinks R3 transfer to the hospital on 4/13/2024 was an involuntary petition transfer. On 5/1/2024 at 10:45 AM, V2 (Director of Nursing) stated R3 was involuntarily discharge or petition. And it was V2 (Licensed Practical Nurse) who sent R3 out to the hospital. Bed hold notice was not given because facility does not have any intention for R3 to come back. V2 also pointed out that it was an error that MDS (Minimum Data Set) place discharge return anticipated. Because during R3's transfer there was no intention for R3 to return in the facility. On 5/2/2024 at 1:34 PM V1 (Administrator) stated that R3 was accepted in another nursing home. And the reason why R3 was not accepted back in the facility was due to the behavior that happened when R3 transferred to the hospital (4/13/2024). V1 stated that it was Saturday and by Monday facility decided not to take R3 back. V2 (Director of Nursing) stated that there was no decision at the time when R3 was transferred to the hospital because it was Saturday (4/13/2024). V2 added, By Monday we decided not to take him back. V1 and V2 was asked if the facility before deciding not to accept R3 determine R3's current status as to his behavior after treatment in the hospital? Was there coordination done between facility and the hospital? V1 stated that R3 was not accepted back because of his behavior during transfer. V2 said that R3 was petition multiple times for involuntarily due to his behavior. (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/2/2024 at 2:03 PM, V11 (Social Service Director) stated that R3 verbalized that he was repetitively abused by family. R3 have multiple behavioral concerns that includes being withdrawn, slapping himself, obsessive compulsive behavior, paranoia, R3 mentioned he wants to hurt himself. Incidents include when R3 said that he wants to harm himself by jumping out of the window. Another incident was not taking his medication, unusual behavior not sleeping in his room instead sleeping on the hallway with his shirt covering his face. And the third was when R3 set his clothes on fire. V11 was asked about facility effort to help R3's behavioral concerns. After reviewing R3's care plan, V11 said, The only thing I saw is that we addressed medication refusal. Self-harm was not addressed in the care plan. You can see it on page 10 and 11. V11 was asked how can the facility determine that R3 was not appropriate to be readmitted when, based on the care plan, efforts were not made to address R3's behavioral concerns? V11 said, I see what you mean. And did not elaborate his answer. Progress notes of R3: Dated 12/28/2023 (7 days after admission) by V11 documents that R3 states he may have considered suicidal ideation at one point but never wanted to act on any such thoughts. - Per V1 facility does not have policy specific to permitting resident(s) to return to facility.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41356 Based on review of records and interview the facility failed to address behavioral concerns in the care plan for a resident that manifest self-harm for 1 resident (R3) in a total sample of 3 residents reviewed for person-centered care plan. This failure affected 1 resident (R3) resulting in a lack of intervention on resident behavioral services' needs. Findings include: R3 is [AGE] years old, initially admitted on [DATE] with depressive disorder. R3 cognition has impaired cognition based on his brief interview of mental status dated 3/22/2024 scoring at 3. Per R3's progress notes resident was discharge to hospital on 4/13/2024. Progress notes of R3 dated 12/28/2024 (7 days after admission) by V11 (Social Service Director) it documents that R3 states he may have considered suicidal ideation at one point but never wanted to act on any such thoughts. Multiple notes of R3 were documented on R3's behavioral concerns are as follows: Dated 4/13/2024 by V3 (Licensed Practical Nurse/LPN) documents that R3 was trying to set his clothes on fire. R3 was placed under involuntary petition for being danger to self and others. On 4/30/2024 at 12:41 PM, V3 (LPN) stated that she was the nurse in-charge of R3 during the time R3 started fire on his clothes. V3 said, When I told him what are you doing? He (R3) said I don't want to live. V3 stated that R3 has a lot of behavioral concerns including fighting with other residents, taking off his clothes and sleeping on the hallway, refusing medication, following a certain nurse the whole day. On 5/2/2024 at 1:34 PM, V2 said that R3 was petition multiple times for involuntarily due to his behavior. On 5/2/2024 at 2:03 PM, V11 (Social Service Director) stated that R3 verbalized that he was repetitively abused by family. R3 have multiple behavioral concerns that includes being withdrawn, slapping himself, obsessive compulsive behavior, paranoia, R3 mentioned he wants to hurt himself. Incidents include when R3 said that he wants to harm himself by jumping out of the window. Another incident was not taking his medication, unusual behavior not sleeping in his room instead sleeping on the hallway with his shirt covering his face. And the third was when R3 set his clothes on fire. V11 was asked about facility effort to help R3's behavioral concerns. After reviewing R3's care plan, V11 said, The only thing I saw is that we addressed medication refusal. Self-harm was not addressed in the care plan. You can see it on page 10 and 11. Care Plan policy dated 3/15/2022 reads: All residents will have comprehensive assessments and an individualized plan of care develop to assist them in achieving and maintaining optimal status. RAI (Resident Assessment Instrument) 3.0 Manual, it reads: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The comprehensive care plan is an interdisciplinary communication tool. It must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.

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F 0684 Level of Harm - Minimal harm or potential for actual harm 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** 41356 Based on record review and interview, the facility failed to monitor vital signs and to identify a change in condition for 1 resident (R2), out of a total sample of 3 residents reviewed for nursing services. This failure potentially affected 1 (R2) resident who was transferred to the hospital and diagnosed with septic shock. Findings include: R2 is [AGE] years old resident was initially admitted in the facility on 6/20/2018. R2 medical diagnosis includes diabetes mellitus with hyperglycemia, hyperlipidemia, hypertension, anemias, dementia, anxiety disorder, bipolar disorder, head injury. R2's has impaired cognition, based on his brief interview of mental status (BIMS) score of 4. Per V9 (Registered Nurse / Hospital) R2 was admitted to Intensive Care Unit (ICU) due to sepsis. Progress notes of R2 dated 4/9/2024 at 6:56 AM by V4 (Licensed Practical Nurse-LPN) documents that R2 was congested, hypotensive, tachycardic, (blood pressure 86/56, respirations 18, temperature 98.6 degrees Fahrenheit, hear rate 113 oxygen saturation 90%RA Blood Sugar 233mg/dl) and was sent to the hospital per physician's order. Although V4 worked from 10:00 PM of 4/8/2024 to 6:00 AM no documentation was noted before 6:56 AM of 4/9/2024. On 5/1/2024 at 11:34 AM, V4 (LPN) stated that per report from the prior shift, R2's blood pressure was low. And what she meant when documenting in the progress notes was R2 was congested because she can hear him having crackles when R2 breathes. Progress notes of R2 dated 4/9/2024 by V5 (LPN) documents that R2 was diagnosed in the hospital for septic shock. On 4/30/2024 at 1:43 PM, V5 stated that when she came around 6:00 AM in the morning, R2 was already declining. And the decline happened on the shift before which was the night shift where V4 was the nurse. V5 stated that she cannot remember if nursing staff are monitoring R2's vital signs daily. Per R2's clinical record last vital signs recorded was 3/30/2024. On 5/1/2024 at 10:45 AM, V2 (Director of Nursing) stated R2 was nasally congested and because of his abnormal vital signs he was sent to the hospital. V2 said that she did not know R2 had sepsis and that until that day that R2 was sent out, there was no signs of infection. V2 said that vital signs need to be checked on a weekly basis. But for resident who are taking blood pressure medicine and is not controlled vital signs, it should be checked before giving medication. After V2 seen in R2's record that there are times R2 has hypertension and there are times R2 was hypotension, V2 stated, He (R2) should really get the daily vitals. R2 then stated that the problem with putting/documenting the vital signs is when there is no order on the MAR (Medication Administration Record). V2 was asked to present documentation that nursing staff was monitoring R2 prior to transferring to the hospital with diagnosis of septic shock. V2 said the only documentation I see was when R2 was sent to the hospital with abnormal vital signs. I understand what you mean, that sepsis cannot happen right away. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Per Center for Disease Control and Prevention (CDC) on Get Ahead of Sepsis - Know the Risks. Spot the Signs. Act Fast. Dated September 11, 2023, it reads: Sepsis is the body's extreme response to an infection. It is a life-threatening medical emergency. Sepsis happens when an infection you already have triggers a chain reaction throughout your body. Infections that lead to sepsis most often start in the lung, urinary tract, skin, or gastrointestinal tract. Most cases of sepsis start before a patient goes to the hospital. Without timely treatment, sepsis can rapidly lead to tissue damage, organ failure, and death. What Can Healthcare Professionals Do? As a healthcare professional you can: Know sepsis signs and symptoms to identify and treat patients early. ACT FAST if you suspect sepsis.