Printed: 03/27/2025
Form Approved OMB
No. 0938-0391

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	01/31/2025

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15301 Based on interview and record review, the facility failed to ensure that a resident remained free from mental abuse for one (R5) of three residents reviewed for abuse. This failure resulted in V4 (Former Certified Nursing Assistant/CNA) taking inappropriate photos of R5 and sending them in a text to her peers. A reasonable person who had inappropriate photos taken of them and shared with others would have felt sad, humiliated, and angry. Findings include: Facility's final incident report of 1/3/2025, documents on 12/30/2024, it was reported that (V4 Former CNA) took some inappropriate photos of (R5) and sent them to a CNA group text. An investigation has been immediately initiated and completed. Upon investigation, it is noted that V4 took photos and posted in CNA group. Face sheet indicates R5 is a [AGE] year-old female admitted to the facility on [DATE], with diagnoses including but not limited to: Cerebral Infarction (stroke), Occlusion and Stenosis of Right Carotid Artery, Coronary Angioplasty Status, Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side (paralysis and weakness on one side of body following stroke), Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side, Dysphagia (difficulty swallowing), and Sepsis (body's extreme reaction to infection). MDS (Minimum Data Set) assessment dated [DATE] indicates R5 has severely impaired cognition. 1/28/2025, at 3:05 PM, V2 (DON-Director of Nursing) said V4 (Former CNA) was terminated on 12/31/2024, for HIPPA (Health Insurance Portability and Accountability Act) and resident rights violations by posting photos of a resident (R5) to CNA chat group members. 1/28/2025, at 4:24 PM, V6 (Certified Nursing Administrator) said she received pictures of R5 via group text from V4 (Former CNA). (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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	1/29/2025, at 11:06 AM, via telephone, V9 (Scheduler) said she received a text from V4 (former CNA) at approximately 10:30 PM on 12/30/2024. Included in the text were two pictures of R5 (V9's aunt). R5's face was visible, diaper open and soiled with feces, buttocks visible. V9 said she was upset V4 sent pictures of R5 to her in a CNA group. V9 said V4 responded, it's not right what's going on, everyone needs to know. V9 reported the incident to V2 (DON) and V11 (Human Resources Director). V2 followed up with all CNAs included in the group text to ensure that pictures were deleted from their phones and not forwarded. R5's family was informed of the incident. 1/31/2025, at 9:02 AM, via telephone, V4 (Former CNA) Spanish speaking states, that day I went to start my night shift, I got to the floor, there were no nurses or CNAs, nobody was on the floor. When I got there, I find R5, hanging from the side rail, full of stool/wet and R5 is a fall risk. V4 continues to state I got scared and how could they leave her like that. My first reaction was that it was not fair to leave a person like that. I took a picture of the status she was in, they always left her like that. V4 reports that they wouldn't keep her safe, they didn't have anyone watching her, on top of that they would close her door because she would yell out. V4 reports that she was added to the group chat via text that was made for support. V4 states that she took one picture of R5 and sent the same picture twice in the group text. V4 states that she doesnt know how many CNAs were in the group chat. V4 continued to state that she did not receive any abuse training in the facility. I'm told to sign things, I don't know what I'm signing. V4 states that she completed her CNA training outside of the facility and she did struggle during the CNA training due to her language barrier. V4 reports that she feels sorry about what she did, but she continues to state she (V4) didn't know she shouldn't send the picture. V4 reports that other CNAs had sent other residents' pictures of bruises in the group chat. 1/30/2025, at 7:49 PM, via telephone, V25 (R5's Daughter) said she was informed by V2 (DON) that a CNA (Certified Nursing Assistant) took pictures of R5 and posted them to other staff via a group chat. V25 said R5 is not in her right mind and could not have given consent for the pictures to be taken. The pictures showed R5's face, she was completely nude. I was very heated, my concern was if R5's picture was posted on social media. V25 said she did not tell R5 about the pictures. V25 added, R5 would have felt sad, humiliated, and angry because it was an invasion of R5's privacy. CNAs Group Text list documents there were 19 CNAs included in the text. Abuse Prevention Program Facility Policy and Procedure (reviewed 1/4/2018) page 6 Photographing and Recording Residents documents in part, staff photographing or recording residents or their private space for other than medical or facility purposes is strictly prohibited. Staff posting or sending a photo or recording on social media or otherwise keeping or sending a photo or record through multimedia messaging other than for facility purposes is also strictly prohibited. Staff taking or using a photograph or recording of a resident in a manner that demeans or humiliates a resident, regardless of the resident's cognitive status or whether the resident consented, is strictly prohibited and will be handled as an allegation of abuse. Photographing or recording includes taking photographs or recordings from any type of device, including smart phones. Screening Assessment to Determine the Presence of Trauma Factors Including Abuse and/or Neglect Policy Protocol (undated) documents Mental Abuse includes, but is not limited to humiliation, harassment, threats of punishment, deprivation, or offensive physical contact. This includes abuse that is facilitated or enabled through the use of technology.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 15301 Based on interview and record review, the facility failed to follow their abuse policy to complete a thorough abuse investigation for one of three residents reviewed for abuse (R4) in the sample of seven. Findings include: 1/29/2025, at 12:37 PM, V11 (Human Resource Director) stated (V11) was told by other staff that V5 (Certified Nursing Assistant/CNA) said bad words to R4. I went to V7 (Former Administrator) and reported that I was told V5 said some bad words to a resident. I don't think he (V7) did a complete investigation. He did not involve social services to interview R4 and other residents and didn't interview additional staff. He kept me out of the loop. Anytime I asked him about the investigation he would say, don't worry about it, I'm handling it. 1/29/2025, at 2:50 PM, via telephone, V7 (Former Administrator) said, it was reported to him, by V6 (CNA) that V5 (CNA) used profanity while performing direct resident care to R4. V6 reported the incident to V2 (Director of Nursing) who reported it to me. I did an investigation; I think I interviewed staff on the unit. I interviewed staff involved (V5, V6). I interviewed the resident and her roommate. My interviews should be included in my investigation. 1/30/2025, at 1:53 PM, V17 (Director of Clinical Services) said I typically dont get involved in abuse investigations. There was a lot of information missing from V7's interviews (names, dates, times, allegation details). I instructed V7 to get a detailed accounting of what happened that night. V7 did not do a thorough investigation. V7's investigation included R4's, V5's (CNA), V6's (CNA), and V26's (Registered Nurse) statements. Statements did not include dates or times that alleged abuse occurred. No other statements for staff who routinely work with V5 or residents V5 routinely takes care of. Abuse Prevention Program Facility Policy and Procedure (reviewed 1/4/2018) page 8, Investigation Procedures, documents in part, Residents to whom the accused has regularly provided care, and employees with whom the accused has regularly worked with will be interviewed to determine whether anyone has witnessed any prior abuse, neglect, exploitation, mistreatment or misappropriation of resident property by the accused individual.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 49666 Based on interview and record review the facility failed to follow the care plan addressing the resident will maintain adequate nutritional and hydration status and failed to implement current professional standards of practice to follow up and/or address a Registered Dietician's recommendations for one resident (R2) out of four residents reviewed for hydration. This failure places residents at risk to be provided with inappropriate care and services to meet the resident's physical, mental and/or psychosocial needs. The findings include: R2's face sheet documents that R2 has diagnoses including but not limited to: severe sepsis with septic shock, unspecified atrial fibrillation, encounter for attention to gastrostomy, adult failure to thrive, type 2 diabetes mellitus without complications, pressure ulcer of other site, unspecified stage, chronic kidney disease, stage 3a, obstructive and reflux uropathy, unspecified, hemiplegia and hemiparesis. R2's MDS/Minimum Data Set Section C dated 12/11/2024 documents that R2 has a BIMS/Brief Interview for Mental Status score of 00/15, indicating that R2 is severely cognitively impaired. R2's MDS/Minimum Data Set section I dated 12/11/2024, documents that R2 has medically complex conditions. On 1/29/2025, at 11:24 AM, V8 (Consultant Dietitian) states that she looks at the labs and recommends repeat labs if she has a concern. V8 states that she requested labs for R2 multiple times several months ago. V8 continues to state that she was unable to obtain them. V8 reports dieticians cannot order labs. V8 states that she informed V10 (Assistant Director of Nursing) and sent recommendations via electronic mail to nursing department which includes V2 (Director of Nursing) and V10. V8 states that V10 responded to V8 that they will ask the doctor. V10 continues to state R2's labs were not good, R2's water provision was way above, with such a large volume going in due to his water flush orders and sodium level was still high, he could have some kind of endocrine concern. V8 states that she monitors R2 monthly, and she states that especially with R2 having wounds, you want to keep him well hydrated. V8 states that she recommended for R2 to get follow up labs at least 4 times. On 01/30/2025, at 9:33 AM, V19 (Nurse Practitioner) states that if the dietitian, wound care specialist, psychiatrist have recommendations that are related to medical concerns, the nursing department should notify V19. V19 continues to state the director of nursing should audit the charts for any new orders or recommendation. V19 states that it is important to follow up on healthcare professional's recommendations. V19 states because that's the way we are providing a good care for the patient, because if they recommend something, it's their best knowledge. V19 reports that R2 has been declining for a very long time due to R2's comorbidities. V19 states that he recommended R2 to be on hospice, his family has refused. V19 states that he never got notification from anyone that the dietician recommended follow up labs. V19 states that if lab is showing abnormal renal function, it's not appropriate to not follow up because it's the patient's life. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/29/2025, at 3:33 PM, V2 (Director of Nursing) states that V10 (Assistant Director of Nursing) is on vacation and V10 is responsible for following up with dietician's recommendations. On 1/30/2025, at 11:49 AM, this surveyor asked V2 what happened with the V8 (Consultant Dietitian) recommendation for R2 to have follow up labs. V2 states I'm not sure what happened with the labs, to be honest. V2 states that when she would follow up with V10 (Assistant Director of Nursing) regarding the notification/recommendations from V8, V10 would respond to V2 that she is following up with the doctor and it is taken care of. On 1/30/2025, at 12:32 PM, V21 (R2's Attending Physician) states that R2 has a lot of complications. V21 states that R2 has a gastrostomy tube, wounds, demented, decubitus ulcer almost closed, and has a permanent urinary catheter which creates high risk for urinary tract infections (UTI). V21 states that R2 had a hospitalization in March of 2024 and again in October 2024. V21 states that he treated R2 in the facility for UTI with antibiotics and to monitor for signs and symptoms of infection. V21 continues to state to be honest with you, we been doing a fairly good job, R2 is a difficult case, he's NPO (nothing by mouth). Wound doctor is doing a terrific job. The urinary catheter creates a problem if it gets infected. V21 states that if he were to have been made aware of the dietician's follow up lab tests recommendation, he would agree. R2's lab report dated 5/13/2024, documents in part R2's blood urea nitrogen (BUN) level is 53mg/dL (flagged as high level), with a reference range of 7-25 ml/dL. R2's lab report dated 5/13/2024, documents in part R2's sodium level is 153 mmol/L (flagged as high level), with a reference range of 135-145 mmol/L. R2's lab report dated 10/25/2024, documents in part blood urea nitrogen (BUN) level is 54mg/dL (flagged as high level), with a reference range of 7-25 ml/dL. R2's lab report dated 10/25/2024, documents in part R2's sodium level is 149 mmol/L (flagged as high level), with a reference range of 135-145 mmol/L. R2's dietary progress note dated 5/21/2024, 2:33 PM, documents in part nutrition Dx (diagnosis): abnormal nutrition related lab values related to hydration status as evidenced by elevated Na+/BUN (sodium/blood urea nitrogen). Intervention: Request new CBC/BMP (complete blood count/basic metabolic panel) r/t (related to) hypernatremia 5/13/24. Monitoring/evaluation: Weight, labs, wound status. R2's dietary progress note dated 8/28/2024, 4:26 PM, documents in part nutrition Dx: abnormal nutrition related lab values related to hydration status as evidenced by elevated Na+/BUN. Intervention: request new CBC/BMP r/t hypernatremia 5/13/24. Monitoring/evaluation: Weight, labs, wound status. R2's dietary progress note dated 9/30/2024, 10:36 AM, documents in part requested new labs. Request new CBC/CMP to assess hydration. Nutrition Dx: Abnormal nutrition related lab values related to hydration status as evidenced by elevated Na+/BUN. Intervention: Request new CBC/BMP r/t hypernatremia 5/13/24 and increased protein burden from feeding. Monitoring/Evaluation: Weight, labs, wound status. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's dietary progress note dated 10/23/2024, 3:41 PM, documents in part wound/enteral nutrition note: Resident is NPO (nothing by mouth) on TF (tube feeding). PMHx (past medical history) includes encephalopathy, sepsis, UTI (urinary tract infection), calculus of kidney, lobar pneumonia, severe pro-cal malnutrition, CKD (chronic kidney disease), malignant neoplasm of prostate, pressure ulcers, dysphagia. Intervention: Request new CBC/BMP r/t hypernatremia 5/13/24 and increased protein burden from feeding. Monitoring/Evaluation: Weight, labs, wound status. R2's care plan documents in part R2 requires tube feeding related to adult failure to thrive, NPO (nothing by mouth). R2 will maintain adequate nutritional and hydration status as evidenced by no signs or symptoms of malnutrition or dehydration. RD (registered dietician) to evaluate quarterly and as needed. Make recommendations for changes to tube feeding as needed. This intervention is indicated for nursing department. Facility document not dated titled care plan documents in part all residents will have comprehensive assessments and an individualized plan of care developed to assist them in achieving and maintaining their optimal status. Approaches are written clearly to be understood by all. Approaches include specific departments and staff member(s) responsible.