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	03/27/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. 30279 Based on observation, interview, and record review the facility failed to ensure that the call lights are within reach for 9 of 9 residents (R1, R2, R3, R6, R8, R10, R12, R13 and R14) reviewed for call lights. Findings include: On 03/24/25 at 12:01pm, R1 noted in the room eating with call light not within reach, R3 noted in bed with call light not within reach, and R14 noted in wheelchair on the right side of the bed with call light not within reach on the left side of the bed. R14 stated I can't reach it. At 12:11pm, V6 CNA (Certified Nurses Aide) stated call lights should be within reach of the resident whether in bed or chair. On 03/24/25 at 12:20pm, R6 noted in bed that was positioned very high and call light noted under the bed, R10 in bed with call light noted on the floor under the bed and not within reach. R13 noted in bed with call light noted under the bed. On 03/24/25 at 12:21pm, R2 noted in the room in a chair with call light not placed within reach. When this was shown to V8 RN (Registered Nurse), V8 stated that R2 is a fall risk and should be monitored, the call light should be within reach for all residents. At 12:24pm, R8 noted in bed with call light not within reach. At 12:28pm, R12 noted in bed with call light on top of the over the bed light. At 12:29pm, R10 observed in bed with call light noted on the floor under the bed not within reach. R1's plan of care for falls focus indicated that R1 is at risk for falls related to weakness, with history of fall-initiated date of 11/10/2023 and last revised 02/19/25. Goal includes R1 will have decrease incident of falling. Listed interventions includes to be sure call light is within reach. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/25/25 at 1:36pm R3 and R14 noted in the room. R3 in a recliner chair with call light not within reach and called the surveyor to put (R3) back in bed. In the same observation R14 noted in wheelchair with call light not within reach. Surveyor brought this to V15 LPN (Licensed Practical Nurse)'s attention and asked about the facility policy on call light placement. V15 stated that the call light should be within the reach of the resident while in bed or chair. On 03/25/25 at 4:10pm, V2 stated that they (referring to staff) know better in making sure all the residents have their call lights within reach whether in bed or in a chair especially for residents who are high risk for falls. The facility Call Light Policy presented with no date documented that the purpose of the policy is to respond to resident's requests and needs in a timely and courteous manner. Listed standards includes but not limited to all residents shall always have the nurse call light system available and within easy accessibility to the resident at the bedside or other accessible location. The facility policy presented dated 2/28/14 on Fall Prevention Program documented that it is the policy of this facility to have a fall prevention program to assure safety of all residents in the facility. Listed guidelines for safety precautions for resident at risks includes but not limited to the frequency of safety monitoring will be determined by the resident's risk factors and plan of care, any resident who falls at least twice within 30 days will be considered at risk and Call lights are kept within reach.

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30279 Based on interview and record review the facility failed to develop and implement appropriate measures to ensure adequate supervision for three of three residents (R1, R2, and R3) identified at high risk for falls reviewed for falls with injury in the sample. This failure affected R1, R2, and R3 who had multiple falls and unwitnessed falls with lacerations requiring adhesive strips, sutures, and staples to correct the lacerations at the local hospital. Findings include: 1. R1's medical record Admission Record showed that R1 was admitted to the facility 11/09/2023. R1 diagnosis list includes but not limited to Alcoholic cirrhosis of liver without ascites, altered mental status, hepatic encephalopathy, abnormal results of liver function studies, alcoholic polyneuropathy, unspecified injury of head, subsequent encounter, anemia, alcohol dependence, uncomplicated, hypertensive heart disease with heart failure, unspecified dementia, unspecified severity, with other behavioral disturbance, thrombocytopenia, unspecified. R1's fall risk review presented dated 11/09/2023 showed that R1 was determined to be high risk for falls. R1's medical record showed that R1 had three unwitnessed falls in the month of February dated 02/20/25, 02/16/25 and 02/27/25. R1' medical record documentation showed that R1 had a fall with no injury on 02/20/25. R1's hospital record dated 02/16/25 documentation showed reason for ER (emergency room) visit as fall and head laceration with diagnosis listed as scalp laceration initial encounter and fall initial encounter. Laceration repaired with four (4) staples. R1's fall risk review presented dated 02/16/25 showed that R1 was determined to be high risk for falls. R1's hospital record dated 02/27/25 documentation showed reason for ER visit as fall with diagnosis listed as chin laceration, initial encounter, and fall initial encounter. Laceration to the chin repaired with eight (8) sutures. R1's fall risk review presented dated 02/27/2025 showed that R1 was determined to be high risk for falls. The facility investigation conclusion for the incident of 02/16/25 final report indicated that it was confirmed that R1 had fallen while visiting a friend who is another facility resident. The staff members were interviewed and reported that the resident (R1) was lying on the floor near the walker in another resident's room during rounds. Facility investigation witness statement V19 CNA (Certified Nurse's Aide) I did not witness the incident. I was assigned to resident (R1). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	According to the facility investigation staff interview/statement post incident/accident report dated 2/27/25, V21 RN (Registered Nurse) wrote that the CNA called my attention saying that the resident (R1) is on the floor in the hallway near the toilet doorway at around (15:30) 3:30pm. V21 wrote that (R1) did not use his walker and (R1) is unaware of safety precautions. On 03/24/25 at 2:45pm, V21 RN (Registered Nurse) stated none of the scheduled staff saw R1 before the fall. R1 was found after the fall. V21 stated that R1 should be under strict supervision since R1 is at high risk for falls because R1 is constantly falling. V21 stated that R1 had a laceration not a skin tear, V21 stated that laceration can be from a blunt trauma, forceful and the wound is a deeper than skin tear. On 03/25/25 at 1:25pm, V16 (Restorative Aide) stated that R1 is high risk for fall. We (facility) put residents in a fall prevention program after they have two to three fall incidents. Right now, starting today (03/25/25). R1 is using non-skid floor mat, chair/bed alarm and since Friday using wheelchair after therapy reevaluation. On 3/26/25 at 12:36pm, V19 CNA (Certified Nurse's Aide) stated that she was in the shower room when the incident occurred on 02/16/25 and that before leaving to assist the resident V20 RN (Registered Nurse) was made aware so that another staff can monitor V19's assigned residents in making sure their needs are met and fall is prevented. The surveyor asks V19 whether in her opinion as a CNA any resident using assistive ambulatory device like a walker should be monitored. V19 stated yes. At 12:43pm, V2 DON (Director of Nurses) who was present during the interview stated that V20 (RN) is no longer working at the facility. V2 stated that one of the other CNAs or V20 should have made the other staff on the floor aware so they can help to monitor. V2 stated that on every shift there should be a staff (CNA) monitoring the hallway. 2. R2's medical record Admission Record showed documentation that R2 was admitted to the facility on [DATE] with list of diagnosis that includes but not limited to chronic kidney disease, hydronephrosis with renal and ureteral calculous obstruction, anemia, laceration without foreign body of scalp, subsequent encounter, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety. R2's medical record showed two unwitnessed falls in the month of March dated 03/07/25 and 03/20/25 with injury. According to facility final investigative report form for 3/7/25 incident R2 had a fall and R2 was sent to the hospital. According to the facility investigation dated 03/07/25, V13 CNA witness statement form documentation, V13 wrote in part that R2's roommate came and got me (V13) to let me know that R2 fell when I (V13) got back from break, R2 was noted on the bed leaning forward and bleeding then V13 called the nurse (Referring to V11). R2's medical record Progress note dated 03/07/25 timed 01:55 (1:55am) V11 documented that (R2) was found in bed following an unwitnessed fall by CNA (referring to V13). Assessment revealed that (R2) hit the head. V11 noted a laceration on the left side of the forehead and blood on the floor. Physician and 911 (local emergency number) called and was sent to the hospital. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 03/07/25 at 10:29am, V23 ADON (Assistant Director of Nurses) documented that when she called the local hospital, she was informed that R2 is admitted to the ICU (Intensive Care Unit) with diagnosis of anemia and subdural hematoma with bleeding. R2's medical record showed that R2 was transferred back to the facility on [DATE] at 4:03pm via ambulance with 2 to 3 stitches. On 03/14/25 at 11:59am, V4 (Wound care Nurse) documented that she removed 3 sutures from the left side of R2's forehead. R2's medical record Progress Note showed documentation that on 03/20/25 R2 had another unwitnessed fall incident with laceration to parietal area with minimal bleeding. R2's hospital record dated 3/20/25 showed that R1 was at the hospital for fall and listed diagnosis includes fall initial encounter and laceration of scalp without foreign body. Laceration corrected with one staple on the scalp. On 03/25/25 at 12:51pm, V11 LPN (Licensed Practical Nurse) stated that she was the nurse in charge for care of R2 with two CNAs on the floor. I (V11) was doing my rounds when the CNA (V13) who was just coming back from break called me that R2's roommate called her that something is wrong with R2. When I (V11) got to the room R2 was on the floor in a pool of blood with laceration to the left side of the forehead. I took the vitals and called the doctor (physician) and R2 was sent to the hospital. V11 stated that the incident occurred around 1:55am, there were two CNAs on the floor and we should have at least three CNAs because we have lots of residents who are at risk for falls. The surveyor asked about how the staff supervise/monitor the residents if one of them goes on break. V11 stated that when one (CNA) goes on break the other ones takes over to monitor the floor that is why we ask them to sit in the hallway. V11 stated that on 03/07/25 I did not hear any, noise, no yelling or crying (from R2) until (V13) called me. 3. R3's medical record Admission Record showed that R3 was admitted to the facility on [DATE] with diagnosis list that includes but not limited to Hydrocephalus, unspecified, cerebral infarction, unspecified, sepsis unspecified organism, presence of cerebrospinal fluid drainage device, traumatic subdural hemorrhage without loss of consciousness subsequent encounter, altered mental status, unspecified, low vision right eye category 2, low density vision left eye category 2, and presence of urogenital implants. R3's medical record showed that R3 had an unwitnessed fall on 02/12/2025, R3 was found on the floor in the west dining room. R3 was sent to the local hospital for evaluation and treatment, R3's CT scan at the hospital showed acute subacute subdural hematoma. Facility investigation report concluded that R3 attempted to reposition self without asking for help and slid out of the wheelchair. R3's medical record showed that R3 had a fall on 03/15/25, according to facility investigation documentation, R3 was turned too far in bed while receiving perineal care (Incontinent care). R3 was sent to the hospital where adhesive strips were applied to correct laceration to the forehead. R3's MDS (Minimum Data Set) dated 1/31/25 scored BIMS as 12. On 03/24/25 at 4:10pm, V2 stated that all these falls happened in the room and there is no way the facility can put the staff in the room with the residents. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 03/26/25 at 10:58am to 11:15am, during interview with V25 (Physician), V25 stated that R1, R2, and R3 have comorbidities that put them at risk for falls. V25 stated that they can all benefit from close supervision to prevent falls and injury to the residents. When the surveyor asked whether these falls can be prevented, V25 stated these residents are being treated with medicine but close supervision by staff is the only way that is successful in preventing their falls (referring to R1, R2, and R3). Yes, they will all benefit from close supervision. Most of these falls happened on nights (Night shift). On 03/26/25 as at 4:25pm, V2 and the surveyor were unable to reach V10 (Nighttime LPN), V20 (Former RN), V23 (Former ADON), V24 (Former RN) via phone for interview. The facility policy presented dated 2/28/14 on Fall Prevention Program documented that it is the policy of this facility to have a fall prevention program to assure safety of all residents in the facility, when possible. the program will include measures which determine the individual needs of each resident by assessing the risk for falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary. Listed guidelines for safety precautions for resident at risk includes but not limited to the frequency of safety monitoring will be determined by the resident's risk factors and plan of care, any resident who falls at least twice within 30 days will be considered at risk. The facility policy on Supervision and Safety dated 3/15 documented that resident safety and supervision are facility-wide priority. Resident supervision is a core component of resident safety. Staff to make visual rounds on residents minimally every two hours and more often, if necessary, based on resident's assessment needs.