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	06/09/2025

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 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** Based on observation, interview, and record review, the facility failed to provide adequate supervision and monitoring for residents. As a result of these failures, R3 fell in the facility on 05/24/2025, while being showered by staff and sustained facial lacerations requiring 12 sutures. These failures affect three (R3, R4, R5) out of five residents reviewed for supervision and monitoring in a total sample of five residents. Findings include: On 06/07/2025, at 10:01 AM, V5 (Certified Nursing Assistant/CNA) states she is unsure of the name of the resident but heard that a resident on the first floor had stitches on their face. V5 states she heard this information approximately 1 week ago. V5 states since then, the facility has educated them on being careful when showering residents and not to leave them unattended during showers. On 06/07/2025, at 10:08 AM, V6 (CNA) states R3 was the resident who fell in the facility and has a scar on his face. V6 states she was not working in the facility that day. R3 fell but she heard of the incident when she returned back to work. V6 states she has cared for R3 and is aware of his behaviors. V6 states R3 moves around a lot, grabs things, and people when they walk past him. V6 states R3 is at risk for falls and wears a helmet in the facility. V6 states R3 needs to have his hand held for guidance and be watched at all times. V6 states she heard that 2 CNAs were showering R3 when he fell. V6 states she does not understand how R3 fell while in the care of 2 CNAs. R3 should not have fallen. V6 states R3's eye looked bad after he fell and R3 required stitches around his right eye. On 06/07/2025, at 10:10 AM, R3 was fully dressed and sitting in a chair located in the first floor hallway next to V7 (Licensed Practical Nurse/LPN). V7 observed with a medication cart and passing medications to residents with R3 sitting next to the medication cart. R3 observed with a gray helmet on his head and 3 steri strips on the side of his right eye. R3 is not verbally responsive and unable to make needs known. On 06/07/2025, at 10:14 AM, V7 (LPN) states she was not working in the facility the day that R3 fell. V7 states when she returned to work, she was informed that R3 fell while taking a shower. V7 states she was informed that there was a CNA (identified as V12) giving R3 a shower when R3 became agitated. V7 states another CNA (identified as V13) was called to the shower room for assistance. V7 states as V13 was putting on her gloves, R3 fell while in the shower. V7 states R3 had discoloration and lacerations above and below his right eye and required a total of 12 stitches. V7 states R3 is at high risk for falls and usually wears a helmet for safety in the facility. (continued on next page)

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
	146062	A. Building B. Wing	06/09/2025

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 0689 Level of Harm - Actual harm Residents Affected - Few	On 06/07/2025, at 10:48 AM, surveyor located on the second floor of the facility and hears a resident call out for staff assistance. V10 (CNA) observed inside of another resident's room without any residents inside. V10 observed with her phone in her hand looking at the screen. V10 states she is currently not on break and is responsible for caring for residents on the second floor. V10 states she should not be located inside of the resident's rooms operating her phone. Surveyor inquires to V10 if she is the CNA responsible for caring for the resident who called for assistance. V10 states that she did not hear a resident call for assistance while she was operating her phone. On 06/07/2025, at 11:12 AM, R4 and R5 observed sitting in a wheelchair inside of the third-floor activity room unsupervised and unattended. On 06/07/2025, at 11:13 AM, V15 (CNA) walks inside of the third-floor activity room and states she is responsible for monitoring the residents located in the activity room because it is her designated monitoring time. V15 states she is responsible for monitoring the third-floor activity room today from 11:00 AM-11:30 AM. V15 states there is supposed to be someone inside of the activity room monitoring the residents at all times. V15 states she is not certain of the resident's fall risk status but believes R5 is at risk for falls. V15 states if residents are not properly monitored, then they can potentially fall or injure themselves. On 06/07/2025, at 2:44 PM, V12 (CNA) states she was the nurse assigned to care for R3 the day he fell on [DATE]. V12 states the incident occurred at approximately 7:30 PM. V12 states she had just given R3 a shower. R3 was still located in the shower room sitting down in a shower chair. V12 states she then had R3 stand up and called her co-worker V13 (CNA) to come into the shower room to monitor R3 while V12 went to retrieve more towels. V12 states she saw V13 coming around the corner putting on gloves. V12 figured that V13 could see R3 from the angle where V13 was standing. V12 states V13 was standing approximately 2.5 feet away from R3 while V13 was putting on her gloves. V12 states she was standing at the shower room doorway getting more towels when she heard a loud boom. V12 states when she returned back to the shower room approximately 2 seconds later. She saw R3 lying face down on the shower room floor bleeding from his face. V12 states they then made the nurse (identified as V14) aware of R3's status and V14 went to the shower room to assess R3. V12 states she felt bad and was crying because R3 should not have fallen. R3's fall could have been prevented. V12 states R3's fall could have possibly been prevented if she had the towels closer to the shower room, or if V13 was standing closer to R3. V12 states R3 is at high risk for falls and requires a lot of 1:1 monitoring in the facility at times. V12 states R3 had a gash underneath his right eye and was sent out to the hospital to be evaluated. V12 states R3 returned back from the hospital the same day and had stitches in his right eye. V12 states R3's eye was also swollen and discolored blue and purple. On 06/07/2025, at 2:18 PM, V2 (DON/Director of Nursing/Fall Coordinator) states she handles the clinical reporting of falls to the state health department. V2 states she was on vacation when R3 fell and was made aware of R3's status. V2 states she followed up to ensure that R3's fall was investigated and reported by another staff member. V2 states she was made aware that V12 (CNA) was giving R3 a shower. V12 went to grab a towel and left V13 (CNA) with R3. V2 states V13 was putting on her gloves and she tried to catch R3 but R3 slipped and fell. On 06/07/2025, at 3:30 PM, V2 (DON/Fall Coordinator) states as a result of R3 falling in the facility, V12 (CNA) and V13 (CNA) were both suspended from work for a total of 3 days. (continued on next page)

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	06/09/2025

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 0689 Level of Harm - Actual harm Residents Affected - Few	On 06/09/2025, at 1:02 PM, V13 (Certified Nursing Assistant/CNA) states V12 (CNA) asked her for help while showering R3 because R3 was aggressive at that moment. V13 states R3 was irritated, aggressive, and trying to fight staff. V13 states V12 went to reach for towels. R3 attempted to walk while V13 was putting on her gloves. V13 states she tried to grab R3 but R3 fell face down in the shower. V13 states she feels really bad about R3 falling and cannot believe it happened. V13 states R3 fell within a matter of one second because they could not handle R3 in that moment. V13 states she was standing close to R3 but was trying to put her gloves on when R3 suddenly fell. V13 states R3 was bleeding close to his eye and V14 (LPN) called the ambulance. V13 states R3 was sent out to the hospital and needed stitches. V13 states she was suspended from work for 3 days and will be returning back to work this week. R3's Facesheet documents that R3 has diagnoses not limited to: Lacerations without foreign body of other part of head, unspecified injury of head, unspecified fall, history of falls, unsteadiness on feet, mild cognitive impairment, lack of coordination, seizures, and unspecified dementia. R3's MDS/Minimum Data Set, dated [DATE], documents that R3 has a BIMS/Brief Interview for Mental Status of 0/15, indicating R3 is cognitively impaired. R3 requires substantial/maximal assistance with showering/bathing. R3 is incontinent of bowel and bladder and ambulates via wheelchair. R3's Fall Risk assessment dated [DATE], documents that R3 is at high risk for falls. R3's care plan documents that R3 is at risk for falls with interventions to include Anticipate and meet individual needs of the resident. Facility Reported Incident dated 05/24/2025, documents that the facility reported to the state agency that R3 fell in the facility while in the shower and sustained injuries. R3's hospital records dated 05/24/2025, documents that R3 was evaluated in the hospital on [DATE], and diagnosed with complex lacerations of the face and required sutures. R3's nursing progress note dated 05/24/2025, at 7:20 PM, written by V14 (LPN) documents, This writer walked to the west side shower room. Writer noticed R3 was half sitting on the floor. Per the two aides who were showering R3, R3 slipped on the floor and fell. R3 was noticed with approximately two and half centimeter cut below the right eye (orbital area) oozing a moderate amount of blood. R3 was also noticed also with approximately 1 centimeter cut below right eye brow, oozing a moderate amount of blood. A pressure dressing was applied to both areas to stop the bleeding. R3 was assessed for any hip injury. Both extremities were equal in length and size. R3 denies any pain during movement of the both legs. R3 did not lose conscious, and was alert to name and situation. R3 was noted with base line mental status, and able to answer simple questions. R3 complained of pain on the forehead and right side of his face. R3 was noticed with swelling on the right facial area, swelling of the chin with bruising, right forehead swelling and purple discoloration, swelling and bruising of the right eye, right facial area edema with ecchymosis on and around the right side of the face. No bumps were noted on the head. R3 was able to grasp with both hands, and able to follow simple commands. R3's pupils were reactive to light. R3's right knee had a small cut, with a scrape. Redness was noted on the right hand by the thumb area with purple discoloration. No skin breaks. Redness was observed on the right side of the chest and abdomen area. 911 call was made and R3 was taken to hospital. (continued on next page)

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	06/09/2025

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 0689 Level of Harm - Actual harm Residents Affected - Few	R3's nursing progress note dated 05/25/2025, at 12:40 AM, written by V7 (LPN) documents Received R3 lying in bed with no signs of distress or discomfort. Writer noted R3 has 4 stitches below the right eyebrow that are intact. R3 has 8 stitches below the right eye (orbital area) that are intact. R3's right side of the face bruise along with swelling of the right eye. R3 right eye sclera redden, no drainage noted from the right eye. R3's chin on the right side has a small abrasion. R3's right knee had 2 redden scrapes with some right knee slight swelling. R3 has no active bleeding. R3 denies pain. No change in neurological status from baseline. Fall precautions implemented. R3 will continue to be monitored. R4's Fall risk assessment dated [DATE], documents that R4 is at high risk for falls. R5's Fall risk assessment dated [DATE], documents that R5 is at high risk for falls. Facility policy dated 03/2015, titled Supervision and Safety documents in part, Our policy strives to make the environment as free from hazards as possible. Resident safety and supervision are facility-wide priorities. 1. Our facility-oriented approach to safety addresses risks for groups of residents such as wanderers, behaviors, aggressiveness, confusion, etc. 4. Resident supervision is a core component to resident risk factors. 9. Staff to decrease safety risk factors as much as possible. Facility policy dated 02/28/2014, titled Fall Prevention Program documents in part, 11. Residents who require staff assistance will not be left alone after being assisted to bathe, shower, or toilet. 22. Monitor gait, balance, and fatigue with ambulation.