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	08/02/2025

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. (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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(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	Based on interviews and record review, the facility failed to provide adequate supervision during provision of ADL (Activities of Daily Living) care for 1 (R2) resident out of 3 residents reviewed for falls. This failure resulted with R2 falling while at the facility on 06/24/2025 and sustaining a facial laceration requiring sutures. Findings include: R2's admission Record documented that R2's diagnoses (include but not limited to) Type 2 Diabetes Mellitus, repeated falls, Alzheimer's disease, dementia, and laceration part of head (Onset Date: 06/25/2025). R2's (05/13/2025) Minimum Data Set documented, in part Section C. Cognitive Patterns. C0500. BIMS (Brief Interview for Mental Status) Summary Score: no entry. C0700. Short-Term memory Ok: 1 memory problem. C0800. Long-Term Memory Ok: 1. Memory Problem. C1000. Cognitive Skills for daily decision making: 3 severely impaired. Section GG - Functional Abilities. GG0130. Self-Care. E. Shower/bathe self: 02 - substantial/maximal assistance - Helper does more than half of the effort. Helper lifts or holds trunk or limbs and provides more than half of the effort. R2's (Revision Date: 05/24/2025) care plan documented, in part Focus: has a Self-Care Deficit and requires assistance with ADL's to maintain the highest possible level of functioning. Goal: will maintain their current level of ADL functioning without a significant decline. Interventions: Provide assistance with all ADL's as required per the residents need dependence: Bathing.R2's (Revision on: 06/22/2023) care plan documented, in part Focus: is at risk for falls R/T (related to) Cognitive Impairments, Dementia. Goal: will remain free of injuries. Interventions: Staff to redirect resident when they see her bending over picking up anything off the floor (initiated: 09/13/2021). Anticipate and meet individual needs of the resident. (Date Initiated: 05/02/2017). R2's (06/24/2025) Fall documented, in part Person Preparing Report: V3 (Licensed Practice Nurse). Nursing Description: This writer was called by the CNA (Certified Nurse's Assistant) to the west side shower room, pt (patient) found lying on the floor leaning toward the left side, noted 2 lacerations on the left forehead above the left eye, bleeding, pressure dressing applied. 911 call was made, ambulance here to take pt to ER via stretcher. Predisposing Physiological Factors: confused, decreased safety awareness, and decreased strength. R2's (06/24/2025) CT Scan report documented, in part FINDINGS: Soft tissues: Swelling and laceration of the frontal scalp on the left side extending into the left periorbital area. R2's (06/30/2025) Final Reportable documented, in part Summary of Investigative Findings: While being showered by CNA (V4), the resident leaned forward, slipped off the shower chair, and fell, hitting her face on the floor. Resident has poor trunk control causing her to fall and sustain head injury, resident was sent out 911 and returned within 24 hours from ER (Emergency Room) with sutures.On 08/01/2025 at 10:32am with V17 (Licensed Practice Nurse) at the facility's first floor dining/activity room, R2 was seated on a wheelchair. R2 was leaning forward and V17 has to touch and guide R2's chin to show R2's face to the surveyor. R2 was observed with approximately 1mm x 2mm, 2mm x 2mm, and 3mm x 3mm scabbing above the corner of R2's left eyebrow. R2 was making noises, clenching her teeth. R2 failed to interact with the surveyor. V17 stated that she (R2) needs extensive assistance with bathing. That there should be 2 persons assisting her. That sometimes she (R2) is not redirectable and will not bear her weight. V17 stated, We need 2 people to safely give her a bath. On 08/01/2025 at 2:10pm, V4 (Certified Nursing Assistant) stated that if a resident is maximum assist with shower, there should be 2-person assisting the resident, that she (V4) took her (R2) to the shower; it was just her during that time and she did not ask other CNAs for assistance. V4 was in front of R2 while she was bathing her. V4 stated R2 tends to lean forward, and she (R2) leaned on her left side, and she (V4) tried to catch her. V4 stated R2 was too heavy for her and she grabbed her (R2) body, trying to protect her (R2) head from the impact but her head still hit the floor. V4 stated that even with the arm rest on both sides of the shower chair and positioned herself (V4) in front of her (R2), she still fell. V4 stated even before the incident on 06/24/2025, she (R2) always leans forward, and she (V4) should have asked for assistance when she gave her (R2) a shower to prevent her from falling. On 08/01/2025 at 12:03pm, V3 (Licensed Practice Nurse) stated that (R2) was being showered and fell; V4 tried to catch her but was unable to do so. That while in the shower room, she (V3) observed R2 with a laceration on the left side above her eyebrow. There were no other staff was present. V3 stated R2 is dependent on everything including shower and that R2 did normally well, but her (R2) trunk control was declining. R2 had poor trunk control prior to the incident. V3 added that there should be 2-person assisting R2 during shower to prevent falls.On 08/01/2025 at 12:31pm, V16 (Restorative Nurse/LPN) stated (R2) is coded substantial/Maximum assist with shower/bathing; that there should be up to 2 people assisting her with shower. R2 is alert only to herself and has a poor safety awareness and for safety, there should be 2