

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146062	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/26/2025
NAME OF PROVIDER OR SUPPLIER Center Home Hispanic Elderly		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>(continued on next page)</p>

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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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on observation, interview, and record review, the facility failed to follow their policy to ensure appropriate wound care treatment is met and carried out for one (R1) out of 3 residents reviewed for pressure ulcers in a sample of 9. Findings Include: Section C documents in part BIMS (brief interview of mental status) of 11 which indicates that R1 is moderate cognitive impaired. On 12/23/2025 at 9:49 AM, surveyor observed R1 laying down on her bed, in an upright position while watching television. R1 seemed comfortable, under no pain or distress. R1 is alert and oriented to person. R1 is not alert and oriented to place and time, and has frequent confusion. Surveyor observed R1 holding the call light with her right hand. Surveyor observed a catheter bag; it was secured and off the ground. Surveyor observed a wheelchair and a walker at the bedside. There were no odors present, and the room was clean and free clutter. On 12/23/2025 at 10:01 AM, R1 stated she went to the hospital a few months ago and was told she had infection. R1, stated she developed the infection while being in the facility. Surveyor asked R1 what type of infection she developed in the facility, but R1 was unable to recall the name and location of the infection. R1 stated she did not have an infection before coming to this facility. R1 stated she has not had her wound care done today. On 12/23/2025 at 11:45 AM, surveyor observed the wound doctor and wound nurse going into R1's room. On 12/23/2025 at 12:46 PM, V17 (Wound Nurse) stated she has been working in the facility for 3 years and she is familiar with the R1. V17 stated when she first started caring for R1, she had existing wounds that had healed, but then she developed the sacral wound while being in the facility. V17 stated R1 requires weekly wound care with the wound care doctor. V17 stated the doctor will assess the wound on a weekly basis, and depending on the assessment the doctor will either change the wound care order or leave it as it is. V17 stated the wound care order has not changed, it is still the same for weekly wound care; apply Santyl ointment to sacrum once a day. V17 stated R1 did not have MRSA in the sacral wound when she began treatment with her 3 years ago. V17 stated R1 went to the hospital one day for wound care, and when R1 returned to the facility she had a diagnosis for Methicillin-resistant staphylococcus aureus (MRSA) of sacral bone. During record review, surveyor asked what it means when there is an empty square shown on the treatment administration record (TAR). V17 stated if it is empty that means it was not documented or it was not done for that day. Surveyor asked V17 what can potentially happen if treatment is not being done daily, V17 stated the wound will not heal properly. On 12/23/2025 at 1:21 PM, V2 (Director of Nursing/ DON) stated R1 was treated for MRSA when she was diagnosed in the hospital on August 27, 2025. V2 stated the MRSA was found in the sacral bone. Surveyor asked V2 if R1 was admitted with MRSA. V2 stated the MRSA was developed here and was discovered in the hospital. On 12/23/2025 at 2:00 PM, V19 (Infection Preventionist) stated R1 was sent to the hospital for wound care, and upon return to the facility she was diagnosed with MRSA in the sacral bone. V19 stated when R1 returned to the facility from the hospital she was placed on contact precautions and was taking antibiotics. V19 stated R1 is currently not taking any antibiotics, and she is no longer a candidate for contact precautions per their new policy. V19 stated she is currently on enhanced barrier precautions due to her wounds. Reviewed R1 treatment administration record, R1 did not receive any wound care treatment on 11/7, 11/9, 11/15, and 11/30. Policy titled Pressure Ulcer with no review date documents in part, It is the policy of this facility that pressure injury and other ulcers, (diabetic, arterial, venous) will be assessed and measured at least every (7) days by licensed nurse and recorded on the facility approved Wound Assessment Form. A notation will be made in the nurse notes, Treatment Administration Record, or on weekly bath sheet when NO skin problems are observed for the skin check.</p>		