<table>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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<td>Continued From page 3 assistance with drinking it. Z1 was notified of the serving temperature measured at 10:25 a.m. to be 160 degree Fahrenheit, and Z1 said that 160 degrees is extremely too hot to serve coffee to R1. According to the progress note dated 8/13/2012 written by Z1 denotes R1 to have a second degree burn to the right thigh. According to R1’s current plan of care there were no plans noted that are developed to assist R1 with eating and/or drinking. There was no plan noting R1’s diagnosis of Parkinson and Tourette’s syndrome with interventions to include assistance with eating and/or drinking. On 8/10/2012 at 9:50 a.m. in the kitchen E7 (lead cook), prepared coffee from the automatic coffee dispenser, the temperature was measured at 172 degrees Fahrenheit. E7 said that the brewing temperature was preset by the manufacturer. E7 also said that he calibrated the thermometer earlier that morning. E7 was observed to prepare coffee and transport the coffee to the third floor where R1 resided. The coffee was dispensed and the temperature taken and measured to be 160 degrees Fahrenheit at 10:25 a.m. On 8/10/2012 at 10:00am Z2 (Dietary consultant), said that and adequate serving temperature should be 120 to 140 degrees Fahrenheit. E1 did not provide the survey team with any policies with guidance for the serving temperature of hot coffee.</td>
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<td>FINAL OBSERVATIONS</td>
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:
146062

(X2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

(X3) DATE SURVEY COMPLETED
C 09/11/2012

NAME OF PROVIDER OR SUPPLIER
CENTER HOME HISPANIC ELDERLY

STREET ADDRESS, CITY, STATE, ZIP CODE
1401 NORTH CALIFORNIA
CHICAGO, IL  60622

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SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETION DATE
F9999

Continued From page 4
LICENSURE VIOLATIONS:
300.610a)
300.1210a)
300.1210b)
300.1210c)
300.1210d)(6)
300.1220b)(2)(3)
300.3240a)

Section 300.610 Resident Care Policies
a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting.

Section 300.1210 General Requirements for Nursing and Personal Care
a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest
Continued From page 5

practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

2) Overseeing the comprehensive assessment of...
## Statement of Deficiencies and Plan of Correction

### Center Home Hispanic Elderly

**Street Address, City, State, Zip Code**

1401 North California

Chicago, IL 60622

### Summary Statement of Deficiencies

Each deficiency must be preceded by full regulatory or LSC identifying information.

**Event ID:**

Facility ID: IL6001523

### Provider's Plan of Correction

Each corrective action should be cross-referenced to the appropriate deficiency.

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the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.

3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These requirements were not met as evidence by:

Based on observation, interview and record review the facility failed to provide assistance and/or supervision while providing hot coffee for 1 of 3 residents R1, all reviewed for feeding assistance in a sample of 3 residents. This failure resulted in R1 sustaining a second degree burn to his right thigh.
F9999 Continued From page 7
Findings include:

According to the facility's unusual occurrence report report dated 8/4/2012 at 5:00pm R1 was taken to the wash room by E4 (certified nurse aide), at 8:30pm. E4 noted that R1's thigh was reddened and blisters were present. E4 noted that R1 was asked what happened, and R1 indicated that he spilled coffee on himself. The report denotes that the event was unwitnessed.

According to the R1's clinical record physician order sheet, R1 has a diagnosis of Parkinson, and weakness. R1's most recent MDS (minimum data sheet) dated 7/5/2012 section I active diagnosis includes Parkinson's disease, and Tourette's syndrome, (Neurological Involuntary Movements).

According to the MDS section G functional status R1 requires extensive assistance with 1 person physical assist with eating and drinking.

On 8/10/2012 at 9:35 a.m. R1 was observed sitting in a wheel chair waiting for assistance to be placed in bed for an assessment of his right thigh. R1 was observed with sporadic muscle twitching and shaking of the bilateral upper extremities. E6 (Nurse) was present and said that R1 has Parkinson disease and a history of intermitted tremors. R1's right hand was also observed to be partially contracted. Once in the bed R1's right thigh was observed to have a large bruised area, with a red open area which as measured by E5 (wound nurse) to be 3cm by 2.5cm. During this observation E5 said that she was a certified wound nurse, and that R1 had sustained a second degree burn.
On 8/10/2012 at 9:40 a.m. R1 said that on 8/4/2012 he was given a cup coffee, and he was in the hallway. R1 said that he attempted to place the cup of coffee on the handrail and the coffee spilled onto his leg. R1 was observed to primarily speak Spanish, E1(Administrator) provided interpretation during this interview.

On 8/16/2012 at 3:30 p.m. via telephone E4 said that she didn't witness R1 spilling coffee on himself, however while assisting R1 to the washroom at approximately 8:00 p.m. on 8/4/2012, she observed bruising and blisters to R1's right thigh. However E4 said that she has taken care of R1 in the past and that R1 didn't require assistance with eating and drinking.

On 8/16/2012 at 3:45 p.m. via telephone E3 (Certified nurse aide) said that on 8/4/2012 around 7:00 p.m. she was passing coffee out to resident in the activity room. E3 said that coffee was being passed out in Styrofoam cups with no lids/cover. E3 said that she was aware that R1 arms shake a little so indicated that she poured R1 a half cup of coffee. E3 indicated that the coffee was hot enough to see steam after it was poured. E3 said that she was unaware of R1's diagnosis of Parkinson and Tourette syndrome. However E3 said that she did inform R1 that the coffee was "caliente" (hot). E3 denies the ability to speak Spanish. E3 said after giving R1 coffee she left the activity room to continue to pass coffee out at the bedside. E3 denied being aware that R1 required physical assistance with eating and drinking.

On 8/10/2012 at 12:45 p.m. Z1 (physician), said...
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<td>Continued From page 9 that she was aware that R1 spilled hot coffee on his right thigh and sustained a burn. Z1 said that she had not seen the burn, however said that she would be in tomorrow to assess R1 status/condition. Z1 said that R1 has very bad tremors, that are difficult to manage. Z1 said that R1 requires some assistance with drinking beverages, Z1 also said that based on R1's frail condition and age that an extreme hot beverage would cause R1 to have a very bad outcome. Z1 said that the facility staff should not have left R1 alone with a hot beverage without providing some assistance with drinking it. Z1 was notified of the serving temperature measured at 10:25 a.m. to be 160 degree Fahrenheit, and Z1 said that 160 degrees is extremely too hot to serve coffee to R1.</td>
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and the temperature taken and measured to be 160 degrees Fahrenheit at 10:25 a.m.

On 8/10/2012 at 10:00am Z2 (Dietary consultant), said that and adequate serving temperature should be 120 to 140 degrees Fahrenheit.

E1 did not provide the survey team with any policies with guidance for the serving temperature of hot coffee.  

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