STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001523	A. BUILDING: _____ B. WING _____	C 03/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER HOME HISPANIC ELDERLY	1401 NORTH CALIFORNIA CHICAGO, IL 60622

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S9999	Final Observations STATEMENT OF LICENSURE VIOLATIONS 300.1210b) 300.1210d)6) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care 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. 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 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)	S9999		

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S9999	Continued From page 1 THESE REGULATIONS WERE NOT MET AS EVIDENCED BY: Based on observation, interview and record review the facility failed to implement effective fall prevention measures for one of three residents (R1) reviewed for falls in a sample of three. This failure resulted in R1 incurring a fracture of the arm and a laceration requiring sutures. Findings Include: The Admission Face Sheet, 12/10/13, documents R1 with diagnoses to include Dementia, Vertigo, History of Falls, and Parkinson's. R1's Care Plan for falls, initiated 1/31/14, documents R1 as requiring use of a non-skid floor mat, keep personal items in reach, anticipate needs, use of a personal alarm, monitor closely and a room close to the nurses station. The Fall Risk Review, 1/11/14, documents R1 at a high risk for falls. On 1/11/14 at 7:25am, the facility incident report documents R1 was found by E3 (Nurse) on the floor in a sitting position in front of the closet door. The report does not document the personal alarm being in place. No injuries were noted. The Nursing Management Investigation Report, 1/11/14, documents R1 stated he was walking towards the closet and lost balance and fell. On 3/14/14 at 9:30am, E3 showed the surveyor the location R1 was found on the floor and E3's location at the nurses station at the time of the fall. E3 stated R1 was found on the floor by the closet. R1's room was directly visible from the	S9999		

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S9999	Continued From page 2	S9999		

nurses station where E3 stated she was sitting (10 feet between the nurses station and R1's room). R1's bed was the first bed inside the room, directly left of the bedroom entrance, which was pushed up against the wall on one side. The closet in that room was across the room near the windows in the room (approximately feet from the foot of R1's bed). E3 stated R1 was found on the floor when she looked over from the nurses station. E3 was unable to indicate if R1's personal alarm was sounding and stated she was aware of the fall when she observed R1 on the floor by the closet.

On 2/20/14 at 1:30pm, the facility incident report, completed by E3, documents R1 was found on the lying on the floor with a laceration to the right eyebrow and complaints of right shoulder pain. The hospital record, 2/20/14, documents R 1 was diagnosed with a fractured arm which was placed in a sling and a laceration to the right eyebrow requiring sutures.

On 3/13/14 at 12:46pm, E4 (Nursing Assistant) stated she responded to a personal alarm in R1's room on 2/20/14 and found R1 on the floor. R1 was face down on the mat with part of R1's upper body off of the mat on the floor.

On 3/14/14 at 12:52pm, E5 (Nursing Assistant) stated on 2/20/14 she entered the room to find R1 on the floor laying on his stomach. R1 was half on the mat with the upper half of his body laying on the floor. E5 was asked to demonstrate the placement of the mat and placed the mat so approximately half of the mat was underneath the bed. E5 stated R1 can remove the personal alarm and move the floor mats. E5 stated R1 uses a personal alarm at all times in the bed and wheelchair.

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On 3/14/14 at 10:25am, E2 (Director of Nursing), stated R1 incurred a laceration requiring 7 sutures and a fracture requiring use of a sling on 2/20/14 after R1 fell. When asked if proper mat placement could have prevented R1 from incurring injuries E2 stated, "Yes, it may have."

On 2/23/14 at 11:34pm, the facility incident report documents E7 (Nurse) heard a loud noise. R1 was found sitting on the floor with juice all over R1's gown and the bedside table on the floor. R1 stated, "I wanted to drink juice."

On 3/14/14 at 10:12am, E7 stated a noise was heard and R1 wasn't in bed. R1 was found on the floor at the foot of the bed. The bedside table fell also and was lying next to R1. Mats were down. R1 stated he wanted a drink and juice was all over R1's gown. The alarm was not sounding. E7 stated R1 can remove the alarm.

On 3/14/14 at 10:25am, E2 stated R1's bedside table should have been within reach. R1 also uses mats and a personal alarm at all times. E2 stated she was unaware R1 would remove the personal alarm.

On 3/14/14 at 11:40am, Z1 stated all falls cannot be prevented. The expectation is to do a fall risk evaluation and implement protocols. Implementation of intervention reduces falls and injuries from falls.

The facility policy, Fall Risk and Post Fall Assessment, undated, documents the purpose of fall risk assessment is to detect reversible causes of falls and identify supportive aids to prevent falls. Residents are to be monitored regularly for changes which might increase the potential for

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S9999	Continued From page 4 future falls. (B)	S9999		