DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 ______	C 09/17/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Incident Report Investigation for Incident 9-5-15/ IL 79986 - F323	F 000		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to develop and implement new intervention after resident falls,and to update resident care plans and Fall Risk Assessments. This has the potential to affect two of three residents (R1 and R3) reviewed for falls of a total sample of three. Findings include: R1 has diagnoses significant for Dementia and Osteoarthritis, per facility face sheet. Review of facility fall occurrences indicates R1 has fallen multiple times at the facility: R1 fell 9-8-15 at 10:30am, where she was found on the floor by her bed without shoes on or her walker nearby. R1 stated she got dizzy, then fell. There is no mention of a bed or chair alarm in place. R1's fall care plan includes their	F 323		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

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interventions "ensure resident is wearing appropriate footwear," be sure call light is within reach" and "educate resident to use her walker at all times." E2 (Director of Nursing) investigated this fall, and concluded it was due to not wearing her shoes, being non-compliant with using her walker, and poor vision.

Facility incident report dated 9-5-15 indicates was brought to the nurses' station by E5 (CNA - Certified Nursing Assistant) due to complaints of abdominal pain. E4 (Nurse) observed R1 guarding her abdomen. R1 stated "my side hurt so bad the other day, I fell." E4 took R1 to her room and examined her, finding a "superficial lump" to R1's right lower abdomen. Z4 (Physician) gave orders to send R1 to the hospital for evaluation of abdominal pain. E4 stated 9-15-15 at 2:32pm she was unaware of R1 falling recently. E5 stated 9-15-15 at 3:00pm she was also unaware of R1 falling recently, and reported this as an unwitnessed fall. E6's nursing note dated 9-6-15 at 9:42am indicates R1 was admitted to the hospital for abdominal pain. Hospital records indicate R1 received An X-ray of R1's right rib cage 9-6-16 found a minimally displaced acute fracture of the right eighth rib anteriorly, and no pneumothorax. E9's (Nurse) nursing note dated 9-7-15 at 10:51pm indicates R1 was re-admitted to the facility with an abdominal binder in place for her fractured rib.

R1 fell 5-7-15 at 9:58pm, when she was found on the floor of her room., per the The Fall Incident report written by E13 (Nurse). This report indicates Z5 (Physician) was made aware and ordered R1 to be monitored and a bed and chair alarm be placed for safety. There are no interventions of a bed or chair alarm listed as

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interventions on R1's care plan, or any other new interventions. An updated fall risk assessment was not done after this fall.

R1 was found on the floor of her room 5-6-15 at 11:30pm. R1's care plan was not updated with any new interventions after this fall.

R1 was reported by her roommate 5-5-15 at 6:05pm to have fallen and got back into bed by herself. R1 sustained a right elbow skin tear and complained of right hip pain. R1 was sent to the hospital, and the X-ray of R1's right hip was negative, but she was admitted to the hospital for a diagnosis of Urinary Tract Infection and Fall. R1's care plan was not updated with any new interventions after this fall.

R1 experienced a witnessed fall 4-7-15 at 3:26pm while a friend was visiting her. R1 slipped getting out of bed. R1 did not have shoes on prior to this fall. R1's care plan was not updated until 4-21-15 with new interventions.

R1 was found on the floor of her room 3-7-15 at 1:44pm.

R1 was seen 9-15-15 at 11:58am to be seated on her bed, her call light draped over the nightstand. R1 could not reach her call light upon command by E11, who interpreted. There was not a bed alarm in place. R1 was again seen 9-15-15 at 4:20pm, standing up at the side of her bed. There was not a bed alarm in place or sounding. R1's call light draped over the back of her nightstand. R1 was once again seen 9-16-15 at 1:25pm standing by her closet. R1 wore only socks, and no bed alarm was seen or was sounding. R1's call light was across the room,

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F 323	Continued From page 3 partially in the bottom drawer. E10 (Restorative Nurse) stated 9-16-15 at 11:57am she assess each new resident upon admission, quarterly, and with a significant change, such as decline in condition/admission into Hospice. She does not routinely re-assess each resident after a fall. E10 attends the weekly Fall/Safety Committee meeting, each Monday. All department heads, such as the Director of Nursing, Assistant Director of Nursing, and The MDS (Minimum Data Set)/Care Plan Coordinator also attend. The falls which occurred during the past week are discussed, and new interventions to attempt to prevent future falls are discussed. If the resident is to receive a bed or chair alarm, E10 would distribute these items to the resident, instruct nursing staff, and update the resident's care plan. If the interventions were of a different safety measure, such as call lights placed within reach, etc., the MDS/Care Plan Coordinator updates the resident's care plan. E10 attended the 9-14-14 Fall/Safety meeting, where R1's injury of unknown origin reported 9-5-15 was discussed. To her knowledge, R1 has never had a bed or chair alarm. Alarms are placed at the decision of the Fall/Safety team, or a Physician may order them. E10 added a bed alarm should be considered for R1, as "we don't want her to get up unassisted." E11 (MDS/Care Plan Coordinator) stated 9-16-15 at 1:00pm she attended the Fall/Safety meeting 9-14-15, where R1's injury of unknown origin resulting in a fractured rib was discussed. The presence or absence of a bed alarm was not discussed. E3 (Assistant Director of Nursing) stated 9-16-15	F 323		

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F 323	Continued From page 4 at 12:14pm the resident's care plan is to be updated with new, preventative interventions after each fall occurrence. The restorative nurse implements any new interventions, such as floor mats or alarms. Thereafter, it is the responsibility of restorative aides, nurses, and CNA's to ensure theses interventions remain in place and are functional. Z3 (Director of Clinical Services) stated 9-16-15 at 4:20pm a resident's fall risk assessment should be updated by the nurse after each fall occurrence. Z3 stated 9-17-15 at 10:12am E13 (Nurse) should have followed through on the physician's order she received 5-7-15 to place a bed and chair alarm for R1. R3 has a diagnosis significant for Dementia. Facility incident written by E4 dated 9-3-15 at 5:24pm indicates R3 was found sitting on the floor near the foot of her bed, stating "I hit the back of my head on the floor." R3's physician gave orders to send R3 to the hospital for evaluation. R3 received a CT scan of her head and Pelvis X-rays at the hospital. E4's nursing note dated 9-3-15 at 6:10pm indicates a pressure chair alarm was received for R3's use by E10. R3's care plan does not include the intervention of a chair alarm. This care plan does include the interventions to apply bed wedges and floor mats when R3 is in bed. E10 stated 9-17-15 at 9:50am she gave a chair/bed alarm to E4 on 9-3-15, and instructed E4 to use it interchangeably on R3's chair and bed, whichever R3 is using at the time. E10 forgot to place this intervention in R3's care plan.	F 323		

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Z3 stated 9-16-15 at 4:20pm R3's Fall Risk Assessment was not updated after the fall 9-3-15, and that this should be done after each resident fall.

R3 was seen in bed 9-16-15 at 2:30pm. E5 was present. R3 did not have a bed alarm on her bed. R3's wheelchair, which was across the room, had the alarm and attached pad on it. R3 did not have bed wedges in her bed, or mats placed on her floor next to her bed.

Facility policy titled "Fall Prevention Program" indicates in part "A Fall Risk Assessment will be performed at least quarterly and with each significant change in mental or functional condition and after any fall incident. Safety interventions will be implemented for each resident identified at risk using a standard protocol."

Facility policy titled "Care Plan," indicates, in part "When a change occurs in a resident's condition the Care Plan Coordinator is notified by a member of the Interdisciplinary Team. The care plan is then reviewed and updated."