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 12/11/2015

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 Complaint Investigation 1586656/IL81966 - No deficiency cited. 1586583/IL81833 - F465 1585839/IL81039 - F309	F 000		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure a timely and thorough assessment was completed due to a change of condition for one resident (R1) of three residents reviewed for falls. Findings include: Nurse's progress Notes dated 10/9/15 at 8:22pm indicate that at 4:10pm while making rounds she was called to R1's room by (E7) CNA (Certified Nursing Assistant) and that upon entering the room (R1) was lying supine across the bed and was unresponsive to verbal stimuli. Note indicates that according to (E7), (R1) was in	F 309		

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

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 12/11/2015

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 309	Continued From page 1	F 309		

process of transferring to the chair when she stood, sat back on the bed and then fell back onto the bed in supine position as her eyes rolled back into her head. Note indicates that (Z1) NP (Nurse Practitioner) immediately came to assess (R1). Note indicates vital signs as blood pressure 203/105, pulse 95, respirations 18 and temperature 98.4 degrees Fahrenheit and that "911" was called. Note indicates that moments later (R1) became verbally responsive with periods of confusion and forgetfulness. Note indicates (R1) was transported to the hospital for evaluation.
Nurse's progress Note dated 10/9/15 at 7:00pm indicates (R1) was transferred to a different hospital due to "large intracranial bleeding resulting in subdural hematoma."

On 12/10/15 at 12:50pm E7, CNA stated that she started the shift (on 10/9/15) at 2pm and saw R1 in her bed before 2:30pm. E7 stated that she" just poked her head in the door" to see R1 and that R1 was in bed, awake. E7 stated that she didn't actually go to change R1 until "someone" told her R1 was wet and needed to be changed. E7 stated that she went into R1's room at that time and couldn't find supplies to change R1 and noticed that R1 "looked different" and stated "(R1) wouldn't look at me" and that "(R1's) eyes seemed different." E7 stated that she then went out of R1's room to get supplies and told E6, LPN that "something's wrong with (R1)." E7 stated that E6 did not go into R1's room at that time to check R1. E7 stated that after obtaining the supplies, she went back into R1's room and proceeded to attempt to "change" R1 and stated "(R1) wouldn't let me change her, she was shaking and still couldn't look at me so I sat her on the side of the bed and stood (R1) up." E7 stated that R1 initially

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 12/11/2015

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 309	Continued From page 2 stood up but that R1's "legs gave out" and R1 sat back on the bed and then fell back across the bed. E7 stated that she then immediately called out for help and that is when Z1, NP (Nurse Practitioner) entered the room and told E7, CNA to call E6, LPN (R1's assigned nurse). On 12/9/15 at 12:15pm E6, LPN (Licensed Practical Nurse) initially stated that she was the first to respond to E7's request for help with R1 and that Z1, NP came in right behind her. Later E6 stated that she may have been in the room prior to R1 becoming unresponsive and then came back when R1 became unresponsive. E6 also stated that the the events "probably happened"as E7 reported them. No vital signs or other assessment documentation, prior to R1 becoming unresponsive, were found or presented. On 12/9/15 at 10:50am Z1, NP stated that the CNA (E7) came into the hall and asked for assistance with R1. Z1 stated that upon entering the room, R1 was lying across the bed on her back and was unresponsive. Z1, NP stated that E7 helped to reposition R1 in the bed and that R1 twice had emesis. Z1, NP stated that at some point R1 woke up and complained of a headache. Z1, NP stated there was no bruising or blood anywhere to indicate an injury, however R1 was incontinent of urine and stool. Z1,NP stated that she was the first and only nurse in the room when E7, CNA called for help. Z1, NP stated that she doesn't recall who the next nurse who entered the room as it seemed like a lot of staff rushed into the room after the code was called. On 12/10/15 at 9:45am E3, DON (Director of Nursing) stated that when a nurse id notified that	F 309		

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 12/11/2015

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 309	Continued From page 3 a resident has a change in condition they should immediately assess the resident, including vital signs. E3 stated that if staff tell a nurse that there is something wrong with a resident and the nurse does not assess the resident, the staff should tell another nurse or the DON as soon as possible. E3 stated "It's common sense not to try to get a resident out of bed if you think something is wrong with them." R1 exhibited a change in condition at the start of the evening shift and no initial nurse assessment was found despite staff indicating the nurse was made aware of R1's change of condition. Staff continued to attempt to transfer a resident from the bed to a wheelchair after status changes were observed. Facility Policy Change In Condition Physician Notification Overview dated 4/14 indicates: 1. All significant changes in resident status are thoroughly assessed and are to be documented in the medical record.	F 309		
F 465 SS=B	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure common bathroom toilets on the third floor flushed properly. This failure has the potential to affect all 23 women who reside on the	F 465		

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 12/11/2015

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 465	Continued From page 4 third floor. Findings include: On 12/8/15 at 12:05pm woman's "common" shower room on the 3rd floor, toilet #1 barely flushed and toilet #2 was noted to have stool in the bowl and when flushed only partial amount of waste was removed. On 12/8/15 at 12:45pm 3rd floor woman's "common" bathroom, both toilets only partially flushed waste out of the bowl when flushed. All toilets did not have enough pressure to adequately remove/flush waste. On 12/9/15 at 3:00pm E11, Maintenance stated that he was not aware that the toilets on the third floor were "slow flushing" before "today." E11 stated that the toilets should be able to thoroughly remove waste when flushed.	F 465		