

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6001523	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/18/2017
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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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S 000	Initial Comments Complaint Investigation 1781882/92894 - No Findings Incident Report Investigation IRI of 4/3/2017 - 300.3300 d)	S 000		
S9999	Final Observations STATEMENT OF LICENSURE VIOLATIONS 3001210b) 300.1210d)3) 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the	S9999	<p>Attachment A Statement of Licensure Violations</p>	

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE 06/21/17
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S9999	<p>Continued From page 1</p> <p>resident's medical record.</p> <p>THESE REGULATIONS WERE NOT MET AS EVIDENCED BY:</p> <p>Based on observation, interview and record review the facility failed to implement individualize interventions for a dementia care resident to decrease aggressive negative behaviors. This applies to one of two residents (R3) identified with a negative behavior, in a sample of nine residents.</p> <p>As a result, R3's behavior escalated leading to injury of one resident (R2) and the facility's decision not to allow R3 back into the facility after a hospital visit for a psych evaluation.</p> <p>Findings Include:</p> <p>R3 was admitted to the facility, 5/24/2016 with diagnosis of Alzheimer's disease. Social Service note dated 5/31/2016 described R3 as being severely cognitively impaired. Note said R3 was assessed for aggression upon admission. No result of the assessment was presented. A care plan was initiated 5/31/2016 stating R3 demonstrates significant mood distress related to adjusting to change. The intervention was identification of stressors which cause R3 to have behaviors.</p> <p>The care plan 11/17/2016 stated, on 11/10/2016 got into a verbal confrontation with another resident. R3 kicked the resident and was sent out for a psychiatric evaluation. Explaining the "Rules of Conduct" for ladies and gentleman was added to R3's care plan.</p> <p>Incident report dated 4/3/2017, R3 was involved</p>	S9999		
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S9999	<p>Continued From page 2</p> <p>in a physical confrontation with his roommate R2. During the altercation between the two residents, R2 was hit in the head and sent out to the emergency room for treatment. R3 was involuntarily discharged from the facility.</p> <p>5/2/2017 at 11am, E7 (Licensed Practical Nurse/LPN) was interview regarding the details of the incident involving R3 and R2. E7 said she was familiar with the behaviors of both R2 and R3. E7 was working 4/3/2017 when the incident happened. R2 spends most of the day in bed and does not like to be disturbed. R3 wanders and paces. R3 was constantly opening and closing the door to room, which disturbed R2. R2 said something derogatory to R3 which caused R3 to hit R2. E7 added R3 had told staff over the weekend he wanted to move back to his old room with his old roommate R9. R9 was not in his room. E7 said R9 propels himself in his wheelchair and is generally not in his room. R3's open and closing the door did not affect R9. E7 said she was going to notify Social Service that R3 wanted to move back to his old room when the incident occurred.</p> <p>5/8/2017 at 2:42pm, E13 (LPN) said she worked Sunday 4/2/2017 the day before the Incident. E13 said R3 wanders. R3 wears a mechanical alarm which sounds when he goes near the exit doors. R3 is not in any special programing. R3 attended group activities. R3 was generally situated in the middle of the room to keep him in the group activity. E13 talked to Z1 (Daughter of R3) 4/2/2017. E13 told Z1 Sunday 4/2/2017 R3 was unhappy in room. R3 wanted to move back to his old room. R3 was constantly going back to his old room and had to be re-directed. E13 said she wrote a note to Social Service about R3 wanting to move back to his room.</p>	S9999		
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S9999	<p>Continued From page 3</p> <p>E1 (Administrator) who is also a member of the Interdisciplinary Team (IDT), on 5/10/2017 at 12:30pm confirmed that he was in the facility either 4/1/2017 or 4/2/2017. E1 said he was informed of R3 wanting to go back to room. E1 said he spoke to the resident and told him a meeting would be held about his request.</p> <p>R3's care plan 5/31/2016 documented R3 demonstrates significant mood distress related to: A difficult time adjusting to losses, placement & changes. Resident expresses a strong desire to work for the sense of purpose. There was a repeated intervention which read: If the resident is having trouble discussing/identifying several means of mobilizing his strengths or is not doing this, staff should list several ways he/she can improve the quality of his /his life, including : admitting/recognizing the depression is a serious problem or planning & attempting to accomplish one small change at a time, focusing on a one day at a time attitude and speaking about feelings/emotions instead of withdrawing & allowing feelings to become repressed & bottled up.</p> <p>5/1/2017 during the daily status meeting E6 (Social Service Director) was asked about programing for R3. E6 said R3 would not benefit from any kind of Programing because of his short attention span. He cannot follow directions. During an earlier interview, E6 said he was not informed about R3 having problems adjusting to a new room and with R2 over the weekend until 4/3/2017. E6 said R3 was moved another room because he was an elopement risk. R3's previous room was nearer to an exit door.</p> <p>Progress Note dated 4/1/2017 at 2:34pm written</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>by E13 stated: informed Social Service of R3 having room problem.</p> <p>No evidence was present in R3's record to indicated that any staff talked or discussed with R3 his adjustment problem to a new room or roommate. In addition, there was no evidence of staff attempting to decrease R3's anxiety about returning to his previous room, a day prior to the incident that lead to his involuntary discharge.</p> <p>(B)</p> <p>300.3300 d)</p> <p>Section 300.3300 Transfer or Discharge</p> <p>d) Involuntary transfer or discharge of a resident from a facility shall be preceded by the discussion required under subsection (j) of this Section and by a minimum written notice of 21 days, except in one of the following instances:</p> <p>This Requirement was not met as evidenced by:</p> <p>Based on interview and record review, one of two residents (R3) given a Notice of Involuntary Discharge was not given the notice prior to being discharged from the facility. Z1 is R3's Power of Attorney (POA) for health was not given a written notice before R3 was discharged from the facility 4/3/2017.</p> <p>Findings Include:</p> <p>5/4/2017 at 1pm, Z1 (Daughter of R3) was interviewed using a Spanish Translator (E12). Z1 said she is R3's Power of Attorney (POA).</p>	S9999		
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S9999	<p>Continued From page 5</p> <p>4/3/2017 at 9:30am, Z1 received a call from the facility. R3 had hit another resident (R2). R3 was being transported to the hospital. After 12pm, Z1 received another call from the facility from a man who did not identify himself and spoke only English. Z1 was able to understand that R3 could not come back to the facility. Z1 had received no paperwork about R3 being discharged from the facility. Z1 did say that Sunday 4/2/2017 she visited the facility and was told by an African American nurse who spoke only English. Z1 did not understand clearly what the nurse said, but she got the impression they did not want R3.</p> <p>5/8/2017 at 4pm, E1 (Administrator) said he gave R3 his Involuntary Discharge paperwork 4/3/2017 when he transferred R3 to the hospital. E1 was aware Z1 is R3's POA. E1 called Z1 on the telephone 4/3/2017. E1 told Z1 R3 was being sent to the hospital and cannot come back to the facility. E1 said he spoke to Z1 in English because she can understand English. E1 told Z1 he would mail her the paperwork. E1 was asked if he sent a bed hold along with the involuntary discharge with R3 because R3 is a recipient of Medicaid. E1 said "No, Medicaid does not pay for bed holds."</p> <p>5/1/2017 at 2:45pm, E6 (Social Service Director) was interviewed. E6 said E1 is responsible for involuntary charges of residents. 4/3/2017 E6 was present in the capacity of Translator when E1 served R3 with his Involuntary Discharge notice. Z1 and the Ombudsman was not present. E6 was not present when E1 called Z1.</p> <p>Progress Note dated 4/3/2017 at 1:41pm said E1 spoke with R3 with a translator present and issued a Notice of Involuntary and an opportunity for a hearing in Spanish and English. The note</p>	S9999		
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S9999	<p>Continued From page 6</p> <p>goes on to say E1 called Z1 by telephone and informed her of the Notice of Involuntary Discharge.</p> <p>R3's Admission Record says he was initially admitted to the facility 5/24/2016.</p> <p>Social Service Note dated 5/31/2016 says R3 is diagnosed with Alzheimer's disease. R3 is severely cognitively impaired. R3's behaviors include aggression.</p> <p>5/8/2017, E1 presented a written document given to the facility upon admission of R3 stating Z1 is R3's POA.</p> <p>Z1 was not given written notice prior to R3 being involuntarily discharged from the facility.</p> <p>(AW)</p>	S9999		
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