STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145625	A. Building B. Wing	09/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
California Terrace	2829 South California Blvd Chicago, IL 60608

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 41356 Based on record review and interviews the facility failed to ensure administration of seizure medication was documented as given to 1 (R1) out of 3 residents (R1, R2 and R3) reviewed for fall safety. This failure has the potential of contributing the cause of R1's fall due to seizure on 9/8/21, and as a result R1 sustained a laceration to left side of eyebrow. Findings include: R1 resident in the facility with medical diagnosis of Epilepsy and Seizures. On 9/23/21 at 11:05 AM. R1 was seen in his room walking and was able to be interviewed upon sitting on his chair. R1 was alert and able to express his needs very well. R1 stated that his fall recently was due to a seizure, and that he has had seizures for a long time. R1 stated that he takes seizure medication when staff give it to him, but he still has seizures from time to time. R1's fall risk assessments and notes documents R1 had a fall on the following days: On 3/23/21 related to seizure activity, 4/5/21 related to seizure activity and 9/8/21 related to seizure activity. On 9/8/21 R1 suffered left eye wound injury with sutures due to the fall. R1 Medication Administration Record shows that on 9/7/21, two (2) medications Levetiracetam tablet 1000 MG and Phenytoin Sodium (Dilantin) Extended Capsule 200 MG for seizures that were scheduled for 9:00 AM were not signed as given. Hospital laboratory result dated 9/8/21 where R1 was sent after the fall reads that Dilantin level was low with result of 6.8 ug / ml (reference level between 10 - 20 ug / ml). Progress noted dated 9/8/2021 10:30 reads: Resident observed lying on left side face down on floor in room. Resident observed in lethargic confused state experiencing seizure activity, duration 3 min at this time. Upon assessment, laceration noted on left side of eyebrow 3 steri strips applied cleansed with normal saline and dry dressing applied tolerated procedure well. Facility Incident final report sent to Illinois Department of Public Health documents the incident happened on 09/08/21 at 10:30 am says R1 was observed on the floor in a lateral laying position with seizure like activities lasting 3 minutes. Open area noted to left eyebrow. And documents, R1 returned to facility at 17:20 pm with 2 sutures to left eyebrow and subtherapeutic phenytoin level. (continued on next page)

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.

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 9/24/21 at 11:06 AM V2 (Assistant Director of Nursing) stated he was not aware that R1's seizure medication was not signed as given because he did not check. And further stated that, when medication is administered it should be signed in the Medication Administration Record as given. V2 also stated that he does not know why R2 Dilantin level was low in the hospital. According to V2 the facility has a Management Risk report that details all fall investigation. And as a policy this report cannot be shared either by looking at it electronically or by printing into a hard copy. Facility also does not give names of staff that are included in the investigation. On 9/24/21 at 12:53 PM V12 (Clinical Nurse Practitioner) stated that R1 has a medical condition of seizure and currently taking medication for seizure. And by missing a single dose of two (2) medications (Levetiracetam tablet 1000 MG and Phenytoin Sodium (Dilantin) Extended Capsule 200 MG) can be considered as contributory cause of seizure. R1 having low Dilantin result can cause seizures. When seizure medication result is low or high compared to its normal values seizure can occur. Facility Falls Management with review date 6/21 reads: Facility Guidelines following a fall incident: Complete a fall event. This event includes the circumstances surrounding the fall, device in use, full body observation for injury, pain, range of motion and neuro checks as needed. All incident and accident with serious physical injury will be initially reported as required to the Health Department. A final written investigation report is required by the Department of Public Health within seven (7) days of the incident.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 41356 Based on observations, interviews and review of records the facility failed to follow food tray distribution schedule and policy related to food temperature. These failures have the potential to affect all 236 residents not including 2 residents that does not take food by mouth. Findings include: On 9/23/21 at 10:30 AM. R2 was seen in his room sitting on his chair. R2 was alert and able to express his thoughts very well during the interview. Food like noodles and crackers were seen on top of the table and heating cooling radiator. R2 stated, food that comes in are already cold and not pleasant to eat. And he eats those instant food because the facility cannot provide proper food. At 11:30 AM the kitchen was reviewed with V3 (Food Services Director), lunch was being prepared that includes beef tacos, rice and corn. Arrangement was made with V3 to have extra tray to check on the food temperature. V3 stated 3rd Floor is scheduled to receive their trays at 12:35 PM and will include test tray. At 12:45 PM, V3 stated that kitchen staff was still preparing 2nd Floor and can include test tray in the 2nd Floor cart instead of the 3rd Floor. At 12:50 PM food cart with trays arrived on the 2nd Floor with 20 trays inside. V3 stated that nursing staff are in-charge of distributing all trays. And dietary staff does not help due to lack of staff availability. After distributing all trays, test tray was reviewed on food temperatures. V3 checked all foods on the tray: Tacos beef filling has 82 degrees Fahrenheit, Rice 84 degrees Fahrenheit and Corn 86 degrees Fahrenheit. V3 stated that she will review facility policy related to food temperature because she does not know it. On the 3rd Floor, food cart arrived at 1:45 PM. Nursing staff distributed all trays and the last tray that was served was given at 2:05 PM. At 1:55 PM, R2 stated that his tacos were cold, placing his finger on the beef filling and said, see it is not warm enough. R4 also said that he often received cold food and because of that it was not pleasant to eat. In the hallway R5 was seen carrying his tray and said, I need to heat it up, this food was already cold when I received it. R2's roommates also stated that so often they received food that were cold. But they need to eat it because they do not have anything to eat. R6 also stated that her food was cold. But she was hungry, so she ate it. On 9/23/21 at 3:11 PM. V3 (Food Service Director) stated that staff needs to distribute tray faster for food to arrive to resident with the right temperature. And that food on the trays must maintain at least 95 degrees Fahrenheit when served. The policy for food palatability-hot food temperature dated 2016 reads: The community prepares and serves food that is palatable, attractive and at the proper temperature. The policy on test trays dated 2016 reads: Serving procedures ensure that the hot food is served at a temperature most clients prefer. Facility meal schedule and times. Effective 6/18/19: Lunch (Tray Line Starts at 11:20 AM) (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1st Floor 11:45 AM - 11:55 AM (2 Carts) 4th Floor 12:00 PM - 12:15 PM (3 Carts) 2nd Floor 12:20 PM - 12:30 PM (3 Carts) 3rd Floor 12:35 PM - 12:45 PM (2 Carts)