

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 05/13/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145625	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2022
NAME OF PROVIDER OR SUPPLIER California Terrace		STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 02569</p> <p>Based on interview , record review and observation the facility failed to provide supervision to 1 of 3 residents (R4) in a sample of 9 by failing to prevent the possession of (ETOH) alcohol while inside the facility. This failure resulted in R4 sustaining a hand laceration requiring 6 sutures, due to intoxication and sent out to hospital.</p> <p>Findings include:</p> <p>R4 is a [AGE] year old male with a diagnosis including Diabetes 2 , Chronic Obstructive Pulmonary Disease , Anxiety Disorder , Alcohol Dependence, and Cocaine Abuse . R4 was first admitted to the facility on [DATE].</p> <p>R4 s April 2022 Minimum Data Set BIMs score is 14.</p> <p>R4 has care plans including :</p> <p>12/30/21 care plan - potential for altercation in cognitive status r/t toxic metabolic encephalopathy 2/2 ETOH and substance abuse and hx of hyperammonemia .</p> <p>7/1/21 care plan - Has mood problem r/t Disease Process alcohol and drug abuse.</p> <p>4/13/21 care plan - Has Delirium or an acute confusion episode r/t alcohol and drug abuse.</p> <p>6/27/22 (recent) care plan - Has potential to demonstrate physical behaviors r/t poor impulse control .</p> <p>6/27/22 R4 was observed intoxicated , became aggressive and punched out the window. Date initiated 6/27/22.</p> <p>Review of documents show that on 6/27/22 the facility sent Illinois Department Of Public Health an incident report . The report included documentation that the nurse heard a loud yelling and noise coming from the room , upon entering room Patient was observed guarding left hand with a cloth and closer look blood was noted . Patient seen belligerent , unsteady gait , slurred speech , combative , screaming , and aggressive towards staff . Patient refused first aid care and vital signs . The window was broken in the room and glass on floor. Team Health On Call called and Nurse Practitioner called and returned call and made aware . 911 called. 911 in facility and Pt. (patient) care for his left hand . BIMs score 13 . Resident denied being abused or mishandled.</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 145625	Facility ID: 145625 If continuation sheet Page 1 of 4

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145625	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2022
NAME OF PROVIDER OR SUPPLIER California Terrace		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of hospital record (6/27/22) shows R4 admitted to hospital with a diagnosis including hand laceration and alcohol intoxication.</p> <p>6/27/22 progress note/behavior note states - Writer (V6) 1AM was at the nursing station and heard a loud yell coming from the back of the unit. Writer immediately went to where the noise was coming from and observed patient in his room with an unsteady gait, slinging his left hand with his clothes noted with blood on it. Patient left hand (back of the hand) was also noted with blood which patient refuses for writer to render first aid care to the hand. Patient appears to be intoxicated with alcohol with slurred speech unsteady gait and also combative towards writer. Rapid response was called which staff nurses in the facility arrived on the unit to assist with patient care. Patient now still combative, screaming and calling staff out of their names with threats of bodily harm. Other staff unable to assist patient due to his aggressive behavior. Patient refuses vital signs to be taken by staff nurses and also refuses to change his clothes which has blood on it. 3-11 pm Supervisor also arrived at the unit to also assist with patient first aid which patient became very aggressive towards supervisor attempting to hit supervisor and also throwing items at supervisor. Patient now at the nursing station still refusing care to his laceration site. 911 called for transportation for patient, awaiting for their arrive to unit. Patient still attempting to fight supervisor again refusing first aid care to his left hand. IPC service called and writer spoke to on call NP (nurse pactionier) who was made aware of patient above listed change of condition with order given to transfer patient to s local hospital for evaluation of laceration to the left back of the hand, order noted and carried out. Patient POA (sister) was also called and made aware of patient above behavior with laceration at the back of the left hand. POA inform that patient is been transfer to the hospital for evaluation of the left hand which she verbalized understanding. 911 personal arrived on unit which patient at the nursing station still refuses for the EMT to render care to the his left laceration side. Patient now aggress to be transfer to the hospital for evaluation. Patient was then taken to St. [NAME] hospital with 911 EMT'S. Writer then called hospital ER and gave nursing report to ER nurse of patient above listed change of condition. Facility administrator and DON both made aware of patient above listed change of condition as listed above by 3-11 pm supervisor. Writer will follow up on patient status later on at the hospital.</p> <p>6/27/22 progress note/ behavior note states resident returned to facility via elite ambulance,with 6 sutures to left hand covered by kerlix dressing. refusing vital signs still s/s of intoxication. 6/27/22 hospital record shows 6 sutures to left hand.</p> <p>6/30/22 progress note/wound care note states resident is a readmission back into the facility and full body assessment performed today by wound care department. Resident is ambulatory and continent of bowel and bladder. Resident noted with surgical wound to the left hand with 6 intact sutures with no drainage noted following assessment by wound care department. MD is aware of readmission, tx and dietary supplement orders given and carried out. Resident declined assessment on yesterday but allowed for assessment on today. Resident is alert and orient x's 3. Resident resting comfortably following assessment by wound care team.</p> <p>On 7/1/22 11AM V4 (Maintenance Director) stated R4 hit the window with his hand and cut his hand. R4 was intoxicated from alcohol . I went to the room after he broke the window and returned from the hospital around 5 AM . He was still very drunk and stumbling all over the room. The nurse in charge on the night shift took a bottle of alcohol from him. R4 had to go to the hospital to get treatment to his hand . R4 is now in another room . This room is kept locked until the window company can replace the glass. I do not know how R4 got the alcohol.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145625	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2022
NAME OF PROVIDER OR SUPPLIER California Terrace		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 7/1/22 11:30AM V6 (Nurse) stated I heard a loud noise. I got to R4s room. R4 was staggering and combative. Blood was all over the room . I call rapid response for help . The nurse (Supervisor nurse) came up . He tried to talk to R4 . R4 was slinging his hand . We called 911. They came in and took him to the hospital. He got 6 stitches . R4 appeared to be intoxicated. He reeked of alcohol . We found a 1 empty bottle and one that was half full . R4 has a community pass to go in community. The policy states that the staff look in the residents bag when they return.</p> <p>On 7/1/22 11:41 AM V5 (Social Service) stated I was aware of R4 incident. R4 did not have a pass to leave the facility . On 3/7/22 R4 was found to appear to be intoxicated. R4s community pass was revoked . R4 was restricted to the building. I do not know how R4 got the alcohol . My staff have been working with him . Social service met with him today. No concerns no behaviors or aggression . I will be meeting with him today to discuss 1:1 counseling.</p> <p>On 7/1/22 12:35 PM R4 stated I got the 2 bottles of rum from a friend. He talked to me on the phone and asked me if I needed anything . I told him to get me rum . He met me out on the facility patio and handed me the two bottles of rum . I took it up to my room . No one checked me when I came back into the facility . There was no staff out on the patio when I received the rum on the outside patio from my friend . He handed it to me over the fence. I brought it up to my room and drank it.</p> <p>On 7/3/22 9:35AM V5 (Social Service) stated I am in charge of the outside patio. The patio is kept locked at all times unless there is a staff person to supervise the residents . All department staff can supervise the outside patio area. Everybody helps with watching the residents when they are out on patio. Yesterday I worked with R4 with his new behavior contract. During this time R4 told me he got the alcohol from and outside visitor outside the building. R4 did not tell me exactly how he did it. R4 does not have unrestricted community pass at this time since the incident.</p> <p>On 7/2/22 10:40AM V1 (Administrator) stated our policy on (ETOH) alcohol in the facility is covered by our policy titled Contraband (Room Search) . Alcohol possession by residents is prohibited . Residents out on the patio are supervised . There are PSAs or staff (CNAs) that supervise the patio when residents are out there. If there is no staff the door to patio is locked . Family members and guest with bring contraband into the facility. There was no report that anyone passed alcohol to R4 over the fence in the patio. No one knows how R4 got the alcohol in the facility. I believe there are cameras out on the patio. Had I known R4 got alcohol from the patio I would have checked the cameras.</p> <p>On 7/1/22 12PM R1s room was observed . The exterior wall lower window was observed broken out . Old blood was observed on the wall directly below the window . This room was observed locked with no resident access.</p> <p>Facility Policy titled Contraband (Room Search) 3/20/22 states including Purpose : To provide a process for searching a residents room and / or belongings when residents exhibit behaviors of self- harm or inflection of harm onto others . Definitions: Contraband : Any item that is banned from the facility and/ or is of harm to the resident or others. Items included but are not limited to : guns , knives, ammunition , chemical substances, illegal drugs or drug paraphernalia, Alcohol , Tobacco , lighters , Flammable substances , and other items that pose safety or risk as determined by staff.</p> <p>(continued on next page)</p>		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 05/13/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145625	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2022
NAME OF PROVIDER OR SUPPLIER California Terrace		STREET ADDRESS, CITY, STATE, ZIP CODE 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	Facility guideline dated 7/10 states To provide monitoring of residents on the patio in addition to any camera monitoring. All facility staff . 1. The patio will be monitored when residents are on the patio if necessary. 2. Staff will monitor the patio as assigned. This on addition to the current cameras that monitor the patio. 3. If a resident exhibits inappropriate behavior , then the resident will be asked to leave the patio. The PRSC or Social Services will be alerted and will provide appropriate intervention.		