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	09/01/2022

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 45644 Based upon record review and interview the facility failed to follow the abuse prevention policy, failed to ensure that one of six residents (R5), remained free from abuse (resulting in serious injury) and failed to provide 1:1 supervision to R4 immediately following aggressive behavior. These failures resulted in R5 sustaining a laceration (above left eye) on 8/18/22 which required suture repair. Findings include: R4's diagnoses include depression. R4's (8/5/22) cognitive assessment determined a score of 15 (cognitively intact). R4's care plan includes (4/6/22) resident presents with behavioral concerns as evidenced by initiating physical aggression towards peers. Intervention: staff to redirect resident when behaviors are present. (6/14/22) Resident may be at risk for potential abuse related to behavior problems as evidenced by combative behavior. Intervention: monitor resident behavior. (6/20/22) Resident has a behavior problem related to displaying verbally aggressive behavior with the potential for physically aggressive behavior related to poor impulse control. Intervention: intervene as necessary to protect the rights and safety of others. Remove from situation and take to alternate location as needed. R4's (8/18/22) progress notes state writer responded to obscene language on unit in hallway and noted resident engaged in altercation with peer. Resident noted standing over peer while delivering blows and kicks to resident head, face and body. Writer able to restrain resident from further aggression at that time, approximately 5 minutes after separation of residents, resident approached peer and initiated another altercation with resident shoving peer to floor and delivering punches to face, head and body. R4 was transferred to the hospital on 8/18/22 at 2:34 pm and did not return to the facility prior to this investigation. R4's documentation excludes 1:1 supervision immediately following 8/18/22 incident. R5's diagnoses include schizophrenia. (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 0600 Level of Harm - Actual harm Residents Affected - Few	R5's (7/21/22) cognitive assessment determined a score of 10 (moderately impaired). On 8/29/22 at 2:24pm, surveyor inquired about the 8/18/22 incident R5 was slow to respond, became angry and stated I ain't got a phone man! and refused to answer any other questions. On 8/31/22 at 10:30am, surveyor inquired about the (8/18/22) incident V9 (LPN/Licensed Practical Nurse) stated that R4 and R5 had a physical altercation on the first floor. V9 separated R4 and R5 from the altercation. V9 sent R4 back to the room and took R5 to the nurse's station. R4 came out of the room and started rushing at R5 with another physical altercation. R5 had a cut on the eye, skin was broken, more like a laceration with some bleeding. On 8/31/22 at 11:05am, surveyor inquired about R5's (8/18/22) injury V6 (LPN) stated R5 had blood coming from R5's eye. an abrasion on R5's cheek and inside lip was swollen and bloody. The (8/18/22) final incident investigation states at approximately 4:30am, (R4) stated that (R5) wandered into R4's room and tried to take R4's phone. (R5) admits to hitting (R4). (R5) returned (from the hospital) with sutures to left eyebrow. On 9/1/22 at 10:31am, surveyor inquired if R4 was immediately placed on 1:1 supervision post 8/18/22 incident V10 (Assistant Director of Nursing) stated social service had a 1:1 with him, I (V10) think they (social service) got here like 8:00am or something. The (11/22/17) abuse prevention policy states if the alleged perpetrator is a resident, the resident will be separated from the alleged victim and resident's condition will be evaluated as soon as reasonably possible to determine the most suitable therapy and placement for the resident. This will be done taking in consideration the safety of other residents and employees of the facility.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 32819 Based upon record review and interview the facility failed to report abuse to IDPH (Illinois Department of Public Health) within regulatory requirements for two of six residents (R4, R5) reviewed for abuse. Findings include: The preliminary facility reported incident states on 8/18/22 at approximately 4:30am, two residents with behavioral diagnosis were observed in a physical altercation in (R4's) room. (R4) stated that (R5) came into his room, tried to steal his (R4) phone and that led to the altercation. IDPH was notified of incident on 8/18/22 at 10:03am [5.5 hours after the incident]. On 8/31/22 at 12:46pm, surveyor inquired about the regulatory for reporting abuse V1 (Administrator) stated The regulation is that we report immediately after we assess that the resident is safe. Surveyor inquired when V1 was notified of the (8/18/22) incident involving R4 and R5 V1 responded I had just gotten to work so about maybe 8:30am or 9:15am. They spoke to the ADON (Assistant Director of Nursing) who was calling me as soon as I got into the parking lot. I guess it had happened in the early hours of the morning. Surveyor inquired when the 8/18/22 incident should have been reported V1 replied They should have called me immediately, I should have reported it by 6am if it happened at 4am. The (11/22/17) abuse prevention policy states in part an initial report to Illinois Department of Public Health, shall be made immediately after the resident has been assessed and the alleged perpetrator has been removed. Immediately is defined as as soon as possible after being made aware of an allegation of abuse but is not more than 2 hours if the events that cause the suspicion result in serious bodily injury. The (8/18/22) final incident investigation stated (R5) returned (from the hospital) with sutures to his left eyebrow.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32819 Based upon record review and interview the facility failed to conduct a thorough abuse and/or theft investigation and failed to conclude that abuse and/or theft were founded with credible evidence to support the findings for five of six residents (R2, R3, R4, R5, R6) reviewed for theft/abuse. Findings include: R2's (6/2/22) cognitive assessment determined a score of 13 (cognitively intact). R2's care plan includes (6/15/22) Resident may be at risk for abuse related to going into other resident's room and removing items without permission. (7/20/22) Resident was involved in an altercation with a peer related to her removing items from peers' room that did not belong to her. On 8/29/22 at 2:15pm, surveyor inquired if R2 takes money and/or belongings from other residents without authorization to do so R2 responded I stopped that and affirmed that she has stolen from residents. Surveyor inquired about abuse in the facility. R2 stated, He (unknown resident) hit me a few weeks ago on the back of my head and right here (pointing to her left cheek), it was a light bruise. The (7/20/22) preliminary facility reported incident (involving R2 and R6) states the facility has an allegation that may involve one or more of the following reportable situations: Physical abuse. [Theft was not selected as warranted]. Staff witnessed (R6) make physical contact with (R2). Residents immediately separated. Both residents found to have no visible injuries. Residents engaged in a verbal disagreement regarding $7.00 (R6) became upset with (R2). Staff was able to retrieve the money from (R2) and returned it to (R6) in the amount of $7.00. The (7/20/22) witness statement documents, (R2) steals $7.00 out of (R6's) room. (R6) slaps (R2) in the face, she (R2) swings at (R6's) lower extremities and (R6) slaps (R2) again. R6's (7/25/22) progress notes (entered by V1/Administrator) state in part met with resident to discuss physical contact with another resident on 7/20/22. (R6) stated that (R2) took his (R6's) $7.00. She (R2) asked why I (R6) told on her (R2) That's why I (R6) hit her (R2). The (7/20/22) final incident investigation states at the completion of this investigation, abuse cannot be substantiated at this time. Based on the known facts from medical record reviewed and interviews, the following conclusions have been determined about the original allegation: Abuse: NOT FOUNDED. –– R3's (8/11/22) cognitive assessment determined a score of 13 (cognitively intact). R3's (11/27/21) care plan states resident has potential to demonstrate behaviors such as invading the privacy of others and not respecting boundaries related to poor impulse control. The (6/15/22) preliminary incident investigation states resident (R5) hit resident (R3). (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/29/22 at 2:04pm, V4 (Restorative Nurse) stated He (R3) is oriented but problematic and affirmed that R3 was involved in physical altercation with a peer. Surveyor inquired about concerns at the facility R3 responded Listen to me, I hear voices from the devil they got cameras on me, watching me. The (6/15/22) final incident investigation states (R3) entered (R5's) room and asked for a cigarette. (R5) responded get out of my room. R3 left the room but returned a few minutes later and asked again for a cigarette. (R5) admitted that he became angry and struck (R3) in the face. At the completion of this investigation, abuse cannot be substantiated at this time. Based on the known facts from medical record review and interviews, the following conclusions have been determined about the original allegation: Abuse: NOT FOUNDED. –– R5's (7/21/22) cognitive assessment determined a score of 10 (moderately impaired). R5's (6/30/22) care plan states resident may be at risk for potential for abuse related to behavior problem as evidenced by aggressive behavior. The (8/18/22) preliminary incident investigation states the facility has an allegation that may involve one or more of the following reportable situations: Physical Abuse [Theft was not selected as warranted]. Two residents were observed in physical altercation. (R4) stated that (R5) came into his (R4's) room, tried to steal his (R4's) phone and that led to the altercation. On 8/29/22 at 2:22pm, surveyor inquired about the (8/18/22) incident involving attempted theft of R4's phone R5 became angry and stated I ain't got a phone man! The (8/18/22) final incident investigation states police were summoned and completed report for simple battery. (R4) admits to hitting (R5). (R5) returned (from the hospital) with sutures to his left eyebrow. At the completion of this investigation, abuse cannot be substantiated at this time. Based on the known facts from medical record review and interviews, the following conclusions have been determined about the original allegation. Abuse: NOT FOUNDED. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/31/22 at 12:46pm, surveyor inquired about the regulatory requirements for reportable incidents V1 (Administrator) stated when someone alleges that they could have possibly been abused I investigate. I interview and then I gather as much information as I can from the initial. We launch our investigation, get witness statements and review video footage if necessary. Then we finalize our final report and submit to IDPH (Illinois Department of Public Health) within 5 days. Surveyor inquired about the (7/20/22) incident investigation involving R2 and R6. V1 stated, I believe that (R6) made physical contact with (R2) regarding her taking something from his room. Staff were able to retrieve it. (R2) asked (R6) why she (R2) reported it or said she (R2) took something from him (R6), he (R6) said he (R6) got mad cause she (R2) was questioning him (R6) saying why would he (R6) say she (R2) took his (R6) stuff. Surveyor inquired why Theft was not marked on the (7/20/22) incident. V1 stated, Theft was not checked because I think maybe I didn't just go in that direction however I guess that should have been checked. Surveyor inquired if R6 struck R2 V1 responded I believe so, yes. Surveyor inquired how the (7/20/22) abuse and theft allegations were unsubstantiated considering the known facts V1 stated I guess the way I interpret is that since he (R6), umm. She (R2) wasn't abused she (R2) really didn't sustain an injury and she (R2) was not fearful or afraid. Surveyor relayed concerns regarding the (6/15/22) incident investigation (involving R5 striking R3) also deemed Unsubstantiated and inquired if striking someone in the face is abusive. V1 responded, Yes. Surveyor inquired why the (6/15/22) incident was unfounded considering the known facts. V1 responded, I guess in hindsight I just didn't see it that way. Surveyor inquired about the (8/18/22) incident investigation. V1 stated, staff reported that there was a physical altercation between (R4) and (R5). Staff said that (R5) needed to get treatment at the hospital. We interviewed (R4) and he (R4) admitted that (R5) came into his (R4) room [ROOM NUMBER] or 7 times in the night. (R5) tried to touch (R4's) phone. He (R4) pushed and shoved him (R5) to get him (R5) out of the room. He (R4) continued to push and shove him (R5) in the hallway. Staff noticed that they were tussling and intervened. Surveyor relayed concerns regarding the (8/18/22) incident investigation also deemed Unsubstantiated considering the known facts. V1 responded, I don't think I'm interpreting it right. Surveyor inquired (again) if striking someone is considered abuse. V1 stated, If someone hits someone it is abuse. The (11/22/17) abuse prevention policy states in part as soon as possible after an allegation of abuse, the administrator or designee will initiate an investigation into the allegation which may include the following elements: interviewing all persons who may have knowledge of the alleged incident; review of the medical record, including care plan; and review of all circumstances surrounding the incident. The investigation shall conclude whether the allegation of abuse can likely be substantiated.