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	10/28/2022

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

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 44314 Based on observation, interview and record review, the facility failed to follow their daily cleaning procedures policy by failing to clean and disinfect resident rooms for 3 residents (R12, R13, R14) of 4 residents reviewed for housekeeping services. Findings Include: On 10/26/2022 at 10:10am, surveyor observed R12 and R13's room to have dirty floors appearing to be not mopped and not swept and appeared to have a smeared look to it. The trash can was full of trash. R12 and R13's bedside tables appeared dirty and not wiped down. R12 and R13's furniture appeared to have dust particles on the surface. R12 and R13's bathroom floor appeared dirty and not mopped, the bathroom mirror appeared smeared, the toilette appeared dirty and not disinfected. R12 and R13's sink appeared to have residue buildup and appeared to not have been disinfected. R12 and R13's paper towel dispenser appeared to have dust particles on the top upper surface. On 10/26/2022 at 10:15am, R12 stated, The housekeepers are supposed to come and clean every day. They are supposed to sweep, disinfect the room and the bathroom. they are supposed to wipe the tables and wash the floors and remove the trash. They sometimes come and do a good job, but other times they might come in and just remove the trash and do nothing else. Yesterday (10/25/2022) the housekeeper only came in and mopped the floor and did nothing else. It's like the housekeeper is in a rush. Then the regular housekeeper is here, she does a wonderful job, and she cleans well and cleans everything. Sometimes there are days that the housekeeper does not come and clean my room at all. On 10/26/2022 at 10:25am, R13 stated, On 10/26/2022 at 10:25am R13 stated, They don't do a good job cleaning at times when the regular housekeeper is not here. Some housekeepers will just come inside the room and remove the garbage and not clean or wipe anything else. Some days the housekeeper will not come into the room at all. The housekeeping issues occur when the regular housekeeper is not here. Look at this room it's dirty and has not been cleaned. The floors are dirty and this room needs to be mopped and the entire room needs to be disinfected. The bathroom is also filthy, the sink needs to be wiped down and disinfected and the toilette needs to be cleaned and disinfected. Sometimes they don't even come in and remove the trash. I don't ask for a lot at all, I just ask for the basic small things, which is to get my room cleaned. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/26/2022 at 11:10am V16 (housekeeper) stated, I come in and I knock on the resident's door and announce myself, I remove the garbage. I sanitize the furniture, and I sanitize the beds. When it comes to the bathroom area, I sanitize the toilette and I check to see if there is enough supply of soap, toilette paper and napkins. I sweep and mops the floors. I even mop under the bed and I dust and wipe down all the surface areas in the resident rooms. This is supposed to be done every day and for every resident that I am assigned to. If I am assigned to the second floor, I have to clean all the resident rooms on the second floor. I am the regular housekeeper for this floor, and I have 32 resident rooms to clean, and I have to deep clean one entire room and deep clean 4 additional resident bathrooms. It is a lot of work to clean 32 rooms which includes deep cleaning. 10/26/2022 at 11:25am V15 (licensed practical nurse) stated, I have heard resident complaining about housekeeping services when the housekeeper, V16, is not here. When V16 is not here the residents complain that their trash is not emptied and that their rooms are not cleaned properly. On 10/26/2022 at 12:01pm, surveyor observed the floor to be dirty and not mopped in R15's room. On 10/26/2022 at 12:02pm R15 stated, We do have a problem with housekeeping. The other day the housekeeper on the weekend who is not the regular housekeeper totally bypassed my room and never even came inside here at all. The housekeeper skipped my room entirely and never came in to clean anything and never even removed the trash from my room. This happens often. When the regular housekeeper is here things are cleaned and disinfected properly and we don't run out of paper towels and toilette paper. When there is a different housekeeper than we don't have enough paper towels and toilette paper. One day they did not have the key to give us the paper towels or the toilette paper, so we did not have it. They do come in and clean the room when the regular housekeeper is here, however, there are days that they slip up and completely bypass my room or they clean but will not do a good thorough job and will only mop, but they won't disinfect entirely. On 10/26/2022 at 12:26pm, V18 (housekeeping) stated, I am a floor tech, so I do the buffing and sometimes I have to assist the housekeeper. They have between 30 to 32 rooms to clean and they also to have deep clean an entire room and deep clean 4 additional bathrooms. It is a lot of work that a housekeeper has to do in one shift. Deep cleaning takes about a total of 30 minutes to do, after the housekeeper removes all the resident personal items and clears the items out of the way, the deep cleaning begin, and that process takes 30 minutes. Sometimes the housekeepers run out of time, and I have to help the housekeepers at times because they have so much work for just one person that they are running behind and they cannot finish on time. Some housekeepers might have to cut corners because they run out of time. It really is a lot of work for just one housekeeper on each floor so I try to help the housekeepers as much as I can. On 10/26/2022 at 12:46pm, V17 (housekeeping) stated, Up here on the 3rd floor I have 30 rooms to clean by myself. out of the 30 resident rooms, I have to deep clean one room which includes the bathroom and I have to deep clean 4 other bathrooms. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/26/2022 at 2:54pm V19 (housekeeping/laundry supervisor) stated, I did meet with the resident council president once and the resident council president had a complaint with tissue paper supply. R14 had a concern with not having enough tissue after the morning shift leaves. It is a housekeeper's job to do a walk though first and at that point they can target which rooms they want to start with first. They do their deep cleaning rooms about 10:30am or close to 11am. Than after that they do their normal routine, which is sweeping, mopping, dusting, remove garbage from resident rooms, wipe the window ledges, doorknobs and wipe the light switches for every room they go in. There are 32 occupied rooms on the second floor and the housekeeper is supposed to clean all 32 resident occupied rooms during the 7am to 3pm shift, which includes 1 entire room that needs to be deep cleaned and includes 4 other bathrooms that need to be deep cleaned. Deep cleaning consists of wiping everything, like high touch areas, remove linen, wipe down garbage cans. Deep cleaning consists of disinfecting everything, like wipe down walls, urinals, wipe down closets, wipe down their beds, wipe down their stands, wipe any build up. We basically wipe down and disinfect the entire room during the deep cleaning session. Also, we take the curtains down and replace them with fresh curtains. During the 7am to 3pm shift, the housekeeper gets a lunch break at 11am for 30 minutes. At 9am the housekeeper gets a 20-minute break. Some days the housekeeper may not get to clean all resident rooms because they run out of time because the workloads are heavy. I will go down to the floors and I will help the housekeepers because I personally feel that it is too much work for one person. Sometimes I will have a floor care tech go and help the housekeepers to clean because they have too much work and they are not able to get to every room. I personally feel that it is too much work for one housekeeper, and I want to put 2 housekeepers on each floor, however, I don't have the budget to put a second housekeeper on each floor. A lot of the times residents will accidentally spill something, and the other staff won't help us, they will call for housekeeping. I think it's a good idea to add a second housekeeper, especially to the floors that need it. The heaviest floor in the facility 4th floor, 2 is heavy but the 4th floor is the heaviest. Resident Council Minutes (dated 07/26/2022) reflects a concern made by R15 stating that R15 wants his room swept and mopped on the weekends. Resident Council Minutes (dated 09/27/2022) reflects a concern made by R15 stating that R15 would like his room clean, and garbage taken out on the weekends. Daily Cleaning Procedures Policy (undated) states: Disinfecting flat surfaces and high-touch items and any flat surface, check and clean routinely to avoid buildup of dust, empty trash, damp mop the perimeter of the room. Clean restroom: disinfect sink area, disinfect toilette area, empty trash.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15301 Based on observation, interview and record review, the facility failed to ensure that residents remain free from abuse. This affected two(R8 abused by R9). This failure resulted in R8 requiring sutures for a forehead laceration. R9 with known aggressive behaviors; facility failed to ensure R1 was free from abuse by R2. R2, a resident with known aggressive behavior. Findings include: R8's medical record (Face Sheet, Minimum Data Set) notes R8 is a severely cognitively impaired [AGE] year-old admitted to facility on 4/17/2019 with diagnoses including but not limited to: Vascular Dementia, Wandering, Paranoid Schizophrenia, and History of Falling. R8's care plan initiated 07/18/2022, notes in part, R8 may be at risk for potential for abuse related behavior problem as evidenced by wandering in peers' rooms. R8's care plan initiated 08/07/2022, notes in part, R8 has a behavior problem related to (touching staff, residents, the nurse's cart, walls, wheelchairs and objects on the unit) secondary to diagnosis of dementia. R9's medical record (Face Sheet, MDS-Minimum Data Set of 07/29/2022) notes R9 is a severely cognitively impaired [AGE] year-old admitted to the facility on [DATE] with diagnoses including but not limited to: Dementia with Behavioral Disturbance, Restlessness and Agitation, Cognitive Communication Deficit and Bipolar Disorder. MDS Section E Behavior, notes in part, R9 exhibits delusions, physical behavioral symptoms (e.g., hitting, pushing) directed towards others and, verbal behavioral symptoms (threatening/screaming/cursing at others). R9's care plans initiated 01/29/2022 note in part, R9 has a behavior problem related to verbally and physically acting out when agitated and R9 has been physically towards peers and staff due to diagnosis of Dementia and poor impulse control. R9's care plan initiated 07/31/2022 notes in part, R9 may be at risk for potential abuse related to behavior problem as evidenced by: poor impulse control, verbally/physically acts out. R9's care plan initiated 09/16/2022 notes in part, R9 presents with behavioral concerns as evidenced by verbal and physical aggression. On 10/26/2022 at 10:50 AM, R9 was observed standing in hallway between Day Room and Nurses Station. Surveyor approached R9, R9 said, Get the f*** away from me. Facility's final incident report (10/16/2022) notes in part, The resident (R8) was walking on the unit and walked into another resident('s) personal space which resulted with the resident being pushed to the floor. Open area noted to forehead. On call called and order given to send to (Local Hospital) for evaluation and CT scan. (R8) returned to the facility with 3 sutures. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	V14 (Licensed Practical Nurse-LPN) on 10/26/2022 at 4:58 PM, said V27 (Certified Nursing Assistant-CNA) told me that R8 walked up to R9, tapped R9 on the shoulder. Before V27 could get up to intervene, R9 pushed R8 and R8 fell . R8 had a laceration to her head. R9 has hit staff. I'm not aware of him hitting any residents. R9 has gone to strike (residents) but we were able to intervene before R9 hit the person. R9 is easily agitated, R9's agitation leads to aggressive behavior. V14 said R8 does wander the hallway and is at risk for abuse. On 10/26/2022 at 5:25 PM, V27 (CNA) said, I was monitoring the unit, doing my POCs (Point of Care documentation) at the nurses station. R8 came out of nowhere, R8 went up to R9 and R9 pushed R8. I couldn't get to them in time. V27 said R8 is a wanderer. R8 goes into other resident's rooms. We try to redirect R8 to R8's room. V27 said, I've seen R9 hit others. On 10/27/2022 at 12:00 PM, V3 (Assistant Director of Nursing-ADON) said, Yes, R9 does have a history of aggression. R9's number one trigger is people getting in R9's space. Once R9 gets up and dressed in the morning, R9 has a spot that R9 likes to stand in. We try to re-direct R9 to a different spot. We have given R9 a chair to sit in. The more we try to re-direct R9, the more likely R9 is to become aggressive and attempt to strike out. V3 said R8 doesn't respect the boundaries and personal space of others. R8 is a wanderer. Facility's Abuse Prevention Policy (effective November 22, 2017) notes in part: -Residents have the right to be free from abuse. -Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. -Abuse is also the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish to a resident. -Physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment. 45111 R1 is a [AGE] year-old individual admitted to the facility on [DATE]. R1 Brief Interview for Mental Status (BIMS) completed on [DATE], document R1 BIMS score as 9/15, indicating R1 has some cognitive disabilities. On 10/26/2022 at 10:20am, R1 was observed in the in the hallway being assisted by staff in combing R1's hair. at 10:32am, R1 was observed in R1's room. R1 said someone pushed R1 but R1 does not remember the name of the person. R1 is alert and oriented to person and place, and R1 has confusion. R2 is a [AGE] year-old individual with initial admitted to the facility on a 4/21/15, readmitted to the facility on [DATE] band discharged from the facility on 10/7/22. R2's Brief Interview for Mental Status (BIMS), completed on [DATE] document R2' BIMS as 10/15, indicating R2 has some cognitive deficits. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 10/26/2022 at 5:34pm, V1(Administrator) said it's the facility expectation is for residents not get physical with each other. V1 said if a resident is physically abused, they can feel unsafe, violated and afraid, and it's the facilities responsibility to keep residents safe. On 10/26/2022 at 12:48PM, V6 (Certified Nurses' Assistant-CNA) V6 said R1 is not aggressive and usually likes to stay in R1's room. V6 said that R2 used to pace and wander a lot, going into other residents' rooms looking for cigarettes and R2 has been involved in altercations with other residents, but no alterations with staff. V6 said in most of the altercations, R2 was the physical aggressor. V6 said residents should not be hitting other residents, and staff do their best to redirect residents. V6 said when a resident is hit by another resident, the resident can feel scared and afraid. On 10/26/2022 at 1:11pm, V5 (Restorative Nurse/LPN (Licensed Practical Nurse) said R1 has psychiatric issues, and likes to sit in the basement on the floor, but R1 is not aggressive at all V5 said that on 10/07/2022, on the fourth floor, between 7:15am and 7:30am, V5 said V5 heard a loud noise while at the nursing station and one of R5's coworker said R1 went flying and hit the floor. V5 said V5 went to R1's room and saw R2 outside R2's room sitting on R1 buttocks. V5 said R1 said he (R2) pushed me (R1). V5 said R2 was standing in the doorway. V5 said V5 asked R2 why R2 pushed R1. V5 said R2 denied pushing R1. R2 said R2 told R1 to get F out of my(R2) room. V5 said R1 said R2 shoved R1 and told R1 to get out of R2 room. V5 said V5 did an assessment on R1 to make sure R1 did not break anything. V5 said (V5) told R1 to go to R1 room, and R1 kept saying He (R2), pushed me(R1) V5 said R1 did not sustain any injuries and R2 went to R1 room. V5 said R2 remained in R2's room until it was time for R2 to get R2 medications and after R2 got his medications, R2 started daily routine. V5 said V5 notified V1(administrator) V5 said residents should not be pushed or hit by another resident. V5 said when a resident is pushed or hit, they can feel unsafe and can be fearful and residents are supposed to feel safe in the facility. On 10/26/2022 at 12:33pm, V24(Certified Nurses' Assistant-CNA) said that R1 was mostly quite and R1 was not aggressive. V24 said that R1 is a little confused sometimes, talks to self, and V24 has not seen R1 go into other resident's room and R1 very compliant with ADL care. V24 said residents should be kept free from harm because they can feel scared and unsafe. V24 said staff try their best to keep residents safe. Facility Final Investigation Report dated 10/10/2022 documents; -Based on the details of this investigation, it is believed R1 did abuse R2 by pushing R2 out of the room and causing R1 to fall onto R1 buttocks. Facility Abuse Prevention Program -Policy, effective November 22, 2017, documents; -Abusee means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. Abuse is also the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish to a resident. -Physical Abuse is the infliction of injury on a resident that occurs other than by means of accidental means. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-Physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment.

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45111 Based on Interviews and Records review, the facility failed to follow their policy and procedure of involuntary discharge for one resident (R2) of three residents reviewed for discharge. Findings include: R2 is a [AGE] year-old individual with initial admitted to the facility on a 4/21/15, readmitted to the facility on [DATE] and discharged from the facility on 10/7/22. R2's Brief Interview for Mental Status (BIMS), completed on July 21, 2022 document R2' BIMS as 10/15, indicating R2 has some cognitive deficits. On 10/27/2022 at 10:46am, V1(Administrator) said the facility felt R2 could be managed at the facility and R2 was manageable at that time, but in June and July of 2022, R2 started to show decline then from August, R2's behaviors changed and R2 started hitting other residents. V1 said at that point, the facility decided they could no longer take care of R2, and R2 would not do the neuro assessments or talk to the doctors or Social Workers. V1 was asked if the facility tried to find placement for R2 at another facility that could take care of R2, V1 said: No, we did not have time. V1 was asked if R2's psychiatrist was notified when R2 was petitioned out. V1 said: The Nurse practitioner (V31) was notified, but the psychiatrist (V32) and the medical Director (V34) were not notified. V1 said V1 did not know how V32 can be reached. V1 said V34 was out of the county on vacation and could not be reached by phone. On 10/27/2022 at 11:35am V28 (psychologist) said that it got to a point where R2 would not acknowledge V28, and when V28 walked over to R2, R2 would close R2 eyes and not talk to V28. V28 said R2 was not engaging with V28 but V28 said I believe he was participating with the psychiatrist. V28 said interventions were provided to staff to use. V28 said V28 did not see any aggressive behavior from R2 towards V28, but R2 would get irritable with V28, however, staff had told V28 that R2 would intermittently explode. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/26/2022 at 1:45pm, V8 (R2's Guardian) said R2's mother told V8 that the facility put R2 in the ambulance and gave R2 a piece of paper while R2 in the ambulance being transported to the hospital. V8 said R2's mother said R2's mother said she did not know what piece of paper was given to R2 and R2 was not able to say what paper R2 was given before leaving the facility. V8 said V8 did not know what piece of paper R2's mother was saying R2 was given when R2 was sent to the hospital. V8 said V8 did not know R2 was discharged from the facility, or why R2 was sent out to the hospital because V8 was not notified that R2 was being sent to the hospital and would not be allowed back to the facility. V8 said R2 has been in and out of the facility for over 7 years and now the facility was sending R2 out and discharging R2 from the facility. V8 said R2 was sent to the far south side of Chicago, and they bypassed near hospitals. V8 said as R2's guardian, the facility is supposed to notify V8 of any change of condition for R2 and upon return. V8 said the facility sent R2 out without notice and the facility said they are not taking R2 back. V8 said as R2's guardian, they should have called V8 and left a message if V8 does not answer. V8 said V8 answers almost always and if a message is left, V8 will call back. V8 said even if it after hours, the person who answers the calls is another state guardian who answers the phone, and that guardian emails the responsible guardian to update them on their residents if any phone call is received. V8 said V4 (Director of Social Services) said that V4 told V8 that V4 sent a copy of the involuntary notice to the hospital with R2, and faxed a copy to the hospital, but V8 said hospital has nothing to do with it. V8 said that all V4 said was all parties were notified, but V8 said the ombudsman, V8, and R2's mother was not notified. V8 said V1 (Administrator) said V4 said V4 faxed the discharge letter to V8 but V8 had not received it. V8 said that V1 told V8 that after the last three complaint investigations involving R2, V1 was asked why R2 is still at the facility if the facility cannot provide services to R2, and that is why when R2 had another incident, the facility decided they did not want R2 back at the facility. On 10/25/2022 at 2:45pm V9 (social worker at the hospital) said V9 has reached out to the facility regarding R2 but the facility does not answer V9's calls or return V9's calls. V9 said the nurses and social worker assigned to R2 have told V9 that R2 is not aggressive at the hospital. V9 said R2 seems ok. V9 said V9 does not know if R2 has a copy of the involuntary discharge paperwork. On 10/26/2022 at 3:15PM, (V4) (Social Services Director) said V4 communicated with V8 (R2's guardian) and ombudsman. V4 said on 10/07/2022 when R2 was being transported to the hospital, V4 gave R2 an envelope to give to the person admitting R2 at the hospital. V4 said R2 was not educated on what was in the envelop. V4 said the sealed envelope contained the original Involuntary Discharge paperwork (IVD). V4 said V1 (administrator makes the determination on involuntary discharge. On 10/27/2022 at 1:12pm, V4 (Social Services Director) said she, V4 is the one who updates care plans. V4 was asked to review care plans with surveyor. V4 said I don't see update regarding all the incidences R2 had. When a resident has an incident, I am supposed to update the care plan with the interventions for the resident regarding the resident behavior. V4 said If the care plan is not update, then staff will not provide the most current interventions. V4 said when we start to notice a resident is having change in behavior that we cannot take care of, we inform the resident, the resident guardian, the resident physician, and if the resident agrees, we start to look for another facility where the resident can better be taken care of, then when we find a facility, we start the discharge process. V4 said I do not recall if we started the discharge process for the R2, I cannot recall if we did any other discharge interventions before we did the involuntary discharge (IVD) for R2, and I do not recall any incidences of aggression for R2. (continued on next page)

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	145625	A. Building B. Wing	10/28/2022

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

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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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/27/2022 at 2:20pm, V31(Nurse Practitioner) said that R2's psychiatrist should be the one giving surveyor more answers regarding R2 behavioral health. V31 said for me, I can only deal with medical issues. The staff and facility should try their best to manage their residents, but it comes a point where the facility cannot manage the resident anymore, and R2 was gradually becoming worse, so was better for the facility and the resident to separate to prevent harm for the residents or this resident. V31 said It is not the best decision, but the facility felt it could not manage R2. V31 said V31 gave the order for R2 to be transferred to the hospital for treatment. On 10/27/2022 at 3:36pm, V1 said V1 does not have V33(Psychiatrist) number and does not know how to contact V32. V1 said V33(Facility Medical Doctor) is on vacation and cannot be reached. On 10/27/2022 at 3:36pm V1 (Administrator) said the facility expectation is that residents are evaluated for safety and family and guardian medical team psychiatrist are notified to get their input. V1 said the facility tries to have impromptu care plan meetings if a resident behavior is settled or if there are significant resident changes. V1 said If a resident has a significant change in condition, we skip the care plan part and go to evaluation. V1 said R2 had significant change from 9/5/2022 to 10/07/2022, it was not like he was bothering peers/staff every day, it was either nothing or him punching somebody. V1 was asked if V1 felt at that time R2 was not fit for the facility and why the facility did not start looking for placement for R2. V1 said R2 was not aggressive all the time therefore the facility did not see a need to transfer R2 at that time, when R2 had altercations with other residents. On 10/25/2022 at 2:45pm V9 (social worker at the hospital) said V9 has reached out to the facility regarding R2 but the facility does not answer V9 's calls or return V9 ' s calls. V9 said the nurses and social worker assigned to R2 have told V9 that R2 is not aggressive at the hospital. V9 said R2 seems ok. V9 said V9 does not know if R2 has a copy of the involuntary paperwork. V9 said another SW said R2 has no signs of aggression, and even the nurses on R2 floor said R2 is not aggressive. V9 said V9 has not seen the involuntary paperwork R2 was supposed to have. V9v said I don ' t know if R2 has a copy, but maybe it was in the paperwork that came with R2. V9 said R3 seems to be ok. V9 said V9 has not contacted the Ombudsman, but V9 said V9 heard the facility refused to take R2 back. V9 said V9 had reached out to the facility, but the facility did not answer calls. Facility Policy titled Involuntary Discharge and dated 7/14, 11/17 documented: The facility will provide notification of an involuntary discharge or transfer according to guideline established by Federal and State and state agency An involuntary discharge will be issued under the following circumstances a) An appropriate alternative placement is located. Review of R2's health records and facility reported incident reports document that R2 had altercations/ incidences with peers where R2 was the aggressor, or R2 was the victim dated: 10/22/2022, 09/05/2022, 09/08/2022, 10/07/2022. No documentation of facility starting the process of placing R2 in another facility were documented. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility Assessment Tool dated 09/26/2022 document facility accepts residents with: Psychiatric /Mood Disorders, Neurological System disorders

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45111 Based on interviews and records review, the facility failed to allow one resident(R2) to return to facility after short stay in the hospital. This failure affected one resident (R2) of three residents reviewed for involuntary discharge. Findings include: On 10/25/2022 at 2:45pm V9 (social worker at the hospital) said V9 has reached out to the facility regarding R2 but the facility does not answer V9's calls or return V9's calls. V9 said the nurses and social worker assigned to R2 have told V9 that R2 is not aggressive at the hospital. V9 said R2 seems ok. V9 said V9 does not know if R2 has a copy of the involuntary paperwork. V9 said another SW said R2 has no signs of aggression, and even the nurses on R2 floor said R2 is not aggressive. V9 said V9 has not seen the involuntary paperwork R2 was supposed to have. V9 said I don't know if R2 has a copy, but maybe it was in the paperwork that came with R2. V9 said R3 seems to be ok. V9 said V9 has not contacted the Ombudsman, but V9 said V9 heard the facility refused to take R2 back. V9 said V9 had reached out to the facility, but the facility did not answer calls. R2 is a [AGE] year-old individual with initial admitted to the facility on a 4/21/15, readmitted to the facility on [DATE] and discharged from the facility on 10/7/22. R2's Brief Interview for Mental Status (BIMS), completed on July 21, 2022 document R2' BIMS as 10/15, indicating R2 has some cognitive deficits. (continued on next page)

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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 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/26/2022 at 1:45pm, V8 (R2's Guardian) said R2's mother told V8 that the facility put R2 in the ambulance and gave R2 a piece of paper while R2 in the ambulance being transported to the hospital. V8 said R2's mother said R2's mother said she did not know what piece of paper was given to R2 and R2 was not able to say what paper R2 was given before leaving the facility. V8 said V8 did not know what piece of paper R2's mother was saying R2 was given when R2 was sent to the hospital. V8 said V8 did not know R2 was discharged from the facility, or why R2 was sent out to the hospital because V8 was not notified that R2 was being sent to the hospital and would not be allowed back to the facility. V8 said R2 has been in and out of the facility for over 7 years and now the facility was sending R2 out and discharging R2 from the facility. V8 said R2 was sent to the far south side of Chicago, and they bypassed near hospitals. V8 said as R2's guardian, the facility is supposed to notify V8 of any change of condition for R2 and upon return. V8 said the facility sent R2 out without notice and the facility said they are not taking R2 back. V8 said as R2's guardian, they should have called V8 and left a message if V8 does not answer. V8 said V8 answers almost always and if a message is left, V8 will call back. V8 said even if it after hours, the person who answers the calls is another state guardian who answers the phone, and that guardian emails the responsible guardian to update them on their residents if any phone call is received. V8 said V4 (Director of Social Services) said that V4 told V8 that V4 sent a copy of the involuntary notice to the hospital with R2, and faxed a copy to the hospital, but V8 said hospital has nothing to do with it. V8 said that all V4 said was all parties were notified, but V8 said the ombudsman, V8, and R2's mother was not notified. V8 said V1 (Administrator) said V4 said V4 faxed the discharge letter to V8 but V8 had not received it. V8 said that V1 told V8 that after the last three complaint investigations involving R2, V1 was asked why R2 is still at the facility if the facility cannot provide services to R2, and that is why when R2 had another incident, the facility decided they did not want R2 back at the facility. On 10/26/2022 at 3:15PM, (V4) (Social Services Director) said V4 communicated with V8 (R2's guardian) and ombudsman. V4 said on 10/07/2022 when R2 was being transported to the hospital, V4 gave R2 an envelope to give to the person admitting R2 at the hospital. V4 said R2 was not educated on what was in the envelop. V4 said the sealed envelope contained the original Involuntary Discharge paperwork (IVD). V4 said V1 (administrator makes the determination on involuntary discharge. On 10/27/2022 at 10:46am, V1(Administrator) said the facility felt R2 could be managed at the facility and R2 was manageable at that time, but in June and July of 2022, R2 started to show decline then from August, R2's behaviors changed and R2 started hitting other residents. V1 said at that point, the facility decided they could no longer take care of R2, and R2 would not do the neuro assessments or talk to the doctors or Social Workers. V1 was asked if the facility tried to find placement for R2 at another facility that could take care of R2, V1 said: No, we did not have time. V1 was asked if R2's psychiatrist was notified when R2 was petitioned out. V1 said: The Nurse practitioner (V31) was notified, but the psychiatrist (V32) and the medical Director (V34) were not notified. V1 said V1 did not know how V32 can be reached. V1 said V34 was out of the county on vacation and could not be reached by phone. On 10/27/2022 at 11:35am V28 (psychologist) said that it got to a point where R2 would not acknowledge V28, and when V28 walked over to R2, R2 would close R2 eyes and not talk to V28. V28 said R2 was not engaging with V28 but V28 said I believe he was participating with the psychiatrist. V28 said interventions were provided to staff to use. V28 said V28 did not see any aggressive behavior from R2 towards V28, but R2 would get irritable with V28, however, staff had told V28 that R2 would intermittently explode. (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/27/2022 at 1:12pm, V4 (Social Services Director) said she, V4 is the one who updates care plans. V4 was asked to review care plans with surveyor. V4 said I don't see update regarding all the incidences R2 had. When a resident has an incident, I am supposed to update the care plan with the interventions for the resident regarding the resident behavior. V4 said If the care plan is not update, then staff will not provide the most current interventions. V4 said when we start to notice a resident is having change in behavior that we cannot take care of, we inform the resident, the resident guardian, the resident physician, and if the resident agrees, we start to look for another facility where the resident can better be taken care of, then when we find a facility, we start the discharge process. V4 said I do not recall if we started the discharge process for the R2, I cannot recall if we did any other discharge interventions before we did the involuntary discharge (IVD) for R2, and I do not recall any incidences of aggression for R2. On 10/27/2022 at 2:20pm, V31(Nurse Practitioner) said that R2's psychiatrist should be the one giving surveyor more answers regarding R2 behavioral health. V31 said for me, I can only deal with medical issues. The staff and facility should try their best to manage their residents, but it comes a point where the facility cannot manage the resident anymore, and R2 was gradually becoming worse, so was better for the facility and the resident to separate to prevent harm for the residents or this resident. V31 said It is not the best decision, but the facility felt it could not manage R2. V31 said V31 gave the order for R2 to be transferred to the hospital for treatment. On 10/27/2022 at 3:36pm, V1 said V1 does not have V33(Psychiatrist) number and does not know how to contact V32. V1 said V33(Facility Medical Doctor) is on vacation and cannot be reached. On 10/27/2022 at 3:36pm V1 (Administrator) said the facility expectation is that residents are evaluated for safety and family and guardian medical team psychiatrist are notified to get their input. V1 said the facility tries to have impromptu care plan meetings if a resident behavior is settled or if there are significant resident changes. V1 said If a resident has a significant change in condition, we skip the care plan part and go to evaluation. V1 said R2 had significant change from 9/5/2022 to 10/07/2022, it was not like he was bothering peers/staff every day, it was either nothing or him punching somebody. V1 was asked if V1 felt at that time R2 was not fit for the facility and why the facility did not start looking for placement for R2. V1 said R2 was not aggressive all the time therefore the facility did not see a need to transfer R2 at that time, when R2 had altercations with other residents. Facility Policy titled Involuntary Discharge and dated 7/14, 11/17 documented: The facility will provide notification of an involuntary discharge or transfer according to guideline established by Federal and State and state agency An involuntary discharge will be issued under the following circumstances a) An appropriate alternative placement is located. No documentation of facility starting the process of placing R2 in another facility were documented. Facility Assessment Tool dated 09/26/2022 document facility accepts residents with: Psychiatric /Mood Disorders, Neurological System disorders