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	02/17/2023

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 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** 46342 Based on interview, observation and record review, the facility failed to protect residents right to be free from physical abuse. This deficient practice affected 4 residents (R2, R7, R8, R13) in a sample of 8 residents (R1, R2, R3, R4, R6, R7, R8, R13) reviewed for abuse. This failure resulted in a.) R8, a cognitively impaired male resident being slapped on the hand by a staff member; b.) R7, a female resident who is non-ambulatory using a wheelchair (R7) being slapped on the face by an ambulatory male resident (R6) who has a history of physically aggressive behavior(s); c.) R1 punching R2 on the back; and d.) R7 hitting and scratching R13's wrist. Findings include, Facility's Final Incident Investigation Report dated (12/24/22) regarding incident which occurred on 12/21/22 between R8 and a staff member documents in part: R8 took a cup of juice from the food cart and V3 (Certified Nursing Assistant) grabbed R8's arm and took the cup away from R8. V3 stated that R8 took a cup of juice from the food cart and spit in it, V3 then grabbed R8's arm and took the juice from R8. R8 has diagnosis not limited Cognitive Communication Deficit, Unspecified Dementia without Behavioral Disturbances, Psychotic Disturbance, Mood Disturbance and Anxiety, Major Depressive Disorder, Schizoaffective Disorder, Hypertension, Personal History of COVID-19, Glaucoma, Gastro-Esophageal Reflux Disease with Esophagitis, Type 2 Diabetes Mellitus with Hyperglycemia. R8's Brief Mental Status Interview (BIMS) dated 12/18/22 documents that R8's cognition is severely impaired. R8's care plans dated 12/23/22 documents in part R8 is at risk for potential abuse related to behavior problems, and mental/emotional challenges. R8's progress note dated 12/21/22 at 12:40, completed by V19 (Licensed Practical Nurse), documents in part, R8 reported to writer (V19) that R8 (was) trying to get some juice off of the cart when a CNA grabbed his (R8)'s hand and hit the cup of juice to the floor. Writer (V19) took R8 to R8's room and assessed R8 for injuries (none noted). R8 denied pain. Writer (V19) reported immediately to Abuse Coordinator. (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	On 02/14/22 at 10:57 AM, V1 (Administrator) stated that V1 did not witness the altercation between R8 and V3 (Certified Nursing Assistant) but was aware of the incident. V1 stated that it was reported to V1 that R8 was reaching for juice after R8 was told not to get the juice by V3 who was preparing the juice for lunch, and then R8 proceeded with trying to grab the juice and that V3 tapped the juice cup out of R8's hand causing the juice to fall on the floor. V1 stated that R8 was immediately separated from V3 by the unit staff and the Abuse Coordinator & V1 were notified. V1 stated at the time of the event V1 was the Social Service Director, not the Administrator. V1 met with R8 for a well-being follow up and R8 told V1 that V3 knocked the juice out of R8's hand. V1 stated that R8's care plan was updated with appropriate interventions. V1 was not sure of what steps the Administrator (V22) took with the CNA (V3) involved but V1 stated that V1 knows V3 is no longer working at the facility. V1 stated that there was a video recording of the incident however stated that after 30 days the recording is deleted. V1 stated that V1 did not view the recording of the incident but that the former Administrator (V22) did watch the video. On 02/14/22 at 1:22 PM, V1 stated to surveyors, residents have the right to be free from abuse. On 02/14/23 at 2:05 PM, V19 (Licensed Practical Nurse) stated that V19 did not witness the event on 12/21/22 between R8 and V3 but after the fact R8 told V19 that V3 had hit R8's hand during lunch pass. V19 stated that R8 will try to grab juice but when told to wait his (R8) turn, R8 responds well to verbal redirection and is cooperative. V19 stated that V19 called the administrator to report the abuse and R8 was separated from V3. V19 stated that V22 (Administrator) removed V3 from the unit immediately to interview V3 and that V3 never returned to the floor again. V19 stated that R8 was monitored for signs or symptoms of abuse and assessed for injury, harm and that no injuries were noted, R8 denied any pain. On 02/14/23 at 2:11 PM, R8 stated that R8 was thirsty and wanted something to drink so R8 took a cup of juice from the beverage cart during lunch time. R8 stated that one of the CNAs smacked my hand hard, and yelled, don't do that! R8 stated that R8 has not seen that CNA for a while, and said, I don't think she works here anymore. R8 stated that R8 feels safe at the facility and that there have been no other times that a staff member or resident has hit him (R8). On 02/15/23 at 11:56 AM, V22 (Former Administrator) stated that on 12/21/22 V30 (Activity Aide) came down to V22's office tearful and upset. V22 stated that V30 reported that V30 saw a resident being abused. V22 stated that V30 reported that V30 saw V3 slap R8's hand. V22 immediately went to the floor and separated R8 from V3 and made sure R8 was assessed to make sure R8 did not have any injuries and R8 was monitored by social services. V22 stated that V22 had V3 go down to the office to get V3's statement or version of what happened. V22 stated that initially, V3 denied touching R8 but, then V3 stated that V3 saw R8 spit into a cup of juice and that V3 asked R8 to put down the glass of juice but that R8 did not listen and that R8 tried to put the cup of juice back on the cart and that is when V3 tried to knock the cup away from R8. V22 stated that V22 watched the video recording of the event and that what V22 saw on the video did not correlate with V3's report of the event. V22 stated that video showed that R8 did not spit into the cup of juice and that V3 very aggressively made contact with V3's hand against R8's hand which was holding the juice causing the contents of the juice to fall on the floor. After V3 watched the video V3 admitted to trying to snatch the cup out of R8's hand. V22 stated V3 then got up and said, I resign and then V3 left the building and has not been in the building since. V22 stated that this event was substantiated as abuse. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 02/15/23 at 01:54 PM, surveyor spoke with V30 (Activity Aide) via phone. V30 stated that V30 did not see the altercation between R8 and V3 on 12/21/22 but that V30 heard the commotion in the hallway. V30 stated that V30 heard V19 (LPN 2nd floor) say to V3, why did you slap that juice out of his hand? V30 stated that V19 was referring to R8. V30 stated that there was juice spilled all over the floor. V30 stated the juice was just sitting there, I don't know why the CNA wouldn't let R8 have it. On 02/17/23 at 11:54 AM, surveyor spoke with V36 (Psychiatric Nurse Practitioner) over the phone. V36 stated that V36 was not aware of the altercation between R8 and a staff member. V36 stated that it is never appropriate for a staff member to hit a resident. V36 stated that the staff members should be trusted to take care of the residents and that staff members do not have any conditions and should be able to control themselves. V36 stated that if a staff member hit a resident, it was intentional and therefore would be considered abuse. Surveyor left voice mail messages for V3 the following dates/times with no response: 02/15/23 at 9:38 AM, 02/15/23 at 10:45 AM, 02/15/23 at 12:30 PM, and 02/17/23 at 1:42 PM. Facility's Final Incident Investigation Report dated (12/24/22) regarding incident which occurred on 12/20/22 between R6 and R7 documents in part: R6 went into R7 room to retrieve R6's jacket which had been taken by R7 from R6's room while R6 was sleeping. R6 stated that R6 went into R7's room and grabbed R6's jacket from R7's hands. At that time both R6 and R7 denied any physical altercation. R7's roommate reported witnessing R6 slap R7, which R7 later confirmed. R6 has diagnosis not limited Cognitive Communication Deficit, Major Depressive Disorder, Epilepsy, Type 2 Diabetes Mellitus, Hypertension, Hyperlipidemia, Vitamin D Deficiency, Nicotine Dependence. R6's Brief Mental Status Interview (BIMS) dated 11/25/22 documents that R6's cognition is moderately impaired. R6's care plan documents in part R6 has been physical aggressive toward peers when angry and displays poor impulse control. R6's MDS section G (Functional Status) documents R6 is able to walk in room and corridor with supervision (oversight, encouragement, cueing). R7 has diagnosis not limited to Bipolar Disorder, Anxiety Disorder, Disorder of Adult Personality and Behavior, Schizophrenia, Adult, Chronic Obstructive Pulmonary Disease, Difficulty Walking, Lack of Coordination, Weakness, Type 2 Diabetes Mellitus, Epilepsy, Diastolic (Congestive) Heart Failure, Anemia, Insomnia. R7's Brief Mental Status Interview (BIMS) dated 12/02/22 documents that R7's cognition is moderately impaired. R7's care plan documents in part R7 may be at risk for potential abuse related to mental/emotional challenges, secondary to behaviors displayed as evidenced by going into peers' rooms and not respecting peers' boundaries. R7's MDS section G (Functional Status) documents R7's ability to walk in room and corridor did not occur 100% of the time. R9 has a diagnosis not limited to Schizoaffective Disorder, Morbid Obesity, Weakness, Lack of Coordination, Difficulty Walking, Alcohol Abuse, Osteoarthritis, Adult Failure to Thrive, Need for Assistance with Personal Care. R9's Brief Mental Status Interview (BIMS) dated 01/11/23 documents that R9 is cognitively intact. R7's progress note dated 12/20/22 at 06:16 completed by V32 (11-7 Registered Nurse) documents in part, R6 wandering the hall all night going in peers room taking their belongings. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	R9's progress note dated 12/20/22 at 06:33, completed by V32 documents in part, R9 complained of R9's roommate (R7) was slapped by a male resident in R9's room. R7's progress note dated 12/20/22 at 06:40 completed by V32 documents in part, R7's roommate informed nurse that R7 had been slapped by a male resident, R7 denied being slapped but later when questioned R7 stated that R7 took R6's coat and gloves looking for money and R6 came into R7's room and snatched R6's coat out of R7's hands and the coat sleeve hit R7. R6's progress note dated 12/20/22 at 06:48, completed by V32 documents in part, R6 stated R6 went to R7's room and snatched R6's coat out of R7's hand that's all, denied striking R7. R6's progress note dated 12/20/22 at 14:33, completed by V1 (Administrator, Former Social Service Director) documents in part R6 hit peer because R6 stated peer (R7) stole R6's jacket and R6 stated, so what. On 02/14/23 at 1:20 PM, surveyor observed R7 in R7's room sitting in a wheelchair. R7 stated that R6 was in R7's room but R7 did not know why. R7 denied taking R6's jacket. R7 stated, he (R6) hit me in the face, here and as R7 made this statement R7 took R7's hand and covered R7's face with R7's hand. R7 stated R6 has not been in R7's room since R6 hit R7. R7 stated, he's a nice guy. On 02/14/23 at 1:24 PM, R9 stated that R6 barged into R7 and R9's room early one morning and asked for R6's jacket back. R9 stated that R7 gave R6 his jacket back and then R6 slapped R7 across the face really hard. R9 stated that R9 told R6 to get out of their room and that R6 left the room at that time. R9 stated that R9 reported what R9 had witnessed to the nurse on duty. On 02/14/23 at 1:32 PM, R6 stated that R7 came into R6's room when R6 was in the washroom and took R6's jacket. R6 stated that one of R6's roommates told R6 that R7 took R6's jacket. R6 stated that R6 went into R7's room to get R6's jacket back. R6 stated that R7 tried to make it like she (R7) didn't have it. But, I saw my jacket on her (R7)'s bed as she (R7) was going through the pockets of my jacket. R6 stated that R6 snatched R6's jacket from R7's bed. R6 stated that R6 did not hit or slap her. R6 stated, I don't hit ladies. Men aren't supposed to hit ladies. R6 stated that R7's roommate told R6 that R6 should not be in the room and told R6 to leave. R6 stated that R6 then left the room with R6's jacket in hand, and said, that was all, I did not touch her. R6 stated that R7 has taken other things from R6's room before but not able to specify what items. On 02/14/22 at 11:15 AM, V1 (Administrator) stated that V1 did not recall or witness the incident between R6 and R7 that occurred on 12/20/22. V1 stated that R7 has a known history of roaming into other resident rooms and taking items from them. V1 stated that initially R7 denied being touched by R6, however later R7 did confirm that R7 was slapped by R6. V1 stated that the facility confirmed abuse had occurred. On 02/14/22 at 1:22 PM, V1 stated to surveyors, residents have the right to be free from abuse. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 02/14/23 at 1:44 PM, V17 (4th Floor Social Worker) stated that R7 constantly goes into other resident's rooms uninvited and takes their things without their permission. V17 stated that R7 took R6's jacket from R6's room and that R6 went into R7's room to get R6's jacket back. V17 denied being aware that R6 hit or slapped R7 when R6 was in R6's room retrieving R6's jacket. V17 stated R6 and R7 continue to reside in the same room on the same unit but that R6 and R7's rooms are on opposite sides of the unit from each other. V17 stated that R6 and R7 don't socialize and that R6 keeps to himself except to participate in smoke breaks and activity functions. V17 stated that staff continue to monitor R7 for roaming behavior as this is an ongoing behavior and try to redirect R7 back to R7's room. On 02/14/23 at 1:54 PM, V18 (Certified Nursing Assistant) stated that V18 has been working at the facility for 6 years. V18 stated that R7 is constantly taking other resident items and selling or trading them to other residents for money or cigarettes. V18 stated that this is R7's long standing behavior and is something R7 is constantly doing including all night and throughout the day. V18 stated that R7 also wanders to the other floors looking for money and cigarettes. V18 stated R6 stays in R6's room and does not wander or roam into other resident's rooms. V18 was not aware of incident between R6 and R7. On 02/15/23 at 11:56 AM, V22 (Former Administrator) reported that on 12/20/22 R7 had taken R6's jacket from R6's room and R6 went into R7's room to retrieve the jacket. V22 stated that R6 grabbed the jacket from R7's hand and that initially, R7 denied being hit by R6 however R7's roommate (R9) reported seeing R6 slap R7 on the face. V22 stated that R7 has a history of denying physical abuse even if it has occurred because R7 would then have to admit to taking items from other residents (for example R6's jacket) which R7 knows R7 is not supposed to do. V22 stated that after facility investigation was conducted the allegation of theft and abuse were both substantiated. On 02/16/23 at 10:21 AM, surveyor spoke with V32 (11-7 Registered Nurse) via phone. V32 stated that V32 has been working at the facility since June 2020 and that V32 works on the 4th floor (11-7 shift). V32 stated that V7 has a long-standing behavior of entering other resident's rooms looking for money, cigarettes or food and taking other resident's belongings. V32 stated that R7 wanders all light long into and out of other resident rooms and that most of the time R7 will respond to redirection provided however sometimes if R7 has drank a lot of soda R7 can get hyped up and in those instances R7 does not respond to redirection. V32 stated that 12/20/22 was one of those nights, R7 was in constant movement all night long, going in and out of other resident's rooms and was not responding to staff redirection. V32 stated that V32 did not see R7 go into R6's room or see R7 take R6's jacket. V32 stated that on 12/20/22 early in the morning, toward the end of V32's shift V32 was passing medications when R7's roommate (V9) approached V32 and told V32 that R6 had entered R7 and R9's room and R9 saw R6 slapped R7 in the face. V32 stated that V32 separated R6 and R7 and went to R7's room to assess R7 for injury. V32 stated R7 had no signs or symptoms of injury and denied pain. V32 state that R7 denied being hit by R6 and that R7 felt safe. V32 notified the nursing supervisor who came to the floor to interview R6 and R7 and the Administrator was notified. On 02/16/23 at 1:06 PM, V21 (Restorative Aide/Certified Nursing Assistant) stated V21 has been working at the facility for 8 years. V21 state that R7 is non-compliant with wandering and stealing behavior and that R7 is constantly wandering around the facility looking for money or cigarettes. V21 stated this is a long-standing behavior. V21 stated that R7 does have the ability to walk however R7 only uses R7's wheelchair when R7 is out of R7's room. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 02/16/23 at 1:10 PM, R9 stated that R7 goes room to room looking for items all day and night and that R7 steals things so R7 can trade them or sell to other residents in the facility. R9 stated that R7's behavior makes the other residents mad and that the residents whose stuff R7 has stolen then come looking for their items in R7 and R9's room and that those residents are very, very angry. R9 stated that R6 burst into their room early one morning when still dark outside and started arguing with R7. R9 stated that R9 got up because of the commotion and that is when R9 saw R7 slap R6 real hard across the face. On 02/16/23 at 3:05 PM, surveyor spoke with V36 (Psychiatric Nurse Practitioner) via phone. V32 stated that V36 provides care to R6 and R7 and that V36 has been covering the facility since the fall of 2022. V36 stated that R6 has a history of being verbally and physically aggressive and that those types of behaviors are usually exhibited when R6 is triggered by something. For example, by the way people talk to R6, or if R6 is told to do something R6 does not want to do. V32 stated that verbal and physical aggression are not new behaviors for R6. V36 stated that R7 displays a lot of aggression and agitation toward staff and other residents. V36 described R7 as being very manipulative, non-compliant with care and roams around R7's unit, and other resident floors within the facility looking for money, or cigarettes constantly. V32 stated that R7's wandering, hoarding, and stealing behaviors are not new behaviors. V36 always sees R7 sitting in R7's wheelchair but has seen R7 transfer herself from R7's wheelchair to the R7's bed when in R7's room. V36 stated that V36 was aware of the altercation between R6 and R7 in terms of R7 stealing R6's jacket but did not realize R6 had slapped R7 on the face when R6 had gone into R7's room to retrieve R6's jacket. V36 stated, that should not be happening at the facility and that physical aggression toward another resident could be triggering for that resident (R7) and for all of the other residents on the unit. V36 stated it is not a safe environment if there is physical aggression between residents. V36 stated that R7 is a high risk of this happening again because of R7's wandering and stealing behaviors are ongoing. V36 stated that the facility needs more people to make sure the residents are safe in their rooms and provide more re-direction as needed to intervene quickly. Surveyor left voice mail messages for V37 on 02/17/23 at 9:40 AM, 10:21 AM, and 12:12 PM with no response. Policy: Abuse Prevention Program - Policy undated, documents in part, Residents have the right to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment. Residents' Rights undated, documents in part, your (residents') rights to safety: you must not be abused, and the facility must ensure that you are free from retaliation. 44314 R1's Face Sheet documents resident is a [AGE] year-old with diagnoses including but not limited to: HYPERLIPIDEMIA, UNSPECIFIED, MAJOR DEPRESSIVE DISORDER, SINGLE EPISODE, UNSPECIFIED, SCHIZOAFFECTIVE DISORDER, UNSPECIFIED, MILD COGNITIVE IMPAIRMENT OF UNCERTAIN OR UNKNOWN ETIOLOGY, FOURTH [TROCHLEAR] NERVE PALSY, LEFT EYE, DIPLOPIA, ALCOHOL DEPENDENCE, UNCOMPLICATED, HOMONYMOUS BILATERAL FIELD DEFECTS, LEFT SIDE, PRESENCE OF INTRAOCULAR LENS, OTHER VISUAL DISTURBANCES. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Final Incident Investigation Report (fated 01/13/2023) documents On 01/13/2023 at approximately 8:15am, AM nurse reported that she witnessed R1 hitting R2 in the back. Both residents were immediately assessed for injuries. No injuries observed. Staffed confirmed that R1 repeatedly asking R2 to leave her room as she was getting dressed. Upon further investigation of this incident, physical abuse was founded. Upon the conclusion of this investigation, it is believed that abuse is substantiated. R1's Care Plan (dated 10/24/2020) documents that R1 presents with verbal/physical act out with peers, easily agitated, poor impulse control. R1's Care Plan (revised on 01/15/2023) documents that R1 may be at risk for potential abuse r/t behavior problem as evidenced by verbally and physically acting out when agitated. R1's Minimum Date Set assignment dated 12/30/2022 indicated R1 has a Brief Interview for Mental Status (BIMS) score of 14, which indicates resident has intact cognitive response. R2's Face Sheet documents resident is a [AGE] year-old with diagnoses including but not limited to: OTHER ASTHMA, UNSPECIFIED SEVERE PROTEIN-CALORIE MALNUTRITION,IRON DEFICIENCY ANEMIA SECONDARY TO BLOOD LOSS (CHRONIC), UNSPECIFIED DEMENTIA, UNSPECIFIED SEVERITY, WITHOUT BEHAVIORAL DISTURBANCE, PSYCHOTIC DISTURBANCE, MOOD DISTURBANCE, AND ANXIETY, SCHIZOPHRENIA, UNSPECIFIED, INSOMNIA, UNSPECIFIED, DYSPHAGIA, ORAL PHASE, RESIDUAL HEMORRHOIDAL SKIN TAGS. R2's Minimum Date Set assignment dated 11/20/2022 indicated R2 has a Brief Interview for Mental Status (BIMS) score of 11, which indicates resident has moderately impaired cognitive response. R2's Care Plan (dated 06/24/2022) documents that R2 may be at risk for potential abuse r/t behavior problem, communication issues/deficits as well as poor impulse control, secondary to mental and emotional challenges. Abuse Prevention Policy (dated 11/22/2017) states: Residents have the right to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment. This includes but is not limited to corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms. On 02/14/2023 at 9:15am, R1 stated, On 01/13/2023, I was sitting on my bed, and I was getting dressed. Suddenly, R2 just barged into my room and stood there and was staring at me. I asked R2 to leave my room, but he did not leave. R2 just stood there and was looking at me getting dressed. So, after I asked him several times to leave, I pushed him out of my room and hit him on his back to get him out. I don't know why R2 came in here in the first place, maybe R2 was confused because R2 just stood there. R2 did not say anything to me when I asked him to leave. R2 just stood there. Finally, I became agitated and pushed R2 out of my room and hit him on his back so that R2 would leave. I didn't hit R2 hard and R2 did not sustain any injuries. I wasn't trying to hurt R2, I just wanted him to leave. I feel safe here, I just wanted some privacy so that I can get dressed. On 02/14/2023 at 9:23am, R2 stated, I don't remember what happened. I don't remember going into anyone's room. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 02/14/2023 at 1:43pm V15 (licensed practical nurse) stated, R1 is not aggressive. R1 is calm and cooperative and keep to herself. R2 is not aggressive and has not been physically aggressive towards other residents. R2 has periods of confusion and during those periods of confusion, R2 can wonder into other resident rooms. R2 wondered into R1's room because R2 was confused at the time. R1 got upset that R2 entered R1's room. On 02/15/2023 at 12:33pm, V1 (administrator) stated, On 01/13/2023, a nurse reported that R1 hit R2 on the back. Both of the residents were separated. I met with R1 first and R1 said that R2 came into her room while R1 was getting dressed. R1 said that R1 asked R2 to leave and R2 refused to leave and R1 hit R2 on the back because R2 would not leave. R1 admitted that R1 hit R2 on the back. R1 said that R2 did not take anything from the room, it was just that R1 was trying to get dressed and R2 would not leave. I asked R2 what happened and R2 indicated that R2 did not know. R2 did not remember the incident. We did a potential for abuse form for R2. R1 was encouraged to seek staff assistance when she becomes triggered. The incident between R1 and R2 was substantiated, and abuse was founded. The resident has the right to be free from abuse. On 02/16/2023 at 10:05am V21 (certified nursing assistant) stated, On 01/13/2023, I was working on the 4th floor, and I heard someone yelling get out of my room. I recognized the voice to be of R1. I immediately stopped what I was doing, and I went to R1's room. When I walked in to R1's room, I saw R1 screaming at R2 telling him to get out of her room. R2 was just standing there, and I asked R1 to calm down. I asked R2 to leave R1's room. R2 just stood there and was staring at me but he didn't move. When I was talking to R2 telling him to leave R1's room, that's when R1 became more agitated and came from behind and hit R2 in the middle of R2's back. I was in between R1 and R2, and R1 came from behind and punched R2 in the middle of his back. After R1 hit R2 on the back, R2 left R1's room and went to his room. R2 did not appear to be injured. R2 just walked to his room. R2 did not scream from pain or anything like that, R2 just left R1's room and went to his own room. After the incident, the nurses assessed R1 and R2 and both residents were immediately separated. R1's Progress Note (dated 01/13/2023) documents, Staff reported to writer co-resident entered res room while res was dressing. Res asked co-resident to leave room three times. Co-resident res did not leave room so res punched co-resident in back. Residents were immediately separated. NP notified. DON notified. POA notified. No s/s of bruising or pain noted. vitals within normal range. No further behaviors noted at this time. 72 hr behavior charting initiated at this time. Will continue to monitor. R1's Social Service Note (dated 01/13/2023) documents, Wellbeing check/ Behavior monitoring 1/3: Writer was made aware by nursing staff that resident initiated physical aggression towards peer. Resident presents to be aox3 and can verbalize her wants and needs with no issues. Resident stated He was in my room while I was changing my clothes, when I asked him to leave. I punched him because he wouldn't leave my room after I asked 3x. Writer encouraged resident to seek staff assistance when needed. Writer encouraged resident to maintain appropriate boundaries. Writer reassured resident that she resides in a safe place. Psychiatrist made aware. Appropriate departments made aware. Resident was able to be redirected and complaint. No reported aggression. Staff to continue to monitor resident accordingly. (continued on next page)

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	145625	A. Building B. Wing	02/17/2023

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	R2's Progress Note (dated 01/13/2023) documents, Staff reported to writer res was seen in co-residents' room. co-resident stated res was asked to leave room three times. res did not leave room so co-resident punched res in back. residents were immediately separated. NP [NAME] notified. POA [NAME] notified. no s/s of bruising or pain noted at this time. vitals within normal range. no further behaviors noted at this time. 72 hr behavior charting initiated at this time. will continue to monitor. R7's Face Sheet documents resident is a [AGE] year-old with diagnoses including but not limited to: BIPOLAR DISORDER, CURRENT EPISODE MIXED, MODERATE, UNSPECIFIED INJURY OF RIGHT ANKLE, INITIAL ENCOUNTER, GENERALIZED ANXIETY DISORDER, TYPE 2 DIABETES MELLITUS WITHOUT COMPLICATIONS, EPILEPSY, UNSPECIFIED, NOT INTRACTABLE, WITHOUT STATUS EPILEPTICUS, UNSPECIFIED DIASTOLIC (CONGESTIVE) HEART FAILURE, DIFFICULTY IN WALKING, NOT ELSEWHERE CLASSIFIED, WEAKNESS, EDEMA, UNSPECIFIED. Final Incident Investigation Report (01/03/2023) states: On 12/30/2023 at approximately 3:40pm, both residents were observed getting off the elevator together on the 4th floor. R7, then suddenly physically hit R13 while at the nurse's station unprovoked. Both residents were immediately assessed for injuries. No injuries observed. Staff confirmed that R7 hit resident in front of the nurse's station. Upon the conclusion of this investigation, it is believed that abuse is substantiated. R7's Minimum Date Set assignment dated 12/02/2022 indicated R7 has a Brief Interview for Mental Status (BIMS) score of 12, which indicates resident has moderately impaired cognitive response. R7's Care Plan (dated 11/15/2021) documents that R7 presents with behavioral concerns as evidenced by being physically aggressive towards peer. R13's Face Sheet documents resident is a [AGE] year-old with diagnoses including but not limited to: SCHIZOAFFECTIVE DISORDER, BIPOLAR TYPE, TYPE 2 DIABETES MELLITUS WITHOUT COMPLICATIONS, DYSPHAGIA, OROPHARYNGEAL PHASE, PNEUMONIA, UNSPECIFIED ORGANISM, DEHYDRATION, HYPO-OSMOLALITY AND HYPONATREMIA, ABDOMINAL RIGIDITY, UNSPECIFIED SITE, REPEATED FALLS, LONG TERM (CURRENT) USE OF ASPIRIN, CHRONIC OBSTRUCTIVE PULMONARY DISEASE, UNSPECIFIED, DYSPHAGIA, ORAL PHASE. R13's Minimum Date Set assignment dated 01/10/2023 indicated R13 has a Brief Interview for Mental Status (BIMS) score of 10, which indicates resident has moderately impaired cognitive response. R13's Care plan (dated 07/10/2022) documents that R13 may be at risk for potential abuse r/t behavior problem as evidenced by verbally and physically acting out when agitated and R13 was involved in a physical altercation in which R13 received physical aggression. Abuse Prevention Policy (dated 11/22/2017) states: Residents have the right to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment. This includes but is not limited to corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms. On 02/15/2023 at 1:20pm, R7 stated, I don't remember hitting anybody. I don't remember it at all. On 02/15/2023 at 10:49, R13 stated, R7 and I were on the elevator together. We got off the elevator and all of a sudden R7 grabbed my arm and scratched my wrist. I don't know why R7 attacked me this way. I didn't do anything to R7. There was no verbal altercation or any issues and R7 just attacked my arm for no reason and scratched me.

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 02/15/2023 at 11:33am V1 (administrator) stated, On 12/30/2023, both residents were getting off the elevator, and that's when R7 suddenly hit R13 without being provoked. R7 hit his arm. R13 did not report any injuries after the incident occurred, but later we learned that R7 scratched R13's arm. R7 was not provoked and hit R13 without any reason. Both residents were separated. We spoke to R7 and R7 did not recall what happened. We spoke to R13 and R13 stated that R7 hit him for no reason, but that he was fine and had no injuries. R7 dos not have a history of aggressive behavior towards other. R7 has a lot of behaviors, however, it is not of norm for R7 to hit other residents without a reason. After the incident, we did an abuse assessment on R13. R7 was encouraged to utilize her positive coping skills in the milieu. R7 was encouraged to refrain from any confrontation with a peer and to refrain from being aggressive towards other. The final investigation of the incident between R7 and R13 was substantiated for abuse. The resident has the right to be free from abuse. R7's Social Service Note (dated 12/30/2022) documents, Writer was made aware that resident was involved in an altercation where she initiated physical aggression towards peer. Resident presents to be aox3 and can verbalize her wants and needs with no issues. When questioned, resident very quiet and stated, I don't remember grabbing on nobody. Resident was verbally redirected to appropriate behavior and encouraged to refrain from being aggressive towards others. Resident was encouraged to continue to utilize her positive coping skills in the milieu and to always refrain f [TRUNCATED]

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44103 Based on observations, interviews, and record reviews, the facility failed to follow their policies and procedures and a resident's care plan to ensure call light was within easy reach for 1 (R11) of 3 residents with multiple history of falls. Findings Include: R11's electronic health record (EHR) shows an initial admitted [DATE] with listed diagnoses not limited to muscle weakness, abnormal posture, dementia, heart failure, unsteadiness on feet, and history of falling. R11's annual Minimum Data Set (MDS) with assessment reference date of 1/7/23 shows R11 has clear speech, able to understand others, and able to make self-understood. This MDS assessment also shows R11 has no functional limitations in range of motion to arms and legs, but has unsteady gait, and requires limited assistance with transfer and toileting. R11's progress notes dated 1/2/23 at 3:17 pm indicates R11 slipped while trying to go to the bathroom and was observed lying on right side on the floor. R11's progress notes dated 1/14/23 at 7:08 am written by V28 (Licensed Practical Nurse) indicates that at 6:32 am, V28 observed R11 sitting on the floor in front of R11's bed in a dark room. R11 sustained a laceration on the forehead. R11's care plan with date initiated on 3/18/19 shows R11 has potential for falls and at risk for injury related to weakness, unsteady gait, poor balance, and history of falls. One intervention reads, Call light within resident's reach when in room. R11's care plan also shows R11 had fall incidents on 1/2/23 and 1/14/23 and to encourage R11 to use call light and wait for staff assistance as part of the interventions. On 2/15/2023 at 9:46 am, surveyor entered R11's room and observed R11 lying in bed alert and able to verbalize needs. R11's call light was nowhere to be found. Surveyor asked R11 if R11 can reach his (R11) call light. R11 stated, I don't know where it is. Interviewed R11 of the incident that happened on 1/14/23 and stated, I was trying to go to the bathroom, and I tripped. R11 stated that R11 hit R11's head. R11 stated R11 could not find R11's call light at that time to call for help, got up to go to the bathroom and tripped. At 9:58 am, surveyor entered R11's room with V14 (Registered Nurse). R11's call light was found on the floor by R11's roommate's bed. V14 stated, It somehow ended over there. V14 stated that R11's call light should be by R11. At 10:22 am, interviewed V23 (Certified Nursing Assistant) and stated that V23 is in-charge of R11. V23 stated R11 knows how to use the call light and it should be within R11's reach. V23 stated R11 needs supervision when transferring and toileting because R11 is high risk for falls. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 12:47 pm, interviewed V29 (Restorative Nurse) and stated that R11 needs assistance with activities of daily living (ADL) and has unsteady gait. V29 stated R11's call light should be placed within R11's easy reach, if not, then R11 would get up and go to the bathroom without calling for help. Facility's CALL LIGHT ANSWERING policy dated 10/21 reads in part: PROCEDURE 5. When the patient or resident is in bed or confined to bed or chair, provide the call light within easy reach of the patient or resident. Facility's Falls Management policy with review date of 6/21 shows fall prevention guidelines for residents, which includes identifying fall risks on the interim plan of care with interventions implemented to minimize fall risk. Facility's Safety and Supervision of Residents policy dated 10/21 includes identifying accident hazards or risk for the resident, and that the care team shall ensure that interventions are implemented to reduce potential for accidents.