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	05/26/2023

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 - Minimal harm or potential for 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** 41356 Based on observations, interviews, and review of records, the facility failed to protect the resident's right to be free from physical abuse and failed to separate 2 residents who were involved in physical aggression to prevent recurrence of similar incident(s). Failures apply to 2 out of 3 residents (R2 and R3) for a total of 3 residents reviewed for abuse. These failures have the potential to affect 2 residents (R2 and R3) in recurrence of similar incident due to proximity. Findings include: R2 is [AGE] years old, initially admitted on [DATE]. R2 has a medical diagnosis of schizoaffective disorder bipolar type. R2's cognition is intact with brief interview of mental status (BIMS) dated 04/03/2023 score of 14. R3 is [AGE] years old, initially admitted on [DATE]. R3 has medical diagnosis of brain injury and epilepsy. R3 has impaired cognition, brief interview for mental status dated 05/11/2023 score of 3. On 05/23/2023 at 12:02 PM. Per resident room assignments on resident records, R2 and R3 were in the same floor. R2's room is in the same hallway as R3's room. V7 (Certified Nursing Assistant) said that R2 can independently wheel his wheelchair. R2 was seen near the Nurse ' s station and agreed to go inside the smoke room for privacy to talk. On 05/23/2023 at 12:34 PM. R2 was able to wheel himself independently going inside smoke room. R2 said, I can transfer from bed to wheelchair using my arms. R3 still owes me 5 cigarettes. And I can tune him up (punching motion like a boxer). I remember what happened in the smoking area, R3 hit me, so I tossed him around. On 05/23/2023 at 12:46 AM, With V8 (Caregiver of R3), R3 was sitting on a walker/wheelchair able to use it as locomotion using his feet. R3 was slow in moving without help of any staff. R3 was alert but have difficult time staying on topic with conversation. R3 said, Yes, I know R2, and 5 to 6 times hit on the head (motion his hand as if to hit his head). Called the police and I cursed his ass out. Then R3 spoke something about his father. V8 tried to ask R3 questions but R3 insists to go out of the room. (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Per report, incident happened on 04/14/2023 at 09:10 AM at the backyard patio during smoke break. R3 passed by R2 and swatted him in the face. R2 pulled on R3's walker and tossed it aside. R3 fell back onto his bottom. Staff intervened to assist R3. Result of abuse investigation was substantiated. Per R2's signed document, it reads: R3 owes him 25 cigarettes and R3 refused to pay. R3 then hit him (R2) when I asked for my cigarettes that he (R3) owes me. Per R3's signed document, it reads: R2 hits him (R3) first because he (R2) is always in my face saying he (R3) owes him (R2) and he (R3) doesn't. R3 further stated R2 pushed him down and threw his walker. Per V10 (Certified Nursing Assistant) signed document, it reads: I seen R2 throwing the walker at R3's legs. On 05/23/2023 at 01:53 PM. V1 (Administrator) said that she cannot answer why R2 and R3 were not separated because she was not yet employed in the facility during that time. V1 further stated that it will be V5 (Social Worker) that can answer the question. On 05/23/2023 at 02:08 PM. V5 (Social Service Director) said, There are days that R2 is super, super, super angry. And I agree, R2 and R3 has tendency to escalate. And I understand that given the proximity of both residents there is a chance for same incident to happen. I will talk to V2 (Director of Nursing) what we can do. Abuse Policy of facility not dated, in part reads: 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. The purpose of this policy and the Abuse Prevention Program is to describe the process for identification, assessment, and protection of residents from abuse, neglect, misappropriation of property, and exploitation. This will be accomplished by: Immediately protecting residents involved in identified reports of possible abuse, neglect, exploitation, mistreatment, and misappropriation of property. Physical abuse is the infliction of injury on a resident that occurs other than accidental means and that requires medical attention. Physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41356 Based on review of records, and interview the facility failed to provide person-centered plan of care for a resident that sustained fracture with surgery due to fall. This failure apply to 1 out of 3 residents (R4) for a total of 3 residents reviewed for care plan. This failure has the potential to lack of addressing care needed of 1 resident (R4) fracture and post operation services. Findings include: R4 is [AGE] years old during review, with medical diagnosis of hemiplegia and hemiparesis following cerebral infarction affecting right dominant side diagnosed on [DATE], seizure diagnosed on [DATE] and displaced intertrochanteric fracture of right femur diagnosed on [DATE] after the R4 had a fall on 04/22/2023. R4's cognition is impaired with brief interview of mental status score of 0 which indicates R4 is rarely or never understood. Incident Report initial and final was dated 04/22/2023. R4 was left in the toilet by himself. R4 transferred by himself and fell . Per Minimum Data Set (MDS) on functional status dated 04/13/2023, documents that R4 needs 1-person extensive assistance on bed mobility, transfers, and toileting. R4's hospital record dated 04/24/2023 to 04/28/2023 documents the following: R4 sustained closed comminuted fracture of the hip, other diagnosis includes impaired functional mobility and activity intolerance and right-sided weakness. Sudden fall or accident can be a life-changing event often need surgery or repair the fracture. R4 undergone a procedure Intramedullary Nail Femur, Antegrade (Right) or right femoral ORIF (Open Reduction Internal Fixation) on 04/25/2023 due to his fracture related to fall on 04/22/2023. V9 presented documentation that R4's care plan for alteration in musculoskeletal status related to fracture of the right hip with goals and interventions were all added on 05/25/2023 after R4 was already discharged on [DATE]. On 05/24/2023 at 10:46 AM. V9 (Minimum Data Set Coordinator) said, Yes, I do some of the care plan for the residents. Care plans are reviewed when things come up as needed and also quarterly as scheduled. When a problem was identified it should be reviewed because you want it to reflect current condition. R4 does not have care plan for his right hip fracture and should have care plan on the day it was identified.

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41356 Based on interviews, and review of records facility failed to protect resident right to be free from accidents, falls, hazards, and injury. And failed to follow safe resident policy to a resident with multiple falls, that needs 1-person extensive assistance but was left by nursing staff to be independent. Failures apply to 1 out of 3 residents (R4) for a total of 3 residents reviewed for accidents and hazards. These failures resulted to 1 resident (R4) sustaining right hip fracture and undergone surgery as a result of the fall. Findings include: R4 is [AGE] years old during review, with medical diagnosis of hemiplegia and hemiparesis following cerebral infarction affecting right dominant side diagnosed on [DATE], seizure diagnosed on [DATE] and displaced intertrochanteric fracture of right femur diagnosed on [DATE] after the R4 had a fall on 04/22/2023. R4's cognition is impaired with brief interview of mental status score of 0 which indicates R4 is rarely or never understood. Incident Report initial and final was dated 04/22/2023. R4 was left in the toilet by himself. R4 transferred by himself and fell . Per Minimum Data Set (MDS) on functional status dated 04/13/2023, documents that R4 needs 1-person extensive assistance on bed mobility, transfers, and toileting. On 05/23/2023 at 04:32 PM, V11 (Certified Nursing Assistant) who was assigned to R4 during incident of fall on 04/22/2023 said, It was during dinner time, and we are busy. The nurse was passing medicine. And I was collecting trays, I was across the room of R4. When I looked up, R4 was on the floor. I cannot remember what happened if R4 was on the toilet or on his wheelchair. The first shift should have not transferred R4 on his chair. Yes, now I remember, I placed R4 on the toilet. But R4 is independent, R4 can transfer on his own, R4 is pretty much independent when he is on the toilet. The only thing R4 needs assistance or help was when I put him on the bed. I wiped him and helped him on the bed. Besides that, R4 is mostly independent. R4 ' s progress notes related to fall are as follows: - V3's (Registered Nurse) notes dated 04/22/2023 documents: R4 was observed on the floor of his bathroom. R4 fell in bathroom while transferring on or off the toilet. Order for right hip and leg X-Ray with neurological checks. During this fall R4 sustained right hip fracture and undergone ORIF (Open Reduction Internal Fixation) surgery. - V25's (Licensed Practical Nurse) notes dated 04/07/2023 documents: R4 had a fall on 04/06/2023 at 07:30 PM. R4 observed on bathroom floor fell attempting to transfer from toilet to chair. R4 requires supervision with transfers. R4 is alert and oriented times 1-3. - V3's notes dated 04/06/2023 documents: R4 was trying to transfer from the toilet to the wheelchair located in his room and fell while transferring. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	- V26's (Registered Nurse) notes dated 03/21/2023 documents: R4 ' s roommate notified her (V24) that R4 has fallen in the bathroom. R4 was on the floor in front of the toilet. - V27's (Licensed Practical Nurse) notes dated 03/16/2023 documents: R4 had a fall was observed laying on the floor on his right side of the bed facing his wheelchair. V3 (Registered Nurse) was assigned to R4 during the incident per V2 (Director of Nursing) and was called on the phone multiple times but did not answer. On 05/23/2023 at 02:04 PM V2 provided complete plan of care for R4 that does not include dates. After further review of R4's care plan, it was found out that V9 made multiple additions and modifications of R4's care plan although R4 was already discharged on [DATE]. On 05/24/2023 at 10:46 AM. V9 (Minimum Data Set Coordinator) said, Yes, I do some of the care plan for the residents. Care plans are reviewed when things come up as needed and also quarterly as scheduled. When a problem was identified it should be reviewed because you want it to reflect current condition. R4 does not have care plan for his right hip fracture and should have care plan on the day it was identified. Yes, I added R4 ' s right hip fracture in the care plan yesterday. I should have not done that because it should have been done when the incident happened. Or it must be added at the time of occurrence. I know that those care plan I just added does not reflect care that really happened because I just added it. But I cannot answer why I added it. V9 admitted that R4 does not have care plan for right hip fracture related to the fall. V9 presented documentation that R4 ' s care plan for alteration in musculoskeletal status related to fracture of the right hip with goals and interventions were all added on 05/25/2023 after R4 was already discharged on [DATE]. On 05/24/2023 at 11:15 AM. V2 (Director of Nursing) stated, R4 needs staff assistance for ADLs (Activity of Daily Living) like transfer, and toileting. Typically, staff needs to stay with the resident during toileting. Nursing staff needs to know care needs of resident. There is a care cards used in the floor that shows each resident needs. It is restorative department that provides those care cards. CNAs (Certified Nursing Assistants) needs to identify and follow up with the nurse and review Care Cards. Yes, V11 obviously does not know what R4 needs and should be guided. R4 is not independent or supervision, because he (R4) needs assistance. As shown in R4'ss assessment that he is rarely or never understood. Then any instructions not to get up may not be understood or followed by R4. V2 was asked that many nursing staff documents in their progress notes that R4 alert and oriented and requires supervision instead of assistance. V2 said, R4 has right-sided weakness due to hemiplegia and needs assistance not only supervision. Yes, I understand that nursing staff should direct care and assistance to residents in choosing safer side. V2 was asked about V9 modifying care plan of R4. Yes, I was informed about modification of care plan of R4. R4 is not here in the facility, and it should not have been done. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 05/24/2023 at 12:59 PM. V17 (Restorative Nurse / LPN) presented Care Alert Cards (CAC) for R4 dated 02/13/2017 and 04/28/2023. CAC dated 02/13/2017 documents that R4 needs 1-person limited assistance during transfers. V17 said that R4 does not have CAC between 02/13/2017 and 04/28/2023 because there was no change of R4 status between those dates. MDS assessment of R4 was presented to V17 that shows R4 needs extensive assistance which requires weight bearing compared to limited assistance that does not require weight bearing assistance. V17 said, Yes, R4 has right-sided weakness and needs weight bearing assistance on his right side. Comparing CAC of 02/13/2017 from CAC 04/28/2023, because of the fall that resulted to fracture of hips and surgery. R4 now requires mechanical lift (sit to stand) with 2-person assistance. V17 said, R4 never was independent in toileting and transfer. R4 needs assistance, staff needs to stay with R4 during toileting. Again, R4 has one side weakness that needs assistance during transfer because R4 cannot bear weight on that side. Minimum Data Set (MDS) of R4 dated 04/13/2023 prior to fall (04/22/2023) on cognitive patterns documents that R4 score was 0 or R4 rarely/never understood. On functional status, R4 needs 1-person extensive assists on bed mobility, transfers, and toileting. On health conditions, R4 had multiple falls since admission. Plan of Care for R4 on ADL (Activity of Daily Living) with multiple dates, documents as follows: R4 has an ADL self-care performance deficit due to hemiplegia diagnosis. R4 requires 1-person assist with toileting, transfers, bed mobility, bathing, and personal hygiene. R4 ' s hospital record dated 04/24/2023 to 04/28/2023 documents the following: R4 sustained closed comminuted fracture of the hip, other diagnosis includes impaired functional mobility and activity intolerance and right-sided weakness. Sudden fall or accident can be a life-changing event often need surgery or repair the fracture. R4 undergone a procedure Intramedullary Nail Femur, Antegrade (Right) or right femoral ORIF (Open Reduction Internal Fixation) on 04/25/2023 due to his fracture related to fall on 04/22/2023. On 05/26/2023 at 10:13 AM. Called V28 (Medical Doctor) and left a message with call back number. Safety Resident Policy not dated, in part reads: Resident transfer status will be reviewed via resident care plan time frame and on an as needed basis. Resident transfer status will be properly communicated with a resident individual Care Service Plan in Electronic Medical Record, coding system or on a Care Card or Kardex.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41356 Based on review of records, and interviews the facility failed to maintain accurate resident records by adding and modifying plan of care for a closed record resident discharged to hospital and not in the facility. This apply to 1 out of 3 residents (R4) for a total of 3 residents reviewed for resident records. This failure has the potential to affect 1 resident (R4) inaccurately documenting on resident records that does not reflect actual care. Findings include: R4 is [AGE] years old during review, with medical diagnosis of hemiplegia and hemiparesis following cerebral infarction affecting right dominant side diagnosed on [DATE], seizure diagnosed on [DATE] and displaced intertrochanteric fracture of right femur diagnosed on [DATE] after the R4 had a fall on 04/22/2023. R4 cognition is impaired with brief interview of mental status scored 0 that indicates R4 rarely or never understood. Incident Report initial and final was dated 04/22/2023. R4 was left in the toilet by himself. R4 transferred by himself and fell . Per Minimum Data Set (MDS) on functional status dated 04/13/2023, documents that R4 needs 1-person extensive assistance on bed mobility, transfers, and toileting. R4's hospital record dated 04/24/2023 to 04/28/2023 documents the following: R4 sustained closed comminuted fracture of the hip, other diagnosis includes impaired functional mobility and activity intolerance and right-sided weakness. Sudden fall or accident can be a life-changing event often need surgery or repair the fracture. R4 undergone a procedure Intramedullary Nail Femur, Antegrade (Right) or right femoral ORIF (Open Reduction Internal Fixation) on 04/25/2023 due to his fracture related to fall on 04/22/2023. On 05/23/2023 at 02:04 PM. V2 provided complete plan of care for R4 that does not include dates. After further review of R4's care plan it was found out that V9 made multiple additions and modifications of R4's care plan although R4 was already discharged on [DATE]. On 05/24/2023 at 10:46 AM. V9 (Minimum Data Set Coordinator) said, Yes, I do some of the care plan for the residents. Care plans are reviewed when things come up as needed and also quarterly as scheduled. When a problem was identified it should be reviewed because you want it to reflect current condition. R4 does not have care plan for his right hip fracture and should have care plan on the day it was identified. Yes, I added R4's right hip fracture in the care plan yesterday. I should have not done that because it should have been done when the incident happened. Or it must be added at the time of occurrence. I know that those care plan I just added does not reflect care that really happened because I just added it. But I cannot answer why I added it. V9 admitted that R4 does not have care plan for right hip fracture related to the fall. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	V9 presented documentation that R4's care plan for alteration in musculoskeletal status related to fracture of the right hip with goals and interventions were all added on 05/25/2023 after R4 was already discharged on [DATE] and not in facility. On 05/24/2023 at 11:15 AM. V2 (Director of Nursing) stated, Yes, I was informed about modification of care plan of R4. R4 is not here in the facility, and it should not have been done.