

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145625	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/06/2024
NAME OF PROVIDER OR SUPPLIER California Terrace		STREET ADDRESS, CITY, STATE, ZIP CODE 2829 South California Blvd Chicago, IL 60608	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>32819</p> <p>Based upon observation, interview and record review the facility failed to ensure that call lights were accessible for two of four residents (R1, R2) reviewed for call lights.</p> <p>Findings include:</p> <p>1. R1's diagnoses include generalized weakness, reduced mobility and lack of coordination.</p> <p>R1's (12/20/23) functional assessment affirms supervision and/or touching assistance is required for transfers.</p> <p>R1's (12/20/23) BIMS (Brief Interview Mental Status) determined a score of 15 (cognition intact).</p> <p>On 2/27/24 at 11:34am, R1 was observed seated in a wheelchair (adjacent the bed), the call light was on the floor (behind the head of bed) and out of reach. Surveyor inquired if R1's able to walk, R1 stated No. Surveyor inquired if residents need help, how do they request for help. R1 responded I gotta go and see em (staff). Surveyor inquired if R1 was lying in bed needing help, how does R1 request help R1 replied It's the same thing.</p> <p>R1's care plan (12/22/23) Resident is able to use call light, intervention: provide frequent monitoring. (12/20/23) Resident is at risk for fall related to co-morbidities, intervention: have commonly used items within reach.</p> <p>On 2/27/24 at 11:39am, surveyors inquired if R1's able to walk V3 (LPN/Licensed Practical Nurse) stated No. Surveyor inquired about the location of R1's call light V3 searched behind the head of R1's bed, located R1's call light and placed it on the bed. Surveyor inquired where R1's call light was found V3 responded On the floor. Surveyor inquired where R1's call light should have been placed V3 replied It should be within reach.</p> <p>2. R2's diagnoses include hemiplegia and hemiparesis.</p> <p>R2's (2/5/24) functional assessment affirms (2 persons) staff assistance is required for transfers.</p> <p>R2's care plan includes (1/31/24) resident is at risk for falls, intervention: be sure call light is within reach.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R2's (2/5/24) BIMS determined a score of 14 (cognition intact).</p> <p>On 2/27/24 at 11:44am, R2 was observed lying in bed. The call light was on the floor (adjacent the bed) and out of reach. Surveyor inquired if R2's able to walk. R2 stated No, not without help. They (facility) have a sit to stand lift they put me on to get me up, it takes 3 or maybe 2 staff. I've always done stuff for myself but my body's telling me don't get up. My body's tired now. Surveyor inquired about the location of R2's call light. R2 searched for the call light to no avail and responded It might be on the floor (affirmed she has cataracts and can't see). I want what I want now, staff get irritated with me putting the light on all the time.</p> <p>R2's (2/20/24) progress notes state resident was unable to sign due to eyes being affected by cataract. Resident stated I can't see.</p> <p>On 2/27/24 at 11:56am, surveyor inquired if R2's able to walk. V4 (LPN) stated She's total I believe. Surveyor inquired about the location of R2's call light. V4 proceeded to pick up R1's call light (from the floor) and placed it on the bed (without securing it - so it doesn't fall) and stated, It should have been in her hand. Surveyor inquired if R2's call light was secured to the resident and/or linens. V4 affirmed it was not and proceeded to clip it to the sheet (after surveyor inquiry).</p> <p>The (9/19) call light policy states all residents shall have the nurse call light system available and within easy accessibility to the resident at the bedside or other reasonable accessible location.</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32819</p> <p>Based upon observation, interview, and record review the facility failed to follow the abuse prevention policy, failed to implement interventions, failed to acknowledge (R4's) behaviors, failed to immediately remove (R4) from resident contact to ensure safety, and failed to ensure that two of four residents (R3, R5) reviewed for abuse remained free from abuse. On (11/25/23) R5 sustained blunt head trauma during physical altercation with (R4) resulting in left frontal scalp contusion/hematoma and age indeterminate mildly displaced right nasal bone fracture. R5 also reported enduring chronic dizziness and headaches subsequent the altercation.</p> <p>Findings include:</p> <p>R4 is [AGE] years old with diagnoses which include bipolar disorder and paranoid schizophrenia.</p> <p>R4 resides on 1st floor.</p> <p>R4's (12/20/23) BIMS (Brief Interview for Mental Status) determined a score of 12 (moderate impairment). Inattention and disorganized thinking present, fluctuates.</p> <p>R4's care plan includes (6/14/23) resident may be at risk for potential abuse related to behavior problem as evidenced by history of verbally threatening/obnoxious behaviors, offensive antisocial habits and wandering. Intervention: monitor resident behaviors. (6/27/24) Resident has a diagnosis of schizoaffective disorder, bipolar disorder and is at risk for changes in mood, energy, and depression. Intervention: watch for behavior changes such as talking very fast, racing thoughts, easily distracted, overly restless, being impulsive. Notify physician if these changes are seen.</p> <p>R4's progress notes include the following behaviors (6/19/23) resident presented with physical and verbal aggression toward staff and peers stating that he was going to Kill all of the black people. (10/20/23) Resident began threatening nurse saying, I will f*** you up, come on, right here, right now. Resident threw his fist up in the position to fight. (11/25/23) Resident was standing in front of the nurse's station and another resident asked him to stay out of his room. Resident turned and looked at this person and put his face close to this person and this person reacted by putting his hand to resident's upper chest area, that's when resident hit this person with full strength (twice) to the face, knocking this person (who is elderly) to the floor. (2/10/24) Resident is verbally aggressive, calling writer profane words. Resident is delusional, thinking writer said she was going to shoot him. Writer did not say anything to him. Resident has been refusing his medications and his Haldol decanoate this month and is observed to be growing increasingly aggressive and delusional.</p> <p>The (11/25/23) initial state report includes incident time: 12:45am, (R4) was allegedly physically aggressive towards (R5).</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The (11/25/23) final state report states (R4) befriended a roommate of (R5). (R4) went into (R5's) room later in the evening on 11/24/23. (R5) came to the nursing station a little after midnight to talk to the nurse. As (R5) was talking to the nurse, (R4) came over to the nurse's station. (R5) can be hard to understand as he speaks with a thick accent. (R4) came over to (R5) and leaned in, towards (R5) as if to hear and understand what (R5) was saying. It was in that moment that (R5) pushed (R4) back, in a manner to state you are too close. As a reflex, (R4) hit (R5) and (R5) lost his balance and fell to the floor. This was an isolated event for (R4). (R4) has been with us since June 2023 and has never shown aggression towards residents or staff. The staff have never seen this behavior from (R4) nor was it ever anticipated [R4's progress notes affirm history of verbal and physical aggression towards staff and residents]. Both residents feel safe in the building [R5's subsequent interview affirms otherwise].</p> <p>On 2/27/24 at 12:01pm, R4 was observed pacing (briskly) in the hallway. Surveyor(s) attempted to speak to R4, he (R4) proceeded to walk by surveyor(s), entered the room and closed the door immediately. Surveyor subsequently knocked on R4's door, R4 did not open the door and/or verbally respond. As surveyor(s) were standing in the hallway (approximately 1 minute later) R4 exited the room, walked (briskly) towards the nurse's station then wandered aimlessly about the unit. [Staff were present however failed to acknowledge R4's behavior at this time].</p> <p>R5 is [AGE] years old with diagnoses which include Alzheimer's disease and bipolar disorder.</p> <p>R5 resides on 1st floor.</p> <p>R5's care plan includes (7/10/23) Resident has hearing deficit. (7/18/23) Resident presents with moderate to extreme anxiety related to persistent worry that something terrible is about to happen and verbal expressions of distress. Intervention: evaluate the potential causal factors contributing to feelings of anxiety. Work with the resident to eliminate causes whenever possible.</p> <p>R5's Nurse Practitioner progress notes state (11/25/23) seen in room today following a short ER (emergency room) visit from blunt head trauma. Patient was hurt by another resident. (12/4/23) Still complaint of residual pain on the left jaw area. X-ray were negative for fracture however R5's (11/25/23) CT (Computed Tomography) scan affirms otherwise.</p> <p>R5's (11/25/23) history & physical states patient here due to being hit in face by resident at the facility. Computerized Tomography (CT) Head: left frontal scalp contusion. CT Maxillofacial: small soft tissue contusion/hematoma anterior to the mandible extending to the left facial soft tissues. There is an age indeterminate mildly displaced right nasal bone fracture. [R5's 10/29/23 facial x-ray states no fractures were identified therefore considering reasonable person concept the fracture likely occurred during 11/25/23 altercation].</p> <p>R5's (1/13/24) BIMS determined a score of 13 (cognition intact).</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/27/24 at 12:05pm, surveyor inquired about the (11/25/24) altercation involving R4. R5 stated I got hit and fell down, he (R4) broke my nose. He (R4) came from behind and hit my face. Surveyor inquired if R5 has encountered any problems since the (11/25/24) incident. R5 responded Because of this guy (R4) I'm still not recovery, I have headaches, dizziness I need to see the doctor, it's been more than 3 weeks (months), it's an emergency. Surveyor inquired if R5 feels safe residing in the facility R5 replied It's not safe, I'm scared for my life right now. The guy (R4) who hit me came up behind me (R5), I'm 76 and he's about [AGE] years old [R4 is 32]. Three days ago, he walked in front of me, I can't say nothing cause he gonna hit me. I need to leave from here!</p> <p>On 2/27/24 at 12:12pm, surveyor inquired about the regulatory requirements for abuse V1 (Administrator) stated in part We immediately separate the alleged victim and the alleged aggressor. If it's residents, we involve psych (Psychiatric) and medical doctors immediately. The victim should be assessed by nursing and medical staff and psych to address their needs. The aggressor should be separated from the individual. Surveyor inquired about the current location of R4 and R5 [both reside on 1st floor - in the same hallway]. V1 responded (R5) is in room (room #) at the end of the hall and (R4) is at the other end of the hall. Surveyor inquired why R4 and R5 reside on the same unit if the aggressor (R4) should be separated (from R5) V1 replied Because at the time that this happened after speaking with them and watching the video it seemed as if (R5) instigated it. (R4) acted to be scared and protect himself. It was my belief that there was some misunderstanding between them. There's never been issues in the past with them. Once they calmed down it wasn't like he (R4) came out of nowhere and punched the guy (R5). It was (R5) getting into (R4) face and (R4) trying to get away from him (R5) [documentation affirms otherwise]. Surveyor inquired about R4's behaviors V1 stated He's (R4) much better since we got him (R4), he was erratic in his behavior. According to his (R4) history he's a nursing home hopper. He's (R4) pretty stable right now. Surveyor relayed concerns regarding R4's current behavior (response towards surveyors, rapidly wandering aimlessly about the unit), lack of staff acknowledgement and/or redirection for R4's behaviors V1 responded I'm gonna have nursing call psych right now if he's erratic and not acknowledging that people are speaking to him, that's not his baseline.</p> <p>On 2/27/24 at 12:25pm, R4 yelled down the hallway (while standing at his doorway) at surveyor(s) stating Hey! If you're wanting to talk to me about my apartment, I'll talk to you. If no, skip it then! however staff failed to acknowledge that R4 was yelling.</p> <p>On 3/4/24 at 11:15am, surveyor inquired about the (11/25/23) incident V9 (RN/Registered Nurse) stated I was the 4th floor nurse, and the 1st floor nurse (V8/RN) asked me to come down to assist him (V8). When I (V9) came down he (R5) was rubbing the right side of his face like around the jaw. He (R5) complained of pain, he just said it hurt bad. Surveyor inquired about R4's behaviors V9 responded He's like all over the place, hard to redirect and non-compliant. Surveyor inquired about R5's behaviors V9 replied He's (R5) not aggressive at all.</p> <p>On 3/4/24 at 12:31pm, surveyor inquired about potential harm to a resident that gets hit in the face (twice) and falls to the ground V10 (Medical Director) stated A fracture could happen if someone is hit in the face, a nasal bone fracture, bruising those are the type of things that could happen. Surveyor inquired if R5's x-ray affirmed no nasal fracture a month prior to 11/25/23 incident would you suspect the nasal fracture occurred during the 11/25/23 incident? V10 responded Its possible it could have happened from that.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>R4's (2/27/24) progress notes state 1:34pm, (after surveyor concerns were reported) resident is intimidating other resident and also provoking other resident in behaviors. Resident cannot be redirected at this time. Order received for resident to be sent out involuntary for psych evaluation.</p> <p>R4 was also involved in a physical altercation with R3 (after 11/25/24 incident). R4 was (again) the perpetrator therefore using reasonable person concept residents likely remained unsafe.</p> <p>R3's (2/12/24) care plan states resident has been the target of peer aggression, placing him at risk for abuse.</p> <p>R3's (2/12/24) progress notes state resident noted to be physically attacked by peer. Writer met with resident to process his feelings regarding being physically attacked by peer. Resident presented with no sign of distress during well-being check, when questioned resident stated He hit me for no reason.</p> <p>R3's (11/28/23) BIMS determined a score of 8 (moderate impairment).</p> <p>On 2/28/24 at 3:13pm, surveyor affirmed that R3 speaks Spanish therefore V7 (Certified Nursing Assistant) translated the interview. Surveyor inquired about the (2/12/24) incident involving (R4) R3 stated I was hit in the face on the right side, I don't remember his name. I don't know why he hit me.</p> <p>The abuse prevention policy (reviewed 1/4/18) includes IV.) Establishing a Resident Sensitive Environment: this facility desires to prevent abuse, neglect, exploitation, mistreatment, and misappropriation of resident property by establishing a resident sensitive and secure environment. This will be accomplished by a comprehensive quality management approach involving the following: Resident Assessment: staff will identify residents with increased vulnerability for abuse, neglect, exploitation, mistreatment, or misappropriation of resident property or who have needs and behaviors that might lead to conflict. Through the care planning process, staff will identify any problems, goals, and approaches, which would reduce the chances of abuse. Staff Supervision: supervisors will monitor the ability of the staff to meet the needs of residents, including that assigned staff have knowledge of individual resident care needs. Situations such as inappropriate language, insensitive handling or impersonal care will be corrected as they occur. VI.) Protection of Residents: the facility will take steps to prevent potential abuse while the investigation is underway. Residents who allegedly abused another resident will be removed from contact with other residents during the course of the investigation. The accused resident's condition shall be immediately evaluated to determine the most suitable therapy, care approaches, and placement, considering his or her safety, as well as the safety of other residents and employees of the facility.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32819</p> <p>Based upon observation, interview and record review the facility failed to follow the abuse prevention policy, failed to report required information, and failed to report accurate information and/or injury to the State Agency for two of four residents (R4, R5) reviewed for abuse.</p> <p>Findings include:</p> <p>R4 is [AGE] years old with diagnoses which include bipolar disorder and paranoid schizophrenia.</p> <p>R4's progress notes include the following behaviors (6/19/23) resident presented with physical and verbal aggression toward staff and peers stating that he was going to Kill all of the black people. (10/20/23) Resident began threatening nurse saying, I will f*** you up, come on, right here, right now. Resident threw his fist up in the position to fight. (11/25/23) Resident was standing in front of the nurse's station and another resident asked him to stay out of his room. Resident turned and looked at this person and put his face close to this person and this person reacted by putting his hand to resident's upper chest area, that's when resident hit this person with full strength (twice) to the face, knocking this person (who is elderly) to the floor.</p> <p>The (11/25/23) initial state report states (R4) was allegedly physically aggressive towards (R5) [residents age, diagnoses, and/or mental status were excluded].</p> <p>The (11/25/23) final state report states (R4) befriended a roommate of (R5). (R4) went into (R5's) room later in the evening on 11/24/23. (R5) came to the nursing station a little after midnight to talk to the nurse. As (R5) was talking to the nurse, (R4) came over to the nurse's station. (R5) can be hard to understand as he speaks with a thick accent. (R4) came over to (R5) and leaned in, towards (R5) as if to hear and understand what (R5) was saying. It was in that moment that (R5) pushed (R4) back, in a manner to state you are too close. As a reflex, (R4) hit (R5) and (R5) lost his balance and fell to the floor [actual injury was excluded]. This was an isolated event for (R4). (R4) has been with us since June 2023 and has never shown aggression towards residents or staff. Staff have never seen this behavior from (R4) nor was it ever anticipated [R4's progress notes affirm history of verbal and physical aggression towards staff and residents]. Both residents feel safe in the building [R5's subsequent interview affirms otherwise]. The allegation of physical abuse is unfounded [evidence affirms that physical contact was made resulting in physical harm].</p> <p>On 3/4/24 at 11:15am, surveyor inquired about R5's (11/25/23) incident V9 (RN/Registered Nurse) stated I was the 4th floor nurse, and the 1st floor nurse (V8/RN) asked me to come down to assist him (V8). When I (V9) came down he (R5) was rubbing the right side of his face like around the jaw. He (R5) complained of pain, he just said it hurt bad. Surveyor inquired about R4's behaviors V9 responded He's like all over the place, hard to redirect and non-compliant. Surveyor inquired about R5's behaviors V9 replied He's (R5) not aggressive at all.</p> <p>R5 is [AGE] years old with diagnoses which include Alzheimer's disease and bipolar disorder.</p> <p>R5's (1/13/24) BIMS determined a score of 13 (cognition intact).</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/4/24 at 2:49pm, V1 (Administrator) inquired about the dates of said occurrences surveyor relayed that the complaint was received on 2/20/24 however actual dates of occurrences are unknown.</p> <p>On 3/4/24, IDPH was notified by the facility that R2 made a complaint that someone threatened to stab me with an ice pick however allegations regarding staff rough handling, and/or threats to send R2 to a mental institution if she does not take all her medications were excluded.</p> <p>On 3/5/24 at 10:15am, surveyor inquired why R2's (2/20/24) state report only includes threats to stab R2 with an ice pick V1 (Administrator) stated That is all he (V6) told me. I'll be sending an addendum to public health.</p> <p>The abuse prevention policy (reviewed 1/4/18) states VIII.) External Reporting: when an allegation of abuse, exploitation, neglect, mistreatment or misappropriation of resident property has occurred, the resident's representative and the Department of Public Health of Public Health's regional office shall be informed that an occurrence of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property has been reported and is being investigated. The report shall include the following: name, age, diagnosis and mental status of the resident allegedly abused, type of abuse reported, date, time location and circumstances of the alleged incident, any obvious injuries or complaints of injury, and steps the facility has taken to protect the resident.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145625	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/06/2024
NAME OF PROVIDER OR SUPPLIER California Terrace		STREET ADDRESS, CITY, STATE, ZIP CODE 2829 South California Blvd Chicago, IL 60608	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>32819</p> <p>Based upon observation, interview, and record review the facility failed to follow the smoking safety policy and failed to provide supervision to one of five residents (R1) reviewed for hazards. These failures have the potential to affect 251 residents.</p> <p>Findings include:</p> <p>The (2/27/24) census includes 251 residents.</p> <p>R1's (12/20/23) smoking risk assessment determined a score of 5, may not be capable of handling/carrying any smoking materials and requires supervision when smoking.</p> <p>On 2/27/24 at 11:34am, surveyor(s) entered R1's room and a strong odor of cigarette smoke was noted. R1 was observed in the room sitting in a wheelchair and a cigarette butt was noted on the dresser in front of R1. A cigarette pack was also observed on R1's bed at this time.</p> <p>On 2/27/24 at 11:39am, surveyors inquired about the odor in R1's room V3 (Licensed Practical Nurse) stated There's a odor, it's kind of musky. Surveyor inquired if cigarettes should be in R1's possession V3 stated No, it should be downstairs with the activity and subsequently removed the cigarette pack from R1's bed at this time.</p> <p>The (5/14) facility smoking safety policy states smoking is only allowed in designated areas established by management. If indoor smoking is prohibited by state or local law the interior of the facility will remain smoke-free at all times. The designated area(s) will be outside in accordance with state/local standards. The facility has the right to enforce a policy prohibiting residents from keeping any smoking materials in his/her possession for health, safety and security reasons. Resident requiring supervision shall receive this monitoring consistent with their assessment and plan of care. If the assessment indicates problems with safety compliance objective documentation explaining the interventions and the resident's response should be recorded.</p>		