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	05/03/2024

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 - Potential for minimal harm Residents Affected - Many	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. 45111 Based on observation, interview and record review, the facility failed to provide residents with needed supplies for Activities of Daily Living such as linen. This failure affects all 252 residents residing in the facility. Findings include: On 04/30/2024 at 12:40pm, R10 stated the facility does not have enough linens and he stated sometimes the beds are not made because of lack of linen. R10 stated he has not had pillowcases for over two weeks now, and he stopped asking staff for them since they are not available. On 04/30/2024 at 11:55am, R11stated there is not enough linens in the facility and because of lack linens, her bed is changed once a week. R11 stated she does not like that her bed is not changed more frequently. On 05/02/2024 at 11:55am, R8 was observed laying on his bed and stated he makes his own bed, and sometimes there is no linen to make his bed, and he has to wait a week to get linen to make his bed. On 04/30/2024 at 12:49am, V11(Certified Nursing Assistant -CNA) stated she has worked at the facility for six months and in the mornings, laundry aides bring a cart of linen up to the units and the CNAs divide the linen up and put it in their clean linen. V11 stated once the clean linens are finished, and the CNAs need more linen for the residents, the CNAs have to go to go to laundry and get more linen, because there is no clean linen in the carts on the units. V11 stated sometimes she has to hind the clean linen in a resident room because other CNAs and residents will take her clean linen and she will not have linen to make residents beds or towels and face towels for her residents to use. V11 and surveyor toured the 2nd floor clean linen closet and observed in the closet was a clean linen cart from laundry with one clean flat sheet, two fitted sheets, one bag of incontinence briefs, one bag of incontinence pads. V11 said the clean linens are not enough for resident care. On 04/30/2024 at 1:22pm, V12 (Certified Nursing Assistant -CNA) said there were no clean linen in the units because the CNAs used them up all this morning and if she (V12) had to make any beds or residents need towels to shower or for ADL(Activities of Daily Living), she would have to go to the laundry room in the basement to look for clean supplies, because there is no stock in the units. V12 and surveyor observed on the 4th floor were seven flat sheets, three fitted sheets and six blankets. No clean towels, pillowcases or face towels were observed on the clean linen carts. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0584 Level of Harm - Potential for minimal harm Residents Affected - Many	On 4/30/2024 at approximately 1:30pm, V13 (Central Supplies Manager) stated after the facility was acquired by this new company, his supplies budget was cut significantly, and this has led to him only being able to order a dozen of each item such a bed sheets (flat and fitted), towels and face towels. V13 stated this is not enough supplies for the residents. V13 stated all the clean linens were used up this morning, and there was no clean linen in the units for resident use. On 4/30/2024 at 1:45pm, V22(Certified Nursing Assistant -CNA) said clean linen run out this morning and if a resident wants towels or bedsheets, she has to go downstairs to the laundry room to get the linen, which makes it difficult to take care of residents without enough supplies. During tour of the fourth floor with V22, there were four empty clean linen carts in the clean linen room, and one empty unit linen cart. there were four full diaper bags observed in the clean linen room. On 05/01/2024 at 1:58pm, during tour of the laundry room, V15 (Laundry Aide) was observed in the laundry room and stated she is just starting her shift and she found one washer washing a load of linen. two washers were observed washing residents' clothes, and two washers were off. Observed in the clean linen storage cart were 18 fitted sheets, 10 flat sheets, 8 bath towels, 5 big towels which were observed to be frayed on the sides. V15 stated the facility does not have enough linen for residents and more linen is needed. On 04/30/2024 at 2:02pm, V16 (Laundry Manager) stated the staff in the units do not send the laundry back to the laundry for washing, and this leads to shortage of linen. V16 stated he goes to the units and asks the CNAs (Certified Nursing Assistants) to send the dirty linen down the shoot, but the CNAs don't send the linen to the laundry for washing. V16 stated the frayed towels and torn bed linen should be separated and put in a pile that will not be used by residents. V16 stated other than what is in the units and the laundry room, there is no extra stockpile for residents to use if they requested clean linen. On 4/30/2024 at 1:52pm V1(Administrator) stated there is not enough linen for the residents, even though the line is ordered every month. V1 stated she believed the CNAs are hoarding the clean linen which they are not supposed and are also not throwing the dirty linen down the shoot to laundry for cleaning. V1 stated the facility could use more linen. Facility grievance log dated 02/28/24 documents R8's family member was upset with staff and filed a grievance stating R8's linen was not changed. Dignity policy dated 1/15, documents: Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality. The facility's resident census sheet dated 4/30/24 documents 252 resident residing in the facility.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49666 Based on observation, interview, and record review the facility failed to ensure a resident who required assistance with incontinence care received necessary services in a timely when requested for one (R6) resident out of three residents reviewed for improper nursing care in the sample. Findings include: On 05/01/2024 at 11:13 AM, observed V12 (Certified Nursing Assistant/CNA) take R3's soiled clothes to laundry out of R3's room. On 05/01/2024 at 11:17 AM surveyor informed V12 that R3 states that she is ready to get up from the bed. V12 states that she has assisted R3 on the bedpan already and V12 states that first thing first she must get the dirty clothes and take it to the laundry. V12 states that R3 is going to have to wait. V12 states that she has a resident that she must clean first. V12 states that R6 is the resident that she will change. On 05/01/2024 at 11:24 AM observed V12 take down the dirty linen down the elevator. On 05/01/2024 at 11:28 AM observed V12 stepped outside from the elevator. R6's Minimum Data Set (MDS), dated [DATE], documents R6 has a Brief Interview for Mental Status (BIMS) of 08 out of 15, indicating R3 has moderately impaired cognitive. R6's care plan dated 4/10/2024 documents in part R6 is incontinent of bowel/bladder .staff will assist R6 with toileting needs throughout the day to minimize episodes of incontinence through next review .keep skin clean and dry. On 05/1/2024 at 11:29 AM R5 Spanish speaking, agreed for surveyor to observe V12 provide care to R5. V12 began to provide perineal care to R5. R5's stool noted dark brown, soft large amount, several stools dried and on R5's skin, and as V12 wiped R5, stool still stuck to skin, sheet visibly soiled. R5 turned to the sides and observed several dry stools to buttocks near hip. Observed V12 rubbing off several times the dry stool off R5's skin. Once V12 completed providing perineal care. Surveyor asked V12 when was the last time V12 saw R5. V12 states that R5 pressed the call button around breakfast time to be changed. V12 states that she was collecting trays and told him that she would come back. V12 states that she has 25 residents assigned to her. V12 states this is the time she came back to him. V12 states that breakfast time is around 9:30am. V12 states that she thinks he pressed the call light around 10:00am and that is when she answered the light and V12 states that is when R5 requested to be changed. On 05/01/2024 at 2:25 PM V2 (Director of Nursing) states the residents should typically wait 5-10 minutes to be changed because it all depends on what supplies the staff need to complete the task. V2 states that if residents wait longer to be changed, that it does have the potential to change their skin and the resident has the potential to feel uncomfortable. V2 states that it can affect their self-esteem related to the incontinence episode. V2 states that the CNA should change the resident prior to collecting trays and taking other residents' soiled linen to the laundry room. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility document not dated, titled Call Light documents in part Purpose: To respond to residents' requests and needs in a timely and courteous manner.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. 49666 Based on observation, interview, and record review, the facility failed to maintain a functioning call light that is accessible to one resident (R7) to allow the residents to call for staff assistance and failed to provide a specialized call light for one resident (R2) who is unable to use standard call light out of three residents reviewed for call lights in the sample. Findings include: 1. 04/30/2024 at 1:47 PM during hallway observation, surveyor observes outside call light of R7's room blinking with the door closed. 04/30/2024 at 1:50 PM continued to observe R7's room call light blinking outside of the room with door closed. 04/30/2024 at 1:53 PM continued to observe R7's call light blinking outside with door closed. 04/30/2024 at 1:56 PM continued to observe call light blinking, observed V7 (Business office Manager) walk by call light blinking. V7 informed surveyor that the call light is broken. V7 states that she did not know how long the call light was broken for, but she will find out. V7 states that there is no resident in the room and in the restroom. 4/30/24 at 2:15 PM V8 (Registered Nurse) states that maintenance keeps fixing R7's call light and it breaks again. V8 states that there are two residents that reside in the room. V8 states that both residents are alert and oriented x3. V8 states that bed two gets up every day and sits in the day room. V8 states that bed one resident usually is in the room but at this time he was smoking. V8 states that bed two needs assistance with ADLs (activities of daily living) and bed one needs supervision due to having bilateral amputee, V8 states that he needs assistance to get up from the bed, V8 states that once he is sitting on his wheelchair, he can come to the nurse's station to ask for assistance. V8 states that bed one is a fall risk. V8 states that the two residents haven't had a fall for a long time. 04/30/24 at 2:26 PM V17 (Maintenance Supervisor) states that sometimes the call light cord in R7's bathroom is loose. V17 states that he was just notified of it not working today. V17 states that sometimes the cord is loose. 05/01/2024 at 11:06 AM R7 states that the room's call light hasn't been working for about a week. R7 states that the call light working comes and goes. R7 states that staff will come and fix it and R7 states that it will be a couple days before they come back up to fix it again. R7 states that another resident might need the call light to work properly for emergency, but R7 states that he doesn't really need it. Facility document not dated, titled Call Light documents in part Purpose: To respond to residents' requests and needs in a timely and courteous manner .Functioning Nurse Call System. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility document dated 11/14, titled Maintenance Program Policy documents in part Purpose: to conduct regular environmental tours/safety audits to identify areas of concern within the facility .resident equipment is in working order .the call light system is in working condition. 2. According to R2 facesheet, R2 has diagnoses that include but are not limited to quadriplegia. R2 Minimum Data Set, 3/25/2024, indicates R2 is cognitively intact; R2's upper and lower extremities are impaired on both sides; R2 is dependent for all mobility activities and all self-care activities except eating which requires substantial/maximal assistance; R2 is always incontinent. 4/30/24 at 11:55 AM, V23 (Certified Nursing Assistant) stated the picture of a lightbulb next to R2's name outside of the room means to monitor R2 every hour because R2 is not able to use the call light. 5/2/24 at 9:45 AM, V30 (Restorative) stated I put R2 on the lightbulb program to let the staff know R2 needs to be frequently monitored, every hour. I personally went to see R2 daily to see if R2 needed anything. We have the pad for quadriplegic to use by bending their neck and pressing the pad with their chin but R2 could not bend at the neck. We don't have the straw to blow. R2 never reported having to yell for assistance and nobody comes. We use sign-off sheets to say that the CNA (Certified Nursing Assistant) went at least hourly to check on the resident. I don't know how R2 could have called for help in between the hourly rounds. The accommodation for R2 was to be put on the lightbulb program. R2 would not be able to call for help without a call light. It is not the responsibility of R2's roommates to get help for R2. The purpose of the call light is for residents to use to let staff know that they need help. R2 can verbalize needs. According to corporate, the company doesn't use the call light assessment form. They want staff to have knowledge to assess if the resident can use the call light. There is no call light assessment for R2. 5/2/24 at 10:25 AM, V31 (Certified Nursing Assistant) stated V31 is familiar with R2. R2 can't use the call light. We know if R2 needs anything by rounding every one to two hours. I did not hear R2 yelling. R2 would call the facility on the telephone. R2's room is too far down the hall from the nursing station to hear R2 yelling. Facility not able to provide a call light assessment for R2. Facility policy Call Light, 9/19, documents in part: 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. 45001