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	01/27/2025

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** 45000 Based on interview and record review, the facility failed to prevent and protect a resident from resident-to-resident physical abuse. This failure affects one (R1) resident out of three residents reviewed for abuse. Findings include: On 01/25/2025, at 10:23 AM, R1 observed lying in bed inside of his room in a left lateral position. R1 is noted with confusion and unable to give an account of the altercation that occurred. On 01/25/2025, at 10:25 AM, R3 states, I know what happened. R3 then states they were located in the dining room on the second floor and a gray-haired male hit R1 in the face and gave R1 a puffy eye. R3 states he is not sure of the resident's name who hit R1. On 01/25/2025, at 10:57 AM, R2 states he was involved in an altercation with R1 in the dining room on the second floor. R2 states R1 was talking too much and R1 told R2 your mother. R2 states he does not know why R1 said that to him. R2 states he then hit R1 in the face. R2 states he was sent to the hospital after hitting R1 in the face. R2 states when he returned back from the hospital, the facility moved his room to the third floor of the facility. R1s' MDS/Minimum Data Set, dated dated dated [DATE], documents that R1 has a BIMS/Brief Interview for Mental Status of 06/15, indicating that R1 is severely cognitively impaired. R2s' MDS/Minimum Data Set, dated dated dated [DATE], documents that R2 has a BIMS/Brief Interview for Mental Status of 11/15, indicating that R2 is mildly cognitively impaired. R3s' MDS/Minimum Data Set, dated dated dated [DATE], documents that R3 has a BIMS/Brief Interview for Mental Status of 09/15, indicating that R3 is mildly cognitively impaired. (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 - Minimal harm or potential for actual harm Residents Affected - Few	On 01/25/2025, at 1:55 PM V4 (Registered Nurse/RN) states she was working on 01/05/25 and was assigned to care for R2. V4 states she was at the second-floor nurses' station when a CNA (certified nursing assistant) staff member informed her that R1 and R2 were fighting in the dining room. V4 states she immediately went to the dining room and when she arrived, R1 and R2 were separated but standing in front of each other. V4 states she assessed R2, and he did not have any bruises on him. V4 states she tried to talk to R2 and ask what happened but R2 told V4 f*** you and started speaking in Spanish. V4 states she tried to redirect R2 but R2 became more aggressive towards her. V4 states V13 (CNA) informed her that R2 punched R1 in the head hard and that the impact of the punch was loudly heard. V4 states she informed the doctor and V1 (Administrator). V4 states the doctor gave orders to send R2 out for psychiatric evaluation. V4 states even when the ambulance arrived, R2 was being aggressive and combative and did not want to go to the hospital. V4 states R2 was very angry, and she did not know why. V4 states R2 was moved to another floor upon returning to the facility from the hospital. On 01/25/2025, at 2:22 PM V10 (Licensed Practical Nurse/LPN) states she was working on 01/05/25 and was assigned to care for R1. V10 states she was at the second-floor nurses' station when a CNA staff member informed her that R1 and R2 were fighting in the dining room. V10 states she immediately went to the dining room. V10 states when she arrived to the dining room, she saw that staff was trying to redirect R2 and R2 was very aggressive. V10 states she then took R1 to his room and assessed R1. V10 states she observed a laceration next to R1s' right eyebrow. V10 states there was a small scant of blood and the area was open. V10 states she cleaned R1s' wound and applied some steri strips. V10 states she also performed passive range of motion with R1 and assessed R1s' vital signs. V10 states R1 did not verbalize being in pain. V10 states she then called the doctor, and the doctor gave orders to send R1 out to the hospital for medical evaluation. V10 states she asked R1 what happened and R1 told V10 that he did not want to talk about it. V10 states she was informed by V13 (CNA) that R2 hit R1 so hard that V13 was surprised that R1 did not get knocked out. On 01/25/2025, at 3:10 PM, V13 (Certified Nursing Assistant/CNA) states she worked on 01/05/25 and was located in the dining room on the second floor. V13 states the staff was passing meal trays for residents to eat their meal. V13 states she observed R1 and R2 passing words to each other in Spanish and staff was trying to redirect them. V13 states that's when R2 punched R1 on the side of his face. V13 states it was a pretty hard punch that R2 gave R1. On 01/25/2025, at 3:41 PM, V1 (Administrator) states she received a phone call informing her that there was an altercation between R1 and R2. V1 states she was informed that R1 and R2 were speaking Spanish and R2 hit R1, and R1 sustained a laceration to the head. V1 states R1 and R2 were both sent out to the hospital. V1 states V4 (RN) informed her that R2 was not redirectable. V1 states she started an initial report and sent it to the state agency the same day on 01/05/25. V1 states she also informed V4 to gather staff statements of what occurred between R1 and R2. V1 states R2s' room was moved to another floor of the facility upon returning from the hospital. R1s' nursing progress note written by V10 (Licensed Practical Nurse/LPN) documents Staff informed nurse that R1 received physical aggression from peer. Upon entering dayroom writer noted skin tear to R1 eyebrow area. No change in consciousness, speech and vision remained at baseline. Area cleansed with normal saline 2 steri strips applied and well tolerated by R2. When asked what happened R1 stated he was fine & did not want to discuss it. R1 remained ambulatory with assistive device. Speech and vision remained within normal limits. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1s' nursing progress note dated 01/05/25 at 3:55 PM documents Nurse called from the emergency department at hospital to inform that R1 showed signs of multiple infarctions and possible stroke. Nurse also stated that R1 had staggered speech and had impaired mobility. R1s' nursing progress note dated 01/05/25 at 9:26 PM documents R1 admitted to hospital with diagnoses as follows, conjunctivitis right eye, laceration right eyebrow, abnormal brain scan, and head trauma. Bed on 10-day hold and belongings secured within facility. awaiting discharge and return to facility. R2s' Nursing progress note written by V4 (Registered Nurse/RN) on 01/05/2025 at 12:40 PM documents Was told by staff that R2 was physical aggressive with his peer and verbally aggressive with staff. R2 would not answer told nurse to get the f*** out his face. Nurse separated residents from each other. Hard to redirect and ignoring staff members. R2 also speak mostly Spanish when staff asked questions. Nurse called nurse practitioner with incident report given with orders to send R2 to hospital to be evaluated and treated. Order noted and carried. R2s' Nursing progress note dated 01/05/25, at 11:17 PM documents Call placed to hospital emergency department to inquire about R2s' status and was told by the nurse. R2 was admitted with diagnosis Aggression / unsocialized behavior. All R2s' belongings are packed and secured in storage. All departments notified of Rs' transfer. Facility Reported Incident dated 01/05/2025, documents that R1 and R2 were involved in a physical altercation and R2 made physical contact with R2s' temple. R1's hospital records dated 01/06/2025, were reviewed and documents that R1 was examined at the hospital with diagnoses of history of stroke and laceration to right eyebrow with bleeding and swelling. R1s' care plan dated 01/05/2025 documents that R1 was the recipient of physical abuse from a peer. R2s' care plan dated 01/05/2025 documents that R2 is care planned for a history of aggressive behavior. R2's hospital records dated 01/05/2025 were reviewed and documents that R2 was examined at the hospital and presented with violence and bizarre behavior. Ombudsman Residents' Rights for People in Long-Term Care Facilities dated 11/2018 documents in part, You must not be abused, neglected, or exploited by anyone - financially, physically, verbally, mentally, or sexually. Facility policy dated 01/24 titled Abuse Prevention Program documents in part, Residents have the right to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45000 Based on observation, interview and record review, the facility failed to ensure the call light system was functional and failed to monitor its call light system. These failures have the potential to affect 121 residents residing on the third and fourth floors of the the facility. Findings include: On 01/25/2025, at 11:01 AM, R8's call light is observed illuminated above his room door, no audible sound is heard. On 01/25/2025, at 11:02 AM, V8 (RN) and V9 (LPN) observed sitting at the third-floor nurse's station. On 01/25/2025, at 11:03 AM, surveyor located at the third-floor nurses' station and observes that R8's call light is not visible from the nurse's station. On 01/25/2025, at 11:05 AM, surveyor asks V8 (Registered Nurse/RN) how does staff know when a resident has activated their call light and need their call light answered. V8 states there is a phone at the nurse's station and when the resident pushes their call light button, the phone displays the resident's room number and makes an audible alert sound. V8 walks over to the call light system phone to demonstrate how the system works and surveyor observes that the call light phone was not plugged in. V8 states it's unplugged then grabs the phone cord and plugs the cord into the call light phone. Surveyor then observes the phone turn on and is now displaying another resident's room number on the screen with no audible sound heard. V8 states the call light phone should not be unplugged. V8 states the call light phone alert sound should be louder and will now call maintenance to report it. On 01/25/2025, at 11:12 AM, V9 (Licensed Practical Nurse/LPN) states if the facility call light system is not functioning properly, then a resident can experience an emergency, press their call light, and staff would not be able to respond in a timely manner. On 01/25/2025, at 11:15 AM, surveyor located at the fourth-floor nurse's station. Surveyor asks V10 (Licensed Practical Nurse/LPN) how does staff know when a resident has activated their call light and need their call light answered. V10 states there is a phone at the nurse's station and when the resident pushes their call light button, the phone displays the resident's room number and makes an audible alert sound. Surveyor walks over to the call light system phone and observes that the phone has a black screen and is unplugged. V10 is also made aware that the call light phone is unplugged. V10 grabs the phone cord and plugs the cord into the call light phone. V10 states it's not supposed to be unplugged. Surveyor then observes the phone turn on and displays a residents' room number on the screen with an audible sound heard. On 01/25/2025, at 11:21 AM, V12 (Licensed Practical Nurse/LPN) states if the facility call light system is not functioning properly, then a resident can experience an emergency or physical altercation, press their call light, and the resident's needs would not be met in time. V12 states she was not aware that the call light phone was not plugged in. V12 states the cord is broken and often comes out of the phone on its own. V12 states she reported this to maintenance. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/26/2025, at 9:33 AM, surveyor observes a resident's room number displayed on the call light phone at the first-floor nurse's station. V16 (LPN) states this resident's call light system is broken and continuously illuminates even if the resident does not press the call light. V16 states she just checked on the resident and the resident is okay. V16 states this broken call light has been an ongoing issue and has been reported to maintenance for repair. On 01/26/2025, at 9:41 AM, R7 states the call light response time is full of s*** R7 states a few weeks ago, he was sick and coughing and pressed his call light for assistance from staff. R7 states he waited 45 minutes for staff to answer his call light. R7 states after staff responded to his call light, he had to be sent out to the hospital and was admitted for 3 days. On 01/26/2025, at 9:48 AM, R8 states he often has to wait for long periods of time to have his call light answered. R8 states he often wait two hours before staff responded to his call light. R7s' MDS/Minimum Data Set, dated dated dated [DATE], documents that R7 has a BIMS/Brief Interview for Mental Status of 15/15, indicating that R7 is cognitively intact. R8s' MDS/Minimum Data Set, dated dated dated [DATE], documents that R8 has a BIMS/Brief Interview for Mental Status of 12/15, indicating that R8 is moderately cognitively impaired. On 01/25/2025, at 3:24 PM, V2 (Director of Nursing/DON) states when residents press their call light, it alarms and alerts the staff at the nurse's station. V2 states he light above the resident's room also illuminates and stays on until the call light is addressed. V2 states there is a phone at the nurse's station that rings and allows the nurses to communicate with the residents when a call light is activated. V2 states the resident's room number will also display to let staff know which room number is calling. V2 states if the facility call light system is not functioning properly, then staff may not be able to meet the needs of the resident. V2 states this could potentially affect a residents' health and well-being if the resident is experiencing an emergency. V2 states in the past, the facility had issues with the call lights, but she is not aware of any issues related to the call light system. Resident council meeting minutes dated 10/29/24 to 12/31/24 were reviewed and documents that on 12/31/2024, R7 reports that he was choking for 15 minutes, and no one came to check on his call light. Facility census report dated 01/25/25 documents that 60 residents reside on the third floor of the facility and 60 residents reside on the fourth floor of the facility. Facility policy dated 09/19 titled Call Light documents in part, Purpose: To respond to residents' requests and needs in a timely and courteous manner. Equipment: Functioning Nurse Call System. Procedure: 1. Answer light (signal) promptly.