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	07/17/2025

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 0584 Level of Harm - Minimal harm or potential for actual 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. Deficiency Text Not Available

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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(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. Based on interview and record review the facility failed to protect one resident (R5) out a sample of 3 from verbal and emotional abuse. This failure has the potential to affect one resident (R5) out of a sample of 3. Findings include:R1 has a diagnosis of but not limited to Chronic Obstructive Pulmonary Disease with (Acute) Exacerbation, Primary Insomnia, Major Depressive Disorder, and Paranoid Schizophrenia.R1 has a Brief Interview of Mental Status score of 15.R5 has a diagnosis of but not limited to Chronic Obstructive Pulmonary Disease, Undifferentiated Schizophrenia, Type 2 Diabetes Mellitus, Anxiety Disorder, Hypertension, and Syncope and Collapse. R5 has a Brief Interview of Mental Status score of 13.On 7/14/2025 at 12:53 PM, R1 stated on 7/03/2025 he (R1) was yelling, in the dining room, at R5 about continuously taking his stuff.On 7/14/2025 at 1:43 PM, V9 (LPN/Unit Manager) stated R1 was upset with R5 and R1 was 'pumped up' (mad and aggressive) with R5 on 7/03/2025.On 7/14/2025 at 1:59 PM, R5 stated R1 was yelling at him saying, You took my cigarettes. He said some other things, but I don't recall what he said.R1's progress note dated 07/03/2025 at 7:00 PM, by V9 (Licensed Practical Nurse-LPN/Unit Manager), documents, in part, V9 made aware by SS (Social Services) that R1 became verbally aggressive, shouting and screaming. When redirected by staff R1 attempted to strike the other resident (R5).On 7/15/2025 at 1:28 PM, V13 (Certified Nursing Assistant) stated on 7/03/2025 R1 and R5 were having a verbal disagreement about R5 taking some of R1's cigarettes. R1 lost his temper and began to move closer to R5 while yelling at R5. On 7/15/2025 at 3:10 PM, V28 (LPN) stated, I do recall the incident. There was a commotion in the parlor area. I went to see what it was about; it happened fast. Stated R1 did not tell her that R5 stole his cigarettes. R1 became aggressive with R5 yelling and screaming at R5.On 7/16/2025 at 2:06 PM, V27 (Assistant Director of Nursing) said, No, verbal or any kind of abuse should not happen in the facility.On 7/16/2025 at 3:01 PM, V1 (Administrator) stated, No, it (abuse) should not occur in the facility.Supervision and Safety Policy with a date of 3/15 documents, in parts, resident safety and supervision are facility-wide priorities.Job Description Charge Nurse updated 7/2024 documents, in part, detect and correct situations that have a high probability of causing accidents or injuries to residents and/or staff.Policy and Procedure Abuse Prevention Program dated 1/2025 documents, in part, Residents have the right to be free of abuse, the facility prevents abuse and this facility desires to prevent abuse by establishing a resident sensitive and resident secure environment.

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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 - 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. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to supervise a confused wandering male resident from wandering in female rooms during smoke times causing resident mental abuse. This failure affected 2 (R2 and R6) residents in a sample of 57. The facility failed to prevent residents from smoking inside the facility (R7, R10) per policy. Findings include: 1. R2 has a diagnosis of but not limited to TYPE 2 DIABETES MELLITUS WITHOUT COMPLICATIONS, MUSCLE WASTING AND ATROPHY, NOT ELSEWHERE CLASSIFIED, MULTIPLE SITES, DIFFICULTY IN WALKING, NOT ELSEWHERE CLASSIFIED, OTHER LACK OF COORDINATION, ABNORMAL POSTURE, ACQUIRED ABSENCE OF RIGHT LEG ABOVE KNEE, UNSPECIFIED ASTHMA, UNCOMPLICATED, OSTEOMYELITIS, UNSPECIFIED, SUICIDAL IDEATIONS, MAJOR DEPRESSIVE DISORDER, RECURRENT.R2 has a BIMS (Brief Interview Mental Status) of 15 which is an indication of an intact cognition. R4 has a diagnosis of but not limited to UNSPECIFIED DEMENTIA, OTHER FORMS OF SCOLIOSIS, LUMBAR REGION, UNSPECIFIED PSYCHOSIS NOT DUE TO A SUBSTANCE OR KNOWN, EPILEPSY, UNSPECIFIED, OTHER PANCYTOPENIA, SYNCOPE AND COLLAPSE, UNSPECIFIED DEMENTIA, UNSPECIFIED SEVERITY, WITHOUT BEHAVIORALDISTURBANCE, PSYCHOTIC DISTURBANCE, MOOD DISTURBANCE, COGNITIVE COMMUNICATION DEFICIT, NICOTINE DEPENDENCE, UNSPECIFIED, UNCOMPLICATED. R4 has a BIMS (Brief Interview Mental Status) of 10 which is an indication of moderately impaired function. R6 has a diagnosis of but not limited to UNSPECIFIED DEMENTIA, UNSPECIFIED SEVERITY, WITH OTHER BEHAVIORAL DISTURBANCE, DYSPHAGIA, OROPHARYNGEAL PHASE, REPEATED FALLS, ACUTE EMBOLISM AND THROMBOSIS OF UNSPECIFIED DEEP VEINS OF UNSPECIFIED LOWER EXTREMITY, ESSENTIAL (PRIMARY) HYPERTENSION, and HYPO-OSMOLALITY AND HYPONATREMIA. R6 has a BIMS (Brief Interview Mental Status) of 8 which is an indication of moderately impaired function. Surveyor reviewed R2's, R4s, and R6's Face Sheet, Care Plan dated (Abuse Focus) 6/13/2025, IDPH Reportables dated 4/2025 to 6/2025, Concerns/Response 4/2025 to 6/2025, Resident Council Meetings 4/2025 to 6/2025, and Abuse Policy with no concerns noted.Surveyor reviewed Grievance document titled, Opportunity Resolution Form dated 6/25/2025 documents in part, (R4) (male resident) is roaming in R2's room in the afternoon during smoke times and the resolution was to in-service staff regarding escorting resident back and forth to the smoking patio.Surveyor reviewed facility's Sex Offenders list and R4 is not listed. On 7/14/2025 at 1:05 PM, R2 stated R4 has been wandering in her (R2's) room for over 4 months going to the washroom and then laying in an empty bed. R2 stated when she (R2) informs R4 that he is in the wrong room, he (R4) swears at her and makes threatening remarks towards her. R2 showed surveyor a picture on her (R2's) phone with a time stamp of 9:02 AM, that shows R4 being escorted out of a bed diagonally across from R2's bed and a second photo with a time stamp around 6 pm with R4 lying in the bed diagonally across from R2 on 6/25/2025. R2 stated on 7/2/2025, she (R2) noticed R4 was sitting in the Parlor around 11:30 AM, which made her feel unsafe since he has a habit of wandering. R2 stated she (R2) found out that R4's room is directly above her room and that is the reason he (R4) keeps wandering in my room. R2 stated R4 has not wandered in her room since 7/2/2025. R2 stated she hasn't experienced any verbal or physical abuse from staff; there are roaches in the facility; the facility never has enough linen and run out of diapers occasionally; checks and credit cards were missing from her room when she returned from the hospital a long time ago, but no belongings missing recently; and has not heard anything about any overdosing in the facility. 7/14/2025 at 1:35 PM, V5 (Certified Nurse Aide) stated she (V5) is aware of R4 wandering in R2's room. She (V5) stated an in-service on a resolution to R4 wandering in R2's room which was to implement escorting R4 to and from the smoking room to prevent him (R4) from wandering in R2's room. V5 stated R4 has not wandered in R2's room since the staff started following the new intervention and she is unaware of a rape occurring in the facility. On 7/15/2025 at 2:45 PM, V9 (Unit Manager/LPN) stated R2 informed her (V9) that R4 was wandering in and out of her room after smoke times on 6/24/2025. V9 stated R4 suffers from confusion and has wandered to R2's room, so a resolution has been implemented to have staff escort R4 to and from the smoking patio before and after smoking times. V9 stated R4 has not wandered in R2's room since that intervention has been put in place to her knowledge. On 7/16/2025 at 12:07 PM, V25 (Housekeeper) stated she (V25) remembers entering R2's room and noticed R4 (male resident) in a female's room. V25 stated, I told him (R4) to leave the room immediately because males