

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  08/02/2025
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)
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.  (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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> F600: Abuse:Based on interview and record review the facility failed to prevent resident to resident physical assault for two (R1, and R2) out of three residents reviewed for abuse. This failure resulted to R1 sustaining a head injury with staples. Findings Include:R1's Minimum Data Set (MDS) dated [DATE], Brief Interview Score/BIMS (14) indicates he is cognitively intact.R2' MDS dated [DATE], BIMS score (15) indicates he is cognitively intact.On 7/30/25 at 10:02 AM, R1 stated he has been in this facility for over a year. R1 stated, on 7/1/25 around 1pm, he was watching a program on his television (TV) and listening to his radio. R1 got up to assist R2 to pick up his lunch tray when R1 accidentally fell on R2. R2 then hit the back/side of R1's head with a dumbbell. R1 stated staff came into his room to attend to his bleeding head. The paramedics picked R1 up to the hospital to treat his bleeding head with two staples. R1 returned to the facility same day, R2 had been moved to another room. R1 had no further contact or interaction with R2 since, and he feels safe in the facility.On 7/30/25 at 10:18 AM, R2 stated that he has been in this facility for over one year. R2 stated he was having verbal altercation with R1 because R1's TV/radio volume was loud. R2 told R1 to lower the volume, but R1 approached him, cursing at him with F word and R2 cursed him back with F word. R2 stated R1 attempted to hit R2 with a food tray but R2 blocked it and hit the back/side of R1's head with a dumbbell. The staff came into the room after the incident to move R2 to another room, R2 did not have contact with R1 since, and he feels safe in the facility.On 7/30/25 at 10:29 AM, V4 (Licensed Practical Nurse/LPN) stated she worked 7am-3pm shift on 7/1/25 with R1 and R2, at about 1pm a resident came to the nursing station to alert the staff that there was a commotion going on inside the room between R1 and R2. V4 went into the room immediately, to separate, call 911/code gray (Physical Altercation). V1 (Administrator), V2 (Assistant Director of Nursing/ADON), V3 (Social Service Director), and other staff came into the room, R1 was bleeding because of a head injury, V4 applied pressure until the paramedics came to take R1 to the hospital. V4 stated that R2 was moved to another room before R1 returned to the facility same day with 2 staples on the back of his head. V4 attends in-services on how to prevent abuse, and that hitting is a form of resident-to-resident physical abuse.On 7/30/25 at 10:43 AM, V5 (Certified Nursing Assistant/CNA) stated she worked on the day of the incident 7/1/25. V5 rounds every two hours and as needed to attend to resident and to prevent abuse. V5 stated that hitting is a form of resident-to-resident physical abuse, and she attended in-service on how to prevent abuse about four weeks ago. On 7/30/25 at 3:20 PM, V1 (Administrator) stated she is the abuse coordinator, it is her expectation that residents are kept safe, free from abuse, and she conducted in-service on how to prevent abuse on 7/2/25. During her investigation, R1 stated that R2 hit him at the back/side of his head with a dumbbell. R2 stated that he told R1 to reduce the volume of his radio/TV, R1 became upset, cursed R2 with F word and he used F word as well. R1 then approached him while lying in bed, and he hit R1 with the dumbbell. V1 stated that R1 is the aggressor because R2 is bed bound. V3 updated the care plan, continues to provide frequent behavioral management counselling in addition with the psych consult. V1 also stated that the dumbbell has been confiscated, locked up, a picture copy, and the police report # JJ316577, BEAT #1032 reviewed.V6 (CNA), V7, V8 (LPNs), V9, and V10 (CNAs). All stated that hitting is a form of resident-to-resident physical abuse and were in-serviced on how to prevent abuse. Documents reviewed but are not limited to the following:R1, R2, and R3's Face Sheet, POS, and Section C of MDS.R1's Hospital Emergency Department (ED) Report dated 7/1/25, documents in part: Assault Victim, Head injury, Laceration of head, and Laceration Repair, return to ED in ten days for staple removal. R1's progress note dated 7/1/25 documents in part, 2 sutures noted to posterior head.R3's written witness statement dated 7/2/25 document in part: R2 got upset, got into the other one's face and R2 hit him (R1) with his weight (Dumbbell).R1 and R2's Assessment for aggressive behaviors.Facility Reported Injury, Initial report dated 7/1/25, and Final Report dated 7/8/25.Abuse in-service dated 01/2025, and 7/2/25.Abuse Policy dated 1/20/25 documents in part: Resident have the right to be free from abuse, and neglect. The facility desires to prevent, prohibits abuse and neglect.Concern/Compliment Forms from 1/6/25 to 6/23/25.Resident Council Meeting Minutes dated 1/28/25 to 7/29/25.</p>		