

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 09/19/2025
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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Reasonably accommodate the needs and preferences of each resident.</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 - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to answer call lights in a timely manner for four residents (R1, R2, R4, R9) and failed to accommodate timely repairs for furnishings for three residents (R1, R3, R4) out of a total sample of 14 residents. Findings include: R1's 'admission Report' documents in part medical diagnoses of quadriplegia, muscle wasting and atrophy in multiple sites, unsteadiness on feet, need for assistance with personal care, difficulty in walking, lack of coordination, limitation in activities due to disability, left side weakness following a stroke, abnormalities in gait and mobility, and generalized muscle weakness. R1's [DATE] Minimum Data Set (MDS) assessment documents in part R1 is cognitively intact. It documents R1 has an impairment to one side of upper and lower extremity. It also documents in part R1 is dependent with toileting hygiene and requires substantial to maximal assistance with oral hygiene, bathing, dressing, and personal hygiene. On [DATE] at 2:29 PM, R1 was alert and oriented to person, place, and time. R1 was sitting in a motorized wheelchair in the bedroom. R1 stated staff take a long time to respond to R1's needs. R1 stated at times staff would come in, turn off R1's call light, and be gone for a long time prior to tending to R1's needs. R1 stated staff can take up to an hour before they answer R1's call light. R1 stated asking staff to move a chair out of the bedroom about ten minutes ago, but staff have not done so. R1 stated the chair was in R9's (roommate who is in a wheelchair) way. R1 pushed the call light at 2:35 PM. The light on the call light box turned on. Surveyor remained in the room and continued the interview with the bedroom door closed. At 2:47 PM, R1 stated, They're supposed to be attentive. Someone could have died by now. At 3:07 PM, R1 asked surveyor to get tissue from the bathroom stating [R1's] nose was running. R1 stated [R1] could not go into the bathroom because [R1's] motorized wheelchair was too wide for the door frame. Surveyor explained role and proceeded to wait for staff to answer R1's call light. At 3:12 PM, R1 pressed the button again and stated, I wonder if it makes noise out there if you hit it. Surveyor stepped out into the hallway. The call light indicator outside the door is on the ceiling and it was flashing. There were also call light indicators near the nurses' station and those were flashing. V4 (Nurse) was sitting at the nurses' station. V4 stated the morning CNAs (Certified Nurse Aides) already left and evening CNAs haven't arrived yet. [V4] was waiting for evening nurse to come in for hand off report. At 3:19 PM, V5 (Nurse) walked past R1's room towards the end of the hall without answering the call light. V5 emerged again and walked past R1's room towards the nurses' station. V4 asked V5 to answer R1's call light. V5 entered R1's room at 3:21 PM (46 minutes after R1 turned it on). During this same observation, R1 also mentioned the bedside table was broken. R1's bedside table had a black, plastic siding was peeling off and hanging from the table. The part hanging was greater than the length of surveyor's laptop keyboard (nine inches). R1 stated it's been since July and the facility has not fixed it. R1 stated its rough at the edge where the siding came off. R1's 'Care Plan Report' documents in part R1 has a self-care deficit (initiated [DATE]) and is at risk for falls (initiated [DATE]). Interventions include to encourage the resident to use the call light for assistance and for staff to respond promptly to all requests for assistance (initiated [DATE]). --- R2's 'admission Report' documents in part medical diagnoses of muscle wasting and atrophy in multiple sites, muscle weakness, need for assistance with personal care, repeated falls, lack of coordination, and abnormal posture. On [DATE] at 11:59 AM, R2 was alert and oriented to person, place, and time. R2 stated staff take about an hour to an hour and a half to respond to call lights. R2's 'Care Plan Report' documents in part R2 has an alteration in musculoskeletal status (revised [DATE]), is frequently incontinent (revised [DATE]), has a self-care deficit (revised [DATE]), and is at risk for falls (revised [DATE]). Interventions include to encourage R2 to use the call light for assistance and for staff to respond promptly to all requests for assistance (initiated [DATE]). --- R3's 'admission Record' documents in part diagnoses of weakness, other lack of coordination, abnormal posture, muscle wasting and atrophy in multiple sites, repeated falls, need for assistance with personal care, and unsteadiness on the feet. R3's [DATE] Quarterly MDS assessment documents in part R3 has an impairment to one side of upper extremity. It also reads R3 requires partial to moderate assistance with toileting hygiene. R3's [DATE] progress note documents in part R3 has a history of stroke with left side weakness. R3's [DATE] 9:17 AM progress note documents in part R3 has left upper extremity with severe limitation. Facility's Resident Council Minutes document in part during the [DATE] meeting, R3 complained of a broken toilet knob. On [DATE] at 11:17 AM, R3 was oriented to person, place, and time. When asked about meeting minutes from July, R3 stated it was not the toilet knob was broken but rather the toilet</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on observations, interviews, and record reviews, the facility failed to provide a clean and home-like environment for six (R2, R4-R8) out of a total sample of 14 residents with a potential to affect multiple residents on the first, second, third, and fourth floors. Findings include: On 9/16/2025 at 11:35 AM, there were multiple brown and dark tan-colored splatter stains on the central walls on the fourth floor including the wall across from the East stairwell. On 9/18/2025 at 11:56 AM, the central walls and wall across from the East stairwell still had brown and dark tan-colored splatter stains. On 9/16/2025 at 11:41 AM, R4 stated facility is slow to fix things. There are brown stains to three ceiling panels by the window, two ceiling panels above bed B, and others by the bathroom. One of the ceiling panels above bed B is curved/bubbled. R4 stated the hallways and dining rooms are also dirty. On 9/16/2025 at 11:53 AM, the third-floor dining room had multiple food particles and other debris (pieces of sugar packets, white paper shreds) on the floor. On the left side of the dining room, there was a table with six dirty/used trays from previous meals. One tray had left over chicken, mashed potatoes, carrots, peas, and bread. The other trays had left over milk and scrambled eggs. At 12:14 PM, facility started serving lunch to the unit. The dining room remained with the used trays and debris on the floor. R6, R7, and R8 were eating lunch in a nearby table to the dirty trays. On 9/16/2025 at 11:59 AM, R2 was alert and oriented to person, place, and time. R2 stated maintenance was slow to fix things and housekeeping do not do a good job cleaning specifically with sweeping. R2's room had brown stains to two ceiling panels in the back left corner of the bed and there was chipped paint to the corner wall near the bathroom. On 9/16/2025 at 12:26 PM, R5 was in the room when [R5] stated facility maintenance department is slow to fix things. R5 pointed to the ceiling tiles near the window. There were tan and brown stains on some of the ceiling panels. R5 pointed to the wall by the head of R5's bed. R5 stated the floor trimming was peeling off and there was chipped paint on the wall. On 9/18/2025 at 10:15 AM, the second-floor dining room had multiple food particles and other debris on the floor. There was a used brown paper towel on the floor near the window. On a table near the proximal wall to the nurses' station, there were five dirty meal trays. At 11:59 AM, R5 and multiple residents were in the dining room for lunch. The paper towel remained on the floor and the used trays were stacked on top of each other on the same table as earlier. Multiple staff walked by the brown paper towel on the floor without picking it up including V12 (Certified Nurse Aide - CNA) and V22 (CNA). On 9/18/2025 at 10:27 AM, the first-floor dining room had multiple food and other paper products (brown paper towel) on the floor by the vending machines. There was also a dark brown spill stain. There was a clear plastic bag in the middle of the room and a bath towel by the cabinets on the other side. At 12:03 PM, residents were eating in the first-floor dining room, but the paper towel, plastic bag, and bath towel remained on the floor. On 9/17/2025 at 11:06 AM, V7 (Maintenance Supervisor) stated staff are supposed to communicate when there are any environmental issues. V7 stated does not go into the residents' rooms daily and rely on staff to report any issues. V7 stated if there's tan or brown stains to the ceiling panels, V7 needs to check on it right away to check for a leak. V7 stated if there's a leak that's causing the ceiling panel to bubble, then it might fall. V7 was not aware of the ceiling panels in R2, R4, and R5's room. On 9/17/2025 at 1:08 PM, V17 (Housekeeping Supervisor) stated the housekeepers are to clean the dining rooms after each meal. V17 stated the purpose is to get the dining rooms ready for the next meal or for when family and friends visit the residents or for when residents want to hang out in there. V17 stated housekeeping staff are also supposed to clean the hallways and resident rooms daily. Staff are to clean the walls whenever they see a spot or dirt on them. On 9/18/2025 at 12:13 PM, V2 (Director of Nursing) stated housekeeping is to ensure the environment is clean for the residents. V2 stated housekeeping should go in after each meal and clean up any issues so that it is clean and readily available to the residents. Facility provided a copy of the 'Illinois Long-Term Care Ombudsman Program - Resident Rights for People in Long-Term Care Facilities.' It documents in part that residents have the right to a safe, clean, comfortable, and homelike environment. Facility's Housekeeping Guidelines (7/14) documents in part that the purpose is to provide guidelines to maintain a safe and sanitary environment for residents, facility staff and visitors. Housekeeping personnel shall adhere to daily cleaning assignments developed so to maintain the facility in a clean and orderly manner. The Administrator and Environmental Services Director will routinely make visual quality control observations to ensure that a high level of sanitation is maintained. Cleaning of curtains, walls, blinds, etc. will be cleaned when dust or soiling is visible. Trash will be removed from all areas of the facility daily and as needed to prevent spillage and odors. Facility's Preventative</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on observations, interviews, and record reviews, the facility failed to follow a resident's (R2) plan of care and failed to recognize potential accident/hazard in the patio. This has the potential to affect all residents who go out to the patio. Findings include: R2's 'admission Report' documents, in part, muscle wasting and atrophy in multiple sites, repeated falls, need for assistance with personal care, lack of coordination, abnormal posture, left hemiplegia, muscle weakness, and lack of coordination. R2's 6/24/2025 Minimum Data Set assessment documents R2 is cognitively intact. R2 has an impairment to one side of lower and upper extremity. R2 is dependent on staff when using the wheelchair. 'Facility Incident Investigation Report' documents on 7/10/2025 R2 complained of left ankle pain. Facility conducted an x-ray which resulted in closed left ankle fracture. Facility investigation reads R2 believes the injury occurred when left leg fell off the leg rest while propelling in the wheelchair. Facility intervention included to place a leg strap on R2's left leg to keep leg from falling off the leg rest while in the wheelchair. 'Facility Incident Investigation Report' reads staff and R2 were educated to use the leg rest strap to prevent further injury. R2's 'Care Plan Report' documents R2 has an alteration in musculoskeletal status related to fracture of the left ankle (initiated 7/11/2025). R2 will utilize an adjustable wheelchair footrest belt strap to maintain support/stability to the ankle when in the wheelchair (initiated 7/18/2025). Intervention includes for staff to ensure the footrest belt strap is in place to maintain support/stability to the left ankle (initiated 7/18/2025). On 9/16/2025 at 12:32 PM, R2 was oriented to person, place, and time. R2 stated R2 cannot move left leg and has minimal feeling to the left leg. R2 stated there has been a few incidents where left leg has fallen out of the footrest while up in the wheelchair. On 9/17/2025 at 11:32 AM, R2 was up in the wheelchair playing bingo in the dining room. R2's left leg was elevated on top of a pillow was on top of the wheelchair's footrest. There was no leg strap. On 9/17/2025 at 11:52 AM, V11 (Nurse) stated R2 is supposed to have a left leg strap when up in the wheelchair but it is missing. V11 was not sure how long it's been missing. On 09/17/2025 at 12:04 PM, V12 (Certified Nurse Aide) stated R2 had a leg strap but it's missing today and don't know when it disappeared. On 9/17/2025 at 1:24 PM, R2 remained up in the wheelchair in the dining room. There was no leg strap to the left leg. R2 stated facility staff could not locate the leg strap. --- On 9/16/2025 at 12:32 PM, R2 mentioned left leg has fallen out of the leg rest while going over the ramp in the patio. R2 stated the bottom of the ramp was uneven and had multiple cracks need to be filled in. On 9/17/2025 at 11:23 AM, V7 (Maintenance Supervisor) and surveyor went out into the patio. There was a cement ramp led from the building to the cement patio. At the end of the ramp there were multiple cracks in the cement. One crack extended past both sides of the railing (V7 measured railing width to be 49 inches). Some of the cracks had 0.5 to 0.75-inch height difference. When the facility opened the smoking patio at 2:02 PM, there were multiple residents in wheelchairs (including R10, R11, R12, and R13) who got caught on the cracks. They had to wiggle or use the handrails to assist them out of the cracks. On 9/17/2025 at 2:13 PM, V19 (Psychosocial Aide) stated roles include to assist residents during smoke breaks. V19 stated the ramp is a hazard because of the multiple cracks. V19 stated asking facility to fix it for almost a year now. V19 stated some residents have a hard time getting over the humps where the cracks are. At 2:18 PM, R14's rollator got caught on a crack. R14 and the rollator started to tip over. V19 caught R14 and assisted [R14] further out into the patio. Interview resumed and V19 stated people can come down the ramp out of control if they hit the cracks the wrong way. V19 stated when going up the ramp, some residents must pull up or lean back to get over the humps. V19 stated it can also cause them to fall back. V19 stated residents can also trip on the cracks or on the loose pieces coming off the cracks. V19 kicked a loose piece of cement was about 4 inches in length out to the dirt. R10-R14's 'Care Plan Reports' document they are all fall risks. R14's 'Care Plan Report' documents multiple falls while out in the patio with one resulting from R14 tripping while coming up the patio ramp. On 9/18/2025 at 12:13 PM, V2 (Director of Nursing) stated to prevent accidents staff are to ensure the environment is free from hazard. Facility provided a copy of the 'Illinois Long-Term Care Ombudsman Program - Resident Rights for People in Long-Term Care Facilities.' It documents residents have the right to a safe, clean, comfortable, and homelike environment. Facility's 'Fall Prevention Program' documents: It is the policy of this facility to have a Fall Prevention Program to assure the safety of all residents in the facility, when possible. Facility is to identify risk factors and remove hazards. Facility's Preventative Maintenance Program (11/2022) documents the purpose is to conduct regular environmental tours/safety audits to identify areas of concern within the facility. The head of maintenance and/or housekeeping are to conduct random</p>		