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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146141	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Terraces at the Clare	55 East Pearson Chicago, IL 60611

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 41356

Based on observation, interviews and records review the facility failed to complete a thorough investigation of the alleged injuries of unknown source to rule out physical abuse. This failure affected 1 (R1) out of 3 residents reviewed for abuse.

Findings include:

R1 subject of the incident is [AGE] years old currently a resident of facility. R1 was initially admitted on [DATE] with medical diagnosis that includes severe dementia, atherosclerotic heart disease of native coronary artery. R1's BIMS (Brief Interview of Mental Status) score is 1 out of 15, indicating R1's cognition is severely impaired.

On 03/12/2025 at 11:17 AM, R1 was seen sitting inside her room. R1 was alert, unable to respond to questions within topic. R1 responded to all questions by saying okay. V3 (Registered Nurse) went inside R1's room to assess both arms and hands of R1. R1's left wrist and right hand noted to have small bruises and left eye that shows bruising and redness. V3 stated that bruising and redness on R1's left eye was there for a long time. At 11:41 AM, V4 (Certified Nursing Assistant) stated that R1 used to have bruises on her arms but now they are healed. V4 was not able to say how R1 got the bruise.

On 03/12/2025 at 01:05 PM, V6 (Registered Nurse) stated that during endorsement with night nurse and morning CNA. She (V6) was informed about the bruising of R1's bilateral arms which she describes as discoloration. V6 stated that the night nurse already identified the bruising but did not say anything. V6 stated that it was the first time she saw R1's bruising and did not know how R1 got bruises. V6 stated that she was the staff that informed V2 (Director of Nursing).

Request to V1 (Administrator) for the full investigation details of incident. V1 stated that V2 (Director of Nursing) did the investigation, and since V2 is not in facility, staff are making contact to V2 to produce full documentation of investigation. V1 suggested that V2 will email documents related to the investigation late when V2 arrives in the facility. V1 was made aware that investigation for injuries of unknown source needs to be readily accessible and is important since this investigation needs to rule out abuse. V1 stated that she will contact V2 and procure the investigation. After a while, V1 came with written statements from the following staff:

(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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NAME OF PROVIDER OR SUPPLIER Terraces at the Clare		STREET ADDRESS, CITY, STATE, ZIP CODE 55 East Pearson Chicago, IL 60611	

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- V4 (Certified Nursing Assistant) documentation on Certified Nursing Assistant Post Accident Report witness statement that reads: I went into the room this morning to give AM care and notice patient arms and reported it to the nurse. - V8 (Certified Nursing Assistant) documented: I worked with R1 on Monday February 3, 2025. I didn't notice any bruising. I worked with her from 6:00 AM to 2:00 PM. - V9 (Certified Nursing Assistant) documented: I was assigned to work 12th floor on 02/04/2025 but was not assigned to work with room where R1 resides. I am unsure at anything that may have occurred with this resident as I did not personally work with her. V1 was asked where the written statements of V6 (Registered Nurse) the nurse who reported to V2 (Director of Nursing) about the bruises of R1. V1 stated that she will ask V2 because she did the investigation. V1 was asked why there was nothing that mention about location of incident? V1 did not answer. V1 was asked is there are any written statements on facility staff that regularly took care of R1 during the time bruises where seen? V1 did not answer. V7 (Assistant Director of Nursing) submitted incident audit report that shows all documentation of V2 (Director of Nursing) was still in progress with date includes 02/07/2025 and 02/09/2025.V7 identified V6 (Registered Nurse) as the nurse that notified V2. V6's name also appears in progress dated 02/04/2025 but no actual notes were seen under V6's name. V7 was asked on the notes of V6 since she does not have any documentation at all. V7 stated she will inform V2 about my question. On 03/12/2025 at 01:39 PM, V7 came back with V2 on speaker phone. V7 stated that V2 needs to speak to writer because per V2 the notes under her name were done by V6 the nurse who informed V2. V2 stated that since V6 was new, she (V2) logged in and made V6 put her notes under her name. V2 said, V6 did the notes, I was at her side. V2 was asked if all written statement received by writer are complete. V2 stated that all written statements were provided. To ensure that V2 understood the question. Names of V4 (CNA), V8 (CNA) and V9 (CNA) were stated for confirmation. V2 confirmed that V4, V8, and V9 are only staff that have written statement. V2 stated that V4 was assigned to R1, V8 was there but not assigned to R1. And V9 was not present on that day (02/04/2025). V2 was asked why prior shift nurse's statement was not included and who informed V6 about the bruising of R1. V2 replied that she has written statement of the night nurse (V10 / Registered Nurse) in her office. Reminded V2 that she stated a while ago that she only had written statements for V4, V8 and V9. V2 replied that she has a written statement from the night nurse in her office. V2 was made aware that written statements are part of abuse investigation, and it must be readily available or accessible when asked. V2 replied I know it is part of the investigation and should be gathered together. V2 was also informed that by letting V6 put her notes under her (V2) name makes documentation inaccurate. Because although the notes were done by V6 it shows her (V2)'s name. V2 replied, To me it is accurate. I signed into the computer because she (V6) is new, and she (V6) made the documentation under my name. V2 was asked why she did not let V6 sign in with her name? V2 did not replied. V2 was informed that document shows her name, although by her statement that it was done by V6, and it makes documentation confusing which facility staff did the writing. V2 replied, I will own the notes. It is my notes. It is my notes not V6. V2 was asked if these are her notes where is V6 notes? V2 replied, I will own that note. (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/12/2025 at 01:55 PM, V1 stated that as the administrator she is also the abuse coordinator. V1 stated that it was V2 (Director of Nursing) who did the investigation. And she (V1) reviewed the investigation of R1 that was done by V2. V1 stated that the correct procedure is to interview all staff or let them provide their statement. Their account of the events should be in the incident report. V1 stated that she is struggling to answer because she wants to know if V10 (Registered Nurse) night nurse reported to V6 the bruises of R1. V1 stated that all the staff involved, and in the surrounding time-period should be interviewed since R1 cannot verbalized. V1 said, I do not want to make excuses, I do believe V2 tried to interview all staff that can provide information. But I understand, I think I need to train other staff on the proper investigation of abuse. V1 stated that she should have reviewed all investigations pertaining to the incident, that they (facility staff) were unprepared and stated We will do training to ensure investigation is properly done. Per facility skin assessment of R1 dated 02/04/2025, R1 sustained multiple bruises on both upper extremities. Facility Final Report of R1's incident dated 02/04/2025 documents the following: Staff denies witnessing any incident during care but did mention that resident gets very stiff and resistant during transfer which might cause R1 to accidentally bump her arms on to something. Conclusion of report reads: After thorough interview of residents and staff, abuse was ruled out. R1's bruise might happen due to the combination of resident being on Plavix and the possibility of resident accidentally hitting her arm on something. On final investigation report it documents that staff did mention that resident gets very stiff and resistant during transfer which might cause R1 to accidentally bump her arms on to something. There was no documentation to support who the staff that mention stated above included in the investigation. No time, date and location of R1 seen to be stiff and resistant to care during transfer. Who were the staff that transfer R1. Who were the staff or employees that provided regular care to R1. None of these are included in the investigation. Incident Audit Report documents that V2 (Director of Nursing), V1 (Administrator) and V6 (Registered Nurse) created documentation. And the only documentation that can be seen is V2's notes dated 02/07/2025 and 02/09/2025 that reads: V2 was made aware about R1's bruises on both upper extremities. R1 unable to verbalize what happened. R1 denies pain, and vital signs results. And to whom notification was provided. Incident Audit Report was not accessible to writer via electronic health records access. It was provided when writer requested full investigation. Review of R1's notes from 02/03/2025 to 02/10/2025 does not provide any information related to incident of R1's bruising that was identified on 02/04/2025. V2 clinical notes created on 02/07/2025 marked as late entry done three (3) days after the incident that occurred on 02/04/2025. Full documentation does not provide any information as to bruising of R1's upper extremities, does not mention any bruising of R1, or any investigation done to rule out abuse. It documents that R1 is rarely or never understood, R1's pain level, and day-to-day activities. The investigation has no documentation of V10 (Registered Nurse) night nurse informing V6 (Registered Nurse), morning nurse about R1's bruises. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/13/2025, V2 submitted resident written statements via email that was dated 03/04/2025 month after identification of R1's bruises. Abuse policy dated 08/27/2024 reads: Internal investigation for resident with injury of unknown source the person gathering facts will document the injury, the location and time it was observed, any treatment given and notification of proper parties. Investigation Procedure, the appointed investigator will, at a minimum, attempt to interview the person who reported the incident, anyone likely to have direct knowledge of the incident and the resident if interviewable. Any written statements that have been submitted will be reviewed, along with any pertinent medical records or other documents. Residents to whom the accused has regularly provided care, and employees with whom the accused has regularly worked will be interviewed. Final investigation, the investigator will report the conclusion of the investigation in writing to the administrator of designee within five days of the reported incident. The final investigation report shall contain the following: - The original allegation (note day, time, location, circumstance surrounding the occurrence and any noted injuries). - Facts determined during the process of the investigation, review of medical record and interview of witnesses. - Conclusion of the investigation based on facts.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41356 Based on review of records and interviews the facility failed to maintain accurate and readily available resident records related to abuse investigation. This failure affected one resident (R1) out of 3 residents reviewed. Findings include: R1 subject of the incident is [AGE] years old currently a resident of facility. R1 was initially admitted on [DATE] with medical diagnosis that includes severe dementia, atherosclerotic heart disease of native coronary artery. R1 cognition is severely impaired with BIMS (Brief Interview of Mental Status) of 1. R1 was investigated by the facility related to bruises resident sustained that was identified on 02/04/2025. On 03/12/2025 at 11:17 AM, R1 was seen sitting inside her room. R1 was alert, unable to respond to questions within topic. Facility Final Report of R1's incident dated 02/04/2025 documents the following: Staff denies witnessing any incident during care but did mention that resident gets very stiff and resistant during transfer which might cause R1 to accidentally bump her arms on to something. Conclusion of report reads: After thorough interview of residents and staff, abuse was ruled out. R1's bruise might happen due to the combination of resident being on Plavix and the possibility of resident accidentally hitting her arm on something. Request to V1 (Administrator) for the full investigation details of incident. V1 stated that V2 (Director of Nursing) did the investigation. And since V2 is not in facility staff are making contact to V2 to produce full documentation of investigation. V1 suggested that V2 will email documents related to the investigation late after when V2 arrives in the facility. V1 was made aware that investigation for injuries of unknown source needs to be readily accessible and important since this investigation needs to rule out abuse. V1 stated that she will contact V2 and procure the investigation. After a while, V1 came with written statements from the following staff: - V4 (Certified Nursing Assistant) documentation on Certified Nursing Assistant Post Accident Report witness statement that reads: I went into the room this morning to give AM care and notice patient arms and reported it to the nurse. - V8 (Certified Nursing Assistant) documented: I worked with R1 on Monday February 3, 2025. I didn't notice any bruising. I worked with her from 6:00 AM to 2:00 PM. - V9 (Certified Nursing Assistant) documented: I was assigned to work 12th floor on 02/04/2025 but was not assigned to work with room where R1 resides. I am unsure at anything that may have occurred with this resident as I did not personally work with her. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	V1 was asked where the written statements of V6 (Registered Nurse) the nurse who reported to V2 (Director of Nursing) about the bruises of R1. V1 stated that she will ask V2 because she did the investigation. V1 was asked why there was nothing that mention about location of incident? V1 did not answer. V1 was asked is there any written statements on facility staff that regularly took care of R1 during the time bruises where seen? V1 did not answer. V7 (Assistant Director of Nursing) submitted incident audit report that shows all documentation of V2 (Director of Nursing) was still in progress with date includes 02/07/2025 and 02/09/2025.V7 identified V6 (Registered Nurse) as the nurse that notified V2. V6's name also appears in progress dated 02/04/2025 but no actual notes were seen under V6's name. V7 was asked on the notes of V6 since she does not have any documentation at all. V7 stated she will inform V2 about my question. On 03/12/2025 at 01:39 PM, V7 came back with V2 on speaker phone. V7 stated that V2 needs to speak to writer because per V2 the notes under her name were done by V6 the nurse who informed V2. V2 stated that since V6 was new, she (V2) logged in and made V6 put her notes under her name. V2 said, V6 did the notes, I was on her side. V2 was asked if all written statement received by writer are complete. V2 stated that all written statements were provided. To ensure that V2 understood the question. Names of V4 (Certified Nursing Assistant), V8 (Certified Nursing Assistant) and V9 (Certified Nursing Assistant) were stated for confirmation. V2 confirmed that V4, V8, and V9 are only staff that have written statement. V2 stated that V4 was assigned to R1, V8 was there but not assigned to R1. And V9 was not present on that day (02/04/2025). V2 was informed why prior shift nurse's statement was not included. And who informed V6 about the bruising of R1. V2 replied that she has written statement of the night nurse (V10 / Registered Nurse) in her office. Reminded V2 that she stated a while ago that she only had written statements for V4, V8 and V9. V2 replied that she has a written of the night nurse in her office. V2 was made aware that written statements are part of abuse investigation. And it must be readily available or accessible when asked. V2 replied I know it is part of the investigation. And should be gathered together. V2 was also informed that by letting V6 put her notes under her (V2) name makes documentation inaccurate, because, although the notes were done by V6, it shows her (V2) name. V2 replied, To me it is accurate. I signed into the computer because she (V6) is new, and she (V6) made the documentation under my name. V2 was asked why she did not let V6 signed in with her name? V2 did not replied. V2 was informed that document shows her name, although by her statement that was done by V6, and that makes documentation confusing which staff did the writing. V2 replied, I will own the notes. It is my notes. It is my notes not V6. V2 was asked if these is her notes where is V6 notes? V2 replied, I will own that note. On 03/12/2025 at 01:55 PM, V1 stated that as the administrator she is also the abuse coordinator. V1 stated that it was V2 director of nursing who did the investigation and that she (V1) reviewed the investigation of R1 that was done by V2. V1 said, All the staff involved, and the in surrounding time-period should be interviewed since R1 cannot verbalized. I do not recognize that we have a complete documentation with all these documentations. V1 stated that staff should document their notes under their name. V1 stated that all documentation that was done in the investigation should be in the same folder. (continued on next page)

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