STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146159	A. Building B. Wing	12/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Terrace	1615 Sunset Avenue Waukegan, IL 60087

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 35541 Based on interview and record review the facility failed to complete ongoing assessments of a resident after the resident had sustained a fall with injury for 1 of 3 residents (R2) reviewed for quality of care in the sample of 3. The findings include: R2's current care plan showed R2 was at high risk for falls due to her history of repeated falls and her impaired cognition related to her diagnosis of dementia. R2 was dependent on staff for cares. R2's fall investigation report dated 11/29/24 showed R2 sustained an unwitnessed fall out of bed on 11/28/24 around 4:00 AM. R2 was immediately assessed by staff and found to have no complaints of pain or obvious injuries. The report showed R2 began complaining of left leg pain on 11/29/24. An X-ray of R2's left leg was completed in the facility on 11/29/24. R2's X-ray report dated 11/29/24 showed R2 had a proximal left femur fracture. The facility attempted to send R2 to the hospital for an evaluation but V18 (R2's family/power of attorney/POA) did not want R2 hospitalized . R2 remained in facility with orders for pain management and order to follow up with an orthopedic physician. R2's post fall assessments. including neurological flow sheets and 72 hour post-fall assessments were reviewed. The assessments showed R2 was initially assessed by staff immediately after her fall on 11/28/24. R2 was assessed by staff, as per facility protocol, from 4:15 AM -10:45 AM on 11/28/24. R2's electronic medical record showed no post-fall assessments were completed on R2 from 11:45 AM-11:59 PM on 11/28/24. On 12/11/24 at 1:30 PM, V2 Director of Nursing (DON) stated any resident that hits their head as a result of a fall or any resident that sustains an unwitnessed fall (as R2 did), staff are to complete a neurological (neuro) assessment on a resident immediately after a fall, then every 15 minutes times 4, every 30 minutes times 4, every hour times four, and then every 8 hours for the remainder of the 72 hours post-fall. V2 stated facility staff are also to assess a resident and complete a 72 hour post-fall assessment, every 8 hours, after any resident falls in the facility. V2 confirmed no neurological assessments or 72 hour post-fall assessments had been completed on R2 from 11:45 AM-11:59 PM on 11/28/24. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Neurological Assessment policy dated 3/2021 showed, Neurological assessment is performed following an injury resulting in actual or suspected head trauma or according to order . Neurological assessment is performed for 72 hours. The accepted time frame is as follows: every 15 minutes X 4 then every 30 minutes X 4 then every 1 hour X 4 then every 8 hours for the remainder of the 72 hours . Five key neurological checkpoints should be monitored and recorded on the Neurological Assessment Flow Sheet. a) Level of Consciousness b) Pupil Response c) Motor Functions d) Pain Response e) Vital Signs .

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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. 35541 Based on observation, interview and record review the facility failed to ensure a resident, that had sustained a recent fall with injury, had fall interventions in place for 1 of 3 residents (R2) reviewed for safety and supervision in the sample of 3. The findings include: R2's fall investigation report dated 11/29/24 showed R2 sustained an unwitnessed fall out of bed on 11/28/24 that resulted in R2 fracturing her left femur. R2's care plan revised 11/29/24 showed R2 was at high risk for falls due to her history of repeated falls and her impaired cognition related to her diagnosis of dementia. R2 was dependent on staff for cares. The plan showed R2 had previously fallen out of bed on 8/22/24, where she sustained an unwitnessed fall out of bed, resulting in a fracture to her right femur. The plan showed, Keep bed in lowest position . Provide floor mats on sides of resident's bed . On 12/11/24 at 9:39 AM, R2 was in bed, awake, but babbling incoherently. No mats were noted on the floor next to either side of R2's bed. On 12/11/24 at 12:02 PM, R2 remained in bed, digging through her purse. R2's bed was approximately 4 feet off the ground. No mats were noted on the floor next to either side of R2's bed. On 12/11/24 at 1:30 PM, V2 Director of Nursing (DON) stated fall interventions for R2 included frequent staff monitoring, placing her bed in the lowest position (close to the floor), ensuring her call light is within reach, and placing fall mats on the floor on both sides of the bed when R2 is in bed. V2 DON stated R2 was cognitively impaired and will try to get out of bed on her own.

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F 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results. 34314 Based on observation, interview and record review the facility failed to ensure x-rays were obtained in a timely manner for a resident with an acute injury. This applies to 1 of 3 residents (R1) reviewed for radiology in the sample of 3. The findings include: On December 11, 2024, R1 was sitting up in a reclining wheelchair coloring in the dining room. She had a long- leg cast to her right lower leg. The facility's injury of unknown cause report dated November 28, 2024 shows, Resident complained of pain on 11/27 (day prior) at 6AM during care. CNA (Certified Nursing Assistant) on duty alerted NOD (nurse on duty) and pain medication was given. NOD completed body assessment on resident, no findings. At 7:15 AM morning CNA was about to give resident a shower, but resident complained of pain again, and CNA alerted NOD that resident was complaining of pain, and she did not want to move resident. NOD alerted DON (Director of Nursing) and DON went into resident's room to assess resident. DVT (deep vein thrombosis) was suspected. DON phones NP (Nurse Practitioner) who gave orders for venous doppler, and STAT X-ray. Upon findings, fracture yielded in results . R1's order entry dated November 27, 2024 shows, an x-ray to right lower extremity and venous doppler to right lower extremity. Both orders were entered on November 27, 2024 at 8:44 & 8:45 AM. On December 11, 2024 at 11:05 AM, V4 Licensed Practical Nurse (LPN) stated, she was the nurse taking care of R1 on November 27, 2024 on day shift. The CNA came to her saying R1 was screaming in pain. R1's right leg was swollen and warm to touch. The DON (V2) also assessed R1's leg. They got orders for an x-ray and venous doppler. V4 LPN works 7 AM - 3PM. When she left for her shift that day, the x-ray had not been done yet. The next day when she came back in to work, she seen the x-ray still wasn't done. The x-ray company finally came that AM. She would have expected the x-ray to be done that evening after she left. On December 11, 2024 at 12:51 PM, V19 NP stated, he assessed R1 on November 27, 2024 around 4:00 PM. His colleague had already given orders for an x-ray and venous doppler. He told the nursing staff to make sure they follow up with x-ray company to find out when the x-ray would be done. Otherwise he would have sent her out to the local emergency department. He would have expected the nursing staff to follow up and if it wasn't done or wasn't going to be done that evening, to contact him to send her out. R1's radiology results report shows, examination date: November 28, 2024 at 9:48 AM (over 24 hours). The same report shows, Findings: Examination of the right tibia/fibula demonstrates an oblique, mildly overriding and distracted fracture of the mid shaft of the tibia presumably acute. There is suspicion of a hairline fracture in the distal tibial diaphysis as well. On December 11, 2024 at 2:08 PM, V1 Administrator stated, they were still trying to figure out what happened with the x-ray and why it wasn't done until the next morning. (continued on next page)

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F 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's laboratory and diagnostic testing policy dated March 2021 shows, Guideline: To accurately, report, and monitor laboratory and diagnostic testing. Standard: Laboratory and diagnostic testing are performed according to the order; testing is based upon the resident condition and/or to monitor therapeutic blood levels for medication management. Oversight and coordination is completed by the Director of Nursing or designee .