STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001333	A. BUILDING: _____ B. WING _____	C 09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALIFORNIA TERRACE	2829 SOUTH CALIFORNIA BLVD CHICAGO, IL 60608

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S 000	Initial Comments Complaint Survey: 2387716/IL164448	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6 300.2210b)2 Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.2210 Maintenance b) Each facility shall: 2) Maintain all electrical, signaling, mechanical, water supply, heating, fire protection, and sewage disposal systems in safe, clean and functioning condition. This shall include regular inspections of these systems. These Requirements were not met as evidenced by: Based on observation, interview and record review the facility failed to follow its policy and procedures for Fall Prevention for one (R2) of three residents reviewed for falls. This failure resulted in R2 sustaining a fall resulting in fractures to the Humerus and finger of R2's left hand. Findings include: On 09/21/2023 at 2:16pm, R2 was observed sitting on her wheelchair smoking on the outside	S9999		

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S9999	Continued From page 2	S9999		

patio. R2 was observed wearing a sling on her left hand and left middle finger. R2 said she fell last Wednesday (09/13/2023), while standing up, after putting on the call light and no staff come to her assistance. R2 said her pants went down, and R8, who was her room mate come to assist her pull her pants up. R2 said as she was trying to pull her pants up, she fell. R2 said she was using her cane to support herself, but she lost her balance and fell. R2 said after she fell and shouted for help, and two staff members came to help her, then she was taken to the hospital.

On 9/21/2023 at 1:56pm during call light system observation with V8(Registered Nurse-RN) on the 1st floor by the nursing station, call light system that alerts the nurses when a resident puts their call light is on was observed to be off with the call light phone screen blank/and with broken screen.

On 9/21/2023 at 1:58pm V8 said the call light phone system is broken and does not light up, therefore nursing staff do not know when a resident call light is on, unless they round. V8 said she did not know what was wrong with the call light system. V8 further stated the call light on the ceiling above the nursing station that turns on when a resident puts the call light on is also malfunctioning and all the lights stay on, therefore it's hard for staff to know which resident room has a call light on. The call lights above the nursing station were observed to be on, with different colors showing on the light. V8 put the call light on in R2's room, call light did not light up outside the door, not ring/light up by the nursing station call light system.

On 09/21/2023 at 1:28pm, V11 (Registered Nurse/2nd floor unit manager) said the call light system has been broken since three weeks ago

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S9999	Continued From page 3 and V1 (administrator) is aware and is reminded every day. V11 said when the call light system is not functioning properly, verbal residents who need staff assistance shout for help, and staff do round every two hours. V11 said the call light by the nursing station that alerts staff when residents need help is blinking all day with a pink light, and staff do not know when the resident call light is on, unless the round. V11 said it is frustrating for staff because they cannot respond to residents in a timely manner when residents need assistance. R2 is a 57 year old individual admitted to the facility on 07/20/2023. R2's diagnosis includes but not limited to: hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, other reduced mobility, muscle wasting and atrophy, not elsewhere classified, multiple sites. R2's BIMS (Brief Interview for Mental Status) dated 8/2/2023 documents R2 has a BIMS score of 13/15, indicating R2 has intact cognition. R2's MDS(Minimum Data Set) dated 8/4/2023 documents R2 needs supervision with Bed mobility, transfer, walk in room, walk in corridor, Locomotion on/off unit, and need limited assistance with dressing, and further documents that R2 needs supervision or touching assistance with eating, Oral hygiene, Toileting hygiene: Shower/bathe self: Upper body dressing, Putting on/taking off footwear, Roll left and right, Sit to lying, Lying to sitting on side of bed, Sit to stand, Chair/bed-to-chair transfer, Toilet transfer, Walk 10 feet, Walk 50 feet with two turns. On 09/21/2023 at 2:22pm, R8 was observed on the outside patio sitting on her wheelchair smoking a cigarette. R8 said when R2 fell, she, R8 was tying to help R2 pull her pants up after	S9999		

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S9999	Continued From page 4 they fell when R2 got up from her bed. R8 said R2 said she had put the call light on and no one came to help R2. R8 said R2 fell next to the bed. R8's BIMS dated 08/14/2023, document R8 has a BIMS score of 13/15, indicating R8 has intact cognation. On 09/21/2023 at 2:34pm, R2 was observed in bed being assisted with repositioning by V30 (R2's family member). R2's bed was observed to be moving from side to side when V30 was assisting R2 to reposition. Surveyor called V13 (registered Nurse) and asked her to observe R2's bed. V13 said the bed was not not stable and was moving around, and may not be locked. V13 said R2's type of bed was new, and she did not know where the wheels of the bed are locked at. V13 looked for the bed lock and found it by the bed wheels, then V13 locked the bed. V13 said the bed is supposed to be locked for safety, so that the bed does not move when R2 getsin and out of bed, to prevent R2 from falling and hurting herself. V13 said it is every staff's responsibility to make sure residents beds are in locked potion to prevent falls. On 09/22/2023 at 10:33am, V4 (Falls Nurse-LPN) said when a resident first comes to the facility, the nurses perform the fall risk assessment, then the falls nurse/restorative nurse (V4) does the restorative assessment note and restorative program tracker, which tells what the resident is able to perform for ADLs, and assists in putting the resident in the right program for Activities of Daily Living(ADLs), and helps the facility know what therapy or assistant the resident will need with ADLs. The CNAs then carry out care based on the assessment. V4 said R2's Functional Abilities and Goals, dated Aug 4, 2023, documents R2 needs Supervision or touching	S9999		

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S9999	Continued From page 5 assistance with ADLs, where the helper provides verbal cues and/or touching/steadying and/or contact, guarding assistance as R2 completes activity. V4 further stated that assistance may be provided throughout the activity or intermittently. V4 further said R2's bed should be locked and in lowest position at all time, as a safety precaution to prevent falls. V4 said all staff know all residents fall precautions should be on beds that are locked and in lowest position when the resident is in bed. V4 said R2 uses a quad cane because her left side hand is impaired related to a stroke, and R2 wears a splint on the left arm, and was wearing it even before the fall, and she was using a quad cane for support. V4 said R2 is ambulatory but may require additional assist and support from staff. On 09/22/2023 at 11:50am, V2 (Assistant Director of Nursing-ADON) said R2 sustained a fracture on the left shoulder and finger after R2 fall on 9/13/2023. V2 said the call light system has not been working for over a week now, and maintenance has been working on it and it is still not working. V2 said if the call light system is not working, residents cannot make their needs known in a timely manner. On 09/26/2023 at 1:32pm, V14 (Director of Nursing- DON) said she was coming down the hallway when she heard R2 say she needed help. V14 said she went into R2's room and and saw R2 sitting on the floor on her buttocks, and V14 said she knew R2 had fallen, and had landed on her left side. V14 said she did Range of Motion (ROM) checks with R2 and noticed that R2 could only perform passive/limited range of motion exercises with the left hand. V14 said R2 was sent to the hospital for further evaluations,	S9999		

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S9999	Continued From page 6 and facility was later notified that R2 had suffered fractures on her left shoulder and middle finger from the fall. Records from community hospital dated 09/13/2023-09/16/2023 document: -R2 was admitted to the community hospital because she suffered a fracture to her left humeral head and left finger due to a fall, and R2 was recommended to keep her hand in a splint -Facility incident report dated 09/13/2023 documents : R2 fell on 09/13/2023 and suffered fractures to the Humerus and finger. Fall prevention policy, no date, documents: STANDARD FALL/SAFETY PRECAUTIONS FOR ALL RESIDENTS: -The bed locks will be checked to assure they are in locked position at all times. -Call lights are kept within reach and answered promptly. (B)	S9999		