

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6001333	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/15/2023
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NAME OF PROVIDER OR SUPPLIER CALIFORNIA TERRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 2829 SOUTH CALIFORNIA BLVD CHICAGO, IL 60608
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S 000	Initial Comments FRI of 7/11/2023/IL163412	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)6 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 resident to meet the total nursing and personal care needs of the resident.	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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S9999	<p>Continued From page 1</p> <p>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:</p> <p>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.</p> <p>These Requirements were not met as evidenced by:</p> <p>Based on observation, interview and record review the facility failed to follow its policy and procedures for Fall Prevention & Post Fall Assessment by a.) not providing individualized preventative fall risk measures, b.) not following fall risk care plan interventions prior to fall, c.) failed to complete new or updated fall risk assessment post fall, d.) failed to update care plan with any new fall interventions after fall incident for one (R3) out of three residents reviewed for falls. This failure resulted in R3 sustaining a fall resulting in a laceration requiring five sutures with risk for falls ongoing for lack of interventions.</p> <p>Findings include:</p> <p>R3 is a 71-year-old female, admitted to the facility 12/07/15 with diagnosis not limited to Dementia, Muscle Weakness, Reduced Mobility, Lack of Coordination, Muscle Wasting And Atrophy, Weakness, Arthritis, Peripheral Vascular Disease, Chronic Ulcer Of Other Part Of Unspecified Foot With Unspecified Severity, Osteomyelitis.</p>	S9999		
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S9999	<p>Continued From page 2</p> <p>R3's MDS (Minimum Data Set) dated 07/19/23 document R3's BIMS (Brief Interview of Mental Status) score of 14/15 indicating intact cognition. R3's Activities of Daily Living (ADLs) Assistance documents that R3 requires supervision with bed mobility, limited assistance with one-person physical assist with transfer and extensive assistance with one-person physical assist with toilet use.</p> <p>R3's MDS (Minimum Data Set) dated 07/19/23 documents that walking did not occur. Activity with balance during transitions and walking, moving on and off toilet, surface to surface transfer between bed and chair or wheelchair is not steady, and R3 is only able to stabilize with staff assistance.</p> <p>R3's care plan dated 06/25/23 documents in part R3 is at risk for falls related to co-morbidities with interventions including but not limited to staff will ensure resident has on appropriate footwear at all times (06/25/23), and to keep resident's immediate environment clutter free (06/25/23).</p> <p>On 09/13/23 at 1:16 PM, observed R3 lying in bed not in the lowest position, and R3's feet were bare. Did not observe any type of footwear nearby. R3's side table was close to R3's bed and covered in 6 cans of soda pop and papers. R3 stated that R3 does not know what caused the fall. R3 said, "they got my program mixed up with the football players program and the weights from Weight Watchers." R3 then stated "I was trying to use the bed pan. I went to stand up and didn't know I couldn't stand up. I was off balanced, and my legs twisted." R3 then stated that the football players injuries was messed up with my injuries and the fall was related to them wanting to weigh</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>me. R3 then stated, "I don't know what happened."</p> <p>On 09/13/23 at 1:20 PM, R17 (R3's Son) who is also a resident at the facility and is R3's roommate stated that R17 was lying in bed on 07/11/23 listening to music and R17 heard a loud thud when R3 fell on the floor.</p> <p>R3's progress notes dated 07/11/23, 2:45 AM and 4:25 AM by V11 (Registered Nurse) documents in part R3 was observed lying on her back near the bed while using the bed-pan in bed and sustained a moderate laceration on her forehead and R3 was transferred to the emergency room for CT scan of head and stitches related to fall.</p> <p>R3's hospital emergency room record dated 07/11/23, 3:05 AM documents in part R3 brought in with laceration to forehead after fall. (R3) states she was trying to go to the bathroom and fell hitting her forehead on floor. (R3) stated she stepped on her bed sheets causing her to slip and strike her head. (R3) has a 3 centimeter (cm) by 2 cm wound on her forehead. Radiology results of CT Head documents in part left forehead laceration with small amount of soft tissue gas and trace hematoma. R3 received five sutures in the emergency room and was discharged back to the facility.</p> <p>R3's progress note dated 07/12/23, 12:50 PM by V29 (Fall Nurse/Licensed Practical Nurse) documents in part R3 had a fall on 07/11/23 at 3:51 PM, observed lying on the floor on her back near the bed, requires limited assist x1 with transfers and care plan updated with interventions.</p> <p>R3's care plan dated 06/25/23 documents in part</p>	S9999		
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S9999	<p>Continued From page 4</p> <p>R3 is at risk for falls related to co-morbidities with the goal for R3 to have no falls with major injuries over next review period. All interventions in R3's fall risk care plan are dated 06/25/23 and include but not limited to staff will ensure resident has on appropriate footwear at all times, and to keep resident's immediate environment clutter free. There is no mention of low bed position in R3's fall risk care plan and R3's fall risk care plan has not been updated since 06/25/23.</p> <p>R3's Fall Risk Assessment dated 06/25/23 documents R3's score at 13 indicating moderate fall risk. A new or updated Fall Risk Assessment was not completed after 07/11/23 fall.</p> <p>On 09/14/23 at 11:00 AM, V22 (R3's Nurse Practitioner) stated via phone interview that R3 has diagnoses that place her at risk for falls including lack of coordination, weakness, muscle wasting and atrophy.</p> <p>On 09/13/23 at 2:18 PM, V29 stated V29 is responsible for investigating falls and updating the fall care plan. V29 stated if a fall occurs the fall would be dated and documented in the resident's care plan and new interventions would be added to the fall care plan. V29 stated that new interventions would need to be added because something would need to change since the old interventions were not effective in preventing the resident from falling. V29 stated that these new interventions would be put in the resident's care plan immediately to prevent or combat another fall from happening. V29 stated that all care plan updates are done directly on the resident's electronic health record (EHR), no paper copies are kept. V29 stated that up until an actual fall occurs there are standard interventions that are in place for everyone who is at risk for a</p>	S9999		
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S9999	Continued From page 5 fall. V29 stated that once a fall occurs then this is when V29 would then adjust or add interventions to individualize the interventions in the care plan based on the root cause analysis of the fall. V29 stated, "I don't change the standard interventions for fall risk care plan unless a resident has a fall." V29 stated that prior to R3's fall on 07/11/23 it was determined that R3 was at risk for a fall and therefore R3 had standardized fall risk care plan in place which included interventions such as having the call light within reach and the bed in the lowest position. V29 stated that all residents who are at risk for falling should have their bed in the lowest position for safety preventive measures, so if a fall does occur the resident will not be falling from a high place to a low position, there is less of a distance to fall. V29 stated that after R3 fell on 07/11/23 the intervention of using non-skid socks was added because the root cause analysis investigation determined that R3 had slipped on a sheet on the floor when R3 was using the bed pan in the middle of the night. Surveyor asked V29 to review R3's fall risk care plan and V29 acknowledged that R3's fall on 07/11/23 was not documented on R3's care plan, and interventions had not been updated since 06/25/23. V29 acknowledged that R3 did not have an intervention for R3's bed to be in the lowest position before or after the fall on 07/10/23. V29 stated having the bed in the lowest position when resident is in bed is not included in R3's care plan because it is a standard for all residents at risk for falls and that the staff knows R3's bed should be kept in the lowest position. V29 also acknowledged that care plan already had intervention that staff will ensure resident has on appropriate food wear at all times dated 06/25/23. On 09/13/23 at 3:12 PM, surveyor went to R3's room with V29 and V30 (Restorative Nurse) and	S9999		

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S9999	<p>Continued From page 6</p> <p>observed R3 lying in bed in bare feet. V30 stated that R3's bed was in the lowest position. Surveyor asked V30 to check and V30 picked up the bed controller at the foot of the bed and was able to lower R3's bed further by at least 5-6 inches until R3's bed was in the lowest position. R3 did not protest or complain about the bed being in the lowest position. V30 stated R3's bed was not in the lowest bed position when we entered R3's room but R3's bed is now in the lowest position. V30 stated R3 does not like her bed to be in the lowest position and then stated to R3 "you don't like the bed like this, right?"</p> <p>On 09/13/23 at 3:18 PM, V31 (Licensed Practical Nurse) viewed R3's fall risk care plan and stated that V31 does not see that the bed being in the low bed position is included as an intervention or that R3's fall on 07/11/23 was documented in R3's fall risk care plan or that there were any changes made to R3's interventions relate to R3's fall. V31 stated V31 would like for R3's bed to be in the lowest bed position because she is a fall risk, and she spends all her time in the bed. V31 stated if the bed is in the lowest position R3 wouldn't have as much of a distance to fall if R3 did have a fall. V31 stated V31 cannot recall trying to lower R3's bed and R3 not letting V31 lower it.</p> <p>Facility policy and procedure titled, Fall Prevention Program undated, documents in part the policy is to assure the safety of all residents in the facility and to include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary. A Fall Risk Assessment will be performed after any fall incident and care plan</p>	S9999		
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S9999	<p>Continued From page 7</p> <p>incorporates preventative measures and interventions are changed with each fall as appropriate.</p> <p>Facility policy and procedure titled, Fall Risk and Post Fall Assessment undated, documents in part the purpose it to improve quality of life for resident, conduct appropriate assessment prior to and after falls and procedure includes if fall prevention plan failed initiate an immediate new intervention, complete or update Fall Risk Assessment, revise resident care assignment according to fall risk type with new interventions, revise the care plan to include all new fall interventions. (B)</p>	S9999		
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