Illinois Department of Public Health

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 11/17/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments FRI of 9/20/2023/IL165217	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

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 11/17/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 1	S9999		

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.

These Requirements were not met as evidenced by:

Based on observations, interviews and record reviews, the facility failed to provide adequate supervision for a dementia resident (R1) who is a fall risk. This failure resulted in R1 falling in the hallway, sustaining a laceration to his forehead, requiring emergency department evaluation and receiving eight sutures.

Findings Include,

R1's clinical record documents in part: R1 is a 78-year-old with the medical diagnosis of dementia, vascular dementia, muscle weakness, history of falling, cognitive communication deficit, unsteadiness on feet, metabolic encephalopathy, dysphagia, weakness, and reduced mobility. Minimum data set [MDS] Brief Interview Mental Status Score indicates R1 is cognitively impaired.

R1's Care Plan documented in part five falls. Two falls 5/24/23 and 9/20/23 resulted in injury.

-R1 is at risk for falls due to co-morbidities:

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 11/17/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 2	S9999		

Fall 10/17/23: Resident stated, "I was getting money out the drawer for a soda", no injuries.
Intervention: Fall 10/17/23: When up out of bed, resident will be monitored in supervised common areas.

Fall 09/20/23 observed lying face down in hallway, facial laceration Rt Forehead
Intervention: Fall 09/20/23: wear safety helmet at all times

Fall 06/19/23 observed sitting on floor near bathroom door, no injuries. S/P Fall res observed sitting on bathroom floor, no injuries.
Intervention: Refer to Therapy for screen and treat

Fall of 05/24/23 resident stated, "I was going to restroom and lost my balance", laceration to Lt hand 4th digit.
Intervention: Ensure proper footwear
5/24/2023 06:57-Health Status/Progress Note
Note Text: Resident return from hospital. R1's left hand 4th digit 3 sutures intact no bleeding noted to site.

Fall of 01/02/23 res stated," I fell trying to go to the bathroom", no injuries. S/P Fall 01/14/23 observed sitting on buttocks in front of bed (laceration to forehead
Intervention: Offered and placed Urinal at bedside.

R1's Progress notes documented in part:

On 9/20/2023 11:00- Nursing Progress Note
Note Text: Writer heard loud noise in hallway noted R1 lying face down. Noted swelling of nose open area to forehead moderate amount of blood noted ice pack applied with pressure dressing.

Illinois Department of Public Health

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 11/17/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 3	S9999		

On 9/20/2023 23:34-Health Status/Progress Note

Note Text: Received a call from hospital stated that all CT scans to cervical spine, facial bones, and head/brain read negative.

On 9/20/2023 22:25-Health Status/Progress Note

Note Text: R1 returned to the facility from Hospital alert and oriented x1. R1 Returned with approximately 6-7 sutures noted to laceration on face.

On 11/15/23 at 11:02 AM, surveyor and V9 [Licensed Practical Nurse] observed R1 was resting in bed without his soft helmet in place. V9 stated, "R1 always needs his soft helmet on, even when in bed, to prevent a head injury incase R1 falls. I last saw R1 around 9:30 AM."
[Surveyor observed V9 look for R1's helmet for several minutes. V9 located R1's helmet underneath R1's bed, near the foot of the bed.]

On 11/15/23 at 12:42 PM, V17 [Certified Nurse Assistant] stated, "I been working with R1 for months. R1 is alert only to himself. R1 need complete assistance with ADL care. R1 needs to be spoon fed one to one. R1 tries to stand up out his bed or wheelchair often, R1 constantly needs supervision. R1 is supposed to always wear his soft helmet even while in bed. I placed on R1's helmet this morning, but I'm not sure why it was off around 11:00 AM."

On 11/15/23 at 11:53 AM, V9 stated, "I was R1's nurse on 9/20/23, the day R1 feel and sustained a laceration to his forehead. I was at the nursing station and heard a loud noise. I observed R1 laying in the hallway, bleeding from his forehead.

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 11/17/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 4	S9999		

I applied a pressure dressing and called 911. R1 received several sutures and returned back to the facility. R1 is alert to himself only and needs constant supervision because he is very impulsive. R1 will stand up and start to walk and needs verbal queuing and redirection."

On 11/16/23 at 11:44 AM, V2 [Director of Nursing] stated, "R1 is confused and impulsive. R1 uses a wheelchair to ambulate the unit. R1 needs supervision, frequent queuing, extensive assist with all areas of care, and one to one feeding. On 9/20/23, R1 was observed on the floor in the hallway. The nurse controlled R1's head bleeding. R1 returned with several sutures to forehead. Intervention was to wear the soft helmet at all times. R1 should wear the helmet at all times to prevent further head injuries from occurring.

Policy documents in part:
Fall Prevention and Management Policy
- Facility is committed to providing a safe and secure environment for residents, staff, and visitors.
-. Individualized fall prevention care plans will be developed based on the resident's risk assessment.
- The fall prevention care plan will be communicated to all staff members involved in the resident's care
- The environment will be routinely assessed for potential hazards, and necessary modifications will be made promptly.
- All staff members will receive regular training on fall prevention strategies, resident-specific care plans, and the proper use of assistive devices
- Ongoing Monitoring:
a. Staff will continually monitor residents for signs of increased fall risk and report changes promptly.

Illinois Department of Public Health

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 11/17/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 5 - Communication among staff members, including handoffs during shifts, will emphasize fall prevention strategies. (B)	S9999		