

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6001333</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/17/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CALIFORNIA TERRACE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2829 SOUTH CALIFORNIA BLVD CHICAGO, IL 60608</b>
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S 000	Initial Comments  Complaint Investigation: 23810620/IL168022	S 000		
S9999	Final Observations  Statement of Licensure Violation  300.610a) 300.1210a) 300.1210b) 300.1210c) 300.1210d)6) 300.1220b)2)3)  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  a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that	S9999		

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

Electronically Signed

TITLE

(X6) DATE

01/31/24

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S9999	<p>Continued From page 1</p> <p>includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)</p> <p>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. Restorative measures shall include, at a minimum, the following procedures:</p> <p>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.</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>	S9999		
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S9999	<p>Continued From page 2</p> <p>Section 300.1220 Supervision of Nursing Services</p> <p>b) The DON shall supervise and oversee the nursing services of the facility, including:</p> <p>2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.</p> <p>3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.</p> <p>This is not met as evidence by:</p> <p>Based on observation, interview and record review, the facility failed to supervise a resident and provide individualized fall prevention interventions, for a cognitively impaired resident, who had four repeated falls. This failure affected one resident (R1) of three residents, reviewed for falls. As a result, R1 was sent to the hospital</p>	S9999		
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S9999	<p>Continued From page 3</p> <p>three times within seven weeks. The last fall incident of R1 resulted in an open fracture of the nasal bone.</p> <p>Findings include:</p> <p>R1's Hospital Records written by V20 (Emergency Room Physician), dated 12/13/23 at 11:44am documented on page 83 "Patient was seen one day ago for concerns of a mechanical fall and had findings for an open fracture of the nasal bones, and was discharged with Augmentin for 7 days."</p> <p>On 1/10/24 at 11:02am, R1 was observed in the dining room sitting in a wheelchair that was not locked, with oxygen nasal cannula prongs on the head, and moving the wheelchair slightly forward and backward. V6 (RN/Registered Nurse/Restorative Nurse) was asked about R1's portable oxygen tank and V6 came to the dining room and put a new portable oxygen tank. At this time, V6 also locked R1's wheelchair, stating that the wheelchair should be locked.</p> <p>On 1/11/24, the following were observed on the fourth floor: At 9:53am, R1 was observed in the wheelchair in the dining room with eight other residents; no staff was present in the dining room to supervise all 9 residents. The surveyor stayed in the dining room for about 10 minutes and then went to the nursing station and asked V15 (RN/Registered Nurse) about who was supposed to be watching the residents in the dining room. V15 stated "No one is watching them right now; I will have to call down to see what time Activities will get here." V15 made a phone call and then stated, "Someone will come soon." Inquired from V15 what time the activities staff is supposed to get here to watch the residents. V15 stated</p>	S9999		
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S9999	<p>Continued From page 4</p> <p>"Activity gets here sometimes at 10am, depending on who." At 10:02am, V6 (RN) also was at the nursing station, and the surveyor asked V6 about who was supposed to watch the residents in the dining room; V6 stated "I'm not working up here today, I don't know when someone will be available, you can talk to the nurses working here." At 10:22am, V16 (Psychosocial Director) came into the dining room and stated, "I will stay here and watch the residents". At 10:19am, V7 (CNA/Certified Nurse Assistant) who is the assigned CNA for R1, was asked about how many of her assigned residents still needed to be cleaned; V7 stated "I have a total of five residents to get up; So far, I have done three residents. I did not get (R1) up, the night shift usually gets him (R1) up." At 10:25am, the surveyor left the dining room with V16 watching the residents (including R1) in the dining room, no Activity Staff arrived on the floor yet.</p> <p>On 1/10/24 at 12:40PM, V2(Director of Nursing) presented the facility's incident reports of R1's fall events dated as follows: 10/21/23 - R1 had an unobserved fall in the room with no injury. 10/26/23 - R1 observed on the floor in the dining room; R1 was sent to the hospital by ambulance. 12/11/23 - R1 fell and hit his head in the dining room and was sent to the hospital by ambulance. 12/12/23 - R1 fell and hit his head in the dining room and was sent to the hospital by ambulance.</p> <p>On 1/10/24 at 12:30pm, V4 (Fall Nurse/LPN/Licensed Practical Nurse) was interviewed about R1's fall prevention interventions. V4 stated that R1 is a high risk for falls because he thinks he can get up by himself and he is weak and has Dementia. V4 added,</p>	S9999		
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S9999	<p>Continued From page 5</p> <p>"We have interventions in place, to make sure he stays in a supervised area when awake, and to monitor him."</p> <p>R1's records reviewed include but are not limited to the following: Face sheet shows that admission diagnoses include but are not limited to Weakness, Multiple Sclerosis, Reduced Mobility, Dementia, And Disorganized Schizophrenia. Fall Risk Review forms dated 12/12/23 and 12/29/23 both show that R1 is at risk for falls. MDS (Minimum Data Set) section GG shows that R1 requires moderate assistance for functional ability activities and transfers. MDS section C dated 10/1/23 shows BIMS (Basic Interview for Mental Status) score of 4 out of 15(severe cognitive impairment). Care plan Intervention dated 12/4/23 states: "Staff will encourage participation in activities when up in chair in dining room." Care plan Intervention dated 12/12/23 states: "Observe frequently and place in supervised area when out of bed." Care plan Intervention dated 12/4/23 states: "Gather information on past falls and attempt to determine the root cause of the fall(s). Anticipate and intervene to prevent recurrence."</p> <p>R1's progress notes dated as follows documents: On 10/21/23 at 10:41am, V13 (LPN/Licensed Practical Nurse) wrote in part: "Writer called by CNA to resident's room, resident noted on floor next to wheelchair. Resident denied hitting head and stated he slipped. Resident assessed head to toe no injuries noted, resident denies any pain/discomfort." On 10/26/23 at 12:11pm, V13 (LPN) documented in part: "Writer's attention called to the dining parlor, resident observed on the floor lying on</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>back. Resident stated he was going to the other spot. Head to toe assessment done, no noted injuries/bruising at the time, able to perform from upper and lower extremities at baseline. NP (Nurse Practitioner) in facility, order given to send to the Hospital."</p> <p>On 12/11/23 at 12:14pm, V13 documented in part: "Writer's attention was called to the dining room, resident lying flat on back with nonskid footwear on. Resident stated I was getting up. Head to toe assessment done, resident hit his head but denies any pain, no swelling or bruising noted at this time. (Ambulance contacted for transportation to the hospital)."</p> <p>On 12/12/23 at 5:47pm, V14 (LPN) wrote: "Writer was called to dining room. Upon entering, writer observed resident on floor lying on his side next to his wheelchair. Staff assisted with transfer. Tolerated transfer well. Resident noted A&amp;Ox1 (Alert and Oriented times 1). Head to toe assessment performed. Writer noted light bleeding to nose, top lip, and mouth. Vital signs obtained. Team Health phoned and spoke with NP with orders to transfer resident to the Hospital for further evaluation."</p> <p>On 12/13/23 at 1:36am, V21 (RN) documented in part: "Resident returned to facility from ER (Emergency Room) with a diagnosis of Open Fracture of Nasal Bone."</p> <p>On 1/11/24 at 10:30am, V13 (LPN) was interviewed regarding how R1's falls happened during three out of four incidents that V13 was R1's nurse. V13 stated that she (V13) was R1's nurse when the falls dated 10/21/23, 10/26/23, and 12/11/23 happened. V13 explained that activity staff was present in the parlor (dining room) when R1 fell on 10/26/23, but the staff could not catch R1 in time to prevent the fall, and it was lunch time. V13 stated "I cannot remember</p>	S9999		
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S9999	<p>Continued From page 7</p> <p>the staff, but I remember someone was there with the residents in the dining room when it happened. For the fall of 12/11/23, I don't remember if staff was present during the fall of 12/11/23, because staff were all passing trays at that time."</p> <p>On 1/11/24 at 10:34am, V17 (Activity Director) was interviewed and stated "It is the responsibility of nursing to watch the residents in the dining room. Activity staff usually gets to the day room at 10:00 AM, but this staff has a day-off today."</p> <p>On 1/11/24 at 12:01pm, V2 (Director of Nursing) was asked why there was no staff watching residents in the dining room on the 4th floor (a total of nine residents sitting there without supervision). V2 stated "Formal activity programs starts at 10am, but activity staff is supposed to be on the units before then, during breakfast and after breakfast. It's not okay to have residents in the dining room without any staff watching them. It's for safety reasons; there should be someone in there."</p> <p>On 1/11/23 at 1:52pm, V19 (NP/Nurse Practitioner) was interviewed regarding R1's frequent falls and why the nursing staff should follow the care plan for fall prevention, especially for a resident like R1 whose fourth fall resulted in a fracture. V19 stated the reason for a fall care plan is to help reduce the incidents of falls for residents, and the interventions stated in the care plan should be followed. V19 added that residents at risk for falls should be supervised more closely by staff. Regarding R1's last fall incident that involved hospitalization and a nasal fracture, V19 stated that the ENT (Ear, Nose, and Throat) doctor saw R1 in the hospital and there is no need for surgery on R1's nose. V19 added that</p>	S9999		
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S9999	<p>Continued From page 8</p> <p>nasal fractures usually heal within 6-8 weeks.</p> <p>On 1/16/2024, at 9:50am, R1 was observed in a different room closer to the nursing station. Inquired from V15(RN) why R1's room was changed; V15 stated "After you left that day, we moved him (R1) to room 429, closer to the nursing station, so we can keep a closer eye on him."</p> <p>On 1/16/24 at 10:32am, V4 (Fall Nurse) stated "I spoke to the nurses on the fourth floor about the fall prevention interventions for (R1) and that was when they decided to move him closer to the nursing station because his room was all the way at the back."</p> <p>Facility's Fall Prevention Program dated 2/28/14 states: "It is the policy of this facility to have a fall prevention program to ensure the safety of all residents in the facility when possible. The program will 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. #3 states: Safety interventions will be implemented for each resident identified at risk using a standard protocol."</p> <p>Facility's document "CNA Job Description" states in part: "Ensure that residents who are unable to call for help are checked frequently. Check each resident routinely to ensure that his/her personal needs are being met in accordance with his/her wishes."</p> <p>(A)</p>	S9999		