

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0055749		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/25/2026	
NAME OF PROVIDER OR SUPPLIER THE TERRACE				STREET ADDRESS, CITY, STATE, ZIP CODE 1615 SUNSET AVENUE , WAUKEGAN, Illinois, 60087			
(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) COMPLETION DATE	
S0000	Initial Comments		S0000			03/30/2026	
	Annual Licensure Survey						
S9999	Final Observations		S9999			03/30/2026	
	Statement of Licensure Violations						
	1 of 2						
	300.610a)						
	300.1210b)						
	300.1210d)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						
	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.						
	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:						

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. These requirements were not met as evidenced by: Based on interview and record review the facility failed to ensure a resident received a higher level of care for a resident experiencing respiratory distress. This delay in medical intervention resulted in R77's death. This applies to 1 of 21 residents (R77) reviewed for care and services in the sample of 21. R77's electronic face sheet shows R77 has diagnoses that include, Chronic Obstructive Pulmonary Diseases, (COPD), Congestive Heart Failure, vascular dementia and diabetes. R77's Physician Order Sheet (POS) dated 1/2026 shows R77 has an order of Oxygen 2Liters (L) per minute, titrate to 3-4L as needed every shift, for Parameters of oxygen (O2) saturation. Notify Physician of O2 Sats (saturation level of blood oxygen) below 92%. R77's death certificate shows R77's cause of death was acute respiratory failure on 1/2/26. On 2/25/26 at 10:20 AM, V23 (Certified Nursing Assistant-CNA) said she was R77's CNA on 1/2/26 working from 11PM to 7AM. V23 (CNA) said at around 3 AM, R77 was in her doorway, gasping for air, calling out, "please help, I cannot breathe call the Nurse." V23 said she hurriedly called the nurse (V20). The Nurse (V20) checked R77's oxygen level and said it was low and applied R77's oxygen. Throughout the shift, R77 continued to complain of not being able to breathe. R77 stayed in her wheelchair, by her doorway, not visible in the hallway but could be seen when passing in her room. At around 4:30 AM-5AM, R77 was in her chair unresponsive. 911 was called, Cardiopulmonary Resuscitation (CPR) was done R77 passed away that same morning. On 2/24/26 at 11:30 AM, V20 (Registered Nurse-RN) said she was the nurse on duty on 1/2/26. V20 (RN) said at around 3AM, V23 (CNA) informed her that R77 was complaining she could not breathe. V20 said she went to check on R77, R77 was struggling to breathe. R77 was not keeping her oxygen on, she kept taking her oxygen off, she was very anxious. R77's oxygen saturation was very low, in the 60's. V20 said she increased R77's			S9999			

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S9999	Continued from page 2 oxygen from 2L to 4L and R77's oxygen saturation went up. V20 said she called V2 (Director of Nursing-DON) who instructed her to put on a nonrebreather mask and to make sure R77's O2 sats were in the 90's. V20 said R77 continued to struggle to breathe, complaining she could not breathe. V20 said R77 was monitored and reminded to keep her oxygen on. V20 said she did not notify R77's Physician regarding R77 experiencing respiratory distress with low oxygen saturation in the 60's and continued complaints of not being able to breathe, she only notified V2 (DON). At around 5AM, R77 became unresponsive. R77 was full code, CPR was done and 911 was called. V20 said R77 died that morning. V20 said she notified R77's physician and family after R77 passed away. On 2/24/25 at 12:13 PM V2 Director of Nursing (DON) said V20 (RN) notified her regarding R77 having respiratory distress and that R77 won't keep her O2 on. V2 (DON) said she instructed V20 to apply a non-rebreather mask and get R77's oxygen saturation up. V2 said she also instructed V20 to notify R77's physician regarding R77's significant change in condition or send R77 out to the hospital. V2 said she did not know why V20 did not notify R77's Physician at that time for timely evaluation and medical treatment. V2 stated "we call the doctor for everything, the physician can assess the severity or decide to transfer resident to the hospital, not sure why she only notified me and did not inform R77's physician." On 2/24/25 at 12:07 PM, V21 (Nurse Practitioner-NP) said R77 was young in her late 60's with COPD and oxygen dependent. V21 (NP) said she was at the facility early in the morning on 1/2/26 making rounds when R77 coded. V21 said she helped with the CPR. R77 was pronounced dead by the paramedics. V21 said she was the NP for R77 but did not get a call regarding her condition change. V21 stated "If I was notified, I would have sent R77 out to the hospital to make sure R77 received the level of care without delay. Breathing problems can worsen fast and lead to respiratory failure." R77's progress notes dated 1/2/26 by V20 (RN) show that at 3:15 AM, R77 was found in her room doorway saying she was having trouble breathing, R77 has taken her oxygen off. (V20) gave R77 nonrebreather mask and checked oxygen saturation level (O2 sats), reading very low at 60 percent (%). RN (V20) did deep breathing exercises, turned oxygen up to 4 Liters via nasal cannula (NC), R77's O2 sats went up to 90 %. Oxygen gradually decreased to 2L. R77 was assisted to bed and reminded the importance of keeping her oxygen on.		S9999				

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S9999	Continued from page 3 R77's progress notes dated 1/2/26 shows that at around 4:30 AM, R77 was still breathing heavy and continues to show signs of air hunger. R77 was placed on non-rebreather mask, O2 sats level at 92 %. R77 continues to remove oxygen saying that she can't breathe, V20 (RN) informed R77 the importance of wearing mask including the risk of death. The DON was notified. R77's progress dated 1/2/6 shows that at around 5:30 AM, R77 was seen bent over in wheelchair, attempted to arouse R77 by yelling her name, doing sternal rub and shaking R77, - no response, no pulse felt, R77 removed from wheelchair, CPR immediately initiated, 911 was notified. 911 arrived and took over CPR. R77 was pronounced dead. R77's family and coroner were notified. Coroner gave permission to release the resident's body. The Facility Policy on Change in Condition (Your role as a Nurse-undated) shows, residents have especially high risk for developing acute conditions because they already have chronic diseases that make them susceptible to acute conditions. Do an assessment of the residents focusing on the area of change. All changes of condition should have full set of vitals. Respiratory: listen to lung sounds, pulse ox, respiratory rate, if resident has oxygen are they using? new or worsening cough. Call the Physician or Nurse Practitioner with the assessment. Practice: A resident complains of Shortness of breath, what would you evaluate? -Vital sign, including pulse ox (oxygen saturation) listen to the lungs, assess for swelling, if resident has an order for O2, apply as ordered. Call the physician or nurse practitioner with the assessment. AA 2 of 2 300.1210a) 300.1210b) 300.1210d)5) 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			S9999			

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S9999	Continued from page 4 and implement a comprehensive care plan for each resident that 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) 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. 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: 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. These requirements were not met as evidenced by: Based on observation, interview and record review the facility failed to identify and assess a pressure ulcer prior to developing a new unstageable pressure ulcer and failed to implement pressure relieving interventions for a resident at risk for developing pressure ulcers. This failure resulted in R59 developing an unstageable pressure ulcer to her right ischium. This applies to 1 of 6 residents (R59) in the sample of 21 reviewed for pressure injuries. The findings include: R59's face sheet shows she has diagnoses including type 2 diabetes, unspecified dementia, hypertensive heart		S9999				

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S9999	Continued from page 5 disease, dysphagia and bilateral hearing loss. On 2/22/26 at 9:51 AM, V10 (Licensed Practical Nurse-LPN) said R59 has an open area to her right buttock with a foam dressing. On 2/22/26 at 1:36 PM, R59 was sitting in her reclining wheelchair with no pressure relieving cushion. R59 was thin and underweight. She was yelling out, help me, help me. V10 and V23 (Certified Nursing Assistant) transferred her with the mechanical lift to her bed and provided incontinence care. A foam dressing was in place to her right buttock. V10 and V23 then transferred R59 back into her recliner chair without a cushion in place. On 2/23/26 at 12:17 PM, V10 (LPN) said R59 is dependent on staff for most cares and has a pressure ulcer to her right buttock, the wound physician is following her wound. We notify the new wounds to V2 (DON/Director of Nursing), V4 (Wound Nurse) and family. The wound is assessed, and treatment orders are put in place. On 2/24/26 at 9:25 AM, V4 (Wound Nurse) said R59 is a high risk for developing pressure ulcers and confirmed she did not have pressure relieving interventions in place prior to developing a pressure ulcer. V4 said she was not aware of R59's open area. She said R59's bottom was red over the weekend, and she had an order for foam dressing and barrier cream. New wounds should be assessed and treatment orders followed. R59's progress note dated 2/13/26 documents wound on right mid buttock with foam dressing in place, weight 96 lb. (pounds). R59's Wound Progress Note dated 2/23/26 shows unstageable (due to necrosis) of the right ischium measuring 2.4 cm (centimeters) x 0.8 cm x 0.2 cm; heavy serous exudate, 80% necrotic tissue. R59's Braden Scale dated 12/17/25 shows she is at risk for developing pressure. R59's current care plan shows she was at risk for skin impairment with no pressure relieving interventions implemented prior to 2/23/26. (B)		S9999				