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 06/09/2023

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CALIFORNIA TERRACE	2829 SOUTH CALIFORNIA BLVD CHICAGO, IL 60608

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S 000	Initial Comments FRI of 4/30/2023/IL160286, FRI of 4/3/2023/IL160288, FRI of 5/19/23/IL604468 & FRI of 5/24/23/IL160284	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	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. These Requirements were not met as evidenced by: Based on observation, interview, and review of records, facility failed to protect residents right to be free from accidents, falls, hazards, and injuries for 4 out of 4 residents (R1, R2, R3 and R4) for a total sample of 4 residents reviewed for accidents and hazards. Failures are as follows: Failed to follow safety resident policy for 1 resident (R4) that needs assistance on transfers and ambulation with multiple falls. Failed to review equipment (rollator/walker) after the fall involving the same equipment (walker/rollator) for 1 resident (R2). Failed to follow policy to review care plan after fall incident and to provide applicable interventions to prevent recurrent of fall for 2 residents (R3 and R1) with multiple falls. These failures resulted to 1 resident (R4) had 2 separate falls with injuries. Resident (R4) sustained forehead laceration with 10 stiches and left 4th digit laceration with 3 stiches for 2 separate incidents of fall. Another resident (R2) sustaining laceration of right lower leg with	S9999		

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stitches. Resident (R2) also sustained long abrasions on her back for subsequent fall. And failure to review care plans for 2 residents (R1 and R3) that have subsequent falls and have the potential for recurrent of similar incidents when identified hazards were not addressed.

Findings include:

R4 was initially admitted on 5/2/2020, MDS 4/7/2023 BIMS scored 6 which means R4 has impaired cognition; bed mobility, transfers, and ambulation supervision with set up, toileting requires 1-person extensive assist.

R4's falls are as follows:

Dated 1/2/2023 notes by V7 (Licensed Practical Nurse), R4 right side lying in his room.

Dated 1/14/2023 notes by V4 (Licensed Practical Nurse) and V9 (Licensed Practical Nurse), R4 sustained frontal/forehead laceration wound with 10 sutures.

Dated 5/24/2023 notes by V4 (Licensed Practical Nurse), R4 sustained left 4th digit finger laceration bleeding with sutures.

Dated 1/14/2023 notes by V4 (Licensed Practical Nurse) and V9 (Licensed Practical Nurse), R4 sustained frontal/forehead laceration wound with 10 sutures.

On 6/6/2023 at 1:20 PM. R4 was seen on his bed alert and answers, left hand 4th finger with sutures. R4 was alert and able to answer questions related to topic. R4 was seen not able to move with ease on the bed. R4 was asked if

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staff are helping him with getting up and walking? R4 said, " No. " R4 was asked if he needs help to get up and while walking? R4 said, " No. " R4 was asked if he had a recent fall? R4 said, " Yes. " R4 was asked if he was assisted when he fell? R4 said, " No. " Then again R4 was asked if he needs help when getting up and while walking? R4 said, " Yes. " R4 was seen unsteady and weak when moving on his bed. V5 (Registered Nurse) said, " R4 can do it on his own, but I don ' t think it is safe. R4 is unsteady. "

On 6/7/2023 at 10:26 AM. V2 (Director of Nursing) was asked how nursing staff regarded R4 ' s ADL (Activity of Daily Living) ability? V2 said, " R4 can get up on his own and can ambulate by himself. But I am not sure if he uses walker. " At 11:25 AM. At the floor V7 (Licensed Practical Nurse) stated, that R4 is ambulatory and able to get up without assistance. Upon entering the room R4 was on the bed on his back. The bed was in a low position. V7 asked R4 multiple times to get up but R4 was very slow and weak to respond. V7 elevated the head of the bed to 90 degrees making R4 sit in upright position. R4 still was not able to get up, extended his right arm for V7 to pull and helped R4 sitting on the edge of the bed. V7 instructed R4 multiple times to get up and stand. R4 tried multiple times (5 times) but every time R4 pushes himself up, R4 sat back down. V7 said, "There are days that R4 is like this, there are better days." At 12:59 AM. V10 (Restorative Nurse) said, "R4 needs help with transfer, it will be limited assistance. If R4 cannot get up with 5 tries, then it is not safe for R4 to get up without assistance or supervision only." R4 was not able to get up and ambulate. At 1:20 PM. V11 (Fall Nurse/Licensed Practical Nurse) said, "R4 sometimes can get up by himself and sometimes he cannot. But it is true, resident

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should be assessed and provided care that is safer. Between supervision and assistance, R4 is safer with assistance. I made a mistake on my notes that R4 needs supervision only. Even after the fall I noted that R4 needs supervision. The staff on the floor needs to be instructed that R4 needs assistance. And level of care of R4 ' s ADL needs to be corrected. Yes, R4 had multiple falls with injuries, and we cannot let him fall again. I need to make changes so that R4 will be given assistance. I am not sure why interventions for R4's fall dated 1/2/2023 and 1/12/2023 shows that I created those interventions on 2/14/2023 but I thought I did it right after the fall. Care plan must be updated as needed or right after the fall. It is important to have interventions to prevent further falls."

On 6/8/2023 at 12:42 PM. R4's bed was elevated around 2 feet from the ground and not in a low position as found prior for 2 consecutive days. V14 (Registered Nurse) was asked if there was changes on R4 ' s approach in preventing falls. V4 said, " I am not familiar with residents on this floor. First floor is my regular floor assignment, And I am not sure if R4 bed needs to be in a low position. "

After R4 ' s 3 falls, with 2 falls with injuries. V11 notes documents as follows:
Dated 1/4/2023 related to fall incident 1/2/2023, dated 1/16/2023 for fall incident 1/14/2023, and 5/24/2023 for fall incident 5/24/2023, V11 documents on all 3 notes that R4 only needs supervision with transfers.

MDS assessment of V11 dated 4/7/2023 under functional status (Section G) documents also that R4 only needs set up with supervision on transfers and bed mobility.

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R2 was initially admitted on 5/6/2020, MDS dated 4/6/2023, BIMS scored 13 which means cognition was intact with moderate impairment; bed mobility, transfers, toileting, and ambulation are all supervision.

R2's falls are as follows:

Dated 9/1/2022 notes by V5 (Registered Nurse), fell on the hallway barefoot.

Dated 4/30/2023 notes by V6 (Registered Nurse), R2 sustained hematoma to right calf with large laceration.

Dated 5/26/2023 notes by V8 (Licensed Practical Nurse), R2 sustained 2 long abrasions at the back.

On 6/6/2023 at 1:11 PM. R2 was seen in her room. R2 was alert and verbally able to express her thoughts within topic. R2 was seen with dressing on right lower around 14 to 16 inches in length. R2 said, " An operation was done (pointing at her right lower leg dressing) because I fell on a wire that was in the middle of the way. I have a broken and not stable wheelchair that is why I fell. I was given a new wheelchair a few couple of weeks ago when I came back. " At 1:21 PM with V5 (Registered Nurse) help raised R2 ' s shirt on her back showing 2 long discoloration of a healing abrasions located mid-right of R2 ' s back. V5 said, " R2 ' s old walker was colored blue but was replaced when family member of R2 brought a new walker. And was not sure if the old walker was stable. But since R2 is oriented and able to express her thoughts well. R2 can tell what happened. "

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On 6/7/2023 at 10:26 AM. V2 (Director of Nursing) was asked about the walker R2 was using during fall dated 4/30/2023. V2 said, " It was a rollator/walker because it has wheels. And the difference between regular walker and the rollator/walker is that a resident can use to sit on it. Yesterday, we located it, and I don ' t know if it was defective or not. But as to the fall on 5/26/2023, I was not aware that R2 ' s sustained abrasions on her back. I will check on it. " V2 was requested to see the rollator/walker which V2 agreed. V2 went to Restorative Office to look for V10 (Restorative Nurse). V2 said that V10 as the restorative nurse can help locate the walker. At 11:01 AM V10 said that they tried to locate the old walker but was not able to locate it. From V10 ' s office to basement area that goes out to exit the facility. V10 said, " We cannot find R2's blue walker. We tried to find it yesterday but cannot find it. This is the place where we put things that are not used and not good to use. We may have thrown it out if it is not good to use. "

On 6/8/2023 at 10:24 AM V11 (Restorative Nurse) " R2 had a fall on 4/30/2023 that resulted to laceration on her leg. No, R2 ' s rollator/walker was not checked after the fall because I focused on to minimize clutter on R2 ' s room. " Pointed out to V11 that on facility ' s final report it was documented that the fall of R2 on 4/30/2023 were R2 sustained laceration on right lower leg was due to R2 ' s failure to lock brakes on rollator prior to attempting to sit which led to the fall. V11 said, " I did not know that, but I understand that rollator/walker should have been checked. R4 fell again I think because of not locking her rollator/walker. "

R3 was initially admitted on 4/18/2020, MDS

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dated 4/22/2023 BIMS scored 0 which means R3 is rarely or never understood; bed mobility 1-person extensive assist, transfers 2-persons extensive assist, toileting 1-person total assist, non-ambulatory, and locomotion 1-person extensive assist.

R3's Falls are as follows:

Dated 12/3/2022 notes by V13 (Licensed Practical Nurse) R3 slip out of the chair.

Dated 4/17/2023 notes by V6 (Registered Nurse), R3 fell on left side of his bed.

Dated 5/19/2023 notes by V5 (Registered Nurse), R3 sustained a wound above left eyebrow.

On 6/6/2023 at 1:32 PM. R3 was on a Geri chair with V15 (Certified Nursing Assistant) feeding R3 at the dining room. R3 was not responsive to conversation. R3 was seen with small (around 0.5 centimeter) closed wound with sutures.

On 6/8/2023 at 10:24 AM V11 (Fall Nurse / Licensed Practical Nurse) " I cannot find R3 ' s care plan for 12/3/2022 after the fall. For the fall on 5/19/2023, since R3 fell inside his room, it could have been avoided if R3 was placed on a common area where staff can monitor R3. If staff placed R3 in his room to perform ADL (Activity for Daily Living) then that staff needs to stay with R3. And do not leave R3 because he is at risk for falls." At 12:42 PM. V5 (Registered Nurse) said, " When R3 fall last month (5/19/2023) as I remember it correctly, R3 was inside his room. Yes, R3 was by himself. Yes, R3 was not place on a common area. I did not know that R3 has multiple falls prior that his fall last month. I think V16 (Certified Nursing Assistant) transferred R3

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from bed to Geri chair. " V16 said, " Yes, it was around breakfast time we are passing trays. I transferred R3 from bed to his Geri chair. I was not aware that R3 has multiple falls in the past. I left R3 inside his room then after maybe around an hour R3 fell. "

R1 was initially admitted on 6/20/2022, MDS dated 4/4/2023 BIMS scored 0 which means cognitively impaired. For bed mobility and transfers, R1 requires 2-persons extensive assist; Toileting 1-person extensive assist. R1 is non-ambulatory and uses wheelchair.

R1's falls are as follows:

Dated 12/19/2022 notes by V8 (Licensed Practical Nurse) R1 fell and sustained hematoma on right side of head.

Dated 2/16/2023 notes by V6 (Registered Nurse) R1 fell by bathroom doorknob.

Dated 4/30/2023 notes by V3 (Licensed Practical Nurse) sustained occipital subdural hematoma and subdural hematoma with back of the head wound with stitches. R1 undergone repaired laceration to the back head.

Dated 5/10/2023 notes by V4 (Licensed Practical Nurse) R1 trying to go to restroom.

On 6/6/2023 at 1:44 PM. R1 was seen with blue helmet on, sitting on his wheelchair. R1 was alert but does not respond to conversation within topic when asked. R4 was seen with healed wound at the lower back of his head.

On 6/8/2023 at 10:24 AM. V11 (Fall Nurse /

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S9999	Continued From page 9 Licensed Practical Nurse) after review of R1 ' s care plan said, "There is no care plan for R1 fall on 12/19/2022, (R1 sustained hematoma on his right side of head), care plan is scheduled to be reviewed or modified quarterly and as needed. There should be an intervention placed on 12/19/2022 after the fall to prevent another fall. On the fall incident dated 4/30/2023 helmet was added in the care plan to protect R1 from another injury in case of another fall. And I also place an intervention to put R1 in common area for staff to monitor. And on fall dated 5/10/2023 laboratory works were added, to rule out confusion due to possible UTI (Urinary Tract Infection). Yes, besides that, there is no other intervention added. The problem was during nighttime when R1 is on bed and cannot be placed in common area where staff can monitor R1. There needs to be intervention to monitor during nighttime because there are falls that occurred during nighttime. " Per progress notes dated 5/10/2023 V4 (Licensed Practical Nurse), R1 fell at 1:55 AM and was made known when R1 ' s roommate yelled out. MDS assessment of V11 dated 4/7/2023 under functional status (Section G) documents also that R4 only needs set up with supervision on transfers and bed mobility. Fall Management policy dated 2/2023 as revised, in part reads all resident falls shall be reviewed, and the resident's existing plan of care shall be evaluated and modified as needed. (B)	S9999		