STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009948	A. BUILDING: _____ B. WING _____	C 07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CITY VIEW MULTICARE CENTER	5825 WEST CERMAK ROAD CICERO, IL 60804

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S 000	Initial Comments Complaint Investigations: -1893866/IL03397 -1893991/IL03525 -1894221/IL03778: F684 cited. -1894270/IL03829: F580, F600, F608, F609 cited.	S 000		
S9999	Final Observations STATEMENT OF LICENSURE VIOLATIONS: 300.610Aa) 300.1210b) 300.1210d)6) 300.3240a) 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	S9999	Attachment A Statement of Licensure Violations	

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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:
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.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

THESE REQUIREMENTS WERE NOT MET AS EVIDENCED BY:

Based on interview and record review, the facility is to ensure that a resident identified at risk for abuse was free from physical trauma from an injury of unknown origin for one of four residents

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S9999	Continued From page 2 (R9) reviewed for abuse in the sample of 14. This failure resulted in R9 sustaining bilateral peri-orbital hematomas (two black eyes), a laceration to the left side of face; a non-displaced, comminuted zygomatic fracture (fractured cheek bone) and a traumatic, subarachnoid hemorrhage (bleeding in the space between the brain and the tissue covering the brain). Findings include: Review of R9's medical record (Progress Notes) documents: "6:06 PM: Writer is called by the CNA (Certified Nursing Assistant) to come and see; upon entering resident('s) room resident is observed in bed face up bleeding from laceration left side of the head. Noted multiple discolorations throughout the face. Resident is alert but disoriented; mouth twisted to the side. Resident is unable to follow simple commands. Hands grasp (hand grasps) are weak pupils reacted to light. VS (Vital Signs): 194/92, 82 (,) 16, 97.8. 911 called." 8:22 PM: "Upon follow up call, resident is admitted for left side face fracture at (local hospital)." Review of R9's medical record (Emergency Department Chart-Nursing Continuation Notes) documents: "(Patient) was found to be victim of trauma of unknown cause. (Bilateral) periorbital hematomas with a 4cm lac (laceration) to the L (left) lateral eyebrow. (Pt) is not at baseline mental status, appears to almost be post ictal (altered state of consciousness after an epileptic seizure)- (Family) denies hx (history) of sz (seizure). (First) attempt to contact NH (Nursing Home) staff at 1900 (7:00 PM)-(I) spoke c (with) a nurse who told me she does not know anything about the patient- (She) just knows he had a fall, I contacte(d) the PCP (Primary Care Physician) for	S9999		

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further clarification- (He) states he was contacted because the patient had scratches to his face and maybe had a sz (seizure)? this was followed by a phone call from a nurse at the NH facility per NH nurse the pt (patient) was found to be normal during vital check at 1500 (3:00 PM), next time he was checked on was at 1700 (5:00 PM) for dinner and was found in bed with trauma to his face so the NH called EMS (Emergency Medical Services).
Additional review of R9's hospital record (CT scan facial bones) demonstrates "a nondisplaced, comminuted fracture of the left zygomatic bone." Discharge summary documents primary diagnosis as "Traumatic intracranial subarachnoid hemorrhage."

Review of ambulance run sheet (06.28.2018, at scene at 5:53 PM) documents (under narrative): "Pt (patient) was bleeding with an approximate 5 mm laceration to left of his left eye. Pt presented with multiple bruises to his face and body, elder neglected (neglect) and abuse is suspected and reported."

Review of R9's "Abuse/Neglect" care plan (initiated 12.14.2017, reviewed 04.21.2018) under Focus: The resident's comprehensive assessment reveals factors that may increase his susceptibility to abuse/neglect. The resident demonstrates periods of disorganized thoughts. Alteration in thought process, Hx (history) of aggression. Resident seeks to play fight with his peers putting him at risk for being a target of aggression." The care plan did not include any resident centered interventions.

Review of the facility's initial incident report (06.29.2018, 12:59 AM) documents: "A Brief Description of Incident": "It was reported from

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(hospital) that resident (R9) was allegedly hit."

Review of R15's interview included in incident report documents: "Resident denies fighting peer or seeing anyone fighting peer. Resident states nothing happened."

V12 (Certified Nursing Assistant, 07.05.2018 at 3:17 PM) said he made rounds of the unit when he started his shift; R9 was in bed sleeping at that time, "I checked to make sure he was breathing." V12 said he made 2nd rounds around 4:30 PM; R9 was still in bed sleeping/breathing. V12 said he went from room to room around 5:30 PM to call residents for dinner, he was about to call R9 for dinner when he (V12) saw blood on R9's pillow. V12 said he saw a cut and bump to left side of R9's face; both eyes were black. "He was responsive, but I couldn't understand what he was saying, he's Hispanic." V12 said he didn't see R9 fall, "he was already in bed."

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V13 (LPN-Licensed Practical Nurse, 07.05.2018 at 4:04 PM, 07.12.2018 at 4:08 PM) said "I don't know what happened to him (R9)."

V14 (LPN, 07.05.2018 at 4:12 PM, 07.12.2018 at 4:08 PM) said she saw R9 in bed around 4:55 PM. V14 said she was called to R9's room by V12. "He was in bed. I saw bright, red blood on his pillow. There was blood coming from the left side of his face, there was bruising to his face (pointed to eyes)." V13 came to the room. "We were thinking, what happened? Did he fall? We didn't see blood anywhere else, the room looked okay. V14 said she has been instructed to report a suspected crime to V1 immediately ("the same way you would report a regular abuse"). V14 said "I don't know what happened to him. I thought he fell. I thought maybe he had a stroke because his

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mouth was twisted to the side. I didn't witness anything. I don't know how he got into bed."

V1 (Administrator, 07.06.2018 at 3:38 PM) said she thought R9 fell. V1 did not respond as to how it was determined that R9 fell as he was found in bed, not on the floor.

V2 (Director of Nursing, 07.06.2018 at 4:25 PM) said she contacted the hospital at approximately 8:30 AM on 06. 29.2018, the day following the incident to get information. She then reached out to R9's physician when she was unable to get any information from the hospital.

R13 was not available for interview. R14 (07.13.2018 at 2:57 PM) said he was not in the room at the time of the incident. R15 refused to speak with this writer.
V21 (Physician) and V22 (Registered Nurse) were not available for interview.

Review of the facility's "Abuse Prevention Program" policy and procedure (revised 09.06.2017) states: ""It is the policy of this facility to prohibit and prevent resident abuse, neglect, exploitation, mistreatment, and misappropriation of resident property and a crime against a resident in the facility."

(B)