

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6009948	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/15/2021
--------------------------------------------------	----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

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

(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 Complaint Investigation: 2196163/IL137454	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.610a) 300.1210b) 300.1210d)6) 300.3240f) 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. 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	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
---------------------------------------------------------------------------------------------------------------	-------	-----------

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6009948	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 09/15/2021
--------------------------------------------------	----------------------------------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------

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

(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	<p>Continued From page 1</p> <p>care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:</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> <p>300.3240 Abuse and Neglect</p> <p>f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act)</p> <p>These Regulations were not met as evidenced by:</p> <p>Based on interview and record review the facility failed to follow their abuse policy by not preventing resident to resident assault against 1 of 3 residents (R5) reviewed for physical abuse. This failure resulted in R5 being physically assaulted by a co-peer (R12), R5 sustained a fracture to the left nasal bone, large periorbital</p>	S9999		
-------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6009948	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/15/2021
--------------------------------------------------	----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

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

(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	<p>Continued From page 2</p> <p>soft tissue hematoma, and a 3cm laceration that required 4 sutures.</p> <p>Findings Include:</p> <p>R5 was admitted to the facility on 2/28/20 with a diagnosis of Schizophrenia, Psychosis, Suicidal Ideations, Delusional Disorders, Arthritis, and Auditory Hallucinations.</p> <p>R5's Minimum Data Set (MDS) dated 7/1/21 under Brief Interview For Mental Status (BIMS) documents a score of 15/15 which indicates cognitively intact.</p> <p>R5's progress note dated 12/12/20 documents: At 2:50 pm resident was on the unit, alert and oriented and in no distress. Around 3:10 pm writer was informed by another peer that the resident allegedly received physical aggression from another male resident in the male bathroom. Writer rushed down to check on him. He was bleeding in his left eye and refused treatment from nurse, denies pain stated he's ready to go to the emergency room.</p> <p>Facility's abuse reportable dated 12/18/2020 documents: R12 made physical contact with R5. Under conclusion documents, R12 admitted to making contact with peer. Staff noted witnessing R5 and R12 going into restroom and R5 exiting with skin laceration.</p> <p>On 9/8/21 1:19 pm, R5 who is alert and oriented at time of interview said he was punched in the face by another resident in the common washroom. R5 said he had limited vision to his left eye before the incident and is now no longer able to see from his left eye.</p>	S9999		
-------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6009948	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/15/2021	
NAME OF PROVIDER OR SUPPLIER CITYVIEW MULTICARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5825 WEST CERMAK ROAD CICERO, IL 60804		
(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	<p>Continued From page 3</p> <p>On 9/10/21 at 9:59 AM, R5 who was alert and oriented said R12 punched him in the face a few times and he fell to the ground. R5 was unable to provide any further details. R5 stated he did not hit R12.</p> <p>Local hospital record dated 12/12/2020 documents: R5 presented to emergency room with head laceration after assault. R5 states he got into an argument with another resident, was hit in the head and suffered a brief loss of consciousness.</p> <p>Notes under physical exam documents: laceration over left eyebrow approximately 3 cm. there is significant soft tissue swelling around the left periorbital region.</p> <p>Notes under results documents: Computerized Tomography (CT) head and facial bones findings; There is an oblique fracture of the left side nasal bones, increased density is seen in left globe, possible hemorrhage with disruption. Large left periorbital soft tissue hematoma. Under procedure note documents; simple laceration repair to forehead total length 3cm. Four sutures were utilized.</p> <p>Facility abuse prevention program revised 3/26/21 documents: It is the policy of this facility to prohibit and prevent resident abuse, neglect, mistreatment and misappropriation of resident property and a crime against a resident in the facility.</p> <p>The facility will not tolerate resident abuse or mistreatment or crimes against a resident by anyone, including staff, other residents, consultants, volunteer, family members, legal guardians or other individuals. Abuse is the willful infliction of injury with resulting harm or pain or</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6009948	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/15/2021
--------------------------------------------------	----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

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

(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	<p>Continued From page 4</p> <p>mental anguish or deprivation by an individual. Physical abuse is hitting, slapping, pinching kicking etc.</p> <p>R12 was admitted to the facility on 10/12/18 with diagnosis of Schizoaffective Disorder, Major Depressive Disorder, abnormalities of gait and mobility.</p> <p>R12's preadmission screening dated 10/18/2018 documents under physical assault injury, a moderate behavior level.</p> <p>Note under description documents: Patient was hospitalized with suicidal and homicidal ideations. He had been noncompliant with his medications and was agitated and felt like hurting someone or hurting himself.</p> <p>R12's progress note dated 12/12/20 documents: Resident initiated physical aggression towards another resident in the male bathroom around 3:10 pm, he denies the allegation but in house camera was able to point him out.</p> <p>R12's progress note dated 12/12/20 at 15:20 documents: Day 1/3 Physical Aggression towards peer social service made aware that resident was allegedly physically aggressive towards peer.</p> <p>Upon meeting with resident, he denies actions stating, "I didn't do anything, I stayed away from him after you told me to."</p> <p>After, further investigation and being presented with information R12 admitted to staff that he hit peer. R12 then expressed his dislike for his behavior towards staff earlier.</p> <p>Resident was encouraged to not intervene in situations that do not pertain to him and allow</p>	S9999		
-------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6009948	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/15/2021
--------------------------------------------------	----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

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

(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	<p>Continued From page 5</p> <p>staff to take care of any difficulties.</p> <p>Resident educated on the importance of maintaining safety and a positive relationship with others. Resident able to verbalize understanding.</p> <p>Nurse on duty contacted Doctor for further instructions and possibility of sending to hospital for further evaluation. Resident will continue to be monitored. Resident aggression assessment and care plan updated. Social services will continue to follow up.</p> <p>R12's care plan dated 9/11/2020 documents: R12 is an identified offender with moderate risk.</p> <p>Interventions dated 9/11/20: Staff will do appropriate supervision/observation, regular monitoring, attention to behavior changes, visual monitoring if warranted and reassessment.</p> <p>Facility abuse prevention program revised 3/26/21 documents: It is the policy of this facility to prohibit and prevent resident abuse, neglect, mistreatment and misappropriation of resident property and a crime against a resident in the facility. The facility will not tolerate resident abuse or mistreatment or crimes against a resident by anyone, including staff, other residents, consultants, volunteer, family members, legal guardians or other individuals. Abuse is the willful infliction of injury with resulting harm or pain or mental anguish or deprivation by an individual. Physical abuse is hitting, slapping, pinching kicking etc.</p> <p>(A)</p>	S9999		
-------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--