Illinois Department of Public Health

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 06/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CITY VIEW MULTICARE CENTER	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 Facility Reported Incident Investigation: FRI of 5-26-21/IL134507 FRI of 5-10-21/IL134088 FRI of 5-2-21/IL134085	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	S9999	Attachment A Statement of Licensure Violations	

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

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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:

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.

300.3240 Abuse and Neglect

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)

These Regulations were not met as evidenced by:

Based on interview and record review, the facility failed to prevent resident to resident physical assault and provide frequent monitoring of a resident that has a history of aggression for 3 of 4

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residents (R15, R16, and R17) reviewed for physical abuse and supervision/monitoring. This failure resulted in R17 physically attacking R15 by hitting R15 in the face with a television resulting in hospitalization requiring sutures and R17 attacking R16 by hitting R16 in the head with a garbage can R16 was sent to the local hospital assessed to have suffered facial fractures.

Findings include:

R15's Progress Note dated 5-5-21 documents R15 came to the nursing station to report that he was hit in his room by another resident (R17), and sustained injury to his face. Hospital Record dated 5-5-21 documents laceration to left lateral eyebrow, hit with unknown object to face while sleeping at nursing home by another resident. R15's Progress Note dated 5-5-21 documents: Resident returned from hospital, alert and oriented x3 ambulating with steady gait. resident denies pain at this time, steri strips noted to left eyebrow area.

On 6-9-21 at 12:30 PM, R15 said he does not remember who hit him, but he recalls being hit in the face with a television and that he went to the hospital for an x-ray and treatment.

R16's Progress Note dated 5-5-21 documents around 5:20 AM the nurse noted R16 being hit with the garbage can by another resident (R17) while he was walking in front of the nursing station. R16 sustained injuries to his face. First aide provided, police notified; resident transferred by ambulance to the local hospital for evaluation, and treatment. Progress Note (5-5-21) documents R16 returned from hospital with reports of orbital and nasal fractures. Hospital Record dated 5-5-21 documents diagnoses:

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closed fracture of orbit (initial encounter) and closed fracture of nasal bone (initial encounter). On 6-9-21 at 12:42 PM, R16 said he remembers R17 hitting him with in the face with a garbage can, R16 said he went to the local hospital, and was treated for facial fracture. R17 was not present at the facility during this investigation. A review of R17's Aggression Care documents R17 history of aggression with interventions requiring frequent monitoring of R17.

On 6-4-21 11:46 AM, V1 (Administrator/Abuse Coordinator) said R17 has history internal hallucinations. R17 threw television and struck R15. R15 required steri-strip to left eye. Thirty seconds later, R17 threw trash can at R16. R16 sustained a fractured nose.

On 6-11-21 at 11:00 AM, V2 (Director of Nursing) said these incidents occurred without staff present and without staff able to intervene. Resident R17 does not require constant 1:1 monitoring but requires frequent monitoring to ensure safety of the residents.
On 6-11-21 at 10:00 AM, V10 (Psychotropic Nurse/ ADON) said R17 requires monitoring to prevent agitation and aggression.
On 6-11-21 at 10:00 AM, V9 (Psychiatric Nurse Practitioner) said R17 is a psych resident and they cycle without warning (very unpredictable). All residents should be supervised.

On 6-8-21 at 9:52 AM, V11 (Supervisor/ LPN) said psych population is unpredictable and residents may be aggressive for no reason at all.

Abuse Policy (revised on 1-2019) documents the facility desires to prevent abuse against a resident by establishing a resident-sensitive and resident-secure environment.

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