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 07/19/2023

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 Complaint Investigations: 2395095/IL161147 2394921/IL160949 2394751/IL160752 2395605/IL161776 2395571/IL161736 2395511/IL161667 2395490/IL161639 2395133/IL161186 2394557/IL160502	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 5: 300.610a) 300.1010h) 300.1210b) 300.1210d)1)2)3)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 300.1010 Medical Care Policies h) The facility shall notify the resident's	S9999	**Attachment A** **Statement of Licensure Violations**	

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 07/19/2023

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
S9999	Continued From page 1 physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. 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: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. 2) All treatments and procedures shall be administered as ordered by the physician. 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	S9999		

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 07/19/2023

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
S9999	Continued From page 2 further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 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 Regulations are not met as evidenced by: A. Based on interview, and record review the facility failed to follow their notification of change policy and notify the physician of changes in condition to include fall incident, complaints of pain, and significant weight loss. This affected 2 of 3 (R12, R3) residents reviewed for notification of changes. This failure resulted in the facility staff failing to notify the physician of a fall incident and complaints of pain for R12 for over 8 hours. R12 subsequently was admitted to the hospital for right hip fracture. This failure also resulted in the facility staff not notifying the physician of R3 experiencing an insidious weight loss of 18 pounds (17.5%) in a 6-week period. B. Based on interview, and record review the facility failed to follow their policy and conduct a comprehensive assessment after an unwitnessed fall with complaints of not being able to move the leg/legs for over 6 hours. This affected 1 of 3 residents (R12) reviewed for comprehensive assessment. This failure resulted in over a six-hour delay in treatment and services for R12 who was subsequently sent to hospital for treatment of a right hip fracture. Findings include:	S9999		

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 07/19/2023

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
S9999	Continued From page 3 R12 face sheet shows diagnosis of osteoporosis without current pathological fractures, COPD (chronic obstructive pulmonary disease), multiple fractures of ribs, right side sequela, other hyperlipidemia, dementia unspecified severity with other behavioral disturbance, pathological fracture hip, presence of right artificial hip joint, difficulty walking, and abnormal posture. R12's facility final report to the department completed by V8 (Director of Nursing) with sent date of 6/11/2023, incident date 6/6/23 denotes in-part resident c/o (complaints of) pain to right hip. Head to toe assessment completed BP (blood pressure) 128/69, PR (pulse rate) 59, RR (respiration) 18, T(temperature) 97.7, spo2 97%, and 8/10 pain scale. PRN (as needed) pain medication administered. MD (medical doctor) made aware, and resident transferred to hospital. Resident remains in hospital for evaluation. Resident is her own responsible party. Investigation initiated. After completing the investigation, it was determined the resident had indicated that she had a fall while in the bathroom the night before and got up went to bed and then early the next morning c/o pain to the hip. The nurse completed an assessment, notified PCP and resident was transferred to hospital for evaluation that determined she had a right hip stress fracture. Resident has returned to the facility and new orders and care plan have been updated with orders. Resident is aware, PCP (primary care physician) aware she has returned to facility. This was an isolated incident for the resident. R12 facility incident report completed by V8 (Director of Nursing) dated 6/6/23 at 8:00AM denotes in-part fall, incident location, residents' bathroom. Resident complaint of pain to the right	S9999		

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 07/19/2023

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
S9999	Continued From page 4	S9999		

hip. Resident stated that she had a fall in the bathroom and fell on her buttocks. Resident assessed, VS (vital sign) stable, pain 8/10, PRN pain medication given. MD made aware with orders to send to ER for evaluation. No injuries observed at time of incident. Level of pain;8, alert, ambulatory without staff assistance. Alert to periods of, orient to place, orientated to person. No injuries observed post incident, predisposing situation factors; toileting needs. Witnesses V60 (Nurse) I did not get report that resident had a fall. V32 (Nurse), per nurse during rounds, resident was complaining of pain to right hip. Nurse assessed resident with no visible injuries. Pain medication was given, and MD called with orders to send to ER. R12, I had a fall last night while in the bathroom. I fell on my buttocks. V27 (Nurse) the resident did not report a fall to me. V28 (CNA) I am not aware of any fall. V26 (CNA) resident complaint of pain and I told the nurse. I do not know about the resident fall. V41 (physician) notified on 6/6/23 at 8:14AM. IDT (interdisciplinary team) met to discuss fall and put in place interventions. Reported to the State Agency. After completion of investigation resident had an unwitnessed fall while in the bathroom on her buttocks and went back to bed. Intervention, wheelchair initiated, abductor to be placed in between legs for proper alignment when in bed. Refer to therapy for safety transfers.

Review of facility incident report there is no statement noted from V18 (Nurse).

R12's emergency room records dated 6/6/23 denotes in-part patient is a 76-year-old white female with history of COPD (chronic obstructive pulmonary disease), and psychosis presents from SNF/NF (skilled nursing facility/nursing facility) to hospital following a fall. Patient was noted to have

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 07/19/2023

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
S9999	Continued From page 5 right lower extremity rotated. Patients X-ray showed acute angular fracture of femoral neck. Patient was treated with morphine and zofran, pre-op labs, EKG (electrocardiogram), CXR (chest X-ray) obtained at local hospital, transferred to another hospital for ortho procedure with doctor. On 6/21/23 at 11:13AM R12 observed sitting in wheelchair in dining room. R12 agreed to interview. R12 was escorted to her room for interview, at 11:15AM R12 observed to be alert to person, place, and situation. R12 said she fell in the bathroom. R12 said she couldn't get up or move her legs. R12 said she called out for help when she was on the floor. R12 said the next day she went to the hospital and her right hip was fractured. R12 said V26 picked her up and the nurse helped V26 (CNA). R12 does not know the nurse's name that helped V26 pick her up. R12 said at the time she fell; she was able to go to the bathroom by herself. R12 said now she's in the wheelchair. R12 said she was using the pink wedge noted in her room but that has stopped. R12 said she has an ortho appointment tomorrow. R12 stated she does have discomfort. R12 stated she wanted something for pain. R12 pressed her call light, V32 (Nurse) arrived. R12 requested pain medicine for her leg. V32 informed R12 that she recently had pain medication and it was not time right now. R12 stated she was walking and taking herself to the bathroom before the fall. On 6/21/23 at 3:17PM V26 (CNA-Certified Nursing Assistant) stated he was doing 1 to 1 with another resident when he heard R12 yelling. V26 stated he went to where the yelling was coming from and saw R12 on the bathroom floor. V26	S9999		

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 07/19/2023

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
S9999	Continued From page 6	S9999		

said it was him, V27 (Nurse) and V42 (unknown female CNA) that picked R12 up. V26 stated he went and got the wheelchair for R12. V26 was asked who had the upper body and who held R12's lower body? V26 stated he really doesn't remember all those details. V26 stated he left the facility after that. V26 stated he did not let the next CNA know R12 fell and was picked up off the floor.
On 6/28/23 at 2:36PM V42 CNA stated she was sitting at the nurse's station when V26 came and got her and to assist with picking R12 up from the bathroom floor. V42 stated when V26 approached the nurse's station he said to V27 (Nurse) "R12 was on the floor if you want to come and look". V42 stated V27 was on the phone, and she was not sure if V27 heard V26. V42 said when she got to the bathroom R12 was sitting on the floor on her buttocks. V42 said the wheelchair was in the bathroom already, and she and V26 picked R12 up and put her in the wheelchair. V42 stated she left the bathroom after that. V42 said she doesn't know what V26 did after picking R12 up from the floor. V42 stated she went to clean up a spill in the dining room. V42 said she did not report R12's fall to anyone. V42 stated she did not report the fall because V26 reported the fall to V27.

Follow up to V42 statement of she doesn't think V27 heard V26, V42 then said she doesn't know if V27 heard V26 or not but V26 told V27. V42 stated V8 (Director of Nursing) did not contact her regarding R12's fall and she has not been interviewed regarding R12's fall. V42 stated, surveyor was the only one to ask her about R12's fall.

On 6/21/23 at 12:16PM V27 (Nurse) stated she was the nurse working with R12 on the

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 07/19/2023

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
S9999	Continued From page 7 3PM-11:00PM shift. V27 denied knowing about R12 having a fall. V27 denied helping V26 pick R12 up from the floor. V27 stated around 9:30PM R12 approached her in a wheelchair and asked for pain medication because her right knee was hurting. V27 stated she gave R12 tylenol. V27 stated she did not ask R12 about her pain level. V27 stated she did not assess R12's right knee nor did she ask R12 any questions about her right knee pain. V27 stated R12 has arthritis but she doesn't know if R12 has arthritis of the right knee. V27 stated R12 is alert and orient and she knows if she's in pain or not. V27 stated she has always seen R12 use a wheelchair. V27 stated she went on break after that, and she doesn't know what time she returned from break. V27 said she worked a double and at 11:00PM she went upstairs to work her next assignment. On 6/22/23 at 4:09PM V18 (Nurse) stated she was the nurse responsible for R12's care on 6/5/23 11PM-7:00AM shift. V18 stated she did not get a report from V27 or V26 that R12 had a fall. V18 said she was doing rounds and R12 informed her that she was in pain, and that she had fallen in the bathroom and V26 picked her up from the floor. V18 said she gave R12 something for pain, but she did not assess R12 at that time. V18 said not too long after that another resident approached her for medications and mentioned that R12 needed to see her. V18 said when she went to see R12, R12 was asking for pain medications again. V18 stated she thought that was strange since she'd given R12 something for pain not too long ago. V18 stated that's when she asked R12 more questions and wanted to assess R12's legs. V18 said when she touched R12's leg, R12 was in severe pain and didn't want to move her leg. V18 said she immediately called V8 (Director of Nursing) and informed her that	S9999		

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 07/19/2023

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
S9999	Continued From page 8 R12 stated she had a fall and V26 picked her up. V18 said she called V8 because she didn't want the incident to be blamed on her or that it happened on her shift. V18 stated V8 did not give her any directives. V18 said she called the doctor after speaking to V8 that morning. V18 stated the doctor ordered an X-ray. V18 stated she put the order in as routine but when she called the radiology company, she told them it was a STAT order. V18 stated the radiology company had not completed the X-ray by the time she left completed her shift. V18 was adamant that she spoke to V8 and informed V8 that R12 had a fall on the 3-11 shift and that R12 stated V26 picked her up from the floor. On 6/22/23 at 1:40PM V8 (Director of Nursing) stated she conducted the investigation for R12's unwitnessed fall. V8 stated R12 had an unwitnessed fall in the bathroom and got herself up and went back to bed. V8 stated the root cause of R12's fall was that R12 was unassisted to the restroom. V8 initially said R12 was independent with toileting. V8 then stated R12 needs one person assist with toileting V8 stated that R12 needs someone to be there just in case R12 needs help. V8 stated when she talked to R12 that morning, R12 said she had fallen in the bathroom on the 3PM-11:00PM shift, that's it. V8 stated R12 did not tell her that she got up from the floor by herself and got back in bed. V8 stated she assumed that R12 got up by herself and so that's what she documented in her investigation report. V8 stated she did not review the facility video surveillance because she did not find anything suspicious with the investigation. V8 said the nurse should be made aware of an unwitnessed fall and that the CNA should not pick a resident up before the nurse completes a head-to-toe assessment of the resident. V8	S9999		

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 07/19/2023

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
S9999	Continued From page 9	S9999		

stated the physician should be notified immediately when the resident has a physical change in condition. V8 stated R12 had a physical change in condition when she was not able to move her legs after her fall. V8 stated R12 is ambulatory.

On 6/28/23 at 10:31AM V8 stated she saw the documentation that V18 (Nurse) got an order for an X-ray for R12, but she didn't think to talk to V18 during her investigation to gather more information regarding R12's fall. V8 stated she helped the morning nurse by completing the incident report and when she saw R12's right leg she did not see any bruising or rotation.

On 7/11/23 at 1:40PM V41 (Doctor) stated he is familiar with the incident with R12. V41 stated he was made aware that R12 had a fall and got back in bed independently. V41 was made aware of the investigation findings that V26 (CNA) stated he picked R12 up after the fall in the bathroom and put R12 in bed. V41 was made aware that R12 stated she did walk to the bathroom independently and had a fall. V41 stated the CNA should have reported the fall to the nurse and the facility needs to in-service all the CNAs about falls, injuries, and head injuries. V41 was made aware that V18 (Nurse) stated R12 reported to her that she fell and V26 picked her up and put her (R12) back in bed. V41 stated the nurse should have called him right away and he would have ordered an X-ray. V41 stated he should have been called/notified, and that he answers his phone at all hours. V41 stated he remembers the facility calling him that morning and he ordered to send R12 out to the hospital for evaluation.

Review of R12 progress notes and medication

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 07/19/2023

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
S9999	Continued From page 10 administration record, there is no documentation denoting that V18 gave R12 pain medication. Review of R12 progress notes and medication administration record, there is no documentation denoting that V27 gave R12 pain medication. Review of R12 POS (physician order sheet) it is denoted that V18 put order in electronic record for R12's X-ray on 6/6/23. On 6/27/23 at 2:43PM V43 (Radiology company rep) stated V18 ordered the X-ray for R12 on 6/6/23 at 7:14AM, V43 stated the X-ray was for right hip with pelvis STAT and it was cancelled at 2:43PM by the facility on 6/6/23. Facility policy titled change in resident condition or status dated 6/26/2011 denotes in-part to ensure that the resident attending physician and representative is notified of change in the resident's condition and/or status. The nurse will notify the resident attending physician when the resident is involved in any accident or incident resulting in any injury including injuries of unknown origin. There is significant change in the resident physical, mental and psychosocial status. Deemed necessary or appropriate in the best interest of the resident. A significant change in the resident condition is a decline or improvement in the resident status will not normally resolve itself without intervention by staff or by implementing standard disease related clinical interventions. The nurse will record in the resident's medical record any changes in the resident's medical condition or status. Facility Fall prevention and management policy version date 8/3/2017 denotes in-part this facility is committed to safety and maximizing each	S9999		

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 07/19/2023

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
S9999	Continued From page 11	S9999		

resident physical, mental, and psychosocial well-being. The purpose of our fall prevention and management program is to provide our residents with an interdisciplinary approach to assess risk of falls. Provide appropriate interventions to prevent falls. Ensure that in the event a fall occurs, the fall will be investigated, appropriate emergency treatment will be provided, and additional interventions will be implemented to prevent another fall from occurring as much as possible. This facility will achieve this goal through an individualized fall risk assessment, interventions that are implemented based upon the identified risk factors, immediate response to residents who fall including assessment for any injuries and the emergency management of any injuries. Reassessment of risk after a fall with modifications and /or additional interventions as appropriate.

2. On 6/27/23 at 9:54AM V8 Director of Nursing, stated I didn't see R3's weight loss triggered until about a month ago. V8 stated R3 usually eats about 100% of her meals. V8 said I contacted V38 Registered Dietician, about R3's weight on June 12. V8 stated on 6/6/23 V33 Nurse Practitioner, misunderstood what the nurse said about R3. V38 stated V33 was wanting to send R3 out for masturbation but V41 physician, stated to not send R3 out. V38 said I didn't know that psych was contacted about R3. V38 stated the nurse did not document that the order was discontinued.

On 6/22/23 at 1:21PM V33 stated I saw R3 on 6/6/23 for psychiatric deterioration. V33 stated they told me R3 has not been eating and that she has been masturbating at night. V33 stated I spoke to R3's psych doctor and we decided to send her out for evaluation. V33 said I told the

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 07/19/2023

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
S9999	Continued From page 12	S9999		

staff to send R3 out for an evaluation because she was manic. V33 stated to my knowledge R3 had not been losing weight. V33 stated on my next visit to the facility, a different day than 6/6/23, I was told R3 refused to go to the emergency room on 6/6/23. V33 stated I don't have my calendar out, so I am not sure what date that was, but it was after 6/6/23. V33 state if I had known on 6/6/23 that R3 refused, I would have told the staff to send R3 out by petition. V33 said I don't recall being notified of R3's weight loss. V33 stated I don't know the results of R3's calorie count. V33 said if they called the doctor instead of me, it should be documented. V33 stated everything should be documented.

R3's weight May 8, 2023, was 103 pounds, May 22, 2023, was 99.5 pounds, and June 12, 2023, was 90 Pounds.
R3's weight dated 6/19/23 was 85 Pounds. R3's weight report identifies weight loss consistently since May 8, 2023.

R3's progress notes dated 6/6/23 written by V33 documents a conversation with psychiatrist who discussed an evaluation and plan of care was discussed with the staff. R3's notes dated 6/6/23 denotes R3 refused to go to the hospital and Director of Nursing was notified.

Review of R3's progress notes from 5/31/23 until 6/23/23 do not have documentation of physician notification of weight loss. Progress notes do not include physician notification.

The facility policy for Change in Resident's Condition or Status dated 6/26/11 denotes the nurse will notify the resident's attending physician when the resident repeatedly refuses treatment or medications.

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 07/19/2023

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
S9999	Continued From page 13 The facility policy Weight Management dated 1/2/23 denotes the physician and the resident or resident representative will be notified by the resident's nurse of any significant unexpected and or unplanned with changes. The nurse will document the notification in the resident's medical record. (A) Statement of Licensure Violations 2 of 5: 300.610a) 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 300.3240 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 Regulations are not met as evidenced by: There are multiple deficient practice statements. Based on interviews and records reviewed the facility failed to prevent an incident of staff to	S9999		

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 07/19/2023

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
S9999	Continued From page 14 resident inappropriate sexual behavior. This affected 1 of 3 residents (R2) reviewed for staff to resident sexual abuse. This failure resulted in V7 being observed receiving oral sex from R2 and V7's finger observed inserted in or on R2's exposed vagina. The findings include: 1. R2 is a 33-year-old with diagnosis include but not limited to bipolar disorder with psychotic features, schizoaffective disorder, bipolar type, personal history of traumatic brain injury, auditory hallucinations, and post-traumatic stress disorder. R2 is alert and oriented to person, place, time, and situation. On 6/16/23 at 11:20 R2 stated I had relations with my baby daddy in the facility. R2 stated they (the staff) accuse me of all sorts of things. During a second interview on 6/20/23 at 10:30AM R2 was shown a picture of V7 from his employee file. R2 responded I recognize him from the facility. R2 stated we talked before about life, goals, and futures. R2 stated "he told me I looked nice". R2 stated I don't know his name. On two phone interviews on 6/16/23 at 1:37PM and 3:07PM V11 Certified Nursing Assistant (CNA), stated I was sitting at the nurse's station and saw V7 Psych Tech, enter the floor from the stairs. V11 stated V7 came to the floor around 11:00PM. V11 stated I did not see him enter R2's room. V11 stated the evening shift nurses had left and the night shift nurses had not arrived, I was on the floor alone. V11 said I got up to do my rounds and went to R2's room. V11 stated I saw R2 giving him (V7) head (oral sex) and he (V7) was fingering R2's exposed vagina. V11 said she	S9999		

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 07/19/2023

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
S9999	Continued From page 15	S9999		

told V7 "to leave several times and he just stared at me". V11 said V7 would not leave. V11 said "I think because he had no clothes on, he didn't want me to see him." V11 said R2 never said nothing to her but was mad and agitated after V7 left. V11 said R2 left the floor like 5-7 minutes after she told him (V7) to leave. V11 stated V15 Supervisor came to the floor, but V7 had left. V11 stated she saw V7 go to the stairs and leave. V11 said all of R2's roommates slept thru everything and never woke up. V11 stated R2 lied to the police and to V15 and said no one was in her room and then she told V15 that a staff member was on the floor. V11 state this is my first time I am talking to anyone about this. V4 Co-Administrator and V20 Administrator, did not talk to me about this. V11 stated I gave V15 a written witness statement and she said she put it in V8's Director of Nursing, mailbox. V11 stated she recognized the male as staff when he came to the floor. V11 stated V7 should not be doing this because he is staff, and it is not right. V11 stated the facility tells us we can't do that, there is no sleeping with the residents. V11 stated this would be abuse, sexual abuse.

On a follow up, in person interview on 6/20/23 at 3:20PM V11 stated I notified V15 that the guy in R2's room was naked. V11 stated I never spoke with V4 Assistant Administrator, V20 Administrator, or a V23 Chief Nursing Officer. V11 stated you are the only one that has called me about this incident. V11 stated I knew I had seen the staff member on social media, so I pulled up his picture and showed it to the police. V11 stated I gave the police my statement that night.

On 6/16/23 at 1:43PM V19 Social Services Director, stated he heard R2 was flirting with security. V19 stated staff spoke with R2 and let

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 07/19/2023

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
S9999	Continued From page 16	S9999		

her know that sex with a staff person is inappropriate and V19 said R2 said she consented to it. V19 said R2 is alert and oriented times four. V19 said it is inappropriate because this is her home and R2 is here for a reason.

On 6/16/23 at 2:23PM V12 Security/Psych Tech/ Central Supply Manger stated V7 was usually assigned to the 3rd or 6th floor. V12 stated I know V7 was terminated for a policy violation, and he was not where he was supposed to be while on duty. V12 stated on 6/6/23 V20 called me at night and told me to remove V7 from the schedule pending investigation. V12 stated I tried to call V7 to tell him, and he did not answer his phone.

On a follow up interview on 6/20/23 at 12:56PM V12 stated I never had the chance to ask V7 anything about R2 because he never answered my calls.

On 6/16/23 at 3:02PM the surveyor requested to see camera footage from V13 Maintenance Director. V13 said he calls the company to obtain a code to watch the security camera footage. V13 said the footage is available for 24 hours. No footage was available to view from 6/6/23 or 6/7/23.

On 6/20/23 at 10:37AM V8 Director of Nursing, stated she was made aware that a male entered a resident room and V11 told him to come out of the room. V11 said all I know is R2 was going to be sent out for evaluation and that R2 refused evaluation and was returned to the facility. V8 stated she had a statement in her mailbox from V11.V8 said I gave the written statement to V4 Co-Administrator.

On 6/20/23 during a phone interview from

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 07/19/2023

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
S9999	Continued From page 17 11:05AM until 11:28PM V7 Psych Tech, stated I worked at the facility as a psych tech. V7 stated on 6/6/23 I was assigned to the 5th floor. V7 said I was terminated by phone on 6/7/23 for not following the rules. V7 stated I was not on my assigned floor. V7 said I have not been asked anything about R2 by anyone at the facility. V7 said not being on my assigned area means I was in R2's room. V7 said we were just talking and then R2 began removing her clothes. V7 said R2 said she wanted to do something. V7 said staff saw me standing over R2, in her bed without clothes, and her legs open. The surveyor asked if V7 was clocked in when this occurred and V7 said yes. V7 stated this was like at 11:00PM. V7 said after the staff saw me, I went down the stairs, punched out, and left the facility. V7 said the interaction with R2 started off friendly, we were just talking, then "it went left." V7 elaborated and said it went left when the nurse walked in on us. V7 said I got no training on what to do if a resident makes sexual advances or flirts with me. V7 stated I had no training on not having sex with a resident. On 6/20/23 during a phone interview at 11:05AM until 11:2AM V20 Administrator stated I started the investigation as soon as I was notified in the night hours of 6/6/23. V20 said she had V15 take the phone to R2's room but R2 was not cooperative and refusing to be examined. V20 stated the allegation was that V11 was in R2's room and should not be on the unit and the staff saw him in R2's room. V11 stated "they weren't sure what happened" V15 did not see anything. V11 stated "I never spoke with V11" or V7. V20 stated V12 spoke with V7 and V7 told V12 nothing happened in R2's room. V20 stated inappropriate friendships with staff and residents should not happen and V7 was terminated	S9999		

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 07/19/2023

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
S9999	Continued From page 18	S9999		

because he was in an inappropriate location in the building. V20 stated I reviewed camera footage and saw V7 go down the hall, on the unit and go into R2's room. V20 stated V7 left R2's room and went thru the stairwell, and V20 state she watched V7 leave the building. V20 stated on the camera footage she saw V11 at the nurse's station, get up, and go to R2's room. V20 stated my conclusion of the investigation is that the allegation cannot be substantiated.

On 6/20/23 at 12:11PM thru 12:21PM during a phone interview, V21 R2's Guardian, stated R2 is upset right now because I told her she can't be having sex in her room while the room mates are present. V21 stated R2 does not understand boundaries. V21 said R2 interprets niceness as an advance, and she is needing male attention.

On 6/20/23 at 3:00PM V4 Assistant Administrator, stated we don't have a statement from V11, I checked.

On 6/21/23 at 9:05AM V15 RN Supervisor, stated on 6/6/23 V11 reported that R2 observed an inappropriate interaction between a male staff and a patient. V11 stated "it was of a sexual nature". V15 stated I was instructed by V20 to get a statement from V11. V20 stated I took V11's statement and put it in V8's box. V11 stated I did not see anything or the male staff person. V15 stated I did call the police. V15 stated there were no witness everyone was asleep.

R2's care plan includes identification that R2 is sexually active and is a trauma survivor. R2 has diagnosis and history of severe mental illness, and poor ability to control impulses.

R2's PASRR (preadmission screening and

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 07/19/2023

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
S9999	Continued From page 19	S9999		

resident review) denotes R2 was admitted to the hospital on 8/15/22 from a shelter, you were not taking your medications, using drugs, and engaging in "high risk sexual behavior". You have a court appointed guardian ad litem. You have been ordered by the court for placement in a nursing facility. You state that you do not need your medication. You are homeless. When manic the patient has a history of engaging in risky sexual behaviors and self-neglect.

R2's trauma screening dated 9/26/22 and 6/7/23 both denote a score of 1.

V11's timecard record identifies he punched in on 6/6/23 at 3:00PM and his end of shift was 11:00PM.

The facility investigation incident date 6/7/23 denotes It was reported by staff that V7 was inappropriate towards R2. Conclusion: Facility conducted a thorough investigation and interviewed staff and residents. (Per V20 and V11, V11 was not interviewed.) Final sentence in the reports denotes "abuse is not substantiated."

R2's Hospital records dated 6/7/23 denote R2 refused assault/rape kit. Records note R2 reported to hospital staff that she has been in a romantic relationship with the security guard for a while now.

Police Report obtained dated 6/7/2023 denotes officer responded to the facility for an alleged criminal sexual assault. Allegedly V11 reported to V15 that V11 walked in on a staff member with R2 engaged in sexual acts. V15 stated R2 did confirm a male staff member was in the room with her but refused to answer any other questions. V11 told officer she observed a male

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 07/19/2023

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
S9999	Continued From page 20 "psych tech" who she did not know by name naked in R2's bed and was getting "head" (receiving oral sex) from R2 while he "fingered" her. The facility Resident Rights document states You must not be abused by anyone- physically, verbally, mentally, financially, or sexually. (A) Statement of Licensure Violations 3 of 5: 300.610a) 300.1210b) 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 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	S9999		

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 07/19/2023

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
S9999	Continued From page 21	S9999		

care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

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 Regulations are not met as evidenced by:

2. Based on observation, interview, and record review the facility failed to ensure staff does not physically harm residents during Crisis Prevention Intervention (CPI) technique. This affected one (R30) of nine residents reviewed for physical abuse. This failure resulted in R30 being observed with a bump on left side of face, lips swollen, and facial bruises after an incident with V69 (Security).

The findings include:

R30's diagnosis include anxiety, bipolar disorder, major depressive disorder, lack of coordination, schizoaffective disorder and weakness. R30's cognitive assessment dated 4/10/23 indicates a score of 13 (cognitively intact).

On 7/7/23 at 1:50PM the surveyor was escorted to R30's room by V37 Licensed Practical Nurse (LPN). R30 observed in gown and underwear on (no pants or shirt) gown open in the front. R30's arms, chest, belly exposed. Surveyor saw no bruises or marks on R30's, neck, belly, chest, arms, or hands. R30 has three purple bruises about the size of a quarter on the right side R30's forehead/temple region. R30 has one round purple bruise along R30's lower left chin. All three

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 07/19/2023

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
S9999	Continued From page 22	S9999		

bruises same color and similar shape. R30 said "the guy beat me up for no reason." R30 said he said to me "you think you hard a**" then he attacked me. R30 said this happened yesterday. R30 said he broke my fingers. R30 said he works here, his name is [derogatory slur]. R30 stated I told the police the same thing I just told you. R30 said my hand and jaw hurts. R30 was unable to say who V37 was by name. R30 became agitated during conversation and surveyor ended interview.

On 7/7/23 at 2:07PM in R5's room. R5 said I saw V69 Security Guard, go into R30's room, right next door, and the door was closed. R5 said I was in the hall and heard noises. R5 said I peeked in the room and saw V69 punch R5 in the face. R5 said I saw V69 and R30 standing face to face with each other hands on each other, close to each other, they were standing by the bed. R5 said I waited outside the room and then saw V69 come out, it went on for like 3-5 minutes. R5 said V69 came out the doorway and said, "I F*** people up." R5 stated I have pictures and showed the surveyor two pictures on his personal broken screen phone. R5 showed two blurry pictures and one picture has R30 holding a white cloth to his face, bright red blood on a white cloth. R5 said I saw V69 hit R30 two or three times. R5 said when V69 came out of the room he was wearing black gloves, like baseball gloves on his hands and was taking them off, he carries them in his pocket. R5 said I saw both, V37 and V69, carrying bloody towels and sheets.

On 7/7/23 at 1:48PM V37 Licensed Practical Nurse (LPN) stated I approached R30 on 7/6/23 because he needed assistance, he wasn't dressed properly, and R30 became aggressive. V37 stated I called V69 to assist. I then left the

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 07/19/2023

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
S9999	Continued From page 23	S9999		

facility for an appointment. V37 stated I did not see the altercation, but I was told about it when I returned. V37 stated in the morning while I was here R30 had no bruises on his face, but when I returned in the afternoon, I saw the bruises on R30's face. V37 stated R30 is alert and oriented times two, he has confusion, and he may have some delusions and hallucinations.

On a follow up interview on 7/8/23 at 9:25AM V37 stated V69 approached R30 saying Mr. (R30) follow me and R30 followed V69 to R30's room. V37 stated V69 then called V37 to look at the mess in R30's room. V37 stated I went to see and there was a mess of linens. V37 stated I did not see blood anywhere at that time. V37 stated R30 was standing in the room with V69 and R30 was not saying anything. V37 stated I did not see V69 with a ripped pocket and no bleeding. V37 stated I left the facility around 10:00AM on 7/6/23 and returned at 4:00PM. V37 stated I did not punch out when I left, because my appointment is related to a facility injury. V37 stated I called V68 Nurse, to notify her I was leaving, and she said she was coming to the unit. V68 said V69 and V57 Scheduler, were on the floor when I left. V37 stated V69 did not report to me the incident that occurred with R30. V37 stated V69 should have told me or to the administrator when it happened.

On 7/7/23 at 2:52PM during a phone interview, V69 Security, stated R30 was argumentative at the nurses' station. V69 stated R30 then grabbed me by the neck and scratched my neck. V69 said I tried to de-escalate the situation by myself, and I did not call for help or a code gray. I didn't think of it. V69 stated after R30 got his clothes, linens, and shower - everything he wanted R30 calmed down. V69 stated I never put my hands on R30. V69 stated R30 didn't fall. R30 was never on the

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 07/19/2023

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
S9999	Continued From page 24	S9999		

ground. R30 was trying to grab me by the neck. V69 stated I was in the room for 3-5 minutes.

During follow up call on 7/11/23 at 10:20AM V69 stated I didn't tell anyone after the incident. I should have reported but V37 was gone. V69 stated I used proper CPI (crisis prevention institute). I didn't touch R30's face. V69 stated R30 only had me in a bear hug from the front he never came at me from behind.

On 7/11/23 at 10:03AM V71 Director of Customer Experience, stated I was doing my rounds and R5 pulled me to the side and showed me some pictures on his phone, and stated the resident had been beat up by a staff member. V71 said this was reported to him a little before 10:00AM. V71 said R5 was holding his phone with a picture in which he saw a man's face and some blood, and his face was down. V71 gave the room number and R30's name as the man in the picture R5 was showing him. V71 stated R30's "face should not look like that. You don't engage in CPI and his face should not look like that." V71 said "you need to call a code and get out the room when behaviors are coming like that." V71 described R30's face as swollen and said V30 said "the [derogatory name] did it. V71 said I have seen V69 with black motorcycle gloves at work.

On 7/7/23 at 2:58PM by phone, V68 (Nurse) stated she received a call from V37 (Nurse) around 10:00AM that she was to cover the floor, while he was out to an appointment. V68 stated she went to the unit shortly after 10:00AM. V68 stated she did not stop on any other unit. V68 said it was around 12:00-12:30PM when V4 (co-administrator) arrived on the unit and asked V49 to come with her because there was an allegation. V68 stated they went to R30's room.

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 07/19/2023

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
S9999	Continued From page 25 V68 stated that R30 reported he got into it with a male security guard. V68 said she did a head-to-toe assessment on R30, and she observed R30's forehead was swollen and R30's lip was swollen. V68 said the inside of R30's lip was swollen, too. V68 requested the surveyor read the incident report that she completed. V68 said she asked R30 what happened to his forehead and lip, R30 replied, the male security guard did it, I told the "nurse". V68 said she and V4 went toward V69 he was sitting by the elevator. V68 said V69 said "no, no, the resident was aggressive". V68 said she observed V69's shirt pocket was ripped and V69 pointed out very minor scratches to his neck. On 7/7/23 at 4:21PM by phone, V12 Security Supervisor, stated a code gray is called when a resident is combative. V12 said if a resident puts their hands on you, that should be a reason to call a code gray. V12 said if you are using CPI to get the resident's hands off your neck the technique would not involve touching the resident's head or face. V12 said the code is called to prevent the situation from escalating and to show the resident they are outnumbered. I did not respond to a code gray involving V69 on 7/6/23. V12 said I did not hear the code gray, I was outside. V12 stated I was called by V20 Administrator, about 12:30PM and told to watch the security footage. I watched the video about 12:45PM. V12 said on the video, I saw R30 at the nurses' station and V37 waving for someone. V12 said I only saw footage at the nurses' station not the hallway. V12 said I was told that R30 said he was hurt. V12 said when I went into the video room, I watched the video alone. V12 said I didn't talk to V69, and I didn't see him before he left. On 7/8/23 at 1:40PM V4 Co-Administrator, stated	S9999		

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 07/19/2023

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
S9999	Continued From page 26	S9999		

I was notified by V71 Director of Customer Service, there was an incident where a resident alleged a staff member was inappropriate. V4 said I went to speak with R30 sometime in the morning of 7/6/23. V30 said she went to the floor and when she got there the first place, she went was to R30's room. V4 said R30 reported he and staff "possibly had some kind of altercation." V4 said R30 said a staff member had "physical contact" with him. V4 said R30 described the person as having "military fatigue," clean cut, and the color of his uniform was black, R30 gave no name. V4 said I asked R30 for a description of the altercation and he seemed disorganized and confused, he cognitively was coming in and out, and seemed tired. V4 said from the description of the staff person R30 gave it was V69. V4 said V68 Nurse, was present during R30's interview. V4 said I obtained R30's written statement before he left. V4 said V69 said he had redirected R30 back to his room. V4 said V69 said that Crisis Prevention Interventions (CPI) was utilized. V4 said generally CPI requires a party of two, but maybe done with one person. V4 said I would expect the incident to be reported if one person CPI technique was used, right after the situation occurred. V4 said the nurse would document in a progress note if CPI occurred. V4 said "I am not trained to see if I saw on injury" on R30. V4 said I did not see blood. V4 said I read V68's progress note where she reported R30 had some possible skin discolorations. V4 said CPI is verbal de-escalation of a situation, physical techniques are a last resort, and the holds are nonaggressive. V4 said R5 reported to her that V69 was in R30's room. V4 said R5 had said he was standing in the hallway. V4 said R5 said he opened the door to R30's room, looked inside, and he possibly witnessed they were having a disagreement and closed the door. V4 said R5

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 07/19/2023

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
S9999	Continued From page 27	S9999		

said there was a possibility that V69 was using CPI on R30. V4 said R5 is alert and oriented times four. V4 said it sounds like the CPI used could have been verbal and possible holds. V4 said the investigation is not yet completed.

On 7/7/23 at 3:12PM V20 Administrator, said I was not in the facility, but I was told by V12 that V69 grabbed R30 from the back. V20 said I did not watch the security video; I was not in the facility on 7/6/23.

On 7/8/23 at 12:40PM the surveyor inquired if the facility has a specific code gray policy, other than the Facility Codes Policy. V20 replied there is no other policy for code gray.

Facility incident report dated 7/6/23 at 11:30AM completed by V68 denotes in-part incident location- resident room, resident location- (room number). Resident (R30) alleged staff member was inappropriate towards him. Head to toe assessment completed, resident noted with bloody lips, and swelling to forehead, ice applied. Co-Administrator (V4) made aware; investigation initiated. Injury type- swelling, right forehead. No witness found.

R30 plan of care dated 04/05/2023 denotes in-part that R30 comprehensive assessment reveals a factor that may increase my susceptibility to abuse/neglect. The resident demonstrates: Diagnosis of Mental Illness The resident will be treated with/ respect, dignity & reside in the facility free of mistreatment (i.e., abuse/neglect) (on-going). Review assessment information. Emphasize treatment of causal factors &/or interventions designed to moderate/reduce symptoms, make treatment of compulsive behavior, substance abuse, anger &

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 07/19/2023

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
S9999	Continued From page 28	S9999		

mental health issues available to the resident, as indicated. Assure the resident that he/she is in a safe & secure environment with/ caring professional. Explain that psychosocial adjustment is often facilitated by developing a trusting relationship with another person (i.e., social worker, nurse, CNA, peer) & by verbalizing thoughts, needs & feelings. Assure the resident that staff members are available to help & department heads maintain an "open door" policy.

R30's plan of care dated 04/10/2023 denotes in-part has a "Self-Care Deficit" with impaired dressing and grooming abilities and would benefit from participation in a dressing/grooming restorative nursing program as evidenced by the following risk factors and potential contributing diagnosis: bipolar disorder, requires one person assist with dressing and grooming, schizophrenia and/or schizoaffective disorder. R30 will be able to dress self-up and comb hair with staff provided ones daily for clean appearance/hygiene potential with no more than supervision assists times one staff, six- seven days weekly to help improve and/or maintain current level of function, unless disease process causes unavoidable deterioration through next review. Explain all tasks prior to performing R30 dressing and grooming assistance. Use task segmentation and verbal cues as needed. Gather all of R30 clothing and grooming supplies prior to assisting me with restorative dressing and grooming program. Notify MD (Medical Director) for significant decline in dressing and grooming status and request an order for skilled PT/OT (physical therapy/ occupational therapy) evaluation and TX (treatment) as indicated. Praise R30 efforts in dressing and grooming program.

MDS (Minimum Data Set) dated 4/10/23 denotes

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 07/19/2023

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
S9999	Continued From page 29 in-part R30 requires limited assist with one-person physical assist with dressing. Progress Notes include documentation by V37 between 10:08AM and 10:10AM, 5 entries. V37's written statement dated 7/6/23 denotes he was sitting at the nurse's station when R30 presented "partially naked." V37 wrote R30 became agitated. V69 came back to nurse and reported the condition of R30's room. V69 said he provided towels for R30 and then left for his appointment. V69's written statement signed 7/6/23 denotes between 10:00AM and 10:30AM R30 spoke very rudely to the nurse. R30 got aggressive, and the nurse called for security. V69 wrote he instructed R30 to go to his room and wait for the nurse when R30 tried to pull V69 to the floor. Security try to back up but R30 kept trying to get on top of security while scratching security face. R5 has a cognitive score of 15, intact, dated 6/16/23. Facility abuse policy with last revision date of 6/28/2023 (a different version that what had been presented prior to 7/6/23) denotes in part the purpose of the policy is to ensure that the facility is doing all that is within its control to prevent and reduce the risk of abuse incidences to the residents of city view multicenter. The types of abuse include neglect, exploitation, mistreatment, sexual, involuntary seclusion, and misappropriation of property. Staff and other relevant ancillary personnel shall have ongoing training on the abuse policy. The education consist of the following: procedure for reporting incidents of abuse, dementia management,	S9999		

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 07/19/2023

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
S9999	Continued From page 30 abuse prevention, inappropriate staff relationships with the residents, and CPI (crisis prevention intervention). The facility Abuse Policy dated 6/28/23 (a different version that what had been presented prior to 7/6/23) states staff will be trained on the procedures for reporting incident of abuse including CPI. Prevention includes identifying inappropriate behavior including rough handling. Facility Codes Policy and Procedure dated 1/2/23 mentions the code gray is used for behavioral health emergency. No instruction for use given. (B) Statement of Licensure Violations 4 of 5: 300.610a) 300.1210b) 300.3240a) 300.3240e) 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		

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 07/19/2023

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
S9999	Continued From page 31 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. 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) e) 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 are not met as evidenced by: Based on observation, interview, and record review the facility failed to prevent incidents of resident-to-resident physical assault, and staff to resident mental abuse. This affected 5 of 9 (R11, R14, R9, R24, and R6) residents reviewed for physical and mental abuse. This failure resulted in R14 hitting R11 with a chair. R1 sustained a facial laceration and multiple left orbital fractures. R24 assaulted R9 with a food tray sustaining a laceration to mouth, and V2 CNA challenging R6 to a fight.	S9999		

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 07/19/2023

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
S9999	Continued From page 32 Findings include: R11's face sheet shows in-part that R11 has diagnosis of cognitive deficits, lack of coordination, weakness, personal history of traumatic brain injury. Facility incident report to the department with date of incident 6/7/2023 denotes in-part, reported by V8 (Director of Nursing), resident (R11) observed with laceration/slight swelling below left eye. Head to toe assessment completed. Area cleaned with NS (normal saline) and ice pack applied to left eye. Resident denies pain. MD (Medical Doctor) made aware and order to send to ER (emergency room) for further evaluation. Resident remains in the hospital. Family made aware. Investigation initiated. After investigation resident was sitting on patio when another resident accidental picked up a chair and it hit R11 in his facial area. This as per resident (R11) was not intentional and did not have initial discomfort. Resident was sent to the hospital with preliminary report of fracture to orbital and jaw. Resident remains in the hospital currently, and we do not have any conformation of hospital interventions currently. If we need to add an addendum we will send as soon as he returns. Final report. R11 emergency room record dated 6/7/23 denotes in-part stated complaint, left face injury, eye emergency, priority 4, assault- left eye trauma, epistaxis, epistaxis due to trauma, blow out fracture of orbital floor, assault, zygomatic fracture -left side, initial encounter for closed fracture left orbital trauma. Patient came via ambulance due to facial trauma with swelling and a superficial laceration on the left side of the face and eye area. Swelling and redness with small	S9999		

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 07/19/2023

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
S9999	Continued From page 33	S9999		

cut to the left eye and left jaw area. Patient (R11) stated that he was hit in the face with a chair by another resident. Patient denies dizziness or loss of consciousness. Paramedics called for patient transfer to (hospital name) ER (emergency room) trauma due to fracture to the orbital area and left zygomatic process. Medical benefits of transfer, possible surgery. CT (computerized tomography) of head w/o contrast suboptimal assessment of the brain due to beam hardening/motion artifact. No definite acute intracranial process such as hemorrhage. Complex comminuted left zygomaticomaxillary fractures as above, multiple left orbital fractures involving the left lamina papyracea, inferior, and lateral orbitals walls with orbital emphysema including retrobulbar gas. There is some medial and inferior herniation of the orbital fat without definite imaging evidence of entrapment. Detailed ophthalmic examination is advised.

On 6/12/23 at 2:30PM State Agency surveyor went to hospital to observe and interview R11. R11 observed alert and oriented able to recall incident with R14. R11 stated it was not an accident when R14 hit him with the chair causing the injury to his face and that the facility was aware of what happened. R11 explained that he was on the patio with R14, R14 was trying to get his attention. R11 stated R14 has tried to get his attention on other occasions, but he is not interested in interacting with her (R14). R11 stated when he refuses to interact with R14 she yells and becomes aggressive and uses the N-word toward him. R11 stated there was an occasion when R14 took off her clothes and stood in front of him and he didn't respond, and she became angry. R11 said he does not report the behavior anymore because he has been told there is nothing, they (staff at facility) can do

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 07/19/2023

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
S9999	Continued From page 34	S9999		

about it. R11 said on 6/6/23 he was on the patio with R14, and she again was trying to get his attention and when he didn't respond, she (R14) picked up a chair and hit him in the face and ran. R11 said the facility provided first aide but did not call an ambulance for quite a while. R11 said his face was bleeding when he was eating breakfast. R11 said he spoke to the police before the ambulance arrived. R11 was very adamant that his injuries were no accident, R14 hit him on purpose.

On 6/16/23 at 11:00AM V8 (Director of Nursing) stated she did not put R14's name in the report to the department because it was a resident-to-resident incident. V8 said there was no staff on the patio monitoring the residents when this incident occurred. V8 said abuse was not substantiated because R14 has behaviors.

On 7/11/23 at 2:40PM V8 said she was summons to the 6th floor on 6/7/23, she observed R11 nose was swollen and disfigured. V8 said R11 nose was not disfigured prior to the incident and R11 had lacerations to the face. V8 stated she can't remember the location of the lacerations. V8 alleges that R11 said R14 bumped into him with a chair by mistake when they were sitting on the patio. V8 was asked if she had any suspicion of abuse/assault after she noticed R11's face with lacerations, disfigured nose and swelling. V8 did not give a response. V8 said when the residents are on the patio staff should be monitoring the patio to supervise the residents for safety. V8 said supervision is to keep the resident safe and redirect the resident if needed. V8 said residents can go out on the patio independently. V8 said the patio door is not locked, so the residents have access to the patio. V8 said there were no witnesses to the incident

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 07/19/2023

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
S9999	Continued From page 35	S9999		

between R11 and R14. V8 said the staff was not monitoring the dining room and patio at that time, they probably were busy taking care of other residents. V8 said she was made aware by the hospital that R11 sustained a fracture to the jaw and to the orbital area. V8 said that information was included in the facility report to the department. V8 said R11's injuries were a result of being hit with a chair. V8 described the chair a dining room chair. V8 pointed out to surveyor a wooden chair. V8 said when she was summons to the unit on 6/7/23, she observed the chair that was used by R14 to hit R11. V8 said residents should not pick up chairs and hit other residents with them.

R11's plan of care denotes in-part potential abuse. My comprehensive assessment reveals a history of suspected abuse, neglect, past trauma and or other factors that may increase susceptibility to abuse/neglect. R11 will be treated with respect, dignity, and reside in the facility free of mistreatment (i.e., abuse/neglect ongoing).

R14's plan of care dated 2/19/2023 denotes in-part resident (R14), needs redirection at all times during groups. Resident has to be redirected from undressing during groups and writing on the wall. R14 has a history of aggressive, inappropriate, attention seeking and/or maladaptive behavior, but has demonstrated stability during the admission screening process and its therefore considered appropriate for admission. R14's history includes conflicts/altercation with others. The resident will behave in a manner consistent with resident conduct policies through the next review.
R14's care plan for aggressive inappropriate, maladaptive behavior does not denote any new interventions, or revaluation of interventions post

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 07/19/2023

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
S9999	Continued From page 36	S9999		

the incident when R14 hit R11 with the chair in the face. The last intervention is noted for 5/20/21.

Facility abuse policy titled Abuse, neglect, exploitation, mistreatment, and misappropriation of property dated 2/2023 denotes in-part the purpose is to assure that the facility is doing all that is within its control to reduce the risk of occurrence of abuse, exploitation, misappropriation of property, mistreatment, or neglect.

The residents' rights for people in long-term care facilities denotes in-part you must not be abused, neglected, or exploited by anyone, financially, physically, verbally, mentally, or sexually.

4. R9's face sheet shows diagnosis of lack of coordination, schizoaffective disorder, major depressive disorder, attention deficits hyperactivity disorder, epilepsy, bipolar disorder, history of traumatic brain injury.

Facility incident report dated 6/12/23 completed by V1 (Nurse) denotes in-part, incident location-dining room, resident observed with small skin tear/cut to top of lip. Resident was in dining room during breakfast when she was accidently hit with food tray on her lip. Resident assessed and lip cleaned no c/o (complaints of) discomfort. MD (medical doctor) aware. Alert and ambulatory without staff assistance. Injury type-skin tear, mental status orientated to place, orientated to person, orientated to place. No witness found. Physician notified at 6/12/23 at 10:53AM.

On 6/15/23 at 12:28PM R9 was observed in dining room, R9 stated R24 hit her in the mouth

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 07/19/2023

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
S9999	Continued From page 37	S9999		

with a food tray. R9 stated he had to move to another floor because of this. R9 pointed to her lip. R9's upper lip on the left side noted with a pinkish scab, the scab was visible.

On 7/7/23 at 1:56PM V72 (Nurse) said she was the only nurse on duty. R9 was not her resident. V72 said she was standing there when the incident happened. V72 said R9 was standing in the foyer near the dining room talking with a social worker when R24 threw her breakfast tray at R9 hitting R9. V72 said R24 has behaviors of yelling out when she sees people talking. V72 said R9 and the social worker were not talking to R24. V72 said she doesn't know who was monitoring the dining room. V72 said she was not monitoring the dining room. V72 said she rendered first aide to R9.

On 6/16/23 at 1:08PM V1 (Nurse) said she had just come on duty; she didn't see the incident however she did render first aide to R9. V1 said R9's upper lip had an opening, a skin tear. V1 said R9 told her that R24 hit her with the food tray. V1 said she doesn't know what happened in the dining room because she was not there at that time, but she was told that R24 hit R9 with the food tray. V1 said she completed the incident report, and she doesn't know why she documented it was an accident when she was not there to witness the incident.

On 7/11/23 at 12:00PM V73 (CNA-certified nursing aide) said she was in the dining room passing breakfast trays. V73 stated she had just given R24 her breakfast tray. V73 said R24 was going to her room to eat, that's what R24 usually does. V73 said she heard commotion after that. V73 said she heard about R24 hitting R9 with the food tray, but she did not see it, she was in the

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 07/19/2023

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
S9999	Continued From page 38 back of the dining room. V73 said V74 (Activity Aide) was in the dining room too. On 7/11/23 at 12:04PM V74 stated she was not working when R24 hit R9 with the breakfast tray on 6/12/23. Review of V74 timecard, V74 has a timecard for being on duty. V74 unit assignment cannot be verified during this survey. R24's face sheet shows diagnosis of schizoaffective disorder and psychosis. MDS dated 4/17/23 denotes BIMS (brief interview for mental status) score of 15 (cognitively intact). Section E for behaviors denotes potential indicators for psychosis- hallucinations and delusions box is checked. Behavior symptoms, presence, and frequency, 1 (behavior of this type occurred 1 to 3 day) is coded for verbal behavioral symptoms directed toward others (threatening, others, screaming at others cursing at others). V24 plan of care dated 4/23/23 denotes in-part aggression: resident has a history of presenting with verbal, physical, threatening, bizarre, erratic behavior, and destruction of property. Increased aggression towards staff, increased auditory hallucination, verbal aggression towards others. Resident appeared to have physical aggression towards peer. Increase agitation. R24 will show a decline in aggressive behavior as evidenced by self and staff report throughout next review. Per episodic event meet with resident to further discuss any triggers for her actions, motivate to seek staff if in distress. Discuss the behavior with resident and doctor for any changes. Provide time to vent her feelings, calm down. Motivate to share her views effectively. Placed on close monitoring.	S9999		

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 07/19/2023

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
S9999	Continued From page 39 PRSC (Psychiatric Rehabilitation Services Coordinator) will counsel resident on causes of agitation. Resident received a mood stabilizer. R24's progress note dated 6/12/23 denotes resident observed in the dining room during mealtime. Being disruptive and belligerent also putting food on the floor. Responding to internal external stimuli. Redirection was unsuccessful after several attempts. PRN (as needed) IM (intramuscular) administered as ordered at this time. Review of R24's medication administration record, there is no initials from V1 (Nurse) denoting as needed medication for behavior disturbances was given to R24 on 6/12/23. R24 clinical records reviewed there is no documentation denoting that the triggers of the incident on 6/12/23 were discussed, or that R24 was placed on one-to-one monitoring after the incident. R24 MAR reviewed, there is no documentation that R24 received a mood stabilizer for her aggression. R24 clinical record with discharge dated 5/22/23 denotes R24 was sent to hospital for psych evaluation for threatening others. R24 plan of care for aggression does not show any intervention updates after the hospitalization on 5/22/23 for threatening others. Facility assignment sheet dated 6/12/23 denotes there was one CNA assigned to the 8th floor unit. Facility abuse policy titled Abuse, neglect, exploitation, mistreatment, and misappropriation of property dated 2/2023 denotes in-part the	S9999		

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 07/19/2023

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
S9999	Continued From page 40 purpose is to assure that the facility is doing all that is within its control to reduce the risk of occurrence of abuse, exploitation, misappropriation of property, mistreatment, or neglect. The residents' rights for people in long-term care facilities denotes in-part you must not be abused, neglected, or exploited by anyone, financially, physically, verbally, mentally, or sexually. 5. R6's face sheet shows diagnosis of major depressive disorder, paraplegia, pressure ulcer sacral area, open wound to hip, diabetes mellitus, malignant neoplasm of pancreases, personal history of physical injury. MDS dated 5/18/23 denotes BIMS score of 15 (cognitively intact). On 6/15/23 at 12:39PM R6 stated on 5/31/23 around 10:00PM V2 (CNA-Certified Nursing Aide) got in her face when she was on the elevator. R6 said they was arguing and V2 said to her "I will slap the s*** out of you, I will kick yo a**". R6 said she made V4 aware of this allegation. V2 said V39 saw what happened on the elevator. On 6/15/23 at 3:13PM V39 (security staff) said he was coming off the elevator when he heard V2 (CNA-Certified Nursing Assistant) and R6 arguing with each other, V2 said he heard R6 tell V2 that "I will have my family come up here", V39 said he saw V2 get in R6 face a say "do you want to fight". V39 said R6 was really going off (verbally attacking) V2, saying many things. V39 said he can't recall everything but R6 was really going off on V2. V39 said he didn't report what he observed to the administrator. V39 asked surveyor about reporting abuse because he was not sure. V39 said V2 did not hit R6.	S9999		

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 07/19/2023

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
S9999	Continued From page 41 On 6/20/23 at 10:46AM V2 (CNA-Certified Nursing Aide) said she went to R6's room per nurse request to inform R6 and her visitors that visiting hours were over. V2 said R6's daughter and R6 began to tell her that you (V2) do too much (informing them that visiting hours are over). V2 said she left the room and informed the nurse that there were visitors in R6's room. V2 said she left the room, and by the time she got to the nurse's station, R2 and her visitors was passing the nurse station. V2 said when R6 passed the nurses station R6 continued to say things to her, V2 said R6 got to the elevator and that's when she said to R6 "god loves you and so do I". V2 was asked why she said something to R6 if R6 was at the elevator and she was at the nurse station. V2 said "well it's something you say to people that is saying nasty things to you (V2)". V2 said her last abuse prevention training was about 3 months ago. On 6/27/23 at 12:24PM V79 (R6 family) said on evening she was visiting with her mom (R6), V79 said she was in the room with R6 and V2 (CNA-Certified Nursing aide) came to the room and said visiting hours are over and you have to leave. (V79) said she told V2 that she (V2) "she was doing too much". V79 said the staff talks to them in a disrespectful manner often. V79 said she did leave, and security (V39) escorted her to downstairs lobby. V79 said V39 called her and informed her that V2 was arguing with R6 and wanted to fight R6. V79 said she knows V39 from the facility. V79 said this incident happened on May 25th or May 30th. V79 said she can't be exact on the date, and the incident did happen. V79 said she doesn't know if R6 reported this to the facility and she haven't asked R6. On 6/27/23 at 11:10AM V4 (Co-Administrator)	S9999		

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 07/19/2023

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
S9999	Continued From page 42	S9999		

stated V2 (CNA-Certified Nursing Assistant) informed her that nothing has every transpired between her (V2) and R6. V4 said she could not validate an incident happened with R6 and V2 on 5/31/23 because V2 did not work that day. V4 said R6 said the date of the incident was 5/31/23 and that's what date she investigated, that's it. V4 was asked what if it was 5/30/23 instead of 5/31/23, V4 continued to say she only investigated that date of 5/31/23 because that's what R6 said. V4 was asked if V2 acknowledged any occurrence with R6, V4 said what V2 did mention is that R6 is verbally aggressive with staff. R6's male guest has issues leaving the room so staff can provide care to R6's roommate. V4 was asked what did V4 say happened when she asked the visitor to leave because that is the date of the incident, V4 said she found out that V39 was dating R6's daughter, and she believes V39 did not give a true statement. V4 did not give response to the incident that transpired when V2 asked R6's visitor to leave on the night in question. V4 said V2 did not mention to her that she said to R6 "god loves you and so do I". Concern was expressed that staff is not informing V4 of everything.

On 6/30/23 at 12:42PM during a conference with V4 and R6, R6 said to V4 "remember when I told you V2 got in my face". V4 did not respond to R6's statement.

Facility abuse policy titled abuse, neglect, exploitation, mistreatment, and misappropriation of property dated 2/2023 denotes in-part the purpose is to assure that the facility is doing all that is within its control to reduce the risk of occurrence of abuse, exploitation, misappropriation of property, mistreatment, or neglect. Verbal/written abuse is defined as the

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 07/19/2023

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
S9999	Continued From page 43 use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their ability comprehend, or disability. Example of verbal abuse include but are not limited to threats of harm; saying things to frighten a resident, such as telling a resident that he/she will never be able to see his/ her family again. Have evidence that all alleged violations are thoroughly investigated. The residents' rights for people in long-term care facilities denotes in-part you must not be abused, neglected, or exploited by anyone, financially, physically, verbally, mentally, or sexually. (A) Statement of Licensure Violations 5 of 5: 300.610a) 300.1210a) 300.1210b) 300.1210c) 300.1210d)6) 300.1220b)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.	S9999		

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 07/19/2023

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
S9999	Continued From page 44 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 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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:	S9999		

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 07/19/2023

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
S9999	Continued From page 45 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 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. These Regulations are not met as evidenced by: Based on interview and record review the facility failed to implement fall prevention interventions to reduce the risk of falling. This affected 2 of 3 residents (R8 and R4) reviewed for fall prevention. This failure resulted in R8 being involved in a fall incident being sent to the hospital for treatment for swelling to the right eye, concussion, and minor brain injury, and R4 being involved in a fall incident resulting in a fracture of	S9999		

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 07/19/2023

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
S9999	Continued From page 46 the right inferior pubic ramus. The findings include: R8's face sheet indicates diagnosis including but not limited to cerebral vascular disease, hypertension, type 2 diabetes, atrial fibrillation, GERD (gastroesophageal reflux disease), anemia, bipolar disorder, hyperlipidemia, schizophrenia, constipation, anxiety, drug induced subacute dyskinesia, delusional disorders, altered mental status, essential tremors, vitamin D deficiency, pain in leg, and lack of coordination. R8's facility incident report dated 6/19/2023 completed by V50 (Nurse) denotes in-part incident location; resident (R8) room. Writer went to resident to bring him a milk supplement and he was observed on the floor. Resident (R8) stated he was trying to get out of bed. Head to toe assessment, right eye swollen, resident denied pain. PRN (as needed) acetaminophen administered, and ice pack applied to eye. V/S (vital signs) stable. MD (Medical Doctor) called. Resident sent out to hospital per facility protocol. No injuries observed at time of incident. R8 in wheelchair alert and orientated to place, Predisposing physiological factors-decreased safety awareness, involuntary movements. Witnesses V52 (CNA) I (V52) was doing rounds and found him (R8) on the floor. V50 (Nurse) I was bringing resident his supplement when I observed him on the floor. I (V50) had just seen resident minutes prior to the fall. Notes: IDT met to discuss fall and put in place interventions; resident was in room when he attempted to get up causing him to fall to the floor. Resident moved closer to nurse station. On 6/29/23 at 9:43AM V50 (Nurse) stated she	S9999		

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 07/19/2023

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
S9999	Continued From page 47 was the nurse working with R8 on 6/19/23 when R8 was observed on the floor. V50 stated R8 was not unresponsive. V8 stated R8 had just received a bed bath and change of clothing. V50 stated R8 had asked for a milk shake (nutritional supplement). V50 stated when she went back to give R8 the supplement she observed R8 on the floor. R8's head was up as if he was trying to get up. V50 stated R8 was laying straight out on the floor in between the two beds. R8's head was at the foot of the bed. V50 said she asked R8 what happened? What was he trying to do? V50 stated she couldn't determine what R8 was saying because R8 has communication deficits. V50 stated she observed swelling above R8's right eyebrow. V50 stated she don't know what R8 hit his right eye on. V50 stated she doesn't know if R8 hit his right eye on the floor or the bed frame. V50 stated she did her assessment, and she and two other staff members lifted R8 up and put R8 in the wheelchair. V50 stated R8 needs 2-person assist with transfers, she believes. V50 stated she always sees R8 in his wheelchair and she never had to assist with transferring R8. V50 stated she called the physician and did not get a response. V50 stated she called V8 (Director of Nursing) and informed V8 that R8 was going to be sent to the hospital and V8 agreed. V50 stated she called the state guardian and did not speak to anyone. V50 said she did not complete an incident report as she was not familiar with the PCC (point click care) electronic medical record system. On 6/29/23 at 11:16AM V52 (CNA) stated she was working on the 6th floor; she was not assigned to work with R8. V52 stated she was serving dinner in the dining room, and she noticed R8 was not there. V52 stated she went to R8's room and observed R8 on the floor. V52	S9999		

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 07/19/2023

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
S9999	Continued From page 48 stated she summoned V50 and the other nurse to the room. V52 stated it was her, V50 and V54 that picked R8 up from the floor. V52 stated R8 had scraped his knee. V52 said V54 was R8's CNA. On 6/29/23 at 11:34AM V54 (CNA) stated she was assigned to work with R8 on 6/19/23. V54 said she last saw R8 in the bed just before dinner trays had arrived. V54 stated V52 is the CNA that found R8 on the floor. V52 stated V52 was going to see why R8 hadn't come for dinner. V54 said R8 had on regular black socks when they picked R8 up off the floor. V54 stated that was her second time working with R8. V54 stated R8 needs help with getting in and out of the bed. V54 stated R8 will transfer himself in and out of bed. V54 stated she provides weight bearing support and pivots R8 in and out of the bed by putting her arms under R8 arms, bringing R8 to a standing position and then pivoting R8 to the wheelchair or bed. V54 stated R8 cannot come to a full standing position. On 6/29/23 at 12:09PM R8 observed in wheelchair self-propelling throughout the unit purposefully. R8 observed with constant involuntary movement to the upper extremities, however, R8 continues to able to self-propel in the wheelchair. R8 communicated with surveyor about going to the dentist. R8 observed to be wearing black crew socks. On 6/29/23 at 12:24PM V5 CAN stated R8 self-propels in the wheelchair. V5 stated R8 needs help getting in and out of the bed. V5 stated she got R8 dressed this morning and R8 assisted by raising his arms when putting on the shirt. V5 stated R8 can also assist with pulling up his pants. V5 stated she put the black socks on	S9999		

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 07/19/2023

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
S9999	Continued From page 49 R8 this morning. V5 stated those are the socks that R8's family provided and so she used them. V5 stated R8 should have on skid free socks. V5 said the skid free socks helps to prevent falls. V5 stated R8 is a fall risk. V5 stated R8's room was recently moved closer to the nurse station because R8 had a fall. When V5 was asked how do you know who needs skid free socks? V5 asked surveyor "is it the resident's that's a fall risk?". V5 was asked does she know who to ask? V5 replied "the nurse". V5 denied R5 refused assistance with care this morning. On 6/30/23 at 11:30AM V8 stated R8 should have on skid free socks. V8 stated its to prevent falls when R8 tries to stand up. V8 stated R8 has unsteady gait/balance. V8 stated the skid free socks is a fall prevention intervention for R8. V8 stated if the family brings regular socks, the staff must continue to put on skid free socks for R8. V8 stated the restorative aide knows what fall preventions the resident's need and they should be checking daily that the fall interventions are in place. V8 stated the restorative aides should inform the aides of what fall interventions the resident needs. V8 said the aides have not been provided any in-service on fall interventions that are in place, specifically skid free socks. V8 stated she will follow up with surveyor regarding how she is ensuring the restorative aides are informing CNAs of what fall interventions that are needed and who has fall interventions in place. V8 then stated there's a binder on the unit and inside the binder is a list of resident's fall interventions. V8 stated she will follow up with surveyor regarding how she's ensuring that the CNA's know about the binder and the fall interventions that are inside the binder. V8 was made aware that on 6/30/23 at around 12:09PM R8 was observed not wearing skid free socks and	S9999		

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 07/19/2023

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
S9999	Continued From page 50	S9999		

that the staff dressed R8 that morning and did not put skid free socks on R8.

Review of R8 plan of care dated 4/24/23 denotes in-part R8 is at risk for falls as evidenced by the following risk factors and potential contributing diagnosis: diabetes mellitus, general weakness, use of anti-seizure medication(s), use of hypoglycemic agents, use of psychotropic medications. R8 will have a safe environment maintained through next review. Interventions dycem applied to wheelchair. R8 sent to the ER for treatment/evaluation, upon return on 5/19/2023 R8 is educated to call for assistance when in need of transfer. R8 sent to hospital for treatment/evaluation, upon return on 6/22/2023. R8 is moved closer to nurses' station for increased monitoring. Keep bed in the lowest position. Nursing staff will complete a fall risk assessment per facility fall protocol. Follow the facility fall protocol. Place R8 call light within reach and encourage me to use it for assistance as needed. Ensure that R8 is wearing appropriate footwear that provide stability and good traction when ambulating or mobilizing in w/c (wheelchair) and during transfers. Staff to anticipate and meet R8 needs. Pharmacy consults to evaluate R8 medications. Check to see that R8 bed brakes are locked prior to transferring. Commode placed over toilet/grab bars to make standing up easier. R8 has a "self-care deficit" with impaired dressing and grooming abilities and would benefit from participation in a dressing/grooming restorative nursing program as evidenced by the following risk factors and potential contributing diagnosis: bipolar disorder, diabetes mellitus, psychiatric disease process, requires 1-person assist with dressing and grooming. R8 requires extensive assist with dressing, requires extensive assist with grooming, schizophrenia and/or

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 07/19/2023

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
S9999	Continued From page 51 schizoaffective disorder, unsteady gait, and balance. R8 will assist as much as possible with dressing/grooming, donning/doffing, pants/shirt, shoes/socks daily with limited 1-staff for hygiene potential thru next review each day and as needed unless the disease process causes unavoidable deterioration, until next review. Provide assistance with all ADL's (activity of daily living) as required per R8 dependence needs eating, transferring, bed mobility, bathing, dressing, personal hygiene, ambulation, and personal hygiene. R8's ER (emergency room record) dated 6/19/23 denotes in-part patient presents to the ER via ambulance with a c/o (complaint of) unwitnessed fall at city view nursing home, patient has swelling to the right eye, patient presents in gown, patient placed on cardiac monitor, labs collected and sent, patient given cold pack to the right eye. Discharge diagnosis- concussion and minor head injury. R8 fall risk assessment dated 6/19/23 denotes in-part score of 15, high risk for falls, no history of falls in past 3 months, yes for resident receiving medications that affects awareness, judgment, or safety. Altered level of consciousness- behaviors present-fluctuates. Adequate vision, ambulation with assist, elimination; incontinent. Balance problems, change in gait pattern when walking, requires use of assistive devices, 1-2 health conditions that predispose resident to be at risk for falls. Total score 15. Facility Fall prevention and management policy version date 8/3/2017 denotes in-part this facility is committed to safety and maximizing each resident's physical, mental, and psychosocial well-being. The purpose of our fall prevention and	S9999		

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 07/19/2023

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
S9999	Continued From page 52	S9999		

management program is to provide our residents with an interdisciplinary approach to assess risk of falls. Provide appropriate interventions to prevent falls. Ensure that in the event a fall occurs, the fall will be investigated, appropriate emergency treatment will be provided, and additional interventions will be implemented to prevent another fall from occurring as much as possible. While preventing all incidents including falls is not possible, this facility is committed to act in a practical manner to identify those residents at risk for falls, plan for preventive strategies, and facilitate as safe an environment as possible. This is accomplished through the fall program. This facility will achieve this goal through an individualized fall risk assessment, interventions that are implemented based upon the identified risk factors, immediate response to residents who fall including assessment for any injuries and the emergency management of any injuries. Reassessment of risk after a fall with modifications and /or additional interventions as appropriate.

Facility titled baseline care plan assessment/ comprehensive care plans with last update of 11/25/2017 denotes in-part, policy; the comprehensive care plan will further expand on the resident's risk, goals and interventions using the person-centered plan of care approach for each resident that includes measurable objectives and timetables t meet the residents medical, nursing, physical functioning, mental and psychosocial needs. These needs will be defined from observation, interviews, clinical medical record reviews and through assessments and CAAs (care area assessments).
2. R4 is a 77-year-old with diagnosis including but not limited to diabetes, major depressive disorder, delusional disorder, history of traumatic

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 07/19/2023

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
S9999	Continued From page 53 brain injury, altered mental status, syncope and collapse, dementia, osteoarthritis, and vitamin d deficiency. According to assessment dated 5/15/23 R4 is severely cognitively impaired with a score of 4. On 6/15/23 at 11:59AM R4 observed in her room ambulating, no staff with her, not wearing a helmet. On 6/22/23 at 12:20PM R4 observed ambulating, no helmet, and staff walking next to her without their hands on her. On 6/22/23 at 1:53PM V32 Registered Nurse (RN), stated R4 takes her helmet off. V32 said we keep R4 with us staff to watch her. V32 stated R4 is alert times one and she is usually walking. On 6/21/23 at 3:27PM V26 Certified Nursing Assistant (CNA), stated R4 is supposed to be a 1:1 monitoring. V26 stated R4 is total care except for ambulation. V26 said you must watch R4 she is confused. V26 stated R4 must be under supervision when we have available staff. On 6/28/23 V44 CNA, said R4 can walk by herself but she needs redirection, she has dementia, she is confused and wanders. V44 stated I was in the dining room, yesterday (6/27/23) and R4 was walking back and forth. V44 stated I was sitting at the table in the dining room, R4 was near the TV (television) in the dining room (surveyor observed TV is on the other side of the room from V44). V44 stated I could not see R4 because she was behind the post in the dining room. V44 stated I was looking down, charting, and I heard the other residents saying no, no. V44 stated when she looked up, she saw R25 holding a chair. R25, had pushed	S9999		

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 07/19/2023

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
S9999	Continued From page 54 R4 and she was sitting on her on the floor. V44 stated she and V32 picked R4 up and took her to the nurses' station. V44 stated R4 is not walking today she is sitting in a wheelchair at the nurses' desk. V44 said R4 was a 1:1 for monitoring about a month or two ago. V44 stated R4 was a 1:1 because of her falling. V44 said sometimes R4 responds to redirection. V44 said R4 is supposed to wear a helmet, but she won't' keep it on. (The surveyor was not shown a helmet and did not see staff attempting to put the helmet on or offering it to R4). On 6/28/23 at 2:04PM V8 Director of Nursing, stated R4's baseline is wandering, and she needs redirection and close monitoring. V8 stated we provide R4 with "close monitoring and redirect when walking". V8 stated R4 was in the dining room yesterday (6/27) and her and another resident had their hands on a chair. V8 stated when V44 looked up due to the commotion R4 was on the floor. V8 said V44 was charting. V8 stated R4 has a fracture and went to the hospital today (6/28). V8 stated the interventions were not effective in preventing a fall and injury for R4. V8 stated R4 was not in sight of the staff. V8 stated R4 had a fracture on 1/26 caused by osteopenia. V8 stated the doctor said R4's walking and weakness caused that fracture. On 6/29/23 at 11:11AM V8 stated R4 is only alert to her name and can't make decisions. On 6/29/23 at 1:12PM V40 Director of Rehab, stated on 6/9/23 R4 was discharged from therapy, and she had mild balance impairments and "100%" cognitive impairments. V40 stated R4 was educated on safety techniques while in therapy. V40 stated R4 is "possibly not able to retain that education" due to her cognition.	S9999		

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 07/19/2023

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
S9999	Continued From page 55 R4's Fall Risk Review dated 12/28/22 identifies R4's category of high fall risk. R4's incident reports reviewed and are as follows: Fall on 9/6/22 obtained laceration on the top of her head. Fall on 11/22/22 obtained a bruise on her left arm. Fall on 11/28/22 obtained hematoma to forehead. Fall on 12/22/22 laceration on head. Fall on 1/5/23 discoloration to right inner thigh. Right hip X-ray performed without fracture. Review of R4's progress notes and X-ray results denote X-ray due to pain and inability to walk dated 1/26/23. X-ray results denote pelvis and left hip fracture presumable acute. Fall on 6/27/23 R4 obtained a skin tear on her chest and X-ray denotes fracture right inferior pubic ramus. R4's Functional Status assessment dated 5/15/23 denotes she required extensive physical assistance from staff for walking, bed mobility, and transfer. R4's balance is noted to not be steady and only able to stabilize with staff assistance. R4's care plan denotes she is at risk for falls related to cognitive impairment, weakness, and use of psychotropic medications. Interventions include monitoring, wheelchair for mobility, labs reviewed, helmet, and redirection by staff. R4's progress notes dated 6/8/23 denotes Gait dysfunction - continue to work with PT (physical therapy) to improve balance. Fall Prevention and Management Program, version 08/03/17, denotes the purpose of the	S9999		

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 07/19/2023

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
S9999	Continued From page 56 program is to provide appropriate interventions to prevent falls. The program will decrease the incidence of falls and falls with injuries. (A)	S9999		