STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. Building B. Wing	09/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
City View Multicare Center	5825 West Cermak Road Cicero, IL 60804

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39340 Based on interview and record review, the facility failed to follow their abuse policy by not preventing resident to resident assault against 1 of 3 residents (R5) reviewed for physical abuse. This failure resulted in R5 being physically assaulted by a co-peer (R12), R5 sustained a fracture to the left nasal bone, large periorbital soft tissue hematoma, and a 3cm laceration that required 4 sutures. Findings Include: R5 was admitted to the facility on [DATE] with a diagnosis of Schizophrenia, Psychosis, Suicidal Ideations, Delusional Disorders, Arthritis, and Auditory Hallucinations. R5's Minimum Data Set (MDS) dated [DATE] under Brief Interview For Mental Status (BIMS) documents a score of 15/15 which indicates cognitively intact. R5's progress note dated 12/12/20 documents: At 2:50 pm resident was on the unit, alert and oriented and in no distress. Around 3:10 pm writer was informed by another peer that the resident allegedly received physical aggression from another male resident in the male bathroom. Writer rushed down to check on him. He was bleeding in his left eye and refused treatment from nurse, denies pain stated he's ready to go to the emergency room . Facility's abuse reportable dated 12/18/2020 documents: R12 made physical contact with R5. Under conclusion documents, R12 admitted to making contact with peer. Staff noted witnessing R5 and R12 going into restroom and R5 exiting with skin laceration. On 9/8/21 1:19 pm, R5 who is alert and oriented at time of interview said he was punched in the face by another resident in the common washroom. R5 said he had limited vision to his left eye before the incident and is now no longer able to see from his left eye. On 9/10/21 at 9:59 AM, R5 who was alert and oriented said R12 punched him in the face a few times and he fell to the ground. R5 was unable to provide any further details. R5 stated he did not hit R12. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Local hospital record dated 12/12/2020 documents: R5 presented to emergency room with head laceration after assault. R5 states he got into an argument with another resident, was hit in the head and suffered a brief loss of consciousness. Notes under physical exam documents: laceration over left eyebrow approximately 3 cm. there is significant soft tissue swelling around the left periorbital region. Notes under results documents: Computerized Tomography (CT) head and facial bones findings; There is an oblique fracture of the left side nasal bones, increased density is seen in left globe, possible hemorrhage with disruption. Large left periorbital soft tissue hematoma. Under procedure note documents; simple laceration repair to forehead total length 3cm. Four sutures were utilized. Facility abuse prevention program revised 3/26/21 documents: It is the policy of this facility to prohibit and prevent resident abuse, neglect, mistreatment and misappropriation of resident property and a crime against a resident in the facility. The facility will not tolerate resident abuse or mistreatment or crimes against a resident by anyone, including staff, other residents, consultants, volunteer, family members, legal guardians or other individuals. Abuse is the willful infliction of injury with resulting harm or pain or mental anguish or deprivation by an individual. Physical abuse is hitting, slapping, pinching kicking etc. R12 was admitted to the facility on [DATE] with diagnosis of Schizoaffective Disorder, Major Depressive Disorder, abnormalities of gait and mobility. R12's preadmission screening dated 10/18/2018 documents under physical assault injury, a moderate behavior level. Note under description documents: Patient was hospitalized with suicidal and homicidal ideations. He had been noncompliant with his medications and was agitated and felt like hurting someone or hurting himself. R12's progress note dated 12/12/20 documents: Resident initiated physical aggression towards another resident in the male bathroom around 3:10 pm, he denies the allegation but in house camera was able to point him out. R12's progress note dated 12/12/20 at 15:20 documents: Day 1/3 Physical Aggression towards peer social service made aware that resident was allegedly physically aggressive towards peer. Upon meeting with resident, he denies actions stating, I didn't do anything, I stayed away from him after you told me to. After, further investigation and being presented with information R12 admitted to staff that he hit peer. R12 then expressed his dislike for his behavior towards staff earlier. Resident was encouraged to not intervene in situations that do not pertain to him and allow staff to take care of any difficulties. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Resident educated on the importance of maintaining safety and a positive relationship with others. Resident able to verbalize understanding. Nurse on duty contacted Doctor for further instructions and possibility of sending to hospital for further evaluation. Resident will continue to be monitored. Resident aggression assessment and care plan updated. Social services will continue to follow up. R12's care plan dated 9/11/2020 documents: R12 is an identified offender with moderate risk. Interventions dated 9/11/20: Staff will do appropriate supervision/observation, regular monitoring, attention to behavior changes, visual monitoring if warranted and reassessment. Facility abuse prevention program revised 3/26/21 documents: It is the policy of this facility to prohibit and prevent resident abuse, neglect, mistreatment and misappropriation of resident property and a crime against a resident in the facility. The facility will not tolerate resident abuse or mistreatment or crimes against a resident by anyone, including staff, other residents, consultants, volunteer, family members, legal guardians or other individuals. Abuse is the willful infliction of injury with resulting harm or pain or mental anguish or deprivation by an individual. Physical abuse is hitting, slapping, pinching kicking etc.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40066 Based on interview and record review the facility failed to ensure staff provided the identified level of assistance to prevent a fall for 1 (R4) of 3 residents reviewed for falls. In addition, the facility failed to implement their care planned safety interventions for 1 (R4) of 3 residents reviewed for safety. Findings include: R4 is [AGE] years old with diagnoses including but not limited to Hemiplegia and Hemiparesis, Diabetes Mellitus, Cerebrovascular Disease, Hyperlipidemia, Hypertension, need for assistance with personal care, visual loss, difficulty walking, and Dementia. R4's care plan notes documents: she requires extensive assist for ambulation and one person assistance for transfer, has Dementia with periods of forgetfulness, and is at risk for falls due to her decreased safety awareness. On 9/8/21 at 12:58 PM R4 observed sitting in her wheelchair in the dining room. R4's wheelchair observed with no extenders on wheelchair with an empty plastic cup hanging upside down from the wheelchair brake handle on the left side. R4 stated she gets herself up from bed and into bed every day. R4 said she does not call the staff to help her. R4 stated she fell last month in the bathroom she didn't get injured and got herself up. On 9/8/21 at 1:05 PM V6, Certified Nursing Assistance (CNA), said R4 is able to transfer by herself, she does not let me do anything for her. She is in the wheelchair when I get here at 7:00 AM and in it when I leave. I don't know when she goes to the bathroom, because she does not tell me. On 9/8/21 at 1:18 PM V7, Restorative Nurse, stated R4 is on restorative programs for walking and assisted range of motion (AROM). V7 statedR4 has bilateral weakness in her legs and she is not safe to stand and transfer independently. V7 stated on 8/5/21 R4 said she fell while she was trying to go to the bathroom. V7 stated R4 should have someone with her when transferring on and off the toilet. V7 stated her initial concern related to R4's fall on 8/5/21 was R4 locking her wheelchair. V7 stated to address this concern she placed an order for wheelchair brake extenders. V7 said I requested these I know they were ordered. V7 was unable to provide documentation that the item was ordered. V7 stated R4 is able to lock the wheelchair. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 9/9/21 at 9:31 AM V10 Licensed Practical Nurse (LPN) stated, the night shift CNA reported that R4 was in the bathroom. V10 said when she went to R4's room R4 told me she had fallen, but she was now sitting in her wheelchair in the bathroom. V10 said R4 said she had missed the toilet and fell . V10 said it is usual for R4 to get up unassisted. V10 said R4 does accept assistance from staff when offered. On 9/9/21 at 1:16 PM V16 Director of Therapy stated, R4 has brake extender devices on her wheelchair to use when she stands. V16 stated we evaluated R4 after her fall on 8/5/21 and she was unchanged from the last time we worked with her. V16 stated whatever the care plan instructed her transfer status to be is what she was. On 9/9/21 at 1:35 PM V17 nurse stated, if a resident is 1 assist, they should not be left alone in the bathroom because they need assistance. If the resident got themselves into the bathroom then staff should stay with them to prevent a fall. On 9/9/21 at 1:50 PM V7 stated a clamp was applied to R4's wheelchair to assist her with locking it. I put the device on R4's wheelchair today. V7 stated, according to R4's Functional Status assessment dated [DATE] she requires 1 person hands on assist for transfers, toilet use, and personal hygiene. V7 stated based on this assessment dated [DATE] R4 is not safe to transfer herself. V7 stated on 8/5/21 R4 should not have self-transferred and today R4 should not be self-transferring. V7 stated R4 should not be left alone in the bathroom, because she needs 1 person assist and she will transfer herself alone. On 9/9/21 at 2:24 PM by phone interview V21 CNA stated on 8/5/21 R4 pulled the call light and was sitting in the wheelchair. V21 stated R4 said she fell . V21 stated I don't know how she got into the wheelchair. V21 stated before the fall she saw R4 in her bed. V21 said R4 gets up by herself around 5:30 to 6:00 AM, she is independent. V21 said R4 does not ask for help. V21 said a 1 assist can't be left along in the bathroom. On 9/10/21 at 10:24AM V2, Director of Nursing (DON), said she expects staff to follow the care plan interventions. V2 said the interventions are put into place to provide consistent care and maintain the safety of the residents. R4's care plan dated 2/17/20 notes educate resident to lock wheelchair before sitting/standing with wheelchair, therapy to screen for proper use of wheelchair. R4's care plan dated 2/18/20 notes refer to therapy for safe transfers and redirect resident to lock wheelchair prior to sitting. R4's care plan dated 8/5/21 notes resident received floor change, brake extenders placed on wheelchair, and staff provided education on proper wheelchair locking, therapy screen. Progress Note dated 8/5/21 written by V10 notes resident was sitting on bathroom floor did not have breaks on wheelchair locked. R4 said I was trying to use the bathroom and fell . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Falls & Accident / Incident Resident Management Review dated 8/5/21 notes facility identified during the investigation that resident has impulsiveness. Order to be placed for break extenders if it is appropriate upon therapy assessment. Functional Status assessment dated [DATE] notes extensive assistance of 1 person is required for transfers, toilet use, and personal hygiene.