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	10/07/2022

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** 34072 Based on interview and record review the facility failed to follow their abuse policy to prevent resident to resident physical assaults. This affected 3 of 3 (R11, R2, and R3) residents reviewed for abuse. These failures resulted in R11 physically assaulting R10, R10 sustained a left orbital fracture requiring 10 facial sutures, this failure also resulted in R4 physically assaulting R3 and R3 sustained a black eye. Findings include: On 10/4/22 at 2:00pm, V4 DON (director of nursing) stated that R10 did not exhibit any behaviors while residing at this facility. V4 stated that based on interviews with staff and residents, it was concluded that R10 fell and hit his eye on the dresser. R10's fall incident report, dated 9/18/22, reviewed with V4. Incident description noted R10 observed with open area to left eyebrow. R10 refused to give description of fall. When questioned what 'other' means in sections: predisposing environmental, physiological, and situation factors, V4 responded that V4 did not know. V4 was not able to elaborate on R10's left eye swelling, bruising, blowout fracture, or how R10 had two lacerations to eyebrow from a fall on level surface. On 10/5/22 at 10:34am, R10 stated that on 9/18/22, R11, R13 (R10's roommate), and V24 (security) were in R10's room. R10 stated that V24 was breaking the lock off R13's dresser because R13 locked keys in the dresser. R10 stated that R10 was lying in bed at this time. R10 stated that R11 started yelling and cursing at R10. R10 stated that R13 and V24 exited the room and R11 hit R10 repeatedly in the face. R10 stated that the previous day, 9/17, R11 brought a bottle of alcohol into R10 and R13's room. R10 stated that R10 and R11 had an argument. R10 stated that when staff came into R10's room, everyone was on R10's side of the room; R11 and R13 informed staff that the alcohol belonged to R10. R10 stated that staff told R10 he would have to go to the disciplinary floor as a result of having alcohol; staff never transferred R10. R10 stated that R13 came back into R10's room and hit R10 in the face. R10 stated that R10 informed a staff member of this. R10 stated that R10 had only been at this facility for a short time and does not remember who the staff member was. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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	On 10/5/22 at 2:30pm, V24 (security) stated that V24 was present on 9/18/22 from 2:00pm until 10:00pm. V24 stated that when V24 came in to work that day, he was told to cut R13's lock off. V24 stated that R13 was present in room at that time, R10 was present in room with curtain closed, and R11 was outside of R10's room. V24 stated that V24 left R10 and R13's room after cutting the lock on R13's dresser. V24 stated that V24 heard a door slam, V24 turned around and saw R10 standing in the hall bleeding and R10 stated that he was attacked. On 10/5/22 at 1:09pm, V26 LPN stated that V26 was R11's nurse on the evening shift on 9/18. V26 stated that V26 does not know what happened. V26 stated that V24 (security) told her that R10 was bleeding; R10 had blood gushing from his face and V26 gave R10 a towel. V26 stated that there was blood on the floor; and a trail of blood between R10's bed and the hallway. V26 stated that R11 denied hitting R10. V26 stated that R11 did acknowledge that R11 and R10 had a verbal altercation the night before. V26 stated that neither resident gave any specific details regarding the incident on 9/17. V26 stated that V26 did not see any alcohol in R10's room nor did R10 appear intoxicated. On 10/6/2022 at 2:00pm, V31 (emergency room manager) stated that blowout fractures are typically seen in physical altercations. On 10/6/22 at 3:23pm, V31 called this surveyor. V31 stated that V31 reviewed R10's hospital record with physician. V31 stated that EMS (emergency medical services) noted R10 was being transported from facility to hospital due to battery. On 10/6/22 at 5:20pm, V23 (housekeeping) stated that V23 does recall having to clean R10's room after incident. V23 stated that V23 noted some blood on the floor. V23 stated that V23 checked all of R10's furniture (bed frame, dresser, and nightstand) and did not find any blood. V23 stated that R10 had a tall dresser. When asked to clarify how tall the dresser was, V23 stated that V23 is 67 inches tall, and the dresser is taller than that. Review of R10's medical record notes R10 is 65 inches tall. R10 was admitted to this facility on 8/23/22 with diagnoses including major depressive disorder and bipolar disorder. Review of R10's BIMS (brief interview of mental status) score, dated 9/2/22, notes R10's score is 15 out of 15. Review of R10's screening assessment for aggressive/harmful behavior, dated 8/23/22, notes R10 is minimal risk for aggression at this time. Review of R10's medical record notes: On 9/17 at 4:10pm, V27 LPN (licensed practical nurse) noted: R10 and R11 arguing. R10 was in R10's room at the time of this behavior. Interventions: R10 and R11 were separated, therapeutic communication. Effectiveness of the interventions: stable. On 9/17 at 4:57pm, V4 DON noted: R10 observed with incoordination, and mood and behavior changes. R10 assessed, vital signs stable. No signs/symptoms of distress noted. R10's room checked, and empty bottles of alcohol recovered. Physician made aware. Social service made aware. R10 will be monitored. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 9/18 at 6:00pm, V19 LPN noted: staff observed R10 in hallway leaning forward. When asked R10 what happened R10 alleged that R11 made physical contact with R10. R10 and R11 were immediately separated. Immediate head to toe assessment completed. Left upper eyebrow area with open area pressure applied. No change in level of consciousness. R10 denied blurred vision headache at that time. Neurological checks at baseline. V1 (administrator) and V4 DON notified. R10 transported to the hospital via 911 EMS (emergency medical services). Review of R10's hospital record, dated 9/18/22, notes R10 presented to the emergency room for a chief complaint of left head injury. R10 stated that while he was lying in bed another individual struck R10 3-4 times in the left side of R10's face. R10 stated that R10 has left head/facial pain. Physical exam noted facial swelling, eye pain, headache, bruising, and two lacerations above left eye. Neurological exam noted R10 was alert and oriented x 3. Psychiatric exam noted R10's behavior normal. CT (computerized tomography) scan of R10's head noted: acute left lamina papyracea blowout fracture with 5-millimeter medial herniation of the infraorbital fat into the ethmoidal air cells. The medial rectus muscle is approaching the fracture site. Left periorbital soft tissue contusion. Laceration: there were two 1.5-centimeter lacerations to the left eyebrow. Both lacerations were cleaned and approximated with 5 sutures each. Review of R11's medical record notes R11 was admitted to this facility on 6/13/22 with diagnoses including schizoaffective disorder, major depressive disorder, bipolar disorder, insomnia, and auditory hallucinations. Review of R11's BIMS score, dated 9/20/22, notes R11's score is 15 out of 15. Review of R11's screening assessment for aggressive/harmful behaviors, dated 6/15/22 and 9/20/22, notes R11 is at moderate risk for aggression. Review of R11's medical record notes: On 8/17/22, nurse noted: R11 was involved in a physical altercation with peer in dining room before staff could intervene. Both residents immediately separated. V1 (administrator) and V4 DON notified, and a police report filed. On 9/17/22 at 4:10pm, V27 LPN noted: R11 arguing with R10. At the time of the incident R11 was visiting R13 in R10 and R13's room. Interventions attempted: R11 and R10 separated, therapeutic communication. Effectiveness of the interventions: stable currently. On 9/18 at approximately 6:00pm, nurse was notified by V24 (security) that while going to cut a lock off, R10 stated that R11 came into R10's room and hit R10 unprovoked. R11 stated that R11 didn't hit R10. Nurse notified V1 and V4. Review of R11's change in condition/evaluation form, dated 9/18/22 notes R11 with behavioral symptoms. R11's physician paged, has not called back yet. There is no documentation found in R11's medical record noting R11's physician called the facility or that staff made any further attempts to contact physician after this incident. On 10/1/22 at 11:40am, R2 stated that R1 hit R2 because he thought R2 had taken R1's snacks. R2 stated that R1 and R2 were in the social services office at the time R1 hit R2. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 10/1/22 at 1:32pm, V5 (social services) stated that V5 was in her office with R2, R2 was sitting next to the door. V5 stated that R1 came in unprovoked and hit R2 on the left upper back and shoulder area. V5 stated that V5 immediately separated R1 and R2. V5 stated that R1 was escorted back to R1's room by security and placed on 1:1 monitoring until R1 was no longer a threat. V5 stated that R1 has a history of aggressiveness and delusions. V5 stated that earlier same day, R1 was restless and had thrown a television and broke it. V5 stated that V5 kept some snacks from R1's family in V5's office. V5 stated that R1 thought R2 was eating R1's snacks; R2 was not eating at all in V5's office. On 10/1/22 at 3:30pm, V9 RN (registered nurse) stated that V9 is familiar with R1. V9 stated that R1 exhibits aggressive behaviors frequently. V9 stated that on 9/13/22, R1 destroyed a television in another resident's room and then slammed a water jug in the hallway on ground and broke it. V9 stated that when V9 questioned R1, R1 stated that R1 didn't like what was being said on the television. V9 stated that R1 was able to be calmed down. V9 stated that R1 hit R2 later that same day because R1 was upset that R2 was taking all of the snacks. Review of R1's medical record notes R1 was admitted to this facility on 6/9/22 with diagnoses including schizophrenia, bipolar disorder, depression, anxiety disorder, and seizure disorder. Review of R1's MDS (minimum data set), dated 9/16/22, notes R1's BIMS score is 15 out of 15. R1 is able to make needs known. Review of R1's screening assessment of aggressive and/or harmful behavior, dated 6/10/22, notes R1 at moderate risk for aggression. R1 comes with history of aggressive behavior. Review of R1's medical record, dated 6/12/22, notes R1 unpredictable, physical and verbal aggression toward staff, hard to re-direct, destruction of property. Interventions attempted: redirection and close monitoring; interventions ineffective. On 6/21/22, notes R1 made physical contact with another resident. R1 came out of his room and went to the dining room and pushed another resident without any provocation. Both residents were separated and redirected to their respective rooms and assessed and put under close monitoring. On 6/21/22, social services noted: Resident seen in relation to alleged physical aggression towards peer. At the time of visit he was noted with some restlessness and responding to internal stimuli. Resident provided with reorientation and redirection. During visit he was asked about alleged behavior for which he was disorganized with his thoughts, delusional saying he was hearing voices of people telling him different things. On 7/26, R1 exhibited physical aggressive behaviors. On 7/27, V5 (social services) noted: R1 seen in relation to alleged physical aggression towards peer. At the time of visit he was noted responding to internal stimuli. On 8/12, V5 noted: R1 was demonstrating restlessness and delusional thought process with various topics. On 9/13 at 3:24pm, V9 RN noted: property destruction. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 9/13 at 4:37pm, V5 (social services) noted: R1 seen to further discuss behavior episode towards R2 while on the unit. R1 at the time removed from area and provided with education on the importance of safety and getting along with others in a positive manner in order to avoid any injuries or further problematic situations. R1 to continue to be monitored. On 9/14, V5 noted R1 noted to be responding to internal stimuli. Review of R2's medical record notes R2 was admitted to this facility on 6/20/22 with diagnoses including schizophrenia, major depressive disorder, schizoaffective disorder, psychosis, generalized anxiety disorder, bipolar disorder 9/13/22, R1 made physical contact towards R2. Complete head to toe assessment initiated, R2 sustained no injuries as a result of this incident. Skin intact. Range of motion within normal limits, neurological checks within normal baseline. V1, physician, and responsible party notified. Review of R2 BIMS score dated 9/13/22, notes R2's score is 15 out of 15. Review of this facility's abuse policy, undated, notes to identify, correct, and intervene in situations in which abuse is more likely to occur. The deployment of staff on each shift in sufficient numbers to meet the needs of the residents and assure that the staff assigned have knowledge of the individual residents' care needs. The assessment and monitoring of residents with needs and behaviors which might lead to conflict, such as residents with a history of aggressive behavior. 34069 On 10-1-22 at 10:58 AM, R3 stated R4 hit him because R3 owed R4 two cigarettes and did not have any when asked. R4 hit R3's eye with his fist. On 10-2-22 at 10:17 AM, V1 (administrator) stated R4 is bipolar with schizoaffective disease. Even with medication and constant behavioral monitoring, R4 has had aggressive behavior in the past. R4 is on the 7th floor which is a male psychiatric unit. All psych patients can have unpredictable changes in behavior. V1 was informed by staff about V4 abruptly hitting V3 in the eye. R3 sustained and swollen eye. Psychiatric patients have no impulse control and will react first before thinking things through. On 10-1-22 at 12:40 PM, V4 (director of nursing) stated R4 is alert, oriented x 3, can be verbally and physically aggressive (re-directable), and can be agitated. On 9-14, R4 was verbally aggressive towards staff. R4 was placed on social service wellbeing checks for 72 hours. Staff will monitor resident every hour alternating with nurse, CNA, and security. Residents are monitored to make sure they are calm, stable, and not any change in condition or concerns. V4 was informed V4 and V3 were in an altercation. R4 hit R3 in the eye and sustained discoloration to right eye. Staff immediately separated R3 and R4. R4 was placed on 1:1 supervision for a couple of days (minimum of 72 hour). R3 was moved to the 4th floor. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 10-1-22 at 10:01 AM, V5 (social worker) state R4 is known to be psychotic and delusional. V5 stated R4 was throwing things at staff on 12-27-21. R4 was delusional and called 911 one time. On 9-14-22, R4 was verbally aggressive toward staff. R4 was started on well-being checks. R4 was rambling off topic. V5 stated she was not on duty at the time of the incident. V5 stated she was told by staff about R4 hitting R3 resulting in a right black eye with no other injury noted. V5 continued with R4's well-being checks. V5 is not aware of R4's previous altercations with R3. R4 can be easily agitated. R4 requires more frequent monitoring every 15 minutes. R4 was noted disorganized with thoughts on 9-14 and 9-15. On 10-1-22 at 11:23 AM, V3 (LPN) stated R4 is alert, oriented x 1-2. with confusion, delusions, and hallucinations. R4 is impulsive and unpredictable. R4 is delusional and will talk about things that nobody understands. R4 can come off as intimidating and aggressive by his peers. V3 stated staff saw R3 with a black right eye on 9-15-22. R3 stated R4 attacked him. V3 stated R3 has a history of entering others, rooms and taking things. R4 told staff R3 took his belongings. R4 admitted to hitting R3. Facility is not able to determine what time this incident took place. V3 stated there is more staff on 7th floor to monitor the residents. R4 requires monitoring more frequently. On 10-2-22 at 10:46 AM, V6 (LPN) stated R4 is alert, oriented x 2, confused, and delusional. V6 stated he thinks R4 has hallucinations. R4 is unpredictable and impulsive. R4 has verbal and physical aggression. R4 can be unpredictable and may require close monitoring. V6 saw R3 with discoloration to right eye on 9-15-22. R3 told V6 that he was hit by R4. R3 could not tell V6 why R4 hit him. V6 talked to R4 and told V6 that R3 took his shit. R4 refused to discuss further with V6. R4 admitted to hitting R3 but no specific reason was given. On 10-2-22 at 11:09 AM, V10 (security guard) stated he was on duty 9-15-22 and was situated in the middle of the main hallway near the elevators and not in clear view of R3 and R4's rooms. V10 did not see the altercation between R3 and R4. V10 heard a commotion coming from R3 and R4's wing and he went to see what was happening. V10 saw R3 walking rapidly towards the nurse station. R3 was seen blinking his right eye. R3 was talking to the nurse. R3 did not give any information to security. Security is not aware of any staff observing this altercation occur. Security does their rounding every hour. R4's MDS- ARD 8-26-22- documents BIMS= 14, Active Diagnoses (not limited to): bipolar disorder, unspecified, and schizophrenia. R4's Progress note dated 9-14-22 documents: Behavior Charting Describe Behavior/Mood: Verbal aggression. What was the resident doing prior to or at the time of behavior/mood: Sitting in room? Interventions attempted: Verbal redirection. Education. Effectiveness of the interventions: Stable R4's Progress note dated 9-15-22 documents: Approx. 8:20 am, resident alleged that another resident had physical contact with him. Approximately 8:20 am, the resident alleged that he got into physical contact with another. Immediately, head to toe assessment performed and revealed alert/oriented x 2, verbal, skin, dry and warm, but not intact, skin discoloration on right eye noted, lungs clear, normal bowel sounds audible in all 4 quadrants, abdomen soft and non-tender, ROM (range of motion) performed on all 4 extremities and tolerated to the resident's baseline, besides skin discoloration on left eye, no visible injuries noted, Resident transferred to another room, MD (medical doctor) notified, new order: monitor for change condition and update, x-ray of face ordered, administrator notified, [NAME] police dept. notified, report filed, contact information on file invalid, social services notified to update information, will continue to monitor. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Initial Reportable dated 9-15-22 documents: Brief Description of Incident: R4 abruptly swung and hit R4 in the eye. Immediate Action Taken: Staff immediately intervened and separated both residents. R4 placed on 1:1 supervision. First aide was rendered to R3. Discoloration of eye noted. R3 placed on social service and nursing well-being checks. Local police notified. MD and families of residents notified. Investigation initiated and is ongoing. Final Reportable dated 9-19-22 documents: Facility conducted a thorough investigation and interviewed both staff and residents. R4 thought R3 took his shirt. R4 became agitated and abruptly swung and accidentally hit R3 in the eye. R4 was counseled on more appropriate ways to express frustration. His plan of care was updated and remains on social service well-being checks. R3 remains on social service well-being checks and states he feels safe at the facility. There have been no further incidents between the 2 residents. Abuse Policy (no date) documents: The purpose is to assure the facility is doing all that is within its control to reduce the risk of occurrences of abuse, exploitation, misappropriation of property, mistreatment, or neglect. R4's Aggression Behavior Care Plan (initiated 11-22-21) documents a history of R4's aggressive behavior. Surveyor requested the police report and was not on hand at this time.

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F 0689 Level of Harm - Actual harm 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** 34072 Based on interview and record review the facility failed to have an effective plan to monitor/supervise residents with known history of physical aggression to prevent resident to resident physical assaults. This affected 3 of 3 (R10, R1, and R4) residents reviewed for supervision. These failures resulted in R11 physically assaulting R10, R10 sustained a left orbital fracture requiring 10 facial sutures, this failure also resulted in R4 physically assaulting R3 and R3 sustained a black eye Findings include: On 10/5/22 at 10:34am, R10 stated that on 9/18/22, R11, R13 (R10's roommate), and V24 (security) were in R10's room. R10 stated that V24 was breaking the lock off R13's dresser because R13 locked keys in the dresser. R10 stated that R10 was lying in bed at this time. R10 stated that R11 started yelling and cursing at R10. R10 stated that R13 and V24 exited the room and R11 hit R10 repeatedly in the face. R10 stated that the previous day, 9/17/22, R11 brought a bottle of alcohol into R10 and R13's room. R10 stated that R10 and R11 had an argument. R10 stated that when staff came into R10's room, everyone was on R10's side of the room; R11 and R13 informed staff that the alcohol belonged to R10. R10 stated that staff told R10 he would have to go to the disciplinary floor as a result of having alcohol; staff never transferred R10. R10 stated that R13 came back into R10's room and hit R10 in the face. R10 stated that R10 informed a staff member of this. R10 stated that R10 had only been at this facility for a short time and does not remember who the staff member was. On 10/5/22 at 2:30pm, V24 (security) stated that V24 was present on 9/18/22 from 2:00pm until 10:00pm. V24 stated that when V24 came in to work that day, he was told to cut R13's lock off. V24 stated that R13 was present in the room at that time, R10 was present in room with curtain closed, and R11 was outside of R10's room. V24 stated that V24 left R10 and R13's room after cutting the lock on R13's dresser. V24 stated that V24 heard a door slam, V24 turned around and saw R10 standing in the hall bleeding and R10 stated that he was attacked. On 10/5/22 at 1:09pm, V26 LPN stated that V26 was R11's nurse on the evening shift on 9/18. V26 stated that V26 does not know what happened. V26 stated that V24 (security) told her that R10 was bleeding; R10 had blood gushing from his face and V26 gave R10 a towel. V26 stated that there was blood on floor; trail of blood between R10's bed and the hallway. V26 stated that R11 denied hitting R10. V26 stated that R11 did acknowledge that R11 and R10 had a verbal altercation the night before. V26 stated that neither resident gave any specific details regarding incident on 9/17. V26 stated that V26 did not see any alcohol in R10's room nor did R10 or R11 appear intoxicated. Review of this facility's fourth floor nursing unit census, dated 9/17/22 and 9/18/22, notes there were 67 residents residing on this unit. Review of this facility's staffing sheets for the fourth-floor nursing unit, dated 9/17/22 evening shift, notes there were two nurses, zero CNAs (certified nurse aides), and zero security working. Review of this facility's staffing sheets for the fourth-floor nursing unit, dated 9/18/22 evening shift, notes there were two nurses, zero CNAs, and one security staff working. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of R10's medical record notes R10 was admitted to this facility on 8/23/22 with diagnoses including major depressive disorder and bipolar disorder. Review of R10's BIMS (brief interview of mental status) score, dated 9/2/22, notes R10's score is 15 out of 15. Review of R10's screening assessment for aggressive/harmful behavior, dated 8/23/22, notes R10 is minimal risk for aggression at this time. Review of R10's medical record notes: on 9/18 at 6:00pm, V19 LPN (licensed practical nurse) noted: staff observed R10 in hallway leaning forward. When asked R10 what happened R10 alleged that R11 made physical contact with R10. R10 and R11 were immediately separated. Immediate head to toe assessment completed. Left upper eyebrow area with open area pressure applied. No change in level of consciousness. R10 denied blurred vision headache at that time. Neurological checks at baseline. V1 (administrator) and V4 DON notified. R10 transported to the hospital via 911 EMS (emergency medical services). Review of R10's hospital record, dated 9/18/22, notes R10 presented to the emergency room for a chief complaint of left head injury. R10 stated that while he was lying in bed another individual struck R10 3-4 times in the left side of R10's face. R10 stated that R10 has left head/facial pain. Physical exam noted facial swelling, eye pain, headache, bruising, and two lacerations above left eye. Neurological exam noted R10 was alert and oriented x 3. Psychiatric exam noted R10's behavior normal. CT (computerized tomography) scan of R10's head noted: acute left lamina papyracea blowout fracture with 5-millimeter medial herniation of the infraorbital fat into the ethmoidal air cells. The medial rectus muscle is approaching the fracture site. Left periorbital soft tissue contusion. Laceration: there were two 1.5-centimeter lacerations to the left eyebrow. Both lacerations were cleaned and approximated with 5 sutures each. Review of R11's medical record notes R11 was admitted to this facility on 6/13/22 with diagnoses including schizoaffective disorder, major depressive disorder, bipolar disorder, insomnia, and auditory hallucinations. Review of R11's BIMS score, dated 9/20/22, notes R11's score is 15 out of 15. Review of R11's screening assessment for aggressive/harmful behaviors, dated 6/15/22 and 9/20/22, notes R11 is at moderate risk for aggression. Review of R11's medical record notes: On 9/17/22 at 4:10pm, V27 LPN noted: R11 arguing with R10. At the time of the incident R11 was visiting R13 in R10 and R13's room. Interventions attempted: R11 and R10 separated, therapeutic communication. Effectiveness of the interventions: stable currently. On 9/18 at approximately 6:00pm, nurse was notified by V24 (security) that while going to cut a lock off, R10 stated that R11 came into R10's room and hit R10 unprovoked. R11 stated that R11 didn't hit R10. Nurse notified V1 and V4. 34069 (continued on next page)

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	10/07/2022

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 0689 Level of Harm - Actual harm Residents Affected - Few	On 10-1-22 at 10:58 AM, R3 stated R4 hit him because R3 owed R4 two cigarettes and did not have any when asked. R4 hit R3's eye with his fist. On 10-2-22 at 10:17 AM, V1 (administrator) stated R4 is bipolar with schizoaffective disease. Even with medication and constant behavioral monitoring, R4 has had aggressive behavior in the past. R4 is on the 7th floor which is a male psychiatric unit. All psych patients can have unpredictable changes in behavior. V1 was informed by staff about V4 abruptly hitting V3 in the eye. R3 sustained and swollen eye. Psychiatric patients have no impulse control and will react first before thinking things through. On 10-1-22 at 12:40 PM, V4 (director of nursing) stated R4 is alert, oriented x 3, can be verbally and physically aggressive (re-directable), and can be agitated. On 9-14, R4 was verbally aggressive towards staff. R4 was placed on social service wellbeing checks for 72 hours. Staff will monitor resident every hour alternating with nurse, CNA, and security. Residents are monitored to make sure they are calm, stable, and not any change in condition or concerns. V4 was informed V4 and V3 were in an altercation. R4 hit R3 in the eye and sustained discoloration to right eye. Staff immediately separated R3 and R4. R4 was placed on 1:1 supervision for a couple of days (minimum of 72 hour). R3 was moved to the 4th floor. On 10-1-22 at 10:01 AM, V5 (social worker) state R4 is known to be psychotic and delusional. V5 stated R4 was throwing things at staff on 12-27-21. R4 was delusional and called 911 one time. On 9-14-22, R4 was verbally aggressive toward staff. R4 was started on well-being checks. R4 was rambling off topic. V5 stated she was not on duty at the time of the incident. V5 stated she was told by staff about R4 hitting R3 resulting in a right black eye with no other injury noted. V5 continued with R4's well-being checks. V5 is not aware of R4's previous altercations with R3. R4 can be easily agitated. R4 requires more frequent monitoring every 15 minutes. R4 was noted disorganized with thoughts on 9-14 and 9-15. On 10-1-22 at 11:23 AM, V3 (LPN) stated R4 is alert, oriented x 1-2. with confusion, delusions, and hallucinations. R4 is impulsive and unpredictable. R4 is delusional and will talk about things that nobody understands. R4 can come off as intimidating and aggressive by his peers. V3 stated staff saw R3 with a black right eye on 9-15-22. R3 stated R4 attacked him. V3 stated R3 has a history of entering others, rooms and taking things. R4 told staff R3 took his belongings. R4 admitted to hitting R3. Facility is not able to determine what time this incident took place. V3 stated there is more staff on 7th floor to monitor the residents. R4 requires monitoring more frequently. On 10-2-22 at 10:46 AM, V6 (LPN) stated R4 is alert, oriented x 2, confused, and delusional. V6 stated he thinks R4 has hallucinations. R4 is unpredictable and impulsive. R4 has verbal and physical aggression. R4 can be unpredictable and may require close monitoring. V6 saw R3 with discoloration to right eye on 9-15-22. R3 told V6 that he was hit by R4. R3 could not tell V6 why R4 hit him. V6 talked to R4 and told V6 that R3 took his shit. R4 refused to discuss further with V6. R4 admitted to hitting R3 but no specific reason was given. (continued on next page)

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	145850	A. Building B. Wing	10/07/2022

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 10-2-22 at 11:09 AM, V10 (security guard) stated he was on duty 9-15-22 and was situated in the middle of the main hallway near the elevators and not in clear view of R3 and R4's rooms. V10 did not see the altercation between R3 and R4. V10 heard a commotion coming from R3 and R4's wing and he went to see what was happening. V10 saw R3 walking rapidly towards the nurse station. R3 was seen blinking his right eye. R3 was talking to the nurse. R3 did not give any information to security. Security is not aware of any staff observing this altercation occur. Security does their rounding every hour. R4's MDS- ARD 8-26-22- documents BIMS= 14, Active Diagnoses (not limited to): bipolar disorder, unspecified, and schizophrenia. R4's Progress note dated 9-14-22 documents: Behavior Charting Describe Behavior/Mood: Verbal aggression. What was the resident doing prior to or at the time of behavior/mood: Sitting in room? Interventions attempted: Verbal redirection. Education. Effectiveness of the interventions: Stable R4's Progress note dated 9-15-22 documents: Approx. 8:20 am, resident alleged that another resident had physical contact with him. Approximately 8:20 am, the resident alleged that he got into physical contact with another. Immediately, head to toe assessment performed and revealed alert/oriented x 2, verbal, skin, dry and warm, but not intact, skin discoloration on right eye noted, lungs clear, normal bowel sounds audible in all 4 quadrants, abdomen soft and non-tender, ROM (range of motion) performed on all 4 extremities and tolerated to the resident's baseline, besides skin discoloration on left eye, no visible injuries noted, Resident transferred to another room, MD (medical doctor) notified, new order: monitor for change condition and update, x-ray of face ordered, administrator notified, [NAME] police dept. notified, report filed, contact information on file invalid, social services notified to update information, will continue to monitor. Initial Reportable dated 9-15-22 documents: Brief Description of Incident: R4 abruptly swung and hit R4 in the eye. Immediate Action Taken: Staff immediately intervened and separated both residents. R4 placed on 1:1 supervision. First aide was rendered to R3. Discoloration of eye noted. R3 placed on social service and nursing well-being checks. Local police notified. MD and families of residents notified. Investigation initiated and is ongoing. Final Reportable dated 9-19-22 documents: Facility conducted a thorough investigation and interviewed both staff and residents. R4 thought R3 took his shirt. R4 became agitated and abruptly swung and accidentally hit R3 in the eye. R4 was counseled on more appropriate ways to express frustration. His plan of care was updated and remains on social service well-being checks. R3 remains on social service well-being checks and states he feels safe at the facility. There have been no further incidents between the 2 residents. Abuse Policy (no date) documents: The purpose is to assure the facility is doing all that is within its control to reduce the risk of occurrences of abuse, exploitation, misappropriation of property, mistreatment, or neglect. R4's Aggression Behavior Care Plan (initiated 11-22-21) documents a history of R4's aggressive behavior. Surveyor requested the police report and was not on hand at this time.