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 07/01/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint Investigation 2194279/IL135104 2193959/IL134717 Facility Reported Incident Investigation of 6/09/21/IL135111	S 000		
S9999	Final Observations Statement of Licensure Violations : 1of 2 300.610a) 300.1210b) 300.3240a) 300.3240e) 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee. These Regulations are not met as evidenced by: 1. Based on interview and record review, the facility failed to protect R2's right to be free from physical abuse as evidenced by R2 being transferred to an acute care hospital with a diagnosis of fracture of the left 7th rib and a right wrist fracture of the distal ulna. This failure applies to one (R2) of four residents reviewed for physical abuse. Findings include: R2 was in the hospital at the time of this survey. 6/22/2021 at 12:51 PM, a telephone interview was conducted with R2 regarding the incident that	S9999		

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S9999	Continued From page 2	S9999		

took place at the facility on the night of 6/20/21-6/21/21. R2 stated, "I was new there, only 2 days. I didn't know nobody there. The man was sitting behind the desk, he was African American with brown skin. He hit me in the stomach with his face. Then twisted my wrist and fractured it. Nobody saw it, it was only him and me. He was mad at me the day before because I said I didn't want to stay there. I pushed the button on the wall to call 911. I didn't get his name. None of the people had name tags on or it was turned around. It happened about 2 or 3 in the morning. When I got up the next day to tell someone he was gone already. I talked to two women who were behind the desk. When I told them, they called 911. I'm not going back there." R2 was very confused about the timeframe of the events and could not give a clear time as to when incident occured or specific time of when he actually reported the incident.

Nursing progress note documents that V8 LPN (Licensed Practical Nurse) received report from R2 on 6/20/21 at 10:30 PM stating someone hit him and told him to stay in his room. V8 LPN completed a head to toe assessment observing discoloration to the right rib cage and swelling to the right hand and wrist. R2 complained of pain to hand and wrist but refused pain medication. V8 LPN notified R2's physician; order received for stat portable x-rays. Police report filed by V8 on 6/20/21 at 11:50 PM; reviewed, family notified.

Progress notes from 6/21/21 at 02:48 AM indicate: V8 LPN notified R2's physician with the x-ray results. Mild distracted oblique fracture in the distal diaphysis of the ulna and mildly displaced right lateral 10th rib fracture. Received orders to send R2 to the hospital.

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S9999	Continued From page 3 Review of R2's care plan indicates he was not assessed at risk for abuse. 6/23/21 at 1:18 PM V5 ADON was interviewed regarding the abuse investigation. V5 ADON stated, "Our investigation is still open, we are still interviewing staff that was on the floor. We have not identified the alleged perpetrator, but we have suspended a staff V3 LPN due to the description of the allegation. It is still under investigation." Review of the 6/21/21 CT (Computed Tomography) Scan of the wrist indicates: isolated distal ulnar fracture with minimal displacement. Review of the 6/21/21 x-ray of the rib's bilateral chest indicates fracture of the left anterolateral seventh rib. Review of the 6/21/21 x-ray of the right wrist indicates fracture of the distal ulna. 6/23/21 at 2:01 PM, V8 LPN stated, R2 came to me around 11PM and he said his hand was hurting and he pulled up his shirt and his side was discolored. His hand was swollen. He was holding his hand down, but he was able to move his fingers. I asked him if he wanted anything for pain because I didn't know what was going on. He said this man did it to me, it was the doctor who did it. R2 said the man who worked behind the desk with the same color uniform as you did it. A lot of the residents call the male staff doctors here. R2 said the man grabbed him by his arm and took him in the room and told him not to come out again, then head butted him in his side. 6/23/21 at 2:18 PM, V9 stated, it was later at night when I heard R2 tell the nurse someone did something to him. I was in the hallway monitoring. He said the doctor that works in the morning did it.	S9999		

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S9999	Continued From page 4 6/23/21 at 2:59 PM, V6 (Assistant Administrator) stated, "R2 stated someone hit him." The resident said it was a doctor. He said the doctor had on blue. We didn't have any doctors in the facility that day. We discussed it with the team and nursing staff initiated our investigation getting social services involved doing well being checks. We interviewed V8 LPN who was his nurse that night and she provided more details that R2 said it was a man. He was sitting behind the nursing station and wears blue. With the new information V8 LPN provided, the nurse in question was suspended pending the investigation." 6/24/21 at 12:06 PM, V14 (Physician) stated, "The CT (computed tomography) scan and x-rays both showed R2 had wrist and rib fractures. The treatment for the wrist is a special type of splint and for the rib fracture the treatment is conservative with pain medication. Abuse can cause this type of fracture. The rib fracture can also happen if someone hit him." The revised 01/2019 Abuse Prevention Program states: Policy: It is the policy of this facility to prohibit and prevent resident abuse, neglect, exploitation, mistreatment, and misappropriation of resident property and a crime against a resident in the facility. Procedure: Any alleged violations involving mistreatment, abuse, neglect, exploitation, misappropriation of resident property, any injuries of unknown origin, or reasonable suspicion of a crime against a resident MUST be reported to the Administrator or Director of Nursing. The Administrator is the Abuse Coordinator of the facility. I. Pre-employment screening of potential	S9999		

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S9999	Continued From page 5 employees. II. Pre-Admission screening of potential residents. III. Orientation and Training of Employees--Sensitivity of resident rights and resident needs. -Staff obligations to prevent and report abuse, neglect, exploitation, mistreatment, any crime against abuse prevention. -How to assess, prevent, and manage aggressive, violent, and/or catastrophic reactions of residents in a way that protects both residents and staff. -How to recognize and deal with burnout, frustration and stress that may lead to inappropriate responses or abusive reactions to residents. -What constitutes abuse (physical, mental, sexual, verbal), neglect, exploitation, mistreatment, and misappropriation of resident property. IV. Reporting- employees are required to immediately report any incident, allegation or suspicion of potential abuse, neglect, exploitation, misappropriation of resident property, mistreatment or a crime against a resident they observe, hear about, or suspect to the Administrator if available or an immediate supervisor who must immediately report it to the Administrator. V. Identification of Allegations/Internal Reporting Requirements VI. Investigation- Any incident or allegation involving abuse, neglect, exploitation, misappropriation of resident property, or a crime against a resident will result in an abuse	S9999		

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investigation.
VII. Protection of Residents- The facility will take steps to prevent mistreatment while the investigation is underway.
Prevention- The facility desires to prevent involving abuse, neglect, exploitation, misappropriation of resident property, or a crime against a resident by establishing a resident-sensitive and resident-secure environment.

2. Based on interview and record review, the facility failed to protect resident's rights to be free from mental abuse as evidenced by staff witnessed speaking inappropriately to residents. This failure resulted in the residents expressing feelings of fear and sadness. This failure applied to four (R3, R4, R5 & R6) residents reviewed for abuse.

Findings include:

6/24/21 at 9:47 AM, V5 (ADON) stated, I was notified the next day from the administration. V13 Assistant PRSC (Psychiatric Rehabilitation Services Coordinator) was called to the unit to find out why the residents were having so many behaviors on that day to see what was going on. She became verbally aggressive towards the residents. V13 was terminated for violating the abuse policy.

6/24/21 at 9:59 AM, V6 (Assistant Administrator) stated, I was notified by V11 (Central Supply Manager). V11 said she witnessed V13 being verbally inappropriate with the residents. V13 was screaming and shouting and making threats to the residents on the unit. V13 was sent home immediately and the managers interviewed the residents to find out if anyone had been affected

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by her behavior. We had a conversation with the residents and there were four residents that were affected. All four consistently stated they didn't understand why V13 was talking to them like that and that they did not like how she spoke to them. R5 stated he was worried he would not get his pass to see his family. V13 was terminated for verbal abuse. V13 admitted to the conversation but not how she spoke to the residents.

6/24/21 at 10:37 AM, R5 stated, she (V13) was hostile and volatile when she addressed everyone. I got scared because she said she would shut down everything on the unit. I was scared that I was going to lose my privileges of socializing on the unit and not be able to smoke or be able to use my pass to see my family.

6/24/21 at 10:26 AM, R3 stated, V13 said she would shut down the whole floor, that she did it once and would do it again. She would shut down the smoking for the whole floor based on the actions of one person. She was yelling. Everybody on the floor could hear what she was saying. The staff just fail to communicate and have a lack of understanding. R3 was asked how V13 yelling made him feel. R3 stated, I just ignored her because based on something I say the staff will stick me with needles and send me out to the hospital.

6/24/21 at 10:49 AM, R4 stated, V13 came up to the floor saying if the floor gets out of hand again, we would not be able to smoke. She was yelling and screaming. I think V13 would have retaliated. It made me feel sad when she was raising her voice at me. I thought she would punish us all because she said she would. Personally, I got scared that whole day. Some of us look up to the staff and I think we have the right to get treated

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S9999	Continued From page 8	S9999		

with respect and dignity. We feel let down because this is a person who we go to when we need something.

6/24/21 at 10:54 AM, R6 stated, V13 came up to the floor to find out what was going on. She said she would shut the whole unit's smoking down. We wrote statements about her. Her voice got louder and louder when she was talking. I felt kind of bad because she was going to shut down the smoking. I think she should have done something about the people who were doing it. She was trying to punish everybody. I felt it was unfair.

6/24/21 at 11:21 AM, V11 stated, I heard the commotion on 7th floor and thought something was going on with the residents and that's when I caught V13's voice. She was just screaming at the top of her lungs! She called the residents out of their room. She kept hitting the top of the nurse's station with her hand and telling them to cut down the radio. She told them to shut up and act like they have some sense. I will shut the whole 7th floor smoking down and no one will smoke. I've done it before and will do it again. She said she would not come up to the 7th floor again. She was talking to the residents like they were her children. I went to my administrators V6 and V14 and told them what happened. I could tell that R3 was upset. Her yelling was making the situation worse, she was stirring up the residents instead of asking them what was going on. R6 was agitated. R4 and R5 were all agitated.

6/24/21 at 1:00 PM, reviewed V13's Assistant PRSC Abuse Prevention Program Policy & Procedure form signed and dated on 2/20/20.

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S9999	Continued From page 9 Review of the Employee Disciplinary Action form signed by V6 dated 6/15/21 indicates: V13 failed to follow facility category 1 number 1 policy of verbal abuse. As a result, the employee will be terminated without rehire privileges. The revised 01/2019 Abuse Prevention Program states: Policy: It is the policy of this facility to prohibit and prevent resident abuse, neglect, exploitation, mistreatment, and misappropriation of resident property and a crime against a resident in the facility. Procedure: Any alleged violations involving mistreatment, abuse, neglect, exploitation, misappropriation of resident property, any injuries of unknown origin, or reasonable suspicion of a crime against a resident MUST be reported to the Administrator or Director of Nursing. The Administrator is the Abuse Coordinator of the facility. I. Pre-employment screening of potential employees. II. Pre-Admission screening of potential residents. III. Orientation and Training of Employees- -Sensitivity of resident rights and resident needs. -Staff obligations to prevent and report abuse, neglect, exploitation, mistreatment, any crime against the resident, theft and how to distinguish theft from lost items and willful abuse from insensitive staff actions that should be corrected through counseling and additional training. Staff should report their knowledge of allegations without fear of reprisal. -Dementia management and resident abuse prevention. -How to assess, prevent, and manage	S9999		

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S9999	Continued From page 10 aggressive, violent, and/or catastrophic reactions of residents in a way that protects both residents and staff. -How to recognize and deal with burnout, frustration and stress that may lead to inappropriate responses or abusive reactions to residents. -What constitutes abuse (physical, mental, sexual, verbal), neglect, exploitation, mistreatment, and misappropriation of resident property. IV. Reporting- employees are required to immediately report any incident, allegation or suspicion of potential abuse, neglect, exploitation, misappropriation of resident property, mistreatment or a crime against a resident they observe, hear about, or suspect to the Administrator if available or an immediate supervisor who must immediately report it to the Administrator. V. Identification of Allegations/Internal Reporting Requirements VI. Investigation- Any incident or allegation involving abuse, neglect, exploitation, misappropriation of resident property, or a crime against a resident will result in an abuse investigation. VII. Protection of Residents- The facility will take steps to prevent mistreatment while the investigation is underway. Prevention- The facility desires to prevent involving abuse, neglect, exploitation, misappropriation of resident property, or a crime against a resident by establishing a resident-sensitive and resident-secure environment.	S9999		

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S9999	Continued From page 11 (A) 2 of 2 300.1010g)1) 300.1210a) 300.1210b) 300.1210d)6) 300.7020a)2)F) 300.1010 Medical Care Policies g) Each resident admitted shall have a physical examination, within five days prior to admission or within 72 hours after admission. The examination report shall include at a minimum each of the following: 1) An evaluation of the resident's condition, including height and weight, diagnoses, plan of treatment, recommendations, treatment orders, personal care needs, and permission for participation in activity programs as appropriate. 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	S9999		

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S9999	Continued From page 12 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. 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. Restorative measures shall include, at a minimum, the following procedures: d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. 300.7020 Assessment and Care Planning a) Resident assessments, in addition to requirements in other applicable State and federal regulations, shall include a standardized, functional, and objective evaluation of the resident's abilities, strengths, interests, and preferences. The assessment shall be completed within 14 days after admission.	S9999		

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S9999	Continued From page 13 2) Assessments shall include at least the following: F) adaptive equipment or activities that allow the resident to function at the highest practical level. These Regulations are not met as evidenced by: Based on interview and record review, the facility failed to adequately supervise and have interventions in place for a resident who was assessed to be at risk for falls and required staff assistance with all Activities of Daily Living (ADLs), including mobility. This failure affected one (R10) of three residents reviewed for falls and resulted in R10 being hospitalized with a pelvic and proximal humerus fracture as a result of a fall. Findings include: R10 is an 81 year old male who was admitted to the facility on 12/24/2020 with past medical history including, but not limited to chronic kidney failure, cardiac arrhythmia, acute kidney failure unspecified, Type 2 diabetes, Benign prostatic hyperplasia, hypomagnesemia, dementia in other diseases classified elsewhere, adult failure to thrive, essential primary hypertension, difficulty walking, weakness, other lack of coordination, etc. Nurse's progress note on 6/5/2021, R10 reported that he fell on his left side in the bathroom, was unable to raise his left arm and complained of severe pain to the left arm, Tylenol was given for pain, physician was contacted and ordered to send resident to the emergency room for further evaluation. R10 was sent to the hospital where an	S9999		

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	IL6009948	A. BUILDING: _____ B. WING _____	C 07/01/2021

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

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S9999	Continued From page 14 x-ray revealed a pelvic fracture and proximal humerus fracture. Review of admission record for R10 shows that he was admitted with weakness and unsteady gait and had a score of 7 in a facility fall risk assessment dated 12/04/2020. Facility Minimum Data Set (MDS) assessment dated 3/11/2021 coded R10 as follows: Section C (Cognition), BIMS (Brief Interview for Mental Status) score of 01 Section G (Functional Status) coded as 3/2 - indicating extensive assistance needed with one-person physical assist for bed mobility, transfer, walk in room, walk in corridor toilet use and personal hygiene, and under mobility device Section H (Bladder and Bowel) documents that R10 is frequently incontinent of bowel and bladder. Facility functional abilities assessment for R10 dated 3/11/2021 also documented that R10 requires substantial/maximal assistance for toileting hygiene, oral hygiene, dressing, toilet transfer, walking 10 feet, etc. Review of R10's comprehensive care plans do not list any interventions related to falls, prior to the fall that occurred on 6/5/21. Care plan was updated on 6/5/21 to with a focus for risk for falls r/t cognitive impairment and includes intervention of a walker for ambulation. 6/29/2021 at 1:09 PM, V27 (C.N.A) stated that she works as a floater but familiar with resident, R10 is quiet and nice, does not ask for much, very co-operative, resident was dependent on staff for ADLS, wears an incontinence brief and is incontinent of bowel and bladder. R10 cannot	S9999		

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S9999	Continued From page 15 walk by himself due to unsteadiness of his feet, requires staff assistance and supervision. V27 added that she was not present when R10 fell and does not know exactly what happened. 6/29/2021 at 2:30PM, V25 (MDS Coordinator) said that R10 needs help with ambulation, he is limited when he gets up and has to be monitored, R10 wears an incontinence brief due to incontinence of bowel and bladder and requires staff supervision for ambulation and physical assist for other ADLs. R10 is a fall risk but the only intervention he had was monitoring and restorative program, he does not have any assistive device like a walker bed alarm or wheelchair. PT was supposed to assess resident and give their recommendations. V25 added that all they can do is try to prevent falls, R10 had an unsteady gait, and was in a room with the bathroom located outside his room in the hallway. 6/30/2021 at 12:32PM, V30 (Doctor of physical therapy and evaluation) stated that R10 came in for evaluation, was able to walk on balance, did not need assistive device upon admission, though resident was high risk for falls, but he walks upon supervision and cueing. R10 was discharged with recommendation for stand by assist and occasional verbal cues for safety awareness while turning, for safe maneuvering in small spaces and for implementation of safety techniques in order to increase independence and safety in room and to prepare to walk to dine for meals. V30 added that R10 was on a dementia unit and was supposed to be supervised by staff. Facility document titled, Fall Prevention and Management Program (undated), states that the facility is committed to safety and maximizing	S9999		

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S9999	Continued From page 16 each resident's physical, mental and psychosocial well-being. The purpose of the fall prevention program is to provide residents with an interdisciplinary approach to assess risk for falls and to provide appropriate interventions to prevent falls. (B)	S9999		