Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009948	A. BUILDING: ______ B. WING ______	07/27/2023

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 Annual Licensure and Certification Complaint Investigations: 2395674/IL161851 2395687/IL161880	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 4: 300.610a) 300.1210b)4)5) 300.1210c) 300.1210d)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 300.1210 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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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:

4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene.

5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.

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:

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

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and assistance to prevent accidents.

These Regulations are not met as evidenced by:

Based on observation, interviews and record reviews, the facility failed to provide adequate supervision and monitoring in preventing falls for one (R288) of ten residents in the sample of 70 reviewed for accidents and supervision. This deficiency resulted in R288 found lying on the floor, was sent to the emergency room and sustained an acute cervical myofascial strain, minor head injury and scalp contusion.

Findings include:

R288 is a 59 year old, male, admitted in the facility on 12/22/2022 with diagnoses of Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side; Secondary Malignant Neoplasm of Unspecified Lung; Secondary Malignant Neoplasm of Brain; Major Depressive Disorder, Recurrent, Unspecified; Bipolar Disorder, Current Episode Manic Severe With Psychotic Features; Schizoaffective disorder, Bipolar Type; Unspecified Psychosis not Due to a Substance or Known Physiological Condition; Headache, Unspecified; and Anxiety Disorder, Unspecified.

On 07/24/23 at 9:45 AM, surveyor went to the 4th floor dining room to observe, and found R288 lying on the floor, in a supine position. No staff was observed present, supervising, and monitoring residents in the dining room at the time. R288 was wearing flat shoes. The shoes were observed not worn properly. He was wearing it like a slipper. V30 (Registered Nurse, RN) came to the dining room, assisted R288 to sit in the chair and assessment was conducted.

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R288 was asked regarding fall incident. R288 replied, "I did hit my head. I was trying to put my tray there in the cart, but I slipped and fell." V30 was asked regarding staff supervision. V30 stated, "We have a CNA (Certified Nursing Assistant) monitoring the dining room. There should be a staff in the dining room at all times. As far as I know, CNA was there. Some of the residents put their trays and put it in the cart but not all. Some residents can do this, or they can wipe tables or clean the dining area but R288 is not one of them. There should be supervision." V31 (CNA) was asked regarding monitoring and supervision of residents in the dining room. V31 verbalized, "I am supposed to be here in the dining room, but I need to go get a milk from the refrigerator. I am the only one working as a CNA." R288 was sent out to the emergency room for further evaluation and management as ordered.

Incident report dated 07/24/23 documented: R288 was observed in the dining room laying in supine position. Was asked what happened, R288 stated, "I was trying to put my tray up and lost my balance." No injuries observed at time of incident.

Hospital records dated 07/24/23 recorded the following:
Seen today for:
Fall from ground level
Acute cervical myofascial strain
Minor head injury without loss of consciousness
Scalp contusion

On 07/25/23 at 10:09 AM, V9 (Restorative Director) was asked regarding R288's fall. V9 replied, "He had a fall incident on 07/24/23. He was observed lying in a supine position in the dining room at 9:45 AM. He had been sent out and was admitted. I know him very well. He is

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alert, oriented, answers simple questions. He can walk but with unsteady gait. He uses a rollator. Sometimes he believed that he could do things independently. Based on my own assessment, he needs constant supervision when he is walking. Dining room should be supervised and monitored by CNAs at all times when there are residents."

V2 (Director of Nursing/Fall Coordinator) was also interviewed on 07/25/23 at 3:11 PM regarding R288's fall incident on 07/24/23. V2 stated, "His fall could have been prevented if there were staff monitoring and supervising residents in the dining room. There should be a staff in the dining room at all times. At the time of incident, he said he lost his balance when he was trying to put his tray up in the dining. He should also be monitored that he wear his shoes properly. Sometimes he wear his shoes like a slipper."

R288's care plans documented the following:
ADL (Activities of Daily Living): "Self-Care Deficit" (initiated 12/24/22)
Interventions/Tasks:
Ambulation - usually require supervision and set-up support for walking (verbal cues and set-up assistance)
Locomotion on unit - usually require supervision and set-up support for locomotion on unit (verbal cues and set-up assistance)
Fall (initiated 12/26/22):
Interventions/Tasks:
Follow the facility fall protocol
Ensure R288 is wearing appropriate footwear that provide stability and good traction when ambulating or mobilizing in wheelchair and during transfers.

On 07/26/23 at 1:52 PM, V33 (Physician) stated during interview that there should be staff

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supervising residents in the dining room.

V1 (Administrator) also stated during interview on 07/26/23 at 2:14 PM, "In my psych units, there are psych technicians, security, CNAs and nurses on the floors. I have enough people to supervise but I don't know how fall happened."

R288 is a resident in one of the psych floors in the facility.

Facility's policy titled "Fall Prevention and Management Program" dated 08/03/17 stated in part but not limited to the following:
This facility is committed to safety and maximizing each resident's physical, mental, and psychosocial well-being.
Benefits of Preventing and Managing Falls
This facility uses a "Safety First" approach for falls prevention
Though an interdisciplinary approach, this facility will provide fall prevention assessment, implement interventions to prevent falls as much as possible, and manage post-fall treatment.

Facility's policy titled "Supervision of Residents" dated 2/1/2022 documented in part but not limited to the following:
Policy: Supervision is an intervention and a means of mitigating accident risk. We will provide adequate supervision to reduce the risk and the prevention of accidents. Adequacy of supervision is defined by type and frequency, based on the individual resident's assessed needs, and identified hazards in the resident environment.
Procedure: 3) Facility staff will monitor and assess the residents throughout their day and determine if a resident will benefit from increased supervision.

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(B)

Statement of Licensure Violations 2 of 4:
300.610a)
300.1210b)
300.1210d)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 300.1210 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:

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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:

Based on observations, interviews, and record reviews, the facility failed to follow their policy for use of extension cords as evidenced by observation of extension cords in resident's rooms and unit bathrooms on the 5th and 6th floors. This failure has the potential to affect all 109 total residents on the 5th and 6th floors.

Findings include:

On 07/23/23 at approximately 12:30 PM, 5th floor observed orange extension cords in resident rooms and in resident bathrooms with water on the floor. There were no staff present when the extension cords were observed in use.

On 07/24/23 at approximately 9:15 AM, 6th floor observed orange extension cords in resident rooms and in resident bathrooms with water on the floor. There were no staff present when the extension cords were observed in use.

On 07/25/23 at 9:23 AM, interview conducted with V13 Maintenance Director regarding concerns with extension cords being used in resident areas. V13 stated, "Extension cords should not be used at all."

The Physical Plant Monthly Inspections policy states in part:

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Multi Gang Outlets and Power Strips: Multi gang outlets and power strips are prohibited in the facility. The only exceptions are if the facility needs to protect electronic equipment (i.e., computers, stereos, televisions, etc.) then the facility is allowed to utilize surge protectors only for connecting this equipment together to an electrical wall outlet.

(C)

Statement of Licensure Violations 3 of 4:
300.610a)
300.1210b)
300.1210d)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 300.1210 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

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

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.

These Regulations are not met as evidenced by:

Based on interview and record review, the facility failed to assess for self-harm behaviors and failed to ensure resident care areas were free of disposable razors. This failure applied to one (R56) of one resident reviewed for supervision and resulted in R56 finding a disposable razor in a resident room and using it to cut her wrists requiring immediate hospitalization.

Findings include:

R56 was admitted to the facility 1/20/22 with diagnoses that include bipolar disorder and major depressive disorder. According to Facility reported incident on 7/07/23, a fellow Resident alerted the nurse on duty that R56 was cutting their wrists in the bedroom. R56 was found by staff with a laceration to the left wrist, rendered first aid, and was subsequently sent to the hospital for psychiatric evaluation. R56 returned to the facility 7/13/23 with sutures to the wrist.

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On 07/26/23 at 10:07 AM R56 was alert, oriented and presenting appropriately to situation. R56 said, I wasn't trying to kill myself. I cut myself so that I could transfer to another nursing home. I was in my friends' room upstairs and saw that she had a disposable razor that was left on the floor. I picked it up and bust it open to take the razor out and cut my wrists with it. I went to the hospital, and they did a medication adjustment and review for 6 days. We are allowed to shave our legs but [nurses] are supposed to watch us in the shower. We aren't supposed to have them. We use them and give them right back for them to throw away.

On 07/26/23 10:19 AM V12 Assistant. Social Services Director said, I was informed R56 cut her wrists and was told that we needed to place her on 1:1 and group sessions. I'm not sure why this group was not provided to R56 prior to this incident. When the incident happened, I updated the care plan and the self-harm assessments. Prior to that, I am not sure when it was updated, but it should be whenever there is an incident or quarterly. This is not the first time R56 has inflicted self-harm and it has happened at least once since I have been working in this facility, so yes there is a history of self-harm. Residents are not allowed to have razors without supervision to prevent harm from happening to them.

On 7/26/23 at 2:20PM V2 DON (Director of Nursing) said, R56 told me that she found a razor on the floor of her co-peer who was in the hospital at the time. I asked the other roommate who was in the room at the time, and they said that they didn't know where the razor came from and that they just noticed R56 bleeding. The residents are not allowed to have razors. This

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incident occurred during the day where most of the staff was on duty. Either the staff didn't properly confiscate or dispose of the razor after a shower, or a resident brought it in from the outside. Either situation put residents at risk for harm and in this case R56 was able to cut her wrists. Initially the wound looked superficial because the bleeding was minimal. When we were notified from the hospital that the wound required sutures, we initiated an investigation to report to IDPH.
Care Plans and Assessments were reviewed in the Electronic Medical Record, however the facility failed to provide copies of the documents requested during this survey.

Care Plan: Self Harm revised 1/26/2023: R56 demonstrated self-harmful behavior of superficial cutting/scratching. When interviewed, expressing episodes of Depression and poor coping skills.
Interventions 1/7/2023:
o Sent out to hospital for further evaluation.
o As warranted, conduct: behavior monitoring of the resident.
o As warranted, conduct a room check/search & remove: any sharp objects or similar contraband (razor blades, razors)
o Intervene when any self-injurious behavior is observed. Counsel and Communicate assertively that the resident is responsible for exercising control over impulses & behavior.

ASSESSMENTS: Self Harm/suicidal ideation
o 1/7/23: Resident demonstrating episode of depression leading to suicidal ideation/self-harm with a plan. Resident placed on close monitoring. Sent out to hospital for further evaluation.

o 7/7/2023 14:48 Resident has a history of suicidal ideation behavior.

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o 7/14/2023 10:39 Resident at this time is low to moderate risk and had a previous attempt. will continue to follow up with resident and document accordingly.

No assessments or updates to the care plan were conducted between 1/7/23 and 7/7/23.

(A)

Statement of Licensure Violations 4 of 4:
300.610a)
300.1210b)

Section 300.610 Resident Care Policies

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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

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

These Regulations are not met as evidenced by:

Based on interview and record review, the facility failed to provide transportation services to one resident (R209) who requires outpatient services at a pain clinic. This failure has caused R209 to miss three scheduled pain clinic appointments since April 2023, which has delayed treatment of worsening pain as voiced by R209.

Findings include:

R209 was admitted to the facility 4/19/22 with diagnoses that include spinal stenosis, Neuropathy, Low back pain and Anxiety Disorder. On 07/23/23 10:52 AM R209 was observed siting in a wheelchair, in the hallway, with noted facial grimacing, while self-propelling. R209 said, I have pain all the time, especially in my back. They are not taking me to my appointments to the pain clinic for pain management. The Nurse Practitioner said I should go because the medicine they give me doesn't always work. I feel pain mostly in my back and shoulders. So far, none of the medications take all the pain away, and most times, I can't win, I'm so uncomfortable. I just sit in the chair or lay in bed. The pain keeps me from wanting to go to other places in the facility and I just have to sit here. I can't do much prevents me from going other places in the facility. They didn't tell me about rescheduling or why they were missed.

Physician Order Sheets were reviewed. Appointments scheduled for 3/14/23, 4/28/23, 6/26/23, and 7/13/23 were all missed due to lack

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 ______	07/27/2023

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	S9999		

of transportation. Order was placed on 6/9/23, to reschedule the appointment and it was not rescheduled until 6/26/23.
Progress notes do not indicate why these appointments were not completed.

On 07/26/23 01:32 PM V36 Scheduler said, when appointments or outside referrals need to be scheduled, either the nurses or the doctor's office will call to make the appointment. Once they put it into the electronic medical record, I can go in view the orders and schedule transportation with the information. I can also call to make follow-ups, when necessary, based on the paperwork they come back with. R209 missed the most recent appointment a few weeks ago because I called to make arrangements for transportation the day before the appointment and found out that he was not able to use a stretcher per the ambulance company. Because it was short notice there were no other options to get him there. It was a delay on my part. I did not notify anyone about the transfer issues, and I don't remember if I told the nurse to cancel the appointment. R209 has missed more than one appointment because I was unable to schedule transportation timely.

07/26/23 02:11 PM V2 I think R209 went to the one appointment in April, and missed the one in June, because we couldn't find transportation. It is our responsibility to make sure the resident has safe and proper transportation to appointments should they need it. R209 is being seen by the pain specialist in the facility, but they are requiring him to come to the clinic for evaluation. I was not made aware that R209 has missed several appointments to the clinic due to transportation issues. It's not communicated to me until things happen.

Illinois Department of Public Health

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S9999	Continued From page 15	S9999		

Care Plan related to pain was initiated for R209 on 4/22/23, revised 4/28/23 and included intervention that stated, "Notify MD for any new resident complaints of pain and/or S/S of pain to obtain new order for medication regiment or break-through pain management."

Facility policy "Management of Pain" (no revision date) states in part: Policy- Our mission is to facilitate resident independence, promote resident comfort and preserve resident dignity. The purpose of this policy is to accomplish that mission through an effective pain management program, providing our residents the means to receive necessary comfort, exercise greater independence, and enhance dignity and life involvement. We will achieve these goals through:

- o Promptly and accurately assessing and diagnosing pain.
- o Encouraging residents to self-report pain,
- o Increasing comfort and reducing depression and anxiety in residents.
- o Optimizing the resident' ability to perform activities of daily living.

No Violation