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 11/24/2021

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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 2198136/IL139874	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1010h) 300.1030a)4) 300.1210a) 300.1210b) 300.1210c) 300.1210d)3) 300.1210d)6) 300.1410a) 300.1410g) 300.1630a) 300.1650a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1010 Medical Care Policies	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1030 Medical Emergencies a) The advisory physician or medical advisory committee shall develop policies and procedures to be followed during the various medical emergencies that may occur from time to time in long-term care facilities. These medical emergencies include, but are not limited to, such things as: 4) Toxicologic emergencies (for example, untoward drug reactions and overdoses). Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and	S9999		

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S9999	Continued From page 2 provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. 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: 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see	S9999		

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S9999	Continued From page 3 that each resident receives adequate supervision and assistance to prevent accidents. Section 300.1410 Activity Program a) The facility shall provide an ongoing program of activities to meet the interests and preferences and the physical, mental and psychosocial well-being of each resident, in accordance with the resident's comprehensive assessment. The activities shall be coordinated with other services and programs to make use of both community and facility resources and to benefit the residents. g) The facility shall provide a specific, planned program of individual (including self-initiated) and group activities that are aimed at improving, maintaining, or minimizing decline in the resident's functional status, and at promoting well-being. The program shall be designed in accordance with the individual resident's needs, based on past and present lifestyle, cultural/ethnic background, interests, capabilities, and tolerance. Activities shall be daily and shall reflect the schedules, choices, and rights of the residents (e.g., morning, afternoon, evenings and weekends). The residents shall be given opportunities to contribute to planning, preparing, conducting, concluding and evaluating the activity program. Section 300.1630 Administration of Medication a) All medications shall be administered only by personnel who are licensed to administer medications, in accordance with their respective licensing requirements. Licensed practical nurses shall have successfully completed a course in pharmacology or have at least one year's full-time supervised experience in administering	S9999		

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S9999	Continued From page 4 medications in a health care setting if their duties include administering medications to residents. Section 300.1650 Control of Medications a) The facility shall comply with all federal and State laws and State regulations relating to the procurement, storage, dispensing, administration, and disposal of medications. These Regulations are not met as evidenced by: These findings resulted in two deficient practice statements. A. Based on interview and record review the facility failed to call 911 to get emergency medical assistance in a timely manner for a resident with a continuous decline in his/her physical status which led to a drastic change after having a change in condition. This applies to 1 of 1 resident (R1) who experienced a change in condition. This failure put R1's life in danger. B. Based on interview and record review the facility failed to have a method or system in place that detects when a resident has unauthorized medications or contraband in her possession, failed to have individualize care plan interventions to monitor for behavior changes, failed to provide therapeutic programming for a resident with mental illness to prevent self-harm and failed to follow their policy and ensure that all residents belongings are accounted for. This applies to 1 of 4 residents (R1) reviewed for supervision. As a result, R1 was discovered to have taken an unspecified amount of previously prescribed medications that she had in her possession while admitted in the facility.	S9999		

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S9999	Continued From page 5 Findings include: A.1. R1's face sheet indicated R1 was a 61-year-old resident who was admitted to the nursing facility on 09/05/2020. R1's face sheet also indicated R1 had diagnoses of Bipolar Disorder current episodes mixed, moderate, Major Depressive Disorder recurrent, unspecified Suicidal Ideations, type 2 Diabetes, Fibromyalgia, Lumbago with Sciatic, Hyperlipidemia, Hypertension, other Psychoactive Substance Abuse with unspecified Psychoactive Substance Induced Disorder, Schizophrenia unspecified. R1's progress notes dated 10/19/21 at 2:20 p.m., documented by V1(Nurse) indicated: resident noted to be lethargic and slow to respond with Generalized Weakness. Resident observed snoring in Postictal state but doesn't have history of Seizures. vitals taken V/S (Vital Signs): T (Temperature) 96.8, P (Pulse) 63, R (Respirations) 20, BP (Blood Pressure) 96/60, Spo2 (Oxygen Saturation) 94% on Room Air. Nurse Practitioner informed and received order to transfer resident out to hospital for medical evaluation. V6 (Director of Nursing) informed, family contact informed and spoke to son. Ambulance Service called for pick up and given 1-hour ETA (Expected time of Arrival). Will continue to monitor. R1's progress notes dated 10/19/2021, documented by V2 (Nurse), shows at 2:35p.m. resident in bed, with head of bed up. SPO2 95% with oxygen (O2) at 2L. V/S: BP-98/61, T-97.0, P-68, R-20. Resident responsive to verbal stimuli, will continue to monitor closely with staff on hand. Awaiting ambulance. At 2:50 p.m. resident remains in bed, continues to respond to verbal and tactile stimuli but sleeping and snoring. Head	S9999		

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of bed at 45 degrees. No SOB (shortness of breath) noted. SPO2 94-95% oxygen at 2L, V/S: T-96.7, P-60, R-20, staff on hand awaiting ambulance pick up.

At 3:05 p.m. resident closely monitored by staff. Resident continues to be lethargic. V/S: BP-98/61, T-96.7, P-60, R-22, resident appears stable. SPO2 94% with O2 at 2L. At 3:20 p.m. resident observed sleeping and snoring, O2 ongoing, SPO2 91%V/S: BP-96/61, T-97.3, P-58, R-22, CNA (Certified Nursing Assistant) assigned to stay by resident. Will continue to monitor.

At 3:40 p.m. called Elite Ambulance, spoke with representative regarding past ETA and nurse was informed resident will be picked up in 45 minutes. Resident SPO2 85% with oxygen at 2 liters, and heart rate dropping from 45 to 35. Oxygen increased to 3 Liters. At 3:50 p.m. resident SPO2 85% with oxygen at 2 liters, and heart rate dropping from 45 to 35. Oxygen increased to 3 Liters, and SPO2 increased to 91%, heart rate continues to drop to 26. 911 called. Resident still lethargic and slow to respond and snoring. Awaiting paramedics. Staff by bedside. Elite ambulance cancelled. At 4:10 p.m., 911 team here, report given. Resident taken to hospital. At 11:00 p.m., called hospital for status. Resident admitted to ICU (Intensive Care Unit) with diagnosis of "Overdose". Supervisor notified; belongings packed.

From the documentation in R1's medical record it took the staff from 2:20 p.m. to 4:10 p.m. to get medical emergency team to the facility to evaluate and transport R1 to the hospital after the identification of R1's change of condition.

A.2. The following staff members were

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interviewed regarding R1's change of condition on 10/19/2021: On 10/27/2021 at 11:01a.m., V1 (Nurse) said she was covering for V2 (Nurse) when she was summons to R1's room because "something was wrong with R1." V1 stated she observed R1 sitting on the side of the bed, when she asked R1 how she was doing R1 responded "I'm okay." V1 stated R1 spoke in a very slow manner. V1 said R1 then tried to stand up, however, R1 sat back down on the bed and she assisted R1 into a lying position. V1 stated R1 began to fall asleep and snore very loudly at a regular pace. R1 presented in a "postictal state" as if she had a seizure, however, when she checked R1's records, R1 did not have any medical history of Seizure Disorder. V1 stated she assessed R1's vital signs and they were stable. V1 stated she called V5 (Nurse Practitioner) and made him aware of her assessments, R1's vitals, and R1's current condition. V1 stated when V2 (Nurse) came back from her break and assessed R1, she mentioned R1 was not at her base line. V1 stated she has seen R1 with her purse, R1 would have her purse in the bottom of her walker (walker that had basket at bottom). V1 stated she last saw R1 about an hour prior to being summons to R1's room.

On 10/27/2021 at 11:53 a.m., V2 (Nurse) stated on 10/19/21 when she came back from her lunch break, V1 reported R1's condition to her. V2 stated when she assessed R1, R1 was laying in the bed, R1 would open her eyes when her name was called, but was not verbal, V2 stated R1 would move her leg a little when asked. V2 said she continued to assess R1's vital signs while waiting for the ambulance to transport R1 to the hospital. V2 stated R1's vital signs were stable initially. V2 stated after one hour of waiting for the

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ambulance, she followed up and that's when she was given another hour for the ETA. V2 stated she continued to assess R1's vital signs and when she noticed R1's heart rate drop from 45 to 35 that's when she called 911 for emergency care. V2 stated she was not aware that R1 had a diagnosis of Suicidal Ideations.

On 10/28/21 at 2:02p.m., V5 (Nurse Practitioner) stated he received one call and the nurse stated that R1 was lethargic but was still moving her head or something like that, and also R1's vitals were a little below her base line, and that's why he gave the order to send to CF hospital. V5 stated he did not receive a follow up call related to R1's status. V5 stated the nurse did not inform him that R1's oxygen saturation dropped, he did not give an order to place R1 on oxygen, and he was not made aware that R1's heart rate had dropped. V5 was not made aware that R1 presented in a postictal state. V5 stated if he was made aware of all the changes in condition for R1, he would have sent her out 911 for further medical evaluation for the decline. V5 continued to say he only received one call, but maybe the collaborating physician was notified.

A.3. R1's hospital records date of 10/19/2021 at 7:39 p.m., documented in-part: patient endorsed SI (Suicidal Ideation). Patient reports taking 20-30 tabs of Amlodipine of unknown dosage. Patient states the Amlodipine is her medication that's in her purse and had it before going to the NH (Nursing home). MD (Medical Doctor) and Pharmacy aware, poison control being contacted. At 8:42 p.m., in brief, patient 61-year-old female patient with PMH (Past Medical History) of Bipolar, Major Depression, Schizophrenia, type 2 Diabetes, Fibromyalgia, HLD (Hyperlipidemia), HTN (Hypertension) who presented to ED

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S9999	Continued From page 9 (Emergency Department) after she was found to be altered at the nursing home. Upon arrival to the ED there was questionable concerns that the patient had taken another residents medication. She was given Narcan for possible Opioids use and started on IV fluids as her BP (Blood Pressure) was 76/52. At the time of ED (Emergency Department) arrival, per ED nurse and attending, minimal information was obtained from the patient as she was drowsy but still arouse-able to tactile stimulation. Upon examination, patient was more alert although drowsy throughout my encounter. When asked for purpose of her ED visit, she stated that she wanted to kill herself. When asked how she tried to do so she mentioned she had taken about 20 pills of Amlodipine. ED Nurse and attending were notified. After further questioning she mentioned that she had these pills before arriving to the nursing home in her purse. (R1) ED H&P (History & Physical) assessment showed: Acute Toxic Encephalopathy secondary to ingestion of multiple tablets of Amlodipine, suicide attempt from Amlodipine overdose, shock most likely secondary to Cardiogenic from Amlodipine overdose, Hypoxia possibly secondary to Atypical Pneumonia versus Pulmonary Edema from fluid resuscitation, Electrolyte Imbalance, and type 2 Diabetes with Hyperglycemia. A.4. On 11/02/2021, a phone conference with E1 (Administrator) was held to discuss the survey teams concerns for the late response to act on R1's change of condition. After the discussion the facility provided documentation from V16 (Physician) dated 11/02/2021 indicating he was in direct contact with V5 (Nurse Practitioner) as it was reported 14:20 hours (2:20 p.m.). V16 (Physician) documented: I was notified of the initial assessment and vitals for the patient and	S9999		

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was in agreement with sending the patient to a local medical center as the patient's condition at the initial assessment did not warrant a 911 emergency call. I was contacted (no time given) by the nurse (not named) at the facility that there was a deviation from the initial assessment that was provided to my Nurse Practitioner and then I gave the order for the resident to be sent to the hospital 911. This second, contact with the medical doctor was not documented in the resident's medical record.

On 11/9/2021 at 10:35 a.m., V16 (Physician) stated V5 (Nurse Practitioner) received the initial call regarding R1 change in condition. V16 stated V5 communicated with him and they agreed that R1 should be sent to CF hospital for evaluation. V16 said he informed V5 that he would be the contact person for R1 at that point. V16 said the nurse did contact him several times before the 911 call at 3:50p.m, V16 stated he does not remember specific times. V16 stated 911 should be called when a resident has a drastic change of condition. V16 described a drastic change in condition could be when a person's pulse is going below 40, oxygen very low of 75% to 80% and blood pressure of 70/50. V16 said R1's condition at 2:20p.m was not drastic, that's why R1 was going to be transported to CF hospital. R1's progress notes dated 10/19/21 at 3:20p.m, V16 stated oxygen saturation of 91% is okay for a patient that smokes, he would be concerned if the oxygen saturation was 70%-75% for someone that smokes. V16 said heart rate of 58 is okay. R1's progress notes date 10/19/21 at 3:40p.m reviewed with V16, V16 said oxygen saturation of 85% could indicate multiple things, one could possibly be an intracerebral bleed and a heart rate of 35 is bad but not drastic, V16 stated that's why he gave orders to send R1 to hospital so that

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S9999	Continued From page 11 she could be evaluated, but the ambulance took their time. V16 stated at 3:40 p.m., he was informed of R1's condition and he directed the nurse to keep him informed, if the resident condition does not improve to call 911, and at 3:50 p.m. the nurse called 911 because the heart rate dropped to 26. V16 stated the nurses did a marvelous job, V16 stated it was okay for the nurse to wait for Elite Ambulance to transport a resident to the hospital for evaluation unless the patient has a drastic change and R1 had a drastic change at 3:50 p.m. and that's when the nurse called 911. When asked does he expect the nurse to call 911 at 3:40 p.m. when the heart rate is 35 and oxygen saturation is 85%, V16 stated the nurse cannot call 911 unless the physician gives directives. V16 stated at 3:40 p.m. he gave directives to the nurse to keep him informed and if R1's condition does not improve to call 911 and that's when the nurse called 911 at 3:50 p.m. Facility policy Titled "Change in Resident's Condition or Status" dated 06/26/2011 shows in-part the purpose is to ensure that the resident's attending physician and representative is notified of change in resident's condition and/ or status. The nurse will notify resident's attending physician when there is a significant change in the resident's physical, mental and psychosocial status. Deemed necessary or appropriate in the best interest of the resident. A significant change of condition is a decline or improvement in the resident status that will not normally resolve itself without intervention by staff or by implementing standard disease related clinical interventions, impact more than one area of the resident health status, and review and revision to the care plan. Except in medical emergencies, notification will be made within 24 hours of a change occurring in the resident condition or status. During medical	S9999		

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S9999	Continued From page 12 emergencies such as unstable vital signs, respiratory distress, uncontrolled bleeding and unresponsiveness 911 will be notified for transport to the hospital. B.1. According to the face sheet R1 a 61-year-old resident was admitted to the nursing facility on 09/05/2020. R1 face sheet also indicated R1 had diagnosis of Bipolar Disorder current episodes mixed, moderate, Major Depressive Disorder recurrent, unspecified Suicidal Ideations, type 2 Diabetes, Fibromyalgia, Lumbago with Sciatic, Hyperlipidemia, Hypertension, other Psychoactive Substance Abuse with unspecified Psychoactive Substance Induced Disorder, Schizophrenia unspecified. R1's death certificate dated 10/28/21 listed R1's cause of death as Amlodipine and probable Lisinopril and Duloxetine toxicity, manner of death is suicide with the date of injury 10/19/21, place of injury shows nursing home, description of how injury occurred is ingested combined drugs, dated pronounced is 10/22/21. R1's POS (Physician Order Sheet) dated 9/15/21 included physician orders for Acetaminophen tablet give 650 milligrams by mouth every 4 hours as needed for pain, Atorvastatin Calcium tablet 20 milligrams give 1 tablet by mouth at bedtime for Cholesterol, Baclofen tablet 10 milligrams give 1 tablet by mouth two times a day for Spasm, Cymbalta capsule delayed release particles 30 milligrams (Duloxetine) give one capsule one time a day related to Major Depression recurrent unspecified, Glimepiride tablet 2 milligram give 1 tablet by mouth two times day related to type 2 Diabetes, Hydralazine HCl tablet 25 milligrams give 1 tablet by mouth in the morning for Hypertension, Lisinopril tablet 30 milligrams give	S9999		

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S9999	Continued From page 13 one tablet by mouth one time a day for Hypertension, Magnesium Hydroxide Suspension 2400/milligrams/10 milliliters give 30 milliliters by mouth every 24 hours as needed for Constipation, Metformin HCl tablet 500 milligrams give 1 tablet by mouth two times a day for DM2 (Diabetes type 2), Mylanta Suspension 200-200-20 milligrams/5 milliliters (Aluminum Hydroxide & Magnesium Hydroxide-Simethicone) give 30 milliliters by mouth every 4 hours as need for Dyspepsia, and Seroquel tablet 200 milligram give one tablet by mouth two times a day for behavior disturbance. R1's POS does not show physician orders for Amlodipine medications. Review of R1's MAR (Medication Administration Record) dated 10/01/2021-10/31/20201, does not show any documentation of "May keep at bedside". Facility policy Titled "Medication Storage in the Facility" with no date noted showed in-part that medication and biological are stored safely and properly following the manufacture or supplier recommendations. The medication supply is assessable only to license nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Facility policy Titled "Medication Self-Administration" no date noted shows in-part the purpose is to provide procedures for determining if the resident can safely self-administer and store medication in their room. Bedside storage of prescription and non-prescription drugs is permitted when the assessment demonstrate the practice is safe. Non-prescription drugs, bearing the manufactures label which may be stored in the resident room include Petroleum Jelly, Talcum Powder,	S9999		

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toothpaste, cold cream, lip balm, make-up, and baby oil. Non- prescription medication stored in resident room will be documented on the medication record. Prescription medications stored in the resident room should be written on the medication record "May keep at bedside".

B.2. R1's progress notes dated 10/19/21 at 2:20 p.m. documented by V1(nurse) indicated: resident noted to be lethargic and slowly to respond with generalized weakness. Resident observed snoring in postictal state but doesn't have history of Seizures. Vitals taken V/S (Vital Signs) T-96.8, P-63, R-20, BP-96/60. Spo2 (oxygen saturation) 94% on Room Air. Nurse Practitioner informed and received order to transfer resident out to hospital for medical evaluation. V6 (Director of Nursing) informed, family contact informed and spoke to son. Ambulance Service called for pick up and given 1-hour ETA (Expected time of Arrival). Will continue to monitor.

R1 progress notes dated 10/19/2021 documented by V2 shows at 2:35p.m resident in bed, with head of bed up. SPO2 95% with oxygen at 2L. V/S (vital signs), BP (blood pressure) 98/61, T (temperature) 97.0, P (pulse) 68, R (Respirations) 20. Resident responsive to verbal stimuli, will continue to monitor closely with staff on hand. Awaiting ambulance. At 2:50p.m resident remains in bed. Continues to respond to verbal and tactile stimuli but sleeping and snoring. Head of bed at 45 degrees. No sob noted. SPO2 94-95% oxygen at 2L. V/S, T 96.7, P 60, R 20. Staff on hand. Awaiting ambulance pick up. At 3:05p.m resident closely monitored by staff. Resident continues to be lethargic. V/S 98/61, T 96.7, P 60, R 22. Resident appears stable. SPO2 94% with O2 at 2L. At 3:20p.m resident observed sleeping and

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snoring. O2 (oxygen) ongoing. SPO2 91%. V/S, BP 96/61, T 97.3, P 58, R 22. CNA assigned to stay by resident. Will continue to monitor. At 3:40p.m called Elite ambulance, spoke with representative regarding past ETA and nurse was informed resident will be picked up in 45 minutes. Resident SPO2 85% with oxygen at 2 liters, and heart rate dropping from 45 to 35. Oxygen increased to 3 Liters. At 3:50p.m resident SPO2 85% with oxygen at 2 liters, and heart rate dropping from 45 to 35. Oxygen increased to 3 Liters, and SPO2 increased to 91% and heart rate continues to drop to 26. 911 called. Resident still lethargic and slow to respond, and snoring. Awaiting paramedics. Staff by bedside. Elite ambulance cancelled. At 4:10 p.m., 911 team here, report given. Resident taken to hospital. At 11:00p.m called hospital for status. Resident admitted to ICU (Intensive Care Unit) with diagnosis of "Overdose". Supervisor notified. Belongings packed.

On 10/27/2021 at 11:01a.m. V1 (Nurse) said she was covering for V2 (Nurse) when she was summons to R1's room because "something was wrong with R1" V1 said she observed R1 sitting on the side of the bed, when she asked R1 how she was doing R1 responded "I'm okay" V1 said R1 spoke in a very slow manner. V1 said R1 then tried to stand up however R1 went sat back down on the bed and she assisted R1 into a lying position. V1 said R1 began to fall asleep and snore very loudly at a regular pace. R1 present in a "postictal state" as if she'd had a seizure, however when she checked R1 records R1 did not have any medical history of seizures disorder. V1 said she assessed R1 vital signs, and they were stable, V1 said she called V5 (Nurse Practitioner) and made him aware of her assessments, R1 vitals and R1 current condition.

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S9999	Continued From page 16 V1 said when V2 (Nurse) came back from her break and assessed R1, she mentioned R1 was not at her base line. V1 said she has seen R1 with her purse, R1 would have her purse in the bottom of her walker (walker that had basket at bottom). V1 said she last saw R1 about an hour prior to being summons to R1's room. On 10/27/2021 at 11:53a.m. V2 (Nurse) said on 10/19/21 when she came back from her lunch break, V1 reported R1 condition to her. V2 said when she assessed R1, R1 was laying in the bed, R1 would open her eyes when her name was called, but was not verbal, V2 said R1 would move her leg a little when asked. V2 said she continued to assess R1 vital signs while waiting for the ambulance to transport R1 to the hospital. V2 said R1 vital signs were stable initially. V2 said after one hour of waiting for the ambulance, she followed up and that's when she was given another hour for the ETA. V2 said she continued to assess R1 vital signs and when she noticed R1 heart rate drop from 45 to 35 that's when she called 911 for emergency care. V2 said she was not aware that R1 had diagnosis of suicidal ideations. R1's progress notes dated 10/19/21 at 2:20 p.m., documented by V1(Nurse) indicated: resident noted to be lethargic and slow to respond with Generalized Weakness. Resident observed snoring in Postictal state but doesn't have history of Seizures. vitals taken V/S (Vital Signs): T (Temperature) 96.8, P (Pulse) 63, R (Respirations) 20, BP (Blood Pressure) 96/60, Spo2 (Oxygen Saturation) 94% on Room Air. Nurse Practitioner informed and received order to transfer resident out to hospital for medical evaluation. V6 (Director of Nursing) informed, family contact informed and spoke to son.	S9999		

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S9999	Continued From page 17 Ambulance Service called for pick up and given 1-hour ETA (Expected time of Arrival). Will continue to monitor. R1's progress notes dated 10/19/2021, documented by V2 (Nurse), shows at 2:35p.m. resident in bed, with head of bed up. SPO2 95% with oxygen (O2) at 2L. V/S: BP-98/61, T-97.0, P-68, R-20. Resident responsive to verbal stimuli, will continue to monitor closely with staff on hand. Awaiting ambulance. At 2:50 p.m. resident remains in bed, continues to respond to verbal and tactile stimuli but sleeping and snoring. Head of bed at 45 degrees. No SOB (shortness of breath) noted. SPO2 94-95% oxygen at 2L, V/S: T-96.7, P-60, R-20, staff on hand awaiting ambulance pick up. At 3:05 p.m. resident closely monitored by staff. Resident continues to be lethargic. V/S: BP-98/61, T-96.7, P-60, R-22, resident appears stable. SPO2 94% with O2 at 2L. At 3:20 p.m. resident observed sleeping and snoring, O2 ongoing, SPO2 91% V/S: BP-96/61, T-97.3, P-58, R-22, CNA (Certified Nursing Assistant) assigned to stay by resident. Will continue to monitor. At 3:40 p.m. called Elite Ambulance, spoke with representative regarding past ETA and nurse was informed resident will be picked up in 45 minutes. Resident SPO2 85% with oxygen at 2 liters, and heart rate dropping from 45 to 35. Oxygen increased to 3 Liters. At 3:50 p.m. resident SPO2 85% with oxygen at 2 liters, and heart rate dropping from 45 to 35. Oxygen increased to 3 Liters, and SPO2 increased to 91%, heart rate continues to drop to 26. 911 called. Resident still lethargic and slow to respond and snoring. Awaiting paramedics. Staff by bedside. Elite ambulance cancelled. At 4:10 p.m., 911 team here, report given. Resident taken to hospital. At	S9999		

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S9999	Continued From page 18 11:00 p.m., called hospital for status. Resident admitted to ICU (Intensive Care Unit) with diagnosis of "Overdose". Supervisor notified; belongings packed. From the documentation in R1's medical record it took the staff from 2:20 p.m. to 4:10 p.m. to get medical emergency team to the facility to evaluate and transport R1 to the hospital after the identification of R1's change of condition. B.3. R1's hospital records date of 10/19/2021 at 7:39 p.m., documented in-part: patient endorsed SI (Suicidal Ideation). Patient reports taking 20-30 tabs of Amlodipine of unknown dosage. Patient states the Amlodipine is her medication that's in her purse and had it before going to the NH (Nursing home). MD (Medical Doctor) and Pharmacy aware, poison control being contacted. At 8:42 p.m., in brief, patient 61-year-old female patient with PMH (Past Medical History) of Bipolar, Major Depression, Schizophrenia, type 2 Diabetes, Fibromyalgia, HLD (Hyperlipidemia), HTN (Hypertension) who presented to ED (Emergency Department) after she was found to be altered at the nursing home. Upon arrival to the ED there was questionable concerns that the patient had taken another residents medication. She was given Narcan for possible Opioids use and started on IV fluids as her BP (Blood Pressure) was 76/52. At the time of ED (Emergency Department) arrival, per ED nurse and attending, minimal information was obtained from the patient as she was drowsy but still arouse-able to tactile stimulation. Upon examination, patient was more alert although drowsy throughout my encounter. When asked for purpose of her ED visit, she stated that she wanted to kill herself. When asked how she tried to do so she mentioned she had taken about 20	S9999		

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S9999	Continued From page 19 pills of Amlodipine. ED Nurse and attending were notified. After further questioning she mentioned that she had these pills before arriving to the nursing home in her purse. (R1) ED H&P (History & Physical) assessment showed: Acute Toxic Encephalopathy secondary to ingestion of multiple tablets of Amlodipine, suicide attempt from Amlodipine overdose, shock most likely secondary to Cardiogenic from Amlodipine overdose, Hypoxia possibly secondary to Atypical Pneumonia versus Pulmonary Edema from fluid resuscitation, Electrolyte Imbalance, and type 2 Diabetes with Hyperglycemia. B.4. On 10/28/2021 at 2:23 p.m. V3 (Social Worker) stated R1 was on her caseload, and she has never seen R1 with a purse however when R1's family picked up R1's belongings, she observed some clothing, a black purse, and a laptop, V3 also stated R1 had a debit card while at the facility but does not know if the debit card was with R1's belongings. On 10/27/2021 at 3:26 p.m. V8 (Laundry Aide) stated she did the inventory of R1's items (V8 reviewed the 2 inventory documents and verified her signature). V8 stated the process is that residents' belongings come to laundry first, V8 stated if contraband is found she would get the nurse or security involved, if there's medication she would notify the nurse, if there's sharps, glass, weapons or anything a resident can use to hurt themselves or others she would notify security. V8 reviewed R1's inventory sheet and stated there is no purse or medication documented on the 2-inventory sheets there must wasn't one in R1's belongings. V8 stated she only gets the bags of belongings, if a resident has something on their person, she will not inventory those items, and she would not see those items	S9999		

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because it would go to the unit with the resident and the nurse would inventory the items. On 10/27/21 at 4:01p.m V12 (Nurse) said he was the nurse that assessed R1 upon her admission and it's been a while since the admission, but he does not think he saw a purse.

On 10/28/21 at 11:50a.m V9 (Activity Director) stated she has seen R1 with a purse, and R1 keeps her purse at the bottom of her walker (walker that has a basket at the bottom).
On 10/28/2021 at 2:23p.m. V3 (Social Worker) stated R1 was on her caseload, and she has never seen R1 with a purse however when R1's family picked up R1 belongings, she observed some clothing, a black purse, and a laptop, V3 also stated R1 had a debit card while at the facility but does not know if the debit card was with R1 belongings.

Review of R1's inventory personal items, dated 09/16/2020 and 09/26/2020, there is no documentation of R1's purse noted nor is there documentation of the pills that R1 admitted to having in her purse.
On 10/27/21 at 8:50a.m V6 (R1's Family member) stated the facility contacted him on 10/19/2021 and informed him that R1 would be sent to the hospital because her blood pressure was low and R1's sugar was high. V6 stated while at the hospital R1 told the doctor that she took pills that she had in her purse, V6 stated R1 expired on 10/22/2021, V6 stated R1 was not supposed to have those pills because she was a danger to herself and R1 was also diagnosed with Bipolar, Schizophrenia and Depression. V6 stated R1's belongings were picked up from the facility and in R1's black purse was a pill bottle along with some receipts, V6 also stated in R1's belongings were her gray laptop and some

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S9999	Continued From page 21 clothing items. V6 stated the pill bottle was empty. Review of the picture that V6 submitted of pill bottle dated 04/10/2020 shows in-part R1's name, a Chicago address, Lisinopril-HTCZ 20/25 milligram, take 1 tablet by mouth daily. Facility policy titled "Resident personal Clothing and Belongings Handling" dated 11/08/2011 shows in-part that policy is to ensure that all residents clothing is identified, stored, and laundered appropriately. Procedure upon admission, personal belongings are to be listed on the Belongings List in the resident chart. New items brought to the facility other that during the admission process, should be added to this list. Upon discharge CNA (Certified Nursing Assistant) assigned to the resident unit will pack residents' belongings and notify housekeeping, housekeeping will move resident belongings to the storage area, residents' belongings will be marked with residents name during storage, social services will contact the family regarding belongings left at the facility, belongings will be stored for 30 days after resident permanent discharge. Facility Policy Titled "Contraband Materials, Inspection of rooms, safe storage and use of recording Devices", no date noted shows in-part Introduction: This organization reserves the right to conduct inspections if there is reason to suspect/believe that a resident has contraband items/ materials in his/her possession. These items include but are not limited to alcohol, illicit (street or over the counter) drugs, weapons (including any sharp objects/ ammunition) and smoking materials (if the individual has assessed as dangerous and irresponsible with smoking related items). The individual may also be	S9999		

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S9999	Continued From page 22 appropriately checked to look for suspected lost or stolen property, if reasonable suspicion exits. No over the counter medication may be kept by the resident. These items must be turned over to facility personnel immediately upon arrival. The origination will try balance individual rights against the safety needs of peers, visitors and staff members in making decisions about further investigation of contraband. In situations where illegal activity appears to have taken place appropriate authorities will be notified. Again, safety and security are of the utmost concern. Policy; the following items are not allowed in resident's rooms at any time and are not allowed on the resident's person unless permission has been granted from administration and supervision is being provided: lighters matches, cigarettes, drugs, over the counter medication, drug paraphernalia, glass bottles, toaster oven, hot plates, coffee makers, rice cookers, microwave oven, silverware, knives, fire arms and ammunition of any type, alcohol, razors, razor blades, caffeinated beverages, needles, safety pins, housekeeping, laundry supplies, staplers, staples, candles, incense. B.5. R1 Nursing Facility Placement Assessment Summary Information dated 10/01/2020 indicated in-part, R1's mental status and presenting behaviors where, adequate concentration, poor memory, absent motivation, cooperative, unremarkable thought disorder, sad facial expression, average intelligence, depressed mood, orientated, no impairment with physical sensory, withdrawn, and speech and voice was appropriate. The narrative summary shows screening completed via phone due to COVID-19. Patient is a 60-year-old hospitalized for Depression Symptoms, endorsing SI (Suicidal Ideation), AH (Auditory Hallucinations). Patient	S9999		

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S9999	Continued From page 23 was alert and orient during screening, denies current SI/ HI (Suicidal Ideation/ Homicidal Ideations). Denies AVH (Auditory-Visual Hallucinations). Ongoing medication non-compliance, limited insight, history of substance abuse, currently homeless, and denies legal issues. Patient referred to FDDP for assessment. Based on medical records and patient presentation during PAS, there is a reasonable basis to believe the patient will benefit from NF (Nursing facility) level of care. We recommend reassessment for TCM/ communication reintegration within 3-12 months or upon Psychiatric Stabilization, poor judgement placing self or others at risk and recent medication non-compliance. R1's Nursing Facility Placement PAS/MH level 2 notice of determination dated 10/1/2020 shows in part the following information is a summary of the findings of your pre-admission screen: special services; professional observation (MD/RN) for medication monitoring, adjustment and stabilization, instrumental activities of daily living training/ reinforcement, mental health rehabilitation activities, illness self-management and community survival activities. V7 (Assistant Director of Social Service) said he was not aware of R1's history of Suicidal Ideations, he was made aware last week. R's care plan with target date of 12/10/2021 shows in-part that R1 requires psychotropic medication to help manage and alleviate: Depression, behavior with depressive features, Mood swings, mood liability. The ff. class (es) of medication are prescribed: Antipsychotic. The ff. class (es) of medication are prescribed: Antidepressant. R1 will be maintained on the lowest therapeutic medication dosage and	S9999		

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	IL6009948	A. BUILDING: _____ B. WING _____	C 11/24/2021

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
S9999	Continued From page 24 engaged in counseling/behavioral programming to facilitate maximum functioning and well-being through: R1 psychotropic medication will be therapeutically reduced if warranted. Assure that the resident's diagnosis corresponds with the medication prescribed, Complete psychotropic evaluation and assessment consistent with protocol. Carry out the medication management regiment as prescribed. Report changes, complications to the doctor., Assess the side effects and complication such as abnormal involuntary movements (i.e., tremors, shaking, pacing, lip/tongue movement, rigidity, stooped posture, etc.) and anticholinergic symptoms (blurred vision, poor balance, urinary retention, constipation, dry mouth, etc.), Offer behavioral counseling and intervention to help the resident cope with mood and/or behavioral distress and dysfunction., Teach the resident coping strategies to enable him/her to compensate for hallucination and/or delusions., If behavioral symptoms are observed, record and document on "Behavior Tracking Form." Report abnormalities to MD. R1's care plan with initiation date of 12/15/2020 shows Auditory Hallucinations: Resident has a history of having Auditory Hallucinations. Resident will experience a decrease in Auditory Hallucinations as evidenced reported by staff through next review date, 9/9/2021. Staff will provide reality-orienting counseling. Staff will provide redirection as needed. R1's care plan with initiation date of 12/15/2020 shows mood Depression: Resident presents with periods of Depression evidenced by resident scoring a 13 on the PHQ-9. Resident stated Depressive symptoms in regard to being isolated in the facility at this time. Resident stated she has trouble sleeping and does not like the status in	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009948	A. BUILDING: _____ B. WING _____	C 11/24/2021

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CITY VIEW MULTICARE CENTER	5825 WEST CERMAK ROAD CICERO, IL 60804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 25 health. Resident stated while in the hospital she did not like the environment. Resident will share concerns and demonstrate a decrease in symptoms as evidenced by improved indicators identified PHQ9 and in Depression Scale through the next review date 9/9/2021. Encourage Resident to seek staff when having any distress or moods leading to Depression. Staff will discuss and offer Resident to participate in Marriage and or 1:1 counseling as needed. R1's care plan with initiation date of 12/15/2020 shows Substance Abuse, R1 has a history of polysubstance abuse which includes alcohol and Benzoates. The resident will refrain from using non-prescribed substances through the next review 9/9/2021. Staff will discuss the negative impacts of using illicit substances as needed, Staff will make resident aware of rules prohibiting use of alcohol, illicit substances & intoxication. R1 care plan with initiation date of 12/15/2020 shows Suicidal Ideations, resident with a history of Suicidal Ideations with no plan. Resident will immediately report any Suicidal Ideation or thoughts of self-harm to staff, as evidenced by staff reports through the next review date of 09/09/2021. Staff will monitor for any mood and behavior changes, and staff will provide counseling as needed. There was no documented monitoring of R1's behavior in the medical record and no evidence of any psycho-social programing. (A)	S9999		