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 10/08/2023

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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: 2398384/IL165273	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)3) 300.3240b) 300.3240g) 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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: 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. Section 300.3240 Abuse and Neglect b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the Department and to the facility administrator. (Section 3-610(a) of the Act) g) A facility shall comply with all requirements for reporting abuse and neglect pursuant to the Abused and Neglected Long Term Care Facility Residents Reporting Act. These Regulations are not met as evidenced by: Based on observation, interviews and record review, the facility failed to prevent an incident of resident-to-resident physical assault that resulted in injury and psychosocial harm to R2, as the facility failed to follow their abuse policy by preventing physical abuse for one resident as a result of a physical attack by a peer (R1). This failure resulted in R2 sustaining swelling and bruising to his left upper lip and right eye, along	S9999		

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S9999	Continued From page 2 with a cut to the bridge of his nose and caused psychosocial harm to R2 as he verbalized fear and feeling scared of another peer attacking him, which makes him not feel safe at the facility. Findings include: On 10/07/2023 at 10:03 AM, observed R2 lying in bed at this time. Observed mild swelling and purple colored bruising to his left upper lip, a small, scabbed area to the bridge of his nose, and light purple-blue bruising to entire right eye area (upper and lower lids), noted several dried reddish brown colored stains to R2's pillowcase. Resident said that two nights ago (Thursday 10/5/23), he was lying on his bed when his roommate at that time (R1), came over to the side of his bed and punched him (R2) "very hard" to the side of his head. R2 added that he sustained the facial injuries because of the "attack" from R1. R2 then stated that after it happened, a staff member took him (R1) out of the room and moved him to a different room on a different floor. R2 also stated he did not receive any medical attention until "last night when they came and x-rayed me". R2 then stated that he was fearful of another attack and would like to transfer to another facility because he "does not feel safe here". R2's Nursing Progress Note by V6 (RN) dated 10/5/2023 15:43 indicated, "during visit with [Nurse Practitioner] resident states he had pain around his eye area and [pain medication] was given. [Nurse Practitioner] ordered x-ray to facial structures and skull". Nursing Progress Note dated 10/6/2023 21:41 indicated, "x-ray of facial structure/skull was done results pending".	S9999		

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S9999	Continued From page 3 No documentation found regarding incident with R1 and R2. Facility provided risk assessment report dated 10/05/2023 12:59 PM that indicated R1 had a verbal disagreement with co-peer and R1 was observed with a "scratch to bridge of nose and discoloration under right eye. Ice applied. Medical doctor made aware. No orders noted. Monitor". R2's face sheet indicated resident admitted to facility on 02/14/2023 and has a past medical history of major depressive disorder, schizoaffective disorder, delusional disorders, osteoarthritis, weakness, and lack of coordination. R2's care plan last reviewed 7/11/2023 indicated resident has the potential for abuse due to history of suspected abuse, neglect, exploitation, past trauma and/or other factors that may increase resident's susceptibility to abuse/neglect; denies any past trauma yet assessment reveals factors including diagnosis of mental illness, aggression, and denial. R2's Trauma Screening dated 10/04/2023 indicated resident scored five which indicated significant trauma-related symptomology. On 10/07/2023 at 11:38 AM, when asked how R2 sustained the facial injuries, V2 (Director of Nursing) who appeared to be unaware of R2's facial injuries stated, R2 had a verbal altercation with his roommate R1 two days ago (Thursday morning). V2 then corrected herself and said, "it was a disagreement not an altercation" then said she noticed a small scratch to the bridge of his nose and a little red dot under his right eye. She added that V1 initiated an investigation on the day	S9999		

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S9999	Continued From page 4 of incident. V2 (DON) then stated R1 was moved to a different room because of the disagreement and because he had voiced wanting to move to another room due to R2's loudness which disturbed his sleep. When asked how R2 sustained facial injuries from a "verbal disagreement" with R1, V2 (DON) gave no response. On 10/07/2023 at 12:15 PM, V1 (Administrator) stated regarding the alleged incident between R1 and R2, there was a verbal disagreement regarding the air conditioner and R1 got upset with R2 because he thought R2 was making too much noise which disturbed his sleep. V1 added that an investigation was initiated for the verbal disagreement. When informed to the extent of R2's facial injuries, V1 appeared to be unaware to the extent of his facial injuries. On 10/07/2023 at 12:26 PM, V2 (Director of Nursing) stated they had immediately removed the residents then initiated an investigation. She added that she briefly spoke to R2 around 12:30 PM on the day of the incident. When she asked what was happening between him and his roommate, R2 said they don't get along and R1 came to his side of the room telling him what he can/cannot do which made him upset which led to a disagreement. R2 told her that a staff member then entered their room and removed R1. V2 (DON) said she saw R2 again yesterday (10/06/2023) and noted no new injuries to his face. On 10/07/2023 at 1:29 PM, V5 (Certified Nursing Assistant) stated she asked R1 why he was moved to the fourth floor and R1 told her, "He couldn't understand it himself". V5 added that she felt like R1 knew why he was moved but didn't	S9999		

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S9999	Continued From page 5 want to say and she didn't want to pressure him about it. On 10/07/2023 at 1:36 PM, V6 (Registered Nurse) stated she worked the day of the incident between R1 and R2 which had occurred in the morning towards the end of third shift. She was told after the incident, that R1 was moved to another floor. V6 then stated that same morning, R2 was seen by the Nurse Practitioner who did not report any facial injuries to R2 but had ordered x-rays due to his complaint of "pain to the eye area". V6 added that she doesn't know the full story regarding the incident and was told by previous nurse (V4) that "everything was taken care of" and she did see a bruise to R2's eye and did a pain assessment then administered pain medication. She added that she did not report the injury because she was told everything was taken care of. On 10/07/2023 at 2:04 PM V2 (Director of Nursing) now stated that R2's injury was "not a red dot but rather red discoloration" that was only to a small area of his eye area. When asked if she noted any blueish purple bruising to the area, she stated "the color of bruising is described differently by different people". V2 also stated after re-interviewing both residents today, R1 stated he approached R2 at the side of his bed and told him (R2) about what he does that aggravates him. R1 is now stating that R2 swung at him, and he swung his hand back at him (R2). R1 then stated he made physical contact with R2 that was not intentional. V2 (DON) stated when she interviewed R2, he said they had a disagreement and R1 came to the side of his bed, got agitated and he (R1) swung his hand at R2. When asked what the protocol was for an injury of unknown origin, V2 stated nurses are to	S9999		

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S9999	Continued From page 6 call her then she initiates an investigation. V2 then said when staff first saw the injury to R2's face, it was not reported because it was not intentional then added that the conclusion was made today after she reinterviewed both residents, that R1 was the cause of R2's facial injuries so V1 submitted an initial report to public health. When asked how it was determined on the day of the incident that the physical contact was not intentional when she was just informed today by both residents that there was physical contact made, V2 offered no explanation. On 10/07/2023 at 2:24 PM, V4 (Licensed Practical Nurse) stated the incident between R1 and R2 happened after she was already gone. V4 added that there was no visible injury to R2's face nor did an incident occur between him and roommate before she left at approximately 7:15 AM Thursday morning (10/05/23). V4 then stated when she came to work on Friday (10/06/23) for the afternoon shift, she saw R2 on the elevator and saw a bruise underneath his right eye that was purple in color. R2 stated he "got into a little fight with his roommate", and that's all he said about it. V4 stated she did not report R2's injury because she assumed it was known. On 10/07/2023 at 2:40 PM V7 (Certified Nursing Assistant) stated she worked Wednesday night into Thursday morning on the fifth floor and no incidents had occurred between R1 and R2 and believed the incident occurred Thursday (10/05/23) after she left. She then stated when she came into work on Thursday night, V4 (Licensed Practical Nurse) told her there was an altercation between R1 and R2, that R1 hit R2 in the face so they moved R1 to a different room. V7 added that she had worked on the fifth floor Thursday night and saw a purple-colored bruise	S9999		

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S9999	Continued From page 7 to his eye but didn't recall which one. She also stated that she did not report the bruise because she assumed it was already known. On 10/07/2023 at 2:51 PM V8 (Nurse Practitioner) stated when she assessed R2 on the afternoon of 10/05/2023, she observed blueish-purple bruising to his right eye and right cheekbone area with minimal swelling. V8 stated she asked the nurse (V6) if they were aware and what had happened, was told that R2 was punched by another resident. V8 stated she assessed R2 for visual changes and pain, then she ordered x-rays be done. Surveyor informed V8 that no progress note was found indicating her assessment. At 3:00 PM, V8 stated the note was documented under an incorrect resident, will correct, and add to R2's electronic record. Reviewed R2's corrected Physician Progress Note dated 10/5/2023 15:02 that reads in part, "he is noted with bruising to the right orbital wall/cheekbone. He explains that he was punched this morning by another resident. He reports mild discomfort, however, denies changes in vision or headache". On 10/07/2023 at 3:47 PM, V1 (Administrator) stated her expectations of staff regarding an injury of unknown origin is to report the injury immediately and to follow policy and procedures to investigate. Reviewed R1's electronic medical records with the following noted: R1's face sheet indicated resident admitted to the facility on 01/16/2019 and has a past medical history not limited to schizoaffective disorder, anxiety, restlessness and agitation, and suicidal	S9999		

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S9999	Continued From page 8 ideations. R1 was out on pass and unavailable for interview. R1's current Screening Assessment for Indicators of Aggressive and/or Harmful Behavior dated 07/11/2023 reads in part, "resident at this time is minimal risk for aggression". Assessment was not completed, showed "in progress" upon review. Reviewed R1's progress notes for last thirty days with no documentation found regarding alleged incident with R2. R1's care plan last reviewed 07/19/2023 reads in part requires psychotropic medication to help manage and alleviate schizoaffective bipolar anxiety disorders and aggressive behavior, depression, behavior with depressive features, mood swings, mood liability, and anxiety; history of demonstrating noncompliance with medications; Identified Offender has a history of criminal behavior. According to the available history, he has been arrested & convicted of Battery in 2009. The state agency performed a criminal history analysis and determined the resident to be a moderate risk; resident has a history of presenting with physically aggressive behavior towards his grandmother; resident has experienced periods of delusions and believes his family is practicing witchcraft, that his grandmother is possessed by the devil. R1's active physician orders showed the following medications ordered day of incident: Haloperidol Tablet 5 milligram (mg) by mouth every six hours as needed for agitation related to schizoaffective disorder (start date 10/05/2023), Haloperidol Lactate Injection Solution 5 mg/ml (milliliter) intramuscularly every six hours as needed for agitation related to schizoaffective disorder (start date 10/05/2023), Chlorpromazine HCl Injection	S9999		

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S9999	Continued From page 9 Solution 50 mg intramuscularly every six hours as needed for agitation related to schizoaffective disorder (start date 10/05/2023). R1's census report indicated resident moved to room 401-A on 10/5/2023. R1's Notification of Room Change dated 10/05/2023 indicated that resident transferred from room 518-A to 401-A for reason indicated as "other". Resident Choice/Compatibility was not selected. Abuse Prevention Policy 01/2022 reads in part: 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. The following procedures shall be implemented when an employee or agent becomes aware of abuse or neglect of a resident, or of an allegation of suspected abuse or neglect of a resident by a third party. Screen-Train-Report-Identify-Investigate-Protect-Prevent (STRIIPP) Procedure: II. Pre-Admission Screening of Potential Residents: This facility shall check the criminal history background on any resident seeking admission to the facility in order to identify previous criminal convictions. Within 24 hours after admission of a new resident to the facility, the facility will: initiate a criminal history background check according to the facility identified offender policy and procedure. While results are pending, the facility shall take the necessary steps to ensure the safety of residents. III. Orientation and Training Employees: During orientation of new employees, the facility will cover at least the following topics: Staff obligations to prevent and report abuse, neglect, exploitation, mistreatment, any crime against the resident, what constitutes abuse (physical,	S9999		

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S9999	Continued From page 10 mental, sexual, verbal) ...and an employee's obligation under the law (Elder Justice Act) for reporting a suspected crime to the facility, the state survey agency, and local law enforcement, the time frames for reporting, and management's obligation to prohibit retaliation against anyone who makes a report. V. Identification of Allegations/Internal Reporting Requirements: 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 is available or an immediate supervisor who must immediately report it to the administrator. The nursing staff is additionally responsible for reporting on a facility incident report the appearance of bruises, lacerations, or other abnormalities as they occur. Upon report of such occurrences, the nursing supervisor is responsible for assessing the resident, reviewing the documentation, and reporting to the administrator, or in the absence to the director of nursing. VI. Investigation: All incidents, allegations or suspicion of abuse, neglect, exploitation, misappropriation of property, or a crime against a resident will be documented. Any incident or allegation involving abuse, neglect, exploitation, misappropriation of resident property, or a crime against a resident will result in an abuse investigation. An injury should be classified as an "Injury of Unknown Origin" when both of the following conditions are met: source of injury was not observed by any person or the source of the injury could not be explained by the resident, and the injury is suspicious because of the extent of	S9999		

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S9999	Continued From page 11 the injury or the location of the injury (the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time. If there is an "Injury of Unknown Origin", the person gathering facts will complete an incident report. Abuse and Crime Reporting policy last revised 01/2019 reads in part: Policy: This facility will not tolerate resident abuse or mistreatment or crimes against a resident by anyone, including staff members, other residents, consultants, volunteers, and staff of other agencies, family members, legal guardians, friends, or other individuals. All personnel must promptly report any incident or suspected incident of resident abuse, mistreatment, neglect, or exploitation including injuries of unknown origin. An injury should be classified as an "injury of unknown origin" when the source of the injury was not observed or known by any person, and the initial skin tear/bruise investigation could not determine the cause of injury. (B)	S9999		