PRINTED: 12/18/2023 **FORM APPROVED** Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ C IL6009948 B. WING 09/28/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **5825 WEST CERMAK ROAD** CITY VIEW MULTICARE CENTER **CICERO. IL 60804** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) S 000 Initial Comments S 000 Complaint Investigation: 2397597/IL164294 \$9999 Final Observations S9999 Statement of Licensure Findings: 300.610a) 300.3300a) 300.3300c)1)A)B)C)D) 300.3300d)1) 300.3300e)1)2)3)4)5) 300.3300g) 300.3300j) 300.3300k) 300.33001) 300.3300o) Section 300.610 Resident Care Policies 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

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

A resident may be discharged from a

facility after he or she gives the administrator, a

physician, or a nurse of the facility written notice of his or her desire to be discharged. If a guardian has been appointed for a resident or if

and dated minutes of the meeting. Section 300.3300 Transfer or Discharge

TITLE

Attachment A

Statement of Licensure Violations

(X6) DATE

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_ IL6009948 B. WING 09/28/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5825 WEST CERMAK ROAD CITY VIEW MULTICARE CENTER **CICERO, IL 60804** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 1 S9999 the resident is a minor, the resident shall be discharged upon written consent of his or her guardian or if the resident is a minor, his or her parent unless there is a court order to the contrary. In such cases, upon the resident's discharge, the facility is relieved from any responsibility for the resident's care, safety or well-being. (Section 2-111 of the Act) Based on interviews and record reviews, the facility failed to establish the rationale for transfers and discharges; failed to communicate and implement the discharge process accordingly for residents with mental illness and medical conditions. These failures affected 54 (R4, R7, R10 - R25, R28, R35 - R42, R45 - R54, R56 -R72) of 54 residents in the sample of 87 reviewed for transfers and discharges. Reasons for Transfer or Discharge A facility may involuntarily transfer or discharge a resident only for one or more of the following reasons: for medical reasons; A) B) for the resident's physical safety: C) for the physical safety of other residents. the facility staff or facility visitors; or for either late payment or nonpayment for D) the resident's stay, except as prohibited by Titles XVIII and XIX of the federal Social Security Act. For purposes of this Section, "late payment" means non-receipt of payment after submission of a bill. If payment is not received within 45 days after submission of a bill, a facility may send a notice to the resident and responsible party requesting payment within 30 days. If payment is not received within such 30 days, the facility may thereupon institute transfer or discharge proceedings by sending a notice of transfer or discharge to the resident and responsible party by registered or certified mail. The notice shall

| NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  \$825 WEST CERMAK ROAD  CICERO, IL 60804  PREFIX TAG  CONSUMARY STATEMENT OF DEFFICIENCIES TAGE THOSE STAND FORRECTION STATEMENT OF DEFFICIENCIES TAGE THOSE STAND FORRECTION STATEMENT OF THE PROPERTY OF THE PREFIX THOSE STAND FORRECTION STAND FORRECTION STAND FORRECTION STAND FORRECTION STAND FORRECTION STAND FOR STA | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING:  |                | (X3) DATE SURVEY<br>COMPLETED  |  |  |
|---|--|--|---|----------------|--|--|--|
| NAME OF PROVIDER OR SUPPLIER  SITE ADDRESS, CITY, STATE, ZIP CODE  \$825 WEST CERMAK ROAD CICERO, IL. 80804  (PA) ID PREFIX (FACH DEFICIENCE SECRIT OF DEFICIENCIES (FACH DEFICIENCIES (FACH DEFICIENCY) PREFIX (FACH DEFICIENCY)  S9999 Continued From page 2  stete, in addition to the requirements of Section 3-403 of the Act and subsection (e) of this Section, that the responsible party has the right to pay the amount of the bill in full up to the date the transfer or discharge is to be made and then the resident shall have the right to remain in the facility. Such payment shall terminate the transfer or discharge proceedings. This subsection (e) does not apply to those residents whose care is provided under the Illinois Public Aid Code, (Section 3-401 of the Act) d) Involuntary transfer or discharge of a resident from a facility shall be preceded by the discussion required under subsection (j) of this Section and by a minimum written notice of 21 days, except in one of the following instances: 1) When an emergency transfer or discharge is obtained and the continuation of the following physician because of the resident's health care needs; (Section 3-402(a) of the Act) e) For transfer or discharge. The notice required by subsection (d) the notice of transfer or discharge. The notice required by subsection (d) of this Section shall be on a form prescribed by the Department and shall contain all of the following: 1) The stated reason for the proposed transfer or discharge; (Section 3-403(a) of the Act) 2) The effective date of the proposed transfer or discharge; (Section 3-403(a) of the Act) 3) A statement in not less than 12-point type, which reads:  "You have a right to appeal the facility's decision to transfer or discharge you. If you think you  |  | IL6009948  |   | B. WING        |  |  |  |
| Summary statement of Deficiencies   Summary statement of Deficiencies   PROVIDER'S PLAN OF CORRECTION   PREFIX   REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX   TAG   PROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH OBTRICHMON ARTON)   PREFIX   TAG   PROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH OBTRICHMON ARTON)   PREFIX   TAG   PROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH OBTRICHMON ARTON)   PREFIX   TAG   PROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH OBTRICHMON ARTON)   PREFIX   TAG   PROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH OBTRICHMON ARTON)   PREFIX   TAG   PROVIDER'S PLAN OF CORRECTION ARTON AR    | NAME OF I  | PROVIDER OR SUPPLIER   | STREET ADI  | ORESS, CITY, S | TATE, ZIP CODE   |  |  |
| CICERO, IL 60804  PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  REGULATORY OR USE DIENTIFYING INFORMATION)  S9999  Continued From page 2 state, in addition to the requirements of Section 3-403 of the Act and subsection (e) of this Section, that the responsible party has the right to pay the amount of the bill in full up to the date the transfer or discharge is to be made and then the resident shall have the right to remain in the facility. Such payment shall terminate the transfer or discharge proceedings. This subsection (e) does not apply to those residents whose care is provided under the Illinois Public Aid Code. (Section 3-401 of the Act)  d) Involuntary transfer or discharge of a resident from a facility shall be preceded by the discussion required under subsection (j) of this Section and by a minimum written notice of 21 days, except in one of the following instances:  1) When an emergency transfer or discharge is a discharge is ordered by the resident's attending physician because of the resident's health care needs; (Section 3-402(a) of the Act)  e) For transfer or discharge made under subsection (d), the notice of transfer or discharge shall be made as soon as practicable before the transfer or discharge. The notice required by subsection (d) of this Section shall be on a form prescribed by the Department and shall contain all of the following:  1) The stated reason for the proposed transfer or discharge; (Section 3-403(a) of the Act)  2) The effective date of the proposed transfer or discharge; (Section 3-403(a) of the Act)  3) A statement in not less than 12-point type, which reads:  "You have a right to appeal the facility's decision to transfer or discharge you. If you think you   | OITV ME  | "14/ \$41 !! TIO A DE OENT   | 5825 WES  | T CERMAK       | ROAD   |  |  |
| EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG   TAG  | CITY VIE   | W MULIICARE CENT   | CICERO, I   | L 60804        |  |  |  |
| state, in addition to the requirements of Section 3-403 of the Act and subsection (e) of this Section, that the responsible party has the right to pay the amount of the bill in full up to the date the transfer or discharge is to be made and then the resident shall have the right to remain in the facility. Such payment shall terminate the transfer or discharge proceedings. This subsection (c) does not apply to those residents whose care is provided under the Illinois Public Aid Code. (Section 3-401 of the Act) d) Involuntary transfer or discharge of a resident from a facility shall be preceded by the discussion required under subsection (j) of this Section and by a minimum written notice of 21 days, except in one of the following instances: 1) When an emergency transfer or discharge is ordered by the resident's attending physician because of the resident's health care needs; (Section 3-402(a) of the Act) e) For transfer or discharge made under subsection (d), the notice of transfer or discharge shall be made as soon as practicable before the transfer or discharge. The notice required by subsection (d) of this Section shall be on a form prescribed by the Department and shall contain all of the following: 1) The stated reason for the proposed transfer or discharge; (Section 3-403(a) of the Act) 2) The effective date of the proposed transfer or discharge; (Section 3-403(b) of the Act) 3) A statement in not less than 12-point type, which reads: "You have a right to appeal the facility's decision to transfer or discharge; (Section 5-403(b) of this you   | PREFIX   | (EACH DEFICIENCY MUST BE PRECEDED BY FULL  |   | PREFIX         | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE |  |  |
| 3-403 of the Act and subsection (e) of this Section, that the responsible party has the right to pay the amount of the bill in full up to the date the transfer or discharge is to be made and then the resident shall have the right to remain in the facility. Such payment shall terminate the transfer or discharge proceedings. This subsection (c) does not apply to those residents whose care is provided under the Illinois Public Aid Code. (Section 3-401 of the Act) d) Involuntary transfer or discharge of a resident from a facility shall be preceded by the discussion required under subsection (f) of this Section and by a minimum written notice of 21 days, except in one of the following instances: 1) When an emergency transfer or discharge is ordered by the resident's attending physician because of the resident's stending physician because of the resident's health care needs; (Section 3-402(a) of the Act) e) For transfer or discharge made under subsection (d), the notice of transfer or discharge shall be made as soon as practicable before the transfer or discharge. The notice required by subsection (d) of this Section shall be on a form prescribed by the Department and shall contain all of the following: 1) The stated reason for the proposed transfer or discharge; (Section 3-403(a) of the Act) 2) The effective date of the proposed transfer or discharge; (Section 3-403(b) of the Act) 3) A statement in not less than 12-point type, which reads: "You have a right to appeal the facility's decision to transfer or discharge you. If you think you   | S9999  | Continued From pa  | ge 2  | S9999          |  |  |  |
| should not have to leave this facility, you may file a request for a hearing with the Department of Public Health within 10 days after receiving this   | 59999  | state, in addition to 3–403 of the Act and Section, that the respay the amount of the transfer or discharges resident shall have facility. Such paymetransfer or discharges subsection (c) does whose care is provious Aid Code. (Section d) Involuntary resident from a faci discussion required Section and by a medays, except in one 1) When an erdischarge is ordere physician because needs; (Section 3–4 e) For transfer subsection (d), the shall be made as soft transfer or discharges subsection (d) of the prescribed by the Dall of the following:  1) The stated of transfer or discharges action (d) as transfer or discharges action (d) of the prescribed by the Dall of the following:  1) The stated of transfer or discharges action (d) as transfer or discharges action (d) as transfer or discharges action (d) as transfer or discharges action (d) of the prescribed by the Dall of the following:  1) The stated of transfer or discharges action (d) as transfer or discharges action (d) are transfer or discharges action (d) as transfer or discharges action (d) are transfer or discharges action (d) as transfer or discharges action (d) are transfer o | the requirements of Section d subsection (e) of this sponsible party has the right to he bill in full up to the date the le is to be made and then the the right to remain in the ent shall terminate the le proceedings. This is not apply to those residents ded under the Illinois Public 3-401 of the Act) transfer or discharge of a lity shall be preceded by the lunder subsection (j) of this inimum written notice of 21 of the following instances: mergency transfer or discharge of the resident's attending of the resident's health care 102(a) of the Act) or discharge made under notice of transfer or discharge on as practicable before the le. The notice required by its Section shall be on a form repartment and shall contain reason for the proposed le; (Section 3-403(a) of the let in not less than 12-point type, appeal the facility's decision leave this facility, you may file ring with the Department of | S9999          |  |  |  |

illinois Department of Public Health STATE FORM

|               |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:      | (X2) MULTIPLI<br>A. BUILDING: | E CONSTRUCTION   | (X3) DATE<br>COMP | SURVEY<br>LETED  |
|---------------|---|--|-------------------------------|--|-------------------|------------------|
|               |   |  | 331                           |  | С                 |                  |
|               | IL6009948                               |  | B. WING                       |  | 1                 | 8/2023           |
| NAME OF       | PROVIDER OR SUPPLIER                    | STREET ADI   | DRESS, CITY, S                | STATE, ZIP CODE  |                   |                  |
|               |   | 5825 WES   | T CERMAK                      |  |                   |                  |
| CITY VIE      | W MULTICARE CENT                        | ER CICERO, I   |                               |  |                   |                  |
| (X4) ID       | SUMMARY STA                             | TEMENT OF DEFICIENCIES                                     | D                             | PROVIDER'S PLAN OF CORRECT   | ON                | (X5)             |
| PREFIX<br>TAG |   | MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)    | PREFIX<br>TAG                 | (EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) |                   | COMPLETE<br>DATE |
| S9999         | Continued From pa                       | ge 3   | S9999                         |  |                   |                  |
|               | notice. If you reque                    | est a hearing, it will be held not                         |                               |  |                   |                  |
|               |   | after your request, and you                                |                               |  |                   |                  |
|               |   | transferred or discharged                                  |                               |  |                   |                  |
|               |   | he decision following the                                  |                               |  |                   |                  |
|               |   | ur favor, you generally will not scharged prior to the     |                               |  |                   |                  |
|               |   | s following receipt of the                                 |                               |  |                   |                  |
|               |   | e transfer or discharge. A                                 |                               |  |                   |                  |
|               | form to appeal the                      | facility's decision and to                                 |                               |  |                   |                  |
|               |   | s attached. If you have any                                |                               |  |                   |                  |
|               |   | Department of Public Health at                             |                               |  |                   |                  |
|               |   | per listed below."; (Section                               |                               |  |                   | ·                |
|               | 3-403(c) of the Act)<br>4) A hearing re | equest form, together with a                               |                               |  |                   |                  |
|               |   | ddressed envelope to the                                   |                               |  |                   |                  |
|               |   | Section 3-403(d) of the Act)                               |                               |  |                   |                  |
|               |   | address, and telephone                                     |                               |  |                   |                  |
|               | number of the pers                      |  |                               |  |                   |                  |
|               |   | pervising the transfer or                                  |                               |  |                   |                  |
|               |   | 3-403(e) of the Act)                                       |                               |  |                   |                  |
|               |   | e notice required by                                       |                               |  |                   |                  |
|               |   | f this Section and Section all be placed in the resident's |                               |  |                   |                  |
|               |   | a copy shall be transmitted to                             |                               |  |                   |                  |
|               |   | e resident, and the resident's                             |                               |  |                   |                  |
|               |   | ection 3-405 of the Act)                                   |                               |  |                   |                  |
|               |   | d involuntary transfer or                                  |                               |  |                   |                  |
|               |   | discussed with the resident,                               |                               |  |                   |                  |
|               |   | sentative and person or                                    |                               |  |                   |                  |
|               |   | for the resident's placement,                              |                               |  |                   |                  |
|               |   | care in the facility. The cussion of the reasons for       |                               |  |                   | 1                |
|               |   | or discharge shall include the                             |                               |  |                   |                  |
|               |   | r or other appropriate facility                            |                               |  |                   |                  |
|               | representative as the                   | ne administrator's designee.                               |                               |  |                   |                  |
|               | The content of the                      | discussion and explanation                                 |                               |  |                   | 12               |
|               |   | ed in writing and shall include                            |                               |  |                   |                  |
|               |   | dividuals involved in the                                  |                               |  |                   |                  |
|               |   | ade a part of the resident's                               |                               |  |                   |                  |
|               | ciinicai record. (Se                    | ction 3-408 of the Act)                                    |                               |  |                   |                  |

Illinois Department of Public Health STATE FORM

Illinois Department of Public Health
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

|                          |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                       | E CONSTRUCTION   | (X3) DATE<br>COMP | SURVEY<br>LETED          |
|--------------------------|--|--|-----------------------|--|-------------------|--------------------------|
|                          | ļ .  |  | A. BUILDING:          |  | С                 |                          |
|                          | IL6009948  |  | B. WING               |  | _                 | 8/2023                   |
| NAME OF                  | PROVIDER OR SUPPLIER   | STREET AD  | DRESS, CITY, S        | STATE, ZIP CODE  |                   |                          |
| CITY VIE                 | W MULTICARE CENT   | TER 5825 WES   | ST CERMAK<br>IL 60804 | ROAD   |                   |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE             | (X5)<br>COMPLETE<br>DATE |
| \$9999                   | k) The facility counseling services discharge of the research of the research sor discharge from a guardian or if the reparent shall have the for a hearing with the following receipt of involuntary transfer (Section 3-410 of the Olimbert of the Department of the D | shall offer the resident is before the transfer or sident. (Section 3-409 of the subject to involuntary transfer in facility, the resident's esident is a minor, his or her ne opportunity to file a request the Department within 10 days the written notice of the or discharge by the facility. The Act of the resident shall eave the facility before the receipt of the notice required do of this Section, or the 10th of the Department's is later, unless a condition allowed transfer or discharge in the described under and (2) of this Section erim. (Section 3-413 of the series of the order of the notice required do of this Section erim. (Section 3-413 of the section and do 07/14/23 to 09/14/23 and do 07 | \$9999                |  |                   |                          |
| 01:                      | tment of Public Health   |  | 1                     |  |                   |                          |

PRINTED: 12/18/2023 FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C B. WING IL6009948 09/28/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **5825 WEST CERMAK ROAD** CITY VIEW MULTICARE CENTER **CICERO, IL 60804** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) \$9999 | Continued From page 5 S9999 AM, he stated that he wanted to go home and not transferred to another facility. On 9/26/23 at 12:53 PM, V6, (Family Member) stated that she was notified of his (R57) discharge to another nursing facility. V6 continued, "However, it was not my decision or his (R57) decision to discharge. The facility had told me that he had wounds that they could no longer care for at the facility. They said he needed to transfer to another facility in order to get the proper care for his wounds." Progress notes dated 07/23/23 indicated that R57 has a wound on the left foot. V7 (Family Member) also mentioned during interview that he was told by R51 that he went to another facility because of nursing care assistance. Per R51's weekly wound evaluation note dated 06/30/23, he has a wound on the left lower leg. On 07/25/23: R52, R53 Social Services notes dated 07/25/23 documented R52 and R53 want to be transferred to another facility. R52 and R53 were discharged the same day, R52 was discharged as agreed by V12 (Family Member). During interview with V12, she stated that she (R52) was transferred because she (R52) needed more nursing care and facility is no longer providing skilled nursing, since she (R52) has a sore on her foot and it's not healing well. R52's Weekly wound evaluation note dated 02/22/23 recorded that R52 has a wound on the right heel.

Illinois Department of Public Health

per progress notes.

R63, R64 requested to be transferred to another facility on 07/28/23 and were discharged on the

R62 was discharged from the facility on 07/31/23 and was moved to another long-term care facility,

same day, per Social Services notes.

|                          |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPL<br>A. BUILDING: | LE CONSTRUCTION   | (X3) DATE<br>COMP | SURVEY                   |
|--------------------------|--|---|------------------------------|---|-------------------|--------------------------|
|                          | IL6009948  |   | B. WING                      |   | С                 |                          |
|                          |  | 12003348  | <u> </u>                     |   | 09/2              | 8/2023                   |
| NAME OF                  | PROVIDER OR SUPPLIER   |   |                              | STATE, ZIP CODE   |                   |                          |
| CITY VIE                 | W MULTICARE CENT   | ER 5825 WES CICERO, I   | T CERMAK<br>L 60804          | ROAD  |                   |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG          | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRICIENCY) | D BE              | (X5)<br>COMPLETE<br>DATE |
| S9999                    | Continued From pa  | ge 6  | S9999                        |   |                   |                          |
|                          |  | sted to be transferred to<br>8/01/23 and were discharged<br>er progress notes.  |                              |   |                   |                          |
|                          | 08/03/23 document<br>be transferred to an  | l Services notes dated<br>ed R61 and R66 requested to<br>other facility. R61 and R66<br>ed on 08/03/23, same day.   |                              |   |                   |                          |
|                          |  | 58, R59, R69, R70, R71 and transfer to another facility and on the same day.  |                              |   |                   |                          |
|                          | R60's Progress note documented R60 w facility.   | es dated 08/07/23<br>as discharged from the   |                              |   |                   |                          |
|                          | R68's Progress note documented R68 w facility.   | es dated 08/09/23<br>as discharged from the   |                              |   |                   |                          |
|                          | R67's Progress note documented R67 was facility.   | es dated 08/10/23<br>as discharged from the   |                              |   |                   |                          |
|                          |  | ess notes dated 08/15/23<br>R49 were discharged and<br>lity.  |                              |   |                   |                          |
|                          |  | ess notes dated 08/16/23<br>R47 were discharged and<br>lity.  |                              |   |                   |                          |
|                          | and R17 were disch<br>During interviews wi<br>both stated that they<br>facility with other res | dated 08/17/23, R15, R16<br>larged to another facility.<br>ith R15 and R16 on 09/20/23,<br>were transported to the new<br>sidents. R15 stated, "I was not<br>e I was going and I got on a |                              |   |                   |                          |

illinois Department of Public Health STATE FORM

|                          |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPL<br>A. BUILDING: | E CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|---|--|------------------------------|---|-------------------------------|--|
|                          |   |  | 7. BOILDING.                 |   | C                             |  |
|                          |   | IL6009948  | B. WING                      |   | 09/28/2023                    |  |
| NAME OF                  | PROVIDER OR SUPPLIER  |  |                              | STATE, ZIP CODE   |                               |  |
| CITY VIE                 | W MULTICARE CENT  | ER 5825 WES<br>CICERO, I   | ST CERMAK<br>IL 60804        | ROAD  |                               |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG          | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY) | D BE COMPLETE                 |  |
| S9999                    | Continued From pa   | ge 7   | S9999                        |   |                               |  |
|                          | bus, and I came he bed here and I am reverbalized, "They to brought me here with packed up my stuff do not want to be he why I had to leave."  Social Services note R19 and R20 reques the facility. POS (Pro 08/18/23 indicated I R7, R18, R19 and R | re. They do not get me out of<br>not happy." R16 also<br>lok me on a minibus and<br>th other residents. They<br>and just told me I was going. I<br>ere, and they did not tell me |                              |   |                               |  |
| 8                        | know why I was transme here and didn't in up, no reason why, also verbalized, "I considered asked us who wanted volunteered and sain According to Social  | Services and Nurses' notes   |                              |   |                               |  |
|                          | expressed desire to facility. R21, R23, R   | 1, R23, R24 and R25 be discharged from the 24 and R25 were discharged a care facility on 08/22/23,   |                              |   |                               |  |
|                          | Hispanic Dementia<br>Member) mentioned<br>was told by V2 (Dire<br>needs the transfer for<br>mentioned, "They ju<br>somewhere else an<br>don't want to transfer  | d didn't tell me why. No, I<br>er. They sent me to the<br>me back, they sent me here.  |                              |   |                               |  |

Illinois Department of Public Health STATE FORM

PRINTED: 12/18/2023 FORM APPROVED Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ B. WING IL6009948 09/28/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **5825 WEST CERMAK ROAD** CITY VIEW MULTICARE CENTER **CICERO, IL 60804** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) S9999 Continued From page 8 S9999 Social Services notes dated 08/25/23 documented R14 asked to be transferred to another facility. R14 left facility on 08/25/23, same day. Social Services notes dated 08/30/23 documented R11, R36, R37, R38, R39, R40, R41 and R42 requested to be transferred to another facility; and were discharged the same day. On 09/20/23 at 10:58 AM, R11 stated during interview, "They asked if anybody wants to go. and I raised my hand. Then they sent me here in four hours. I'd rather go back; I want to come back." R37 also verbalized that it was a mutual agreement between him and facility to be discharged, R37 continued, "I just followed orders with what they told me to do. I do whatever I am asked to do. I was transported on a bus with other residents. It was a surprise, they asked me to go, and I left the same day." R36 stated that he does not want to be in the new facility. Social Services notes dated 08/31/23 documented R28 was discharged from the facility and went to another long-term care facility. Per Social Services notes dated 09/08/23, R12, R13 and R35 all inquired about discharging to another facility. All were discharged to another facility on 09/08/23. In an interview conducted on

personal items missing.

09/26/23 at 2:55 PM, V8 (Family Member) stated that R12 wants to be transferred only because residents were bothering him and has issues with

Per Social Services notes dated 09/15/23, R54 inquired about discharge from facility. R54 was discharged on the same date inquiry was made.

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_ B. WING IL6009948 09/28/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **5825 WEST CERMAK ROAD CITY VIEW MULTICARE CENTER CICERO, IL 60804** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE TAG DEFICIENCY) S9999 Continued From page 9 S9999 Progress notes dated 09/19/23 recorded R48 requested to be transferred to another facility. R48 was discharged the same day. V5 (Social Services Director) was interviewed on 09/18/23 at 1:59 PM regarding residents. discharge. V5 verbalized, "When residents verbalized, they want to transfer, we document it. we do referrals and give residents choices. We ask residents if they have another nursing home facility that they would like us to send referrals to. The referral sheets include face sheet, social services and nursing progress notes; vital signs and medication list." On 09/26/23 at 3:28 PM, V2 was asked regarding discharge. V2 replied, "All documentation is in the progress notes, discharge planning review and Social Services notes. If they have POA (Power of Attorney)/Guardian, we notify them of discharge and if they are okay with it, we document it in progress notes. If resident is responsible for self and requests a discharge, we send a referral packet to preferred facility and wait for acceptance. If they are accepted, we let these residents know and go ahead with discharge. We asked them what's their preference, facility they have been before. Social Services confirmed with them and if it is okay, we go ahead with discharge. All notes for those discharged residents were in the progress notes. and discharge planning and Social Services notes." Further review of R4, R7, R10 - R25, R28, R35 -R42, R45 - R54, R56 - R72 interdisciplinary progress notes/medical records showed no documentation pertaining to reasons and necessity of transfers to another facility, whether

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their needs can still be met or not while in the

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Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C B. WING IL6009948 09/28/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5825 WEST CERMAK ROAD **CITY VIEW MULTICARE CENTER CICERO, IL 60804** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 10 S9999 facility; neither documentation of the services the new facility could provide for ongoing care. According to R4, R7, R12 - R14, R17, R19 - R21, R24, R25, R35, R38 - R42, R48, R50, R53, R54, R56, R58, R59, R61, R63, R64, R66, R69 - R72 progress notes, when they inquired about transfers, they were discharged on the same day, several hours after they did the inquiry. R51, R52 and R57 were discharged because of medical conditions requiring skilled nursing care, that facility could no longer provide. On 09/14/23 at 3:00 PM, V1 (Administrator) stated that they still have skilled nursing care services in the facility. R28, R45, R46, R47, R49, R60, R62, R67 and R68 were discharged with no validated reasons indicated, R10, R11, R15, R16, R18, R23, R36, R37 were discharged, however residents do not exactly know the reason for discharge. Also, there were no recorded maladaptive behavior concerns which posed a threat to oneself or others; and serious medical conditions on R4, R7, R10 - R25, R28, R35 - R42, R45 - R54, R56 -R72 at the time of transfers. V3 (Assistant Social Services Director) was interviewed on 09/28/23 at 12:36 PM regarding residents' discharge. V3 verbalized, "I don't have to explain anything to them regarding discharge and possible resources in the new facility. If resident expressed desire to be transferred, we ask which facility and location, then we send referrals and once they are accepted, we go ahead and discharge them. If they have a POA (Power of Attorney), yes, we involve family, notify regarding discharge and if ok with POA, we go ahead and do the discharge. For residents responsible for themselves, we don't have to notify family or representatives." Per discharge care plans, the following

PRINTED: 12/18/2023 FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ C B. WING IL6009948 09/28/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **5825 WEST CERMAK ROAD CITY VIEW MULTICARE CENTER CICERO, IL 60804** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DATE DEFICIENCY) S9999 Continued From page 11 S9999 interventions were documented: R11: Staff will discuss with resident the discharge R12, R19, R35, R42 and R63: Arrange a meeting with the family/significant other to discuss what services might be needed and what services are available. Review costs, especially those not covered by insurance. Encourage family to express any concerns they have well in advance of the tentative discharge date. R20 and R24: As necessary, meet with the resident/representative on a regular basis to help with mental preparation for discharge. Provide the resident with an opportunity to express any thoughts or feelings. Address concerns prior to discharge. R12 and R35: Arrange a meeting with the family/significant other to discuss what services might be needed and what services are available. Review costs, especially those not covered by insurance. Encourage family to express any concerns they have well in advance of the tentative discharge date; As necessary, meet with the resident/representative on a regular basis to help with mental preparation for discharge. Provide the resident with an opportunity to express any thoughts or feelings. Address concerns prior to discharge. R40: Arrange a meeting with the family/significant other to discuss what services might be needed and what services are available. Review costs. especially those not covered by insurance. Encourage family to express any concerns they

discharge.

have well in advance of the tentative discharge

resident/representative on a regular basis to help with mental preparation for discharge. Provide the resident with an opportunity to express any thoughts or feelings. Address concerns prior to

date; As necessary, meet with the

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| OR SUPPLIER  | STREET ADI   | DRESS, CITY, S   | TATE, ZIP CODE  |  |  |
| CADE CENT  | -EB 5825 WES   | T CERMAK   | ROAD  |  |  |
| DAKE CEN   | CICERO, I  | L 60804  |   |  |  |
| SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   |  | ID<br>PREFIX<br>TAG  | (EACH CORRECTIVE ACTION SHOUL   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (COMMON COMMON  |  |
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| plain to res<br>vices that he<br>ty for dischesignificant<br>range a me<br>discuss what services a<br>'s abilities a<br>g physician<br>lent will nea<br>ge the fam<br>re long before   | ident the discharge process e will possibly require; Review arge on a quarterly, annually changes. eting with the family/significant at services might be needed are available; Discuss the and needs with the nurse and to determine what services ed in the community; ily to voice any worries they are the anticipated discharge   |  |   |  |  |
| and Procedul mited to the re: resident is the transferesponsible of except we fety of indiversity of indiversity of the engered; sident's here mediate transferesponsid 2 days not be facility whering the redischarge pand give the pe/Bedhold ne facility commend to the facility of the fac | re" dated 1.1.17 stated in part e following:  to transfer within the facility, er is given to the e party at least 2 days before hen: viduals would be endangered; individuals in the facility would eath improves sufficiently to diate transfer or insfer is required by the edical needs. Eible party waives the otice.  It level of care or another long here the facility will be estident's medications procedure and reason to be original State Transfer and form notice as required, popy to the transfer form.   |  |   |  |  |
|  | care cent summary state defection of the control of | CARE CENTER  SUMMARY STATEMENT OF DEFICIENCIES H DEFICIENCY MUST BE PRECEDED BY FULL JUATORY OR LSC IDENTIFYING INFORMATION)  The defendance of the discharge process of the process of th | SUMMARY STATEMENT OF DEFICIENCIES H DEFICIENCY MUST BE PRECEDED BY FULL TAGE  and From page 12  plain to resident the discharge process vices that he will possibly require; Review by for discharge on a quarterly, annually significant changes.  range a meeting with the family/significant discuss what services might be needed at services are available; Discuss the sabilities and needs with the nurse and go physician to determine what services tent will need in the community; get the family to voice any worries they be long before the anticipated discharge  Policy titled "Transfer and Discharge and Procedure" dated 1.1.17 stated in part imited to the following:  re:  resident is to transfer within the facility, if the transfer is given to the variety of individuals would be endangered; saith of the individuals in the facility would nigered; sident's health improves sufficiently to more immediate transfer or mediate transfer is required by the surgent medical needs.  Individuals would be endangered; sident's health improves sufficiently to more immediate transfer or mediate transfer is required by the surgent medical needs.  Individuals would be endangered; sident's health improves sufficiently to more immediate transfer or mediate transfer is required by the surgent medical needs.  Individuals would be endangered; sident's health improves the decidity will be ering the resident's medications discharge procedure and reason to and give the original State Transfer and jet/Bedhold form notice as required.  In procedure in the cities of the procedure in the resident representatives. | SAUMMARY STATEMENT OF DEFICIENCIES HOEFICIENCY MUST BE PRECEDED BY FULL LATORY OR LSC IDENTIFYING INFORMATION)  and From page 12  plain to resident the discharge process vices that he will possibly require; Review tys for discharge on a quarterly, annually significant changes.  ange a meeting with the family/significant discuss what services might be needed at services are available; Discuss the sabilities and needs with the nurse and g physician to determine what services lent will need in the community; get he family to voice any worries they re long before the anticipated discharge  a Policy titled "Transfer and Discharge and Procedure" dated 1.1.17 stated in part mitted to the following: re: resident is to transfer within the facility, the transfer is given to the responsible party at least 2 days before an except when: flety of individuals would be endangered; sident's health improves sufficiently to more immediate transfer or mediate transfer is required by the surgent medical needs.  Interpolation of the procedure of the | SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES H DEFICIENCY MUST BE PRECEDED BY FULL LIATORY OR LSC IDENTIFYING INFORMATION)  ad From page 12  plain to resident the discharge process vices that he will possibly require; Review by for discharge on a quarterly, annually significant changes. ange a meeting with the family/significant discuss what services might be needed it services are available; Discuss the s abilities and needs with the nurse and g physician to determine what services lent will need in the community; ge the family to voice any worries they e long before the anticipated discharge and Procedure" dated 1.1.17 stated in part mited to the following: re: resident is to transfer within the facility, it he transfer is given to the responsible party at least 2 days before an except when: fetty of individuals would be endangered; salth of the individuals in the facility would regered; sident's health improves sufficiently to nore immediate transfer or mediate transfer is required by the surgent medical needs. nufresponsible party waives the d 2 days notice, ge to a lower level of care or another long e facility where the facility will be ening the resident's medications discharge procedure and reason to and give the original State Transfer and pe/Bedhold form notice as required, the facility copy to the transfer form. esident representatives. |

PRINTED: 12/18/2023 FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_ B. WING IL6009948 09/28/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **5825 WEST CERMAK ROAD** CITY VIEW MULTICARE CENTER **CICERO, IL 60804** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG **DEFICIENCY)** S9999 Continued From page 13 S9999 copies of any portion of the health record necessary for care of resident. (For example: Physician's orders. History & Physical, chest X-ray, Immunization information, any pertinent lab work, etc. 6. Send original of transfer form and portions of health record that was copied with the resident, attach the second copy of the portions of the health record to the facility copy of the transfer form. Give the third copy of the transfer form to the DON. Facility's "Facility Assessment Tool" dated 09/01/23 documented in part but not limited to the following: Part 2: Services and Care We Offer Based on our Residents' Needs Resident support/care needs Skin integrity - Pressure injury prevention and care, skin care, wound care (surgical, other skin wounds) Mental health and behavior - Manage the medical conditions and medication-related issues causing psychiatric symptoms and behavior, identify and implement interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment, care of individuals with depression, other psychiatric diagnoses. B. Based on interview and record review, the facility failed to adequately notify the power of attorney and resident representative when transferring and/or discharging residents. This

transfer and discharge.

Findings include:

failure applied to eight (R11, R15, R16, R37, R54, R57, R58, and R61) of 87 residents reviewed for

PRINTED: 12/18/2023 FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ B. WING IL6009948 09/28/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **5825 WEST CERMAK ROAD CITY VIEW MULTICARE CENTER CICERO, IL 60804** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) S9999 Continued From page 14 S9999 Per facility census and resident face sheet, R11 was discharged from the facility on 8/30/23 to another long-term care facility and has a responsible party contact listed. On 9/20/23 at 10:58AM, R11 was interviewed regarding discharge. R11 said the facility asked me if I wanted to discharge to another nursing facility and within four hours I was discharged. It was so quick. I did not receive all my belongings and I would rather go back to the facility than be here. At 12:35PM, V10 (Responsible Party) was interviewed. V10 said I was told somehow that R11 was discharging to another facility. However, it was last minute, and I only found out when the discharge was taking place. I did not have a choice in the matter if R11 discharged. Per facility census and resident face sheet, R15 was discharged from the facility on 8/17/2023 to another long-term care facility and has a power of attorney (POA) listed. It is to be noted that this surveyor attempted to call R15's POA, however the contact listed is invalid. On 9/27/23, V2 said R15 is their own responsible party even though there is a POA listed on R15's face sheet. On 9/20/23 at 10:10AM, R15 was interviewed regarding discharge. R15 said I feel as if the facility put me on a bus and dumped me at this new facility. I was not made aware of where I was going.

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responsible party.

Per facility census and resident face sheet, R16 was discharged from the facility on 8/17/23 to another long-term care facility and is his own

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Illinois Department of Public Health

Per facility census and resident face sheet, R58 was discharged on 8/3/23 to another long-term care facility and has a POA contact listed. This surveyor requested notification of R58's power of

attorney. It is to be noted that the facility documented on 9/26/23 that the power of attorney was attempted to be notified of

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA  | (X2) MULTIPL        | E CONSTRUCTION   | (X3) DATE |                          |
|--|--|--|---------------------|--|-----------|--------------------------|
| AND PLAN OF CORRECTION IDENTIFICATION NUMBER:    |  | A. BUILDING:   |                     | COMPLETED  |           |                          |
|  |  | IL6009948  | B. WING             |  | 09/2      | )<br>8/2023              |
| NAME OF  | PROVIDER OR SUPPLIER   | STREET AD  | DRESS, CITY, S      | STATE, ZIP CODE  |           |                          |
| CITY VIE   | W MULTICARE CENT   | 5825 WES   | T CERMAK            | ROAD   |           |                          |
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| (X4) ID<br>PREFIX<br>TAG                         | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTS<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE     | (X5)<br>COMPLETE<br>DATE |
| 59999  | Continued From pa  | ge 16  | S9999               | -  | 17        |                          |
|  | -  | esponse. No prior notification   |                     |  |           |                          |
|  | was discharged from another long-term of responsible party of discharged on 8/3/2 facility and has a read on 9/26/23, this surfor R11, R37, R54, party. V2 said all of representative. It is R37, R54, R57, and party contact listed by this surveyor regiparties were notified on 9/26/23 at 10:10 interviewed regarding discharging or transevery situation is different to the responsibility of the responsibility the responsibility that responsibility the responsibility that responsibility the responsibility that responsibility th | DAM, V1 (Administrator) was no notification when sferring a resident. V1 said fferent depending on if the responsible party or if they orney (POA) or representative ituation, the staff is expected sible party on where the charging to, when the place, what kind of ing utilized, and any home etc. In majority of cases family stacts are made aware of the e but it depends on the |                     |  |           |                          |
|  | Condition or Status'<br>part but not limited the<br>ensure that the resi   | Change in Resident's dated 6/26/2011 states in to the following: Purpose: to dent's representative is in the resident's condition  |                     |  |           |                          |

**FORM APPROVED** Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_\_ B. WING IL6009948 09/28/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **5825 WEST CERMAK ROAD CITY VIEW MULTICARE CENTER CICERO, IL 60804** SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX **PREFIX** TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG DEFICIENCY) S9999 Continued From page 17 S9999 and/or status. The nurse will notify the resident's representative when a decision has been made to discharge the resident from the facility. (B)