

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145850	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/14/2024
NAME OF PROVIDER OR SUPPLIER  City View Multicare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  5825 West Cermak Road Cicero, IL 60804	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>34490</p> <p>Based on interview and record review the facility failed to ensure the treatment plans from an infectious disease practitioner and a dermatologist were implemented for a resident with a rash for 1 of 3 residents (R3) reviewed for quality of care in the sample of 13.</p> <p>The findings include:</p> <p>On 11/8/24 at 9:35 AM, R3 was sitting on the bed in his room. R3 lifted his shirt and he had multiple areas of small red spots on the front and back of his upper body. This surveyor was unable to visualize the rest of his body. R3 said that they itch at times.</p> <p>R3's Infectious Disease Consult Note from V21 (Infectious Disease Nurse Practitioner) dated 10/10/24 and 10/17/24 shows, Patient noted with disseminated, maculopapular rash on trunk and all 4 extremities Patient does report mild itching Discussed patient at length with ADON (Assistant Director of Nursing), discussed oral anti-fungal .Possible fungal in nature per my assessment Assessment/Plan: Disseminated Rash-recommend anti-fungal cream .Recommend Fluconazole (oral antifungal) 400 mg (milligrams) q (every) day x 14 days F/U (Follow-Up) with specialist as planned, derm (dermatology) consult .</p> <p>R3's October Medication Administration Record (MAR) does not show that an antifungal cream or Fluconazole was administered.</p> <p>On 11/12/24 at 10:03 AM, V9 (Assistant Director of Nursing/Infection Preventionist) said that V21 puts in all of her own orders in the system. V9 said that if V21 did not discuss the orders with the staff, they have no way of knowing that anything was ordered.</p> <p>R3's Dermatology Consult Note dated 11/1/24 shows, Visit Reason: Rash/chest and back Assessment and plan: #1 papular urticaria differential diagnoses Grover's disease scheduled for skin biopsy agree with treating with permethrin (antiparasitic) prophylactically once a week for 4 weeks</p> <p>R3's October and November MAR shows that he did not receive any doses of permethrin between 10/10/24 and 11/7/24.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>On 11/8/24 at 3:31 PM, V9 (Assistant Director of Nursing/Infection Preventionist) said that if a resident goes out to a specialist for consult and they do not come back with orders, the nurse should call the specialist office to verify the orders upon their return. V9 said that she does not know why R3's recommendation for permethrin cream was not verified or ordered.</p> <p>On 11/8/24 at 3:04 PM, V21 (Infectious Disease Nurse Practitioner) said that she saw multiple residents with rashes when she started at the facility in October. V21 said that some of the rashes appeared fungal and some appeared like a contact dermatitis. V21 said that they are currently trying different treatments to see what can resolve the rashes.</p> <p>The facility's undated Physician's Orders Policy shows, The physician's new order may be received on the Admission Physician's Order form, by telephone or handwritten on the Physician Order Sheet. All drug orders received via transfer sheet must be verified by the attending physician and transcribed onto the Physician Order Sheet .The following steps are initiated to complete documentation: Clarify order; Enter the orders on the medication order</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 33760</p> <p>Based on interview and record review, the facility failed to ensure a cognitively impaired resident on an altered diet did not have access to a regular consistency sandwich. This failure resulted in R5 who was found choking and subsequently died .</p> <p>These failures resulted in an Immediate Jeopardy.</p> <p>The Immediate Jeopardy began on [DATE] when R5 experienced a choking episode and dying at the hospital on [DATE]. V1 (Administrator) was notified of the Immediate Jeopardy on [DATE] at 9:44 AM.</p> <p>This surveyor confirmed by observation, interview and record review that the Immediate Jeopardy was removed on [DATE]; however, noncompliance remains at a Level 2 because additional time is needed to evaluate the implementation and effectiveness of the in-service training.</p> <p>The findings include:</p> <p>R5 is a [AGE] year-old male admitted to the facility on [DATE] with terminal illness under hospice services with diagnoses of frontotemporal neurocognitive disorder, dementia, diabetes, bipolar schizophrenia.</p> <p>Per facility assessment dated [DATE], R5's BIMS (Brief Interview for Mental Status) score was 7 which means R5 has severe cognitive impairment. The same assessment showed R5 was in need of supervision when eating and R5 is up and ambulatory independently.</p> <p>Physician Order Sheet (POS) dated ,d+[DATE] showed R5's diet order as: no added salt and no concentrated sweets diet, pureed texture, nectar consistency.</p> <p>R5's progress note dated [DATE] timed at 7:45 PM, documents: at approximately 7:40 PM showed staff reported that resident appeared to be choking, Heimlich Maneuver performed, 911 arrived and took over Heimlich maneuver. Resident left via emergency services with a pulse and was breathing.</p> <p>R5's progress note dated [DATE] timed at 8:20 PM, showed a call as received from the local hospital ER (emergency room ) that the resident had expired. Resident was pronounced dead at 7:48 PM, cause of death recorded as hypoxic cardiopulmonary arrest.</p> <p>R5's incident report dated [DATE] by V8 (License Practical Nurse-LPN) showed observed resident standing struggling for breath appeared to be choking as he was trying to cough .attempted Heimlich maneuver and when resident continued to be SOB [shortness of breath], we sat him down on his buttocks and continued Heimlich [maneuver]. I had already instructed staff to call 911. When 911 arrived, they continued Heimlich [maneuver] no food removed and then placed him on cart to hospital.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Emergency Medical Services (EMS Police Dept) report dated [DATE] showed, summoned for [AGE] year old male unresponsive. Upon arrival patient was found at the nursing home being held up sitting up by nursing staff. Per the staff on scene they state that the patient was eating a sandwich when he began choking. Heimlich maneuver was not being performed by nursing staff. Patient continued choking and [the] crew initiated Heimlich maneuver on the patient. Patient was unresponsive with agonal respirations, crew initiated ventilations on the patient. Patient was transferred to the ambulance where crew continued patient care . Patient became pulseless and initiated ACLS [Advanced Cardiac Life Support] protocols. Patient arrived at the receiving ED [Emergency Department] nursing staff.</p> <p>R5's ED hospital records dated [DATE] showed, Patient was found choking at nursing home called EMS. Upon EMS arrival at the nursing home, patient was unresponsive but had a pulse. said they performed Heimlich maneuver and was transported to ER. On the way patient arrested and intubated patient for airway protection. EMS said after intubation patient arrested .CPR [Cardiopulmonary Resuscitation] was performed. Upon arrival to ER, patient was actively vomiting with ET [endotracheal tube] tube in mouth, information from nursing home showed he was hospice and DNR [Do Not Resuscitate]. CPR was terminated. Confirmed deceased at 7:48PM ([DATE]).</p> <p>On [DATE] at 3PM, V20 (Medical Legal Investigator (Local County)) said R5's cause of death was: Immediate-asphyxiation-choked on food bolus, Secondary-neuro cognitive disorder manner of death-accident. An autopsy was performed on R5.</p> <p>On ,d+[DATE]/ 24 at 8:53 AM, V21 (Medical Examiner (Local County)) said he performed an external autopsy on R5. External autopsy result showed R5 was found with solid foods on his distal trachea. V21 also said that a police report showed that facility staff V8 (License Practical Nurse-LPN) and V12 (Certified Nursing Assistant-CNA) both informed the police responders that R5 grabbed a turkey sandwich and ate the sandwich. (R5 was on pureed diet.)</p> <p>On [DATE] at 10:42 AM, V12 (Certified Nursing Assistant-CNA) said it was after dinner approximately around 7PM. V12 said he was coming out from the dining room after having break. He saw R5 by the elevator wearing just an incontinent brief with no gown on. V12 said he went to R5 to redirect him to his room. We made few steps then he suddenly stopped, put his head down so I asked him, 'Are you ok?' He did not respond gasped for air, so I called the nurse. The Nurse (V22 LPN) came and did the Heimlich maneuver.</p> <p>On [DATE] at 8:28 AM, V22 (LPN) said he was by the nurses' station when he heard V12 (CNA) calling for help. V22 said he ran to R5. R5 was clutching his throat. R5 was trying really hard to cough. V22 said he tried to open R5's mouth and R5's mouth was full of saliva. V22 said he cannot recall if he did a mouth sweep. Heimlich maneuver was done and 911 was called R5 was sent to the emergency room .</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>On [DATE] at 1:30 PM, V8 (LPN) said she was R5's nurse last [DATE]. At around 6:30ish on [DATE], she was in the nurses' station with the other nurse when they were alerted by V12 that R5 appeared to be choking. V8 said she ran by the elevator where R5 and V12 were. R5 was short of breath, gasping for air and not talking. R5 was tall, so R5 was lowered to the floor, the Heimlich maneuver was done, back blows, and abdominal thrust. No food was coming out, did a mouth sweep did not feel any food. 911 was called. Paramedics came and also performed Heimlich maneuver then R5 was brought to the ER. Later, got a call from the ER and asked for his code status. R5 was a DNR. R5 coded on his way to the ER. V8 said she was informed R5 passed away shortly. V8 said R5 is up and able to ambulate independently. R5 has dementia and was on pureed diet. V8 said she does not recall telling the paramedics about R5 having a sandwich. V8 said residents with pureed diets should not have regular sandwich.</p> <p>On [DATE] at 11:15 AM, V13 (CNA) said she was R5's CNA for the day and PM shift last [DATE]. R5's dinner was pureed food. R5 ate 100%. After dinner V13 walked with R5 to his room because he needed to be changed. R5 was provided bedtime care. R5 was left in his room lying in bed with gown and clean incontinent brief. V13 said he later learned R5 was sent to ER due to possible choking. R5 might have gotten up from bed after he was provided bedtime care. R5 was able to walk around independently.</p> <p>On [DATE] at 3:23 PM V23 (CNA) said she was one of the CNAs working on [DATE] PM shift. She was in one of the residents room taking care for another resident when she heard what happened to R5. V23 said the incident happened around 7PM. V23 said she had taken care of R5 in the past. R5 is a tall, large guy, able to walk, he can come out in his room, walks around the hallways then goes back to his room. V23 said bedtime snacks come around that time. R5 gets apple sauce. Other resident gets either PBJ or turkey sandwich.</p> <p>On [DATE] at 10:15 V16 (Dietary Manager) said she was at the facility that time [DATE] during the evening meal. The kitchen was short of staff, so dinner trays were prepared in the kitchen instead of the usual steam table. The menu on [DATE] evening meal was grilled cheese sandwich, tossed salad and pudding. V16 said R5 was served pureed diet. After dinner was when bedtime snacks were served that consisted of deli sandwiches- turkey sandwich and peanut butter and jelly sandwich. Residents on puree diets cannot have regular sandwich</p> <p>On [DATE] at 1:10 PM V18 (Assistant Director of Nursing (ADON)) said she was on call ([DATE]) and that evening, she was informed code blue was called on R5. Not sure what happened or how R5 choked. Staff performed Heimlich maneuver and was sent to the hospital via 911. R5 expired that same evening. R5 has behaviors of paces and wanders, R5 had declined in cognition that was why he was on hospice.</p> <p>On [DATE] at 2:35 AM V2 (Director of Nursing) said she was informed that on Saturday [DATE], R5 was in distress and was sent to the ER via 911. V2 said she was told the incident happened around 7PM when dinner was already done. Dinner was at 5:30ish (PM)</p> <p>V2 said she was told that V12 (CNA) was the first staff who noticed R5 was having SOB. R5 was trying to talk and cannot talk so he called for the nurses (V8 and V22 both LPN) who performed Heimlich on R5. V2 said R5 was on pureed diet, ambulatory on hospice due to dementia. V2 said V3 (Chief Nursing Officer) did the investigation.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>On [DATE] at 9:30 AM, V3 (Chief Nursing Officer) said she was the one who did R5's possible choking episode investigation. R5 was able to feed himself on pureed diet. R5 was ambulatory, on hospice services due to dementia and was DNR. V3 said her investigation showed that none of the staff could tell her what happened. V3 said the coroner has an ongoing investigation regarding R5's death.</p> <p>The updated policy and procedure dated [DATE] showed: -Supervision of Residents on Puree diets; residents that are on pureed diet require supervision that they are not able to get non pureed foods as it relates to their swallowing ability as determined by a speech therapist. Delivery of food to the Nursing Units; To ensure that food, such as snacks and meals is always under supervision. The dietary department will ensure that the food delivered is handed to the nursing department or dietary staff are serving the food.</p> <p>During this investigation, R5's police report and death certificate were requested, but both were unavailable as of [DATE].</p> <p>The surveyor confirmed through observation, interview, and record review that the facility took the following actions to remove the immediate jeopardy:</p> <p>The facility respectfully submits this abatement plan today, [DATE]. The facility requests that this abatement plan is accepted today, [DATE] and requests that the immediacy be removed.</p> <p>Actions taken by the facility</p> <p>-On [DATE], the facility did the following:</p> <p>-Assessed the residents on a pureed diet and ensured that they cannot obtain food that is not on their pureed diet;</p> <p>-Speech therapy is currently reevaluating all 4 residents who are on a pureed diet to ensure that it is still the most appropriate diet for them;</p> <p>In-servicing has been initiated which included all Nursing, dietary and activity staff regarding residents on Pureed diets and supervision of the residents on pureed diets that they do not have access to other food. In servicing is on-going and will continue until all staff in serviced.</p> <p>-In regards to delivery of bedtime snacks and all snack deliveries, dietary staff must get a signature from nursing for the snacks that were delivered. All snacks delivered to the floors will be held in the locked Nutrition Room on each floor.</p> <p>-An audit tool was created to supervise residents on pureed diets - auditing will be conducted 5 times a week for 2 weeks, 2 times a week for 2 weeks and 1time a week for 2 months.</p> <p>-Emergency QAPI (Quality Assurance and Performance Improvement) Meeting informed Medical Director of the citation as it relates to an IJ called for F689 on [DATE] at 0944 (am). Medical Director reviewed the abatement plan and approved it. IDT (Interdisciplinary Team) has been notified of the IJ 689 as well in the emergency ad hoc QAPI meeting held today, [DATE].</p> <p>The following was reviewed in the emergency ad hoc QAPI meeting held today:</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Policy and Procedure/System Revision</p> <p>1) Food delivery</p> <p>2) Care of residents on pureed diets.</p> <p>QAPI is held on a monthly basis and the DON, ADON and Dietary Manager will be responsible for reporting on the on-going audit tools.</p> <p>Education:</p> <p>In-servicing began today, [DATE], and is on-going.</p> <p>The following staff are included in the in-servicing: Licensed nursing staff, certified staff, dietary staff, restorative staff, social services, and activity staff. In-servicing topics are as follows:</p> <p>New Policy and Procedures as it relates to providing Pureed diet to those residents that are on a Pureed diet and safeguarding that they do not have access to regular foods.</p> <p>1) QAPI Plan</p> <p>The IDT Team have been educated on the IJ that was [DATE].</p> <p>Topic: New Policy and Procedures relating to pureed diets/supervision as it relates to IJ.</p> <p>Education, Audits, and Plan:</p> <p>-New Policy Resident Access to food.</p> <p>-Care of residents on Pureed Diets.</p>

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<p>F 0808</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law.</p> <p>34490</p> <p>Based on observation, interview and record review the facility failed to ensure a resident was served a no concentrated sweets diet as ordered by the physician for 1 of 3 residents (R3) reviewed for therapeutic diets in the sample of 13.</p> <p>The findings include:</p> <p>R3's Facesheet shows a diagnosis of: diabetes mellitus with hyperglycemia.</p> <p>R3's Physician's Order Sheet shows a diet order dated 8/4/22 for: No Concentrated Sweets diet.</p> <p>On 11/8/24 during the noon meal, R3 was served a dessert of mandarin orange fluff. R3 consumed the dessert.</p> <p>The facility provided Diet Spreadsheet for 11/8/24 shows that residents on a CCHO (LCS) (Consistent Carbohydrate, Limited Concentrated Sweets) diet should receive mandarin oranges instead of mandarin orange fluff.</p> <p>On 11/8/24 at 3:03 PM, V16 (Dietary Manager) said that all residents should receive what is on the spreadsheet for each meal based on their ordered diet. V16 said that residents on a CCHO (LCS) diet should have received mandarin oranges for the noon meal because the fluff part of the mandarin orange fluff contains a lot of sugar.</p> <p>The facility's Menu and Nutritional Adequacy Policy dated 4/2019 shows, The facility will provide each resident a diet ordered by the physician. The facility's CCHO Diets (LCS) (Consistent Carbohydrate) (Limited Concentrated Sweets) Guidelines dated 2022 shows, The CCHO Diet is for diabetics who eat well but may require some additional dietary modifications to aid in blood sugar control .This diet replaces the No Concentrated Sweets Diet .</p>