STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
City View Multicare Center	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)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46344 Based on interview and record review, the facility failed to report a physical abuse allegation to the State Agency. This failure applied to one (R1) of three residents reviewed for abuse. Findings include: R1 is a [AGE] year-old female, who originally admitted to the facility on [DATE], and continues to reside in the facility. R1 has multiple diagnoses including but not limited to the following: COPD (Chronic Obstructive Pulmonary Disease), migraine, muscle spasms, anxiety, ADHD (Attention Deficit Hyperactivity Disorder), intervertebral disc degeneration, behavioral and emotional disorders, PTSD, insomnia, and dental restoration. R2 is a [AGE] year-old male, who originally admitted to the facility on [DATE], and continues to reside in the facility. R2 has multiple diagnoses including but not limited to the following: bipolar disorder, strange and inexplicable behavior, violent behavior, anxiety, brief psychotic disorder, and depression. On 4/30/2025 at 10:45AM, R1 said, One day last week, I was in the elevator and (R2) physically assaulted me. (V4, Licensed Practical Nurse) was present at the time of the assault and is aware. (V5, Licensed Practical Nurse) was on duty at the time of this incident and is aware. (V3, Psychotherapist) and (V7, Physician's Assistant) were also informed of this physical abuse, but nothing was done. I was never interviewed about the incident after this day by (V1, Administrator) or (V2, Director of Nursing). The police were never called, and an incident report was never filed. At 1:50PM, V1 said, On 4/22/2025, (V4) called me and told me (R1) was alleging that she got beat up, and that her dentures were broken. I could hear her sobbing on the other end of the phone, screaming for an anxiety medication. She had no physical marks on her face. She would not talk to me or get on the phone. She went to sleep that night and she was fine. I checked in with her the following day, and she was fine. She did not bring anything up regarding the abuse, and her topics she wanted to discuss were all over the place. Typically, I file an abuse report right away, however, since she could not give me any sort of description and did not want to talk to me about it, I did not file a report. V1 was asked if R1 alleged physical abuse, and she said, Yes, I should have reported it. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	V1 filed an initial facility reported incident for R1 on 4/30/2025, 8 days after alleged incident. Facility abuse policy, dated 2/1/2025, states: To allegations of abuse, the facility will ensure that all alleged violations involving abuse are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the stage survey agency).

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46344 Based on interview and record review, the facility failed to thoroughly investigate an allegation of resident to resident physical abuse. This failure applied to one (R1) of three residents reviewed for abuse. Findings include: R1 is a [AGE] year-old female, who originally admitted to the facility on [DATE], and continues to reside in the facility. R1 has multiple diagnoses including but not limited to the following: COPD (Chronic Obstructive Pulmonary Disease), migraine, muscle spasms, anxiety, ADHD (Attention Deficity Hyperactivity Disorder), intervertebral disc degeneration, behavioral and emotional disorders, PTSD, insomnia, and dental restoration. R2 is a [AGE] year-old male, who originally admitted to the facility on [DATE], and continues to reside in the facility. R2 has multiple diagnoses including but not limited to the following: bipolar disorder, strange and inexplicable behavior, violent behavior, anxiety, brief psychotic disorder, and depression. On 4/30/2025 at 10:45AM, R1 said, One day last week, I was in the elevator and (R2) physically assaulted me. (V4, Licensed Practical Nurse) was present at the time of the assault and is aware. (V5, Licensed Practical Nurse) was on duty at the time of this incident and is aware. (V3, Psychotherapist) and (V7, Physician's Assistant) were also informed of this physical abuse, but nothing was done. I was never interviewed about the incident after this day by (V1, Administrator) or (V2, Director of Nursing). The police were never called, and an incident report was never filed. At 1:50PM, V1 said, On 4/22/2025, (V4) called me and told me (R1) was alleging that she got beat up, and that her dentures were broken. I could hear her sobbing on the other end of the phone, screaming for an anxiety medication. She had no physical marks on her face. She would not talk to me or get on the phone. She went to sleep that night, and she was fine. I checked in with her the following day, and she was fine. She did not bring anything up regarding the abuse, and her topics she wanted to discuss were all over the place. V1 filed an initial facility reported incident for R1 on 4/30/2025, 8 days after alleged incident. All documentation related to this investigation were requested, however, no documentation was received with dates prior to 4/30/2025. Facility abuse policy, dated 2/1/2025, states: Facility response to allegations of abuse, the facility will have evidence that all alleged violations are thoroughly investigated.