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	10/28/2025

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview and record review, the facility failed to update one resident's falls care plan with new interventions to prevent or reduce the risk of further falls. This affected one of three residents (R1) reviewed for plan of care.Findings include: R1's falls care plan, initiated 3/18/25, notes R1 is not at risk for falls as evidenced by the following risk factors and potential contributing diagnosis: bipolar disorder with mood and/or behavioral disturbance. The only intervention noted: nursing staff will complete a fall risk assessment per facility fall protocol. This intervention was reviewed on 3/18, 6/23, and 9/22.There is not an at risk for falls care plan initiated prior to R1's fall or a high risk for falls due to actual fall care plan initiated post fall on 9/19/25.R1's falls report, dated 9/19/25, notes V4 (nurse) observed R1 on floor lying near table on stomach. R1 stated R1 moved away, another resident was going to touch R1, R1 took the other resident's coffee, and it spilled. Predisposing physiological factors include impaired memory, impulsive, agitated/anxious, delusions, use of high-risk medications, decreased safety awareness, receives antipsychotics, and hallucinations.R1's hospital record, dated 9/21/25, notes R1 presented to the emergency room after a traumatic fall. R1's CT (computed tomography) scan of right shoulder shows an acute traumatic comminuted fracture through the lateral greater tuberosity and transverse surgical neck fracture. There is 5mm (millimeters) impacted foreshortening across the surgical neck fracture. A fracture line is noted along the deep lateral portion of the bicipital groove. Generalized soft tissue swelling around the shoulder and posttraumatic joint effusion. CT scan of R1's facial bones show a mildly displaced left nasal bone fracture. R1's fall risk review, dated 9/23/25, notes fall history - does R1 have a history of falls within the last three months; response documented is no. Health conditions - does resident have any health condition that predisposes them to be at risk for falls (other fractures); response documented is none.R1's occupational therapy evaluation, dated 9/24/25, notes R1 with a decline in strength, balance, activity tolerance, and non-weight bearing right arm. R1 requires maximum staff assistance with ADLs (activities of daily living). Due to the documented physical impairments and associated functional deficits, R1 is at risk for falls.On 10/20/25 at 1:20 PM, V2, DON (Director of Nursing) stated a residents care plan should be reviewed and updated after each fall. V2 stated V2 completed R1's fall risk review when R1 was re-admitted after a fall on 9/23/25. When questioned reason V2 noted 'no' on R1's fall history (does R1 have a history of falls within the last three months), V2 responded V2 interpreted this to mean falls other than the current fall on 9/19. V2 stated R1 is not at risk for falls.On 10/27/25, V1 (Administrator) presented the following: any resident who comes into the facility is always at risk [for falls]. When someone falls, they are put on high risk for falls no matter how many falls they have had. They are given a yellow wrist band. Care plans are at risk for falls. The facility's care plan policy, undated, notes residents' care plans will be reviewed and updated with any significant changes in condition.The facility's fall prevention and management program policy, dated 8/3/2017, notes the purpose is to ensure that in the event a fall occurs, additional interventions will be implemented to prevent another fall from occurring.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to effectively monitor/supervise residents in the dining room to prevent an avoidable accident. This affected one of three residents (R1) reviewed for supervision.Findings include:R1's medical record notes diagnoses including but not limited to generalized anxiety disorder, paranoid schizophrenia, drug induced secondary Parkinsonism, encephalopathy, psychoactive substance abuse with psychoactive substance-induced psychotic disorder with delusions, and strange and inexplicable behavior.R1's functional abilities assessment, dated 6/24/25, notes R1 requires supervision or touching assistance with walking 10 feet, 50 feet with two turns, and 150 feet.R1's fall risk review, dated 7/30/25, notes R1's fall risk score is 3; R1 is not at risk for falls.R1's fall risk review, dated 9/23/25, was completed for re-admission after hospitalization for a traumatic fall. R1's fall risk score is 3; R1 is not at risk for falls.R1's BIMS (Brief Interview of Mental Status) score, dated 7/2/25, notes R1's score is 10 out of 15. R1's cognitive is moderately impaired.R1's fall report, dated 9/19/25 at 9:00 PM, V4 (nurse) noted R1 observed on the floor lying near table on stomach. R1 stated, I moved away, he was going to touch me, I took his coffee, and it spilled. R1's hospital record, dated 9/21/25, notes R1 presented to the emergency room after a traumatic fall. R1's CT (computed tomography) scan of right shoulder shows an acute traumatic comminuted fracture through the lateral greater tuberosity and transverse surgical neck fracture. There is 5mm (millimeters) impacted foreshortening across the surgical neck fracture. A fracture line is noted along the deep lateral portion of the bicipital groove. Generalized soft tissue swelling around the shoulder and posttraumatic joint effusion. CT scan of R1's facial bones shows a mildly displaced left nasal bone fracture.V15's (orthopedic surgeon) note, dated 10/10/25, notes R1 with humeral head/neck fracture and R1 will require a surgical procedure, right reverse total shoulder, to repair fracture. Surgery scheduled for 10/15/25 at local hospital.On 10/18/2025 at 11:30 AM, V11 (nurse) and V12 (nurse) were observed sitting at the nurses' station. Both stated there is no CNA (Certified Nurse Aide) working on this nursing unit today. When questioned who is supervising the residents in the dining room today, V11 responded there is no staff. V11 stated the residents are independent.On 10/18/25 at 1:10 PM, V10, RN (Registered Nurse) stated R1 was delusional daily. V10 stated R1 spoke to himself as he paced in the hallway.On 10/18/25 at 1:30 PM, V4 (nurse) stated V4 worked the evening shift on 9/19/25. V4 stated it was close to 10:00 PM when V4 was called to go to the dining room. V4 observed R1 lying on the floor. V4 does not recall if R4 or R5 were in the dining room. V4 does not recall who the other residents were in the dining room at the time of R1's fall. V4 cleared the other residents out the dining room to attend to R1. R1 was speaking, but nothing he was saying was making any sense. R1 began talking about coffee. V4 asked R1 where he got coffee from; R1 did not respond. V4 observed spilled coffee on the floor near R1. R1 became irate and really aggressive. V4 stated normally R1 paces in the hallway talking to no one. Typically, one cannot have a conversation with R1. R1's baseline is disoriented. R4 and R5 typically do not interact with others.On 10/18/25 at 1:40 PM, V14, PA (Physician Assistant for orthopedic surgeon) stated a repeat x-ray was obtained at R1's follow-up appointment with V15 (orthopedic surgeon). V14 stated the x-ray showed R1's right humerus fracture was more displaced than the previous x-ray. R1 had a comminuted fracture of the head and neck of the humerus. R1's fracture could have worsened just from R1 lying in bed, because R1 wore his sling. V14 believes R1 informed her that he fractured his arm during an altercation with another resident.On 10/20/25 at 10:25 AM, V6, RN, stated she was at the nurses' station on 9/19 at time of R1's fall in dining room. V6 stated there weren't many residents in the dining room, not sure who was all in there. V6 stated staff do not monitor residents on the eighth-floor nursing unit, as they are all independent. V6 denied going into dining room to assist after informed R1 was on the floor or afterwards.On 10/20/25 at 11:00 AM, V7 (Nurse Supervisor) stated V7 spoke with R1 and R1's family member regarding the incident. V7 stated R1 took another resident's coffee, not sure which resident it was. The other resident swung at R1 and R1 fell. V7 stated he does not recall any further details, but his note dated 9/20 is an accurate account of incident.R1's medical record, dated 9/20/25 at 9:13 PM, V7 (Nurse Supervisor) noted V7 was made aware R1's family member requested a call back from supervisor as regards to R1's welfare. V7 returned call to R1's family member and updated family member on R1's condition. V7 assured R1's family member tan x-ray of the right arm will be done due to pain, while R1 was receiving pain medication to relieve the pain pending the outcome of the x-ray. V7 also explained to R1's family member R1 confirmed to V7 that R1 took and spilled peers coffee, who in turn swung back at R1, leading to a fall. On 10/22/25 at 2:00 PM, V8, CNA (Certified Nurse Aide)