STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005896	A. BUILDING: _____ B. WING _____	C 03/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYFIELD CARE AND REHAB	5905 WEST WASHINGTON CHICAGO, IL 60644

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S 000	Initial Comments Complaint # 2281789/IL144328	S 000		
S9999	Final Observations Complaint # 2281789/IL144328 STATEMENT OF LICENSURE VIOLATIONS: 300.610a) 300.690b) 300.1010h) 300.1210d)6) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.690 Incidents and Accidents b)The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. Section 300.1010 Medical Care Policies h)The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health,	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care d)Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.3240 Abuse and Neglect a)An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These regulations were not met as evidenced by: Based on interviews and record reviews, the facility failed to provide (R3) 1 of 3 residents reviewed for falls with injuries access to immediate medical attention, failed to follow the established policy and procedures for monitoring a resident after an unwitnessed fall, failed to notify the physician or do continued monitoring of neurological checks, of a fall for a resident on an anticoagulant. This failure resulted in R3 being transported to the Emergency room via	S9999		

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ambulance 3 days after the unwitnessed fall and diagnosed with Traumatic Subarachnoid Hemorrhage without loss of consciousness (Bleeding on the Brain).

Findings Include:

R3 is an 83-year-old with the following diagnoses, Dehydration (3/3/2022), Traumatic Subarachnoid Hemorrhage (3/3/2022), Peripheral Autonomic Neuropathy, Long Term (Current use of Anticoagulants), Spinal Stenosis, Thrombocytopenia, Dementia without behavioral disturbances. History of a healed fracture and chronic kidney disease (stage 3). R3's medications include Heparin therapy, putting R3 at a greater risk for bleeding.

R3's MDS (Minimum Data Set) dated 12/22/2021 scored R3 for self- performance at a 3 indicating R3 requires extensive assist from staff for weight bearing. R3 was scored as a 2 for support indicating R3 needs one-person physical assist to perform for all Activities of Daily Living (ADLs).

During a face- face interview on 03/15/2022 at 2:40 pm with V1 (Administrator), surveyor asked V1 for the reportable incident of R3 's fall on 02/27/2022. V1 stated we didn't report it because she didn't go out to the hospital until a couple days later. Surveyor asked V1 if he notified IDPH of R3's injury of a brain bleed due to a fall and delayed medical treatment. He stated "honestly, I did not report it to IDPH."

V1 (Administrator) was asked for an internal investigation of the incident, V1 said he didn't do an investigation. V1 was asked if he was aware

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that V4 (Nurse) left R3 on the floor in her room crying and told R3 that she needs to stay on the floor and wait until she completes care with another resident. V1 said yes, I am aware of that progress note where V4 told R3 she would be back after she took care of another resident. V1 said V4 was told to change the documentation. There were two progress notes dated approximately 3 minutes apart by V4. Both progress notes by V4 noted V4 told R3 she would get her off the floor and back to bed after she finishes giving care to another resident.

During a phone interview with V4 (Nurse) on 3/17/2022 at 5:07 pm, V4 was asked about the fall incident with R3 on 2/27/2022. V4 said she was told that R3 does a lot of screaming and crying but this was the first time it happened on her shift. V4 said she was doing tracheostomy care on another resident across the hall when she heard a lot of yelling and screaming coming from R5 (roommate) across the hall. R5 was screaming that R3 had thrown herself onto the floor. V4 stated she stopped and went to see what was going on. V4 said she observed R3 laying on the floor with her arm under her head. V4 stated R3 didn't appear to be hurt, she was crying and wanted to go back to bed. V4 said she told R3 she would have to wait until she finished taking care of another resident. When I finished doing Trach care on the resident, I came to see about R3. I had to wait to get help to put R3 back into the bed. V11 (Nurse) came and helped me put R3 back to bed.

Review of physician note dated 02/27/2022 at 11:32 pm by V10 (Advance Practice Nurse - APN), 83 y/o Caucasian female resident with h/o CKD, DM-2, obesity, depression, anemia, HLD, anxiety, Covid-19, low back pain, spinal stenosis-

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S9999	Continued From page 4 lumbar region and dementia seen and examined earlier today as per NOD request. NOD reported resident found lying on the floor and her roommate told she did on purpose. Resident is alert and verbal, now back to bed, resting, forgetful in baseline, denies any pain and discomfort at present. ASSESSMENT/PLAN: # S/p Fall- found lying on the floor: - Monitor vitals, neuro- notify if any deviation from baseline - Offer pain medication - Fall precautions/prevention - call light in reach - explained resident to give call light and wait for assistance - Maintain hydration, nutrition, ADLS - Keep skin dry and clean - Continue all other Tx - Discussed about covid precautions Plan of care discussed with PCP, nursing staff, and patient, Time of the note does not necessarily correlate to the time or date the patient was seen. Time Spent: Total Time Spent with Patient including assessment, medication review, education, POC, 25 min. On 3/16/22 , at 11:42 am, V1(Administrator) was asked for a contact number to speak with V10(Advanced Practice Nurse) . V1 said V10 is out of the country and will be gone at least a month. Surveyor was not able to interview V10 about her order for monitoring vitals and neurological checks. During interview on 3/16/2022 at 10:50 am with V2 (Director of Nursing), V2 was asked to provide the neurological assessments on R3 and the flow sheets for vitals. V2 stated "I only have the assessment completed on 02/27/2022 by V4 (Nurse) after they got R3 back to bed. Surveyor	S9999		

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asked V2 for the Fall policy and the Neurological Assessment Policy. Surveyor asked V2 is there anyway to get the other neuro assessments. V2 stated we don't have any other assessments, I have checked. Surveyor asked how often are the neuro checks documented, V2 stated several times within the first few hours and then over a period of time.

During a phone interview on 03/17/2022 at 1:32 pm with V12 (Physician), V12 was asked if he received a call from V4 (Nurse) on 2/27/22 about R3 being found on the floor. V12 said no he answers and returns all his calls. Surveyor asked if he knew R3 was found on the floor with no apparent injuries and receiving Heparin as an anticoagulant what orders would be given to the nurse. V12 stated he would order neuro checks regularly and monitor for change in condition. Surveyor asked the doctor was he aware that the resident was complaining of pain to the head and was observed with bruising to the right temple on 3/2/2022. (V12) stated "obviously R3 hit her head, this is why neurological checks are done. They waited too long to contact me, I would have ordered R3 out to the hospital for a CT scan."

During a phone interview with V9 (Nurse) on 3/17/22 at 1:50 pm, V9 stated R3 was complaining of a headache. On 3/2/22 pain medication was given. V9 stated she spoke with V12 (physician) about a bruise to R3's left temple, I was given an new order to send R3 out to the local hospital for CT scan.

Review of hospital note by V13 (Nurse) on 3/2/2022 at 7:43 pm - V13 spoke with nurse at the hospital, R3 is being transferred to higher level of care hospital r/t Subarachnoid Hemorrhage (Brain Bleed). R3 will be admitted to

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S9999	Continued From page 6 room XXX under care of Dr. YYY. Spoke with MD and made him aware, DON aware, and brother aware. Progress Note dated 3/4/2021 at 10:00 pm by V11 (Nurse), F/U readmit R3, Received in bed. A&O x2 breathing easy & unlabored no SOB. Good appetite. Incontinent of B&B kept clean & dry. Meds taken as ordered. VSS. Able to make needs known. At dinner time resident was noted crying. When asked what was wrong, she stated that "my table is too far from me". Writer educated resident that she could pull her table closer to her herself. Writer moved table closer to resident & resident was ok. Call light within reach. Staff will continue to monitor. Care Plan Revision: Date 2/27/2022 - review of R3's care plan noted no information pertaining to R3 being sent out for a hospital stay related to the fall on 2/27/22 with an injury of Brain Bleed and returning back to the facility on 3/2/2022. Fall Policy/Prevention: Revised 05/2021: #5. Upon arrival of the nurse, a quick head to toe scan will be performed without unnecessary movement, palpating, and examining all areas for break in the skin and or other abnormal findings. #6. Obtain vitals #7. Obtain neurological checks per policy for unwitnessed fall or any fall with evidence of injury to head. #10. The nurse will complete an incident report. #12. Resident fall will be evaluated for 72 hours post fall, including vital signs every shift. #13. The Director of Nursing (DON) will be notified immediately for falls resulting in injury and or transfer. The DON will notify State Agency per state specific requirements.	S9999		

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S9999	Continued From page 7 Facilities Policies: Neurological Assessments: dated 5/2021: Neurological assessments are performed to evaluate a resident's nervous system including brain function. Early detection of an injury or underlying condition provides the best chance of decreasing long term complications. Resident/patient with conditions resulting in changes, or potential changes, in their neurological status will be assessed for transfer to the acute care setting. Neurological assessments Policy: Neurological assessments will be completed by a licensed nurse: 1. To assess central nervous system status of a resident/patient. 2. To assess level of consciousness for a traumatic or potentially traumatic injury to the head, after any loss of consciousness or change in condition that may have resulted from stroke or adverse event 3. To assess neurological status after an un-witnessed fall. 4. Neurological assessments will be completed as follows: a. Every 15 minutes x first hour b. Every 30 minutes x 2 hours c. Every hour x 2 hours d. Every shift x 72 hours e. Then as primary healthcare provider orders PROCEDURE: 1. The licensed nurse will complete the Neurological Assessment Flowsheet for data collection. a. Identify resident/patient, explain procedure, and provide privacy, wash hands.	S9999		

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S9999	Continued From page 8 2. Complete data collection. 3. Immediately report changes or concerns to the primary healthcare provider and family. (A)	S9999		