Illinois Department of Public Health

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 08/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYFIELD HEALTH CENTER	5905 WEST WASHINGTON CHICAGO, IL 60644

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S 000	Initial Comments 2083387/IL122534	S 000		
S9999	Final Observations Statement of Licensure Violation: 2 of 2 Violations 300.610a) 300.1210b)4)5) 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 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological	S9999	**Attachment A** **Statement of Licensure Violations**	

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well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:

4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene.

5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.

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

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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. (A, B) (Section 2-107 of the Act)

This requirement is not met as evidenced by:

Based on interviews, observations, and records reviewed the facility failed to follow their identified care plan interventions to prevent a fall. The facility failed to implement a care plan with interventions related to the contributing factors of a fall and failed to implement care plan interventions implemented after a fall. This failure resulted in R8 sustaining an acromioclavicular separation and scalp hematoma after falling from bed during care.This failure affected 3 of 4 (R8, R1, R2) residents reviewed for falls.

Findings include:

R8's diagnosis include but not limited to dislocation of right acromiclavicular joint, chronic obstructive pulmonary disease, diabetes, hypertension, syncope, arthritis, gout, contusion of scalp, end stage renal disease, and history of falling.

During an interview on 8/12/20 at 8:50AM with

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V3, Unit Manager, she said an initial fall risk assessment is completed on admission and after every fall. V3 said the floor staff is notified of residents at risk for falls in report, during stand-up meetings, with the use falling star symbols, and oral reports given to CNAs daily.

During an interview on 8/13/20 2:00PM, V2, Director of Nursing, said a Certified Nursing Assistant improperly rolled R8 on 7/12/20 and walked away and R8 rolled off the bed. V2 said R8 sustained a closed hematoma on her forehead and a right acromion process dislocation.

During an interview on 8/13/20 at 2:17PM V16, Certified Nursing Assistant (CNA), said R8's care before the fall included staff to bathe her, 2 persons for transfers, and dependent on staff for incontinent cares. V16 said R2 requires 2 persons to reposition her. V16 said R8 now has a rail for her to grab and pull while in the bed. V16 said R8 did not always have the rail before the fall because it is removable. V16 said if R8 has a pillow or wedge she could be left on her side. V16 said R8 would not be safe left on her side without a device to support her.

During an interview on 8/14/20 at 9:29AM with V26, Nurse Practitioner, she said she expects the facility to follow the resident plan of care, so if 2 persons are required for care then they should be using 2 persons. V26 said the fall on 7/12/20 was the cause of R8's shoulder dislocation. V26 said on her assessment prior to the fall R8 was able to move her arms without difficulty. When R8 was sent to the emergency room for evaluation following the fall they found she had the dislocation immediately on 7/12/20.

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During an interview on 8/14/20 at 11:52AM with V25, CNA, she said she was providing care to R8 on 7/12/20. R8 was in the bed and V25 left her to get more towels. V25 said she was providing care to R8 alone and no other staff was in the room.

On 8/13/2020 at 3:06PM R8 observed awake and alert, in her bed eating a snack. Half side rails up, call light on her lap, name tag on her right wrist. No arm sling noted on either arm. There is a #2 posted on the wall above head of bed. R8's name appears as the first name on the list of residents outside of the room, but there is no star next to her name.

During an interview on 8/14/20 at 9:25AM V29, Nurse, said R8 is cooperative with wearing her sling. V8 was a 2 person assist because she is heavy weight for one person to turn and reposition while in the bed.

8/14/20 Record review of R8's care plan for self-care performance deficient dated 2/22/20 intervention for bed mobility dated 2/22/19 states 2 staff to turn and reposition.

Record review of R8's Fall Report on 8/14/20 dated 7/12/20 written by V24, Nurse, notes when asked what happened CNA reported that she attempted to roll resident to one side and went to go pick up materials, resident rolled out of bed. Evaluation noted to have a hematoma to forehead with swelling and bleeding.

Record review of R8's care plan on 8/14/20 note date initiated 7/12/20 R8 had an actual fall with injury. CT scan performed positive for right acromion dislocation. Interventions dated 7/13/20 note CNA in service on how to do an Activity of Daily Living care regarding proper placement,

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repositioning and gathering material prior to attending to residents. Right arm sling to wear at all times except during ADL care.

Review of Occupational Therapy Plan of Care dated 7/20/20 notes R8's Functional Deficits for Activity of Daily Living for hygiene required maximum assistance prior to the fall and her current level is dependent. R8's prior Functional Deficits for Activity of Daily Living for upper body dressing was moderate assistance and her current level of assistance is dependent.

Record review of R8's physician orders on 8/14/20 dated 7/20/20 note Occupational therapy to evaluate and treat. Tramadol HCL tablet 50mg as needed for pain.

Record review on 8/14/20 of R8's Emergency Department Chart Report dated 7/12/20 notes chief complaint fall. Diagnosis: Injury of head, AC (acromioclavicular) separation, and scalp hematoma.

2). R1's diagnosis include but not limited to stroke, depression, chronic kidney disease, and blind. R1's most recent admission date listed on the face sheet is 12/18/17. R1 is no longer in the facility.

During an interview on 8/12/20 at 1:43PM V12, Nurse, said during her rounds on 4/13/20 she saw R1 sitting on the floor. R1 told her he did not know how he got to the floor. V12 said following a fall the department heads will discuss the fall the next day and discuss new interventions. V12 said prior to the fall she can not recall if R1 has any fall precautions in place.

During an interview with V14, Nurse, on 8/12/20

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at 3:15PM, he said Fall Risk Assessments should be done on admission. V14 said the purpose of a Fall Risk Assessment is plan interventions to prevent falls.

During an interview on 8/13/20 at 9:17AM V2 said if she would have done the fall follow up for R1 she would have a care plan entry for each fall dated 4/13/20 and 4/15/20. Surveyor asked V2 for the care plan following R1's 4/13/20 fall and V2 said "It's not there that is why I didn't bring it."

During an interview on 8/13/20 at 11:30AM V20, CNA, said she didn't think R1 was a fall risk. V20 said if a resident is a fall risk, she is made aware by the resident's gait and walking ability and the nurses will tell you who is a fall risk. V20 said the nurses never said R1 was a fall risk. V20 said someone who falls twice within a couple of days should be a fall risk.

During an interview on 8/13/20 at 2:31PM with V21, Nurse, she said on 4/15/20 during rounds she saw R1 was on the floor. V21 said she was not familiar with R1 because she is a float nurse. V21 said she received report from the prior shift's nurse on 4/15/20. V21 said she was not made aware during report that R1 had a fall on 4/13/20.

Record review on 8/12/20 of R1's Fall reports include fall on 4/13/20 and a fall on 4/15/20.

Record review on 8/13/20 of Fall Risk Assessments dated 4/13/20 and 4/15/20. No other Fall Risk Assessments are present in R1's electronic record for review.

Record review on 8/13/20 of R1's care plan includes a fall focus dated 4/15/20. Interventions to monitor the resident and neurological checks

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are both dated 4/15/20. No other interventions are on the care plan.

3). R2's diagnosis includes but not limited to hypertension and joint pain.

During an interview with R2 on 8/12/20 at 12:40PM he said he fell a few weeks ago. R2 said he fell trying to change his brief while in bed because no one had changed him and he was wet.

During an interview on 8/13/20 at 11:50AM with V18, Nurse, said on 7/24/20 R2 told her he was sitting at the edge of the bed and he slid to the floor. V18 said all residents are at risk for falls. V18 said the care plan interventions added should be something that address the situation related to the resident's fall. V18 said R2's wheel chair was not involved in this fall. V18 said the nonskid pad intervention will help when the resident is in the wheel chair, but if the resident is not in the wheel chair it won't help.

During an interview on 8/13/20 at 11:18AM V19, Director of Rehab, said we had added R2 to case load on 7/22/20, before he fell, for decline involving problems with transfers and bed mobility. We screened him and noticed he had changed. V19 said after the fall R2 had told her he was trying to get his balance while sitting on the bed and he said he lowered himself to the floor. V19 said R2 is alert, oriented, and credible. V19 said she discovered R2 was on the floor and the wheel chair was nowhere near him when she saw him on the floor.

On 8/13/20 at 10:48AM During an observation of R2 with V27, CNA, present R2 stood up from his wheel chair with assistance of V27. While

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standing surveyor observed wheel chair cushion in wheel chair. No non-skid device was on top of the cushion. Surveyor asked V27 if the nonskid is present under the cushion. V27 lifted the cushion and said no nonskid is present under the cushion. V27 said she had gotten R2 ready and into his chair in the morning.

Record review on 8/12/20 of R2's Fall report dated 7/24/20 written by V18, Nurse, reads resident statement "I slid while sitting at the edge of my bed." On the same report mental status documented as oriented to person, place, and situation.

Record review on 8/12/20 of R2's Progress Notes dated 7/24/20 written by V18 read when resident was asked what happened verbally told slid while sitting at the edge of my bed.

Record review on 8/12/20 of R2's Care Plan date initiated 3/3/20 notes the resident had an actual fall with no injury. Intervention dated 7/24/20 reads continue interventions, nonskid pad to wheel chair cushion, and rehabilitation to evaluate and treat as orders post fall. (Rehab had already been initiated on 7/22/20.)

R2's Order Summary Report includes an order dated 7/20/20 for Occupational therapy to evaluate and treat. An order for Physical Therapy clarification for evaluation and treatment dated 7/22/20 is present. A second order for Occupational therapy to evaluate and treat dated 7/23/20 is present. The 3 orders are prior to the date of the fall on 7/24/20.

R2's assessment for Functional Status dated 7/30/20 stated R2 requires extensive assistance with bed mobility, transfers, dressing, toilet use,

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and personal hygiene. Assessment dated 7/30/20 for Balance During Transitions and Walking is assessed as activity did not occur.

Record review on 8/14/20 of the facility's undated Incident / Accident Facility Responsibility List states fall care plan interventions updated with date.

The facility's undated Fall Program Guidelines reviewed on 8/18/20 states: Purpose to define guidelines in implementing a falls program to promote resident safety and prevent or reduce falls. Enroll resident's in Falling Star Program and communicate interventions to staff. Resident's identified as a fall risk will have an individualized care plan to address the contributing factors that place them at risk, goals to prevent falls / injuries, and interventions / approaches to promote safety of the resident.

(B)

300.690b)

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.

This Requirement is not met as evidenced by:

Based on interview and record review the facility failed to report a fall resulting in serious injury for

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R8 who fell from her bed and suffered a hematoma and right acromion process dislocation. This failure affected one resident (R8) in a sample of 3 residents reviewed for falls with injury.

Findings include:

During an interview on 8/13/20 at 2:00PM with V2, Director of Nursing, said on 7/12/20 a Certified Nursing Assistant improperly rolled R8 and walked away from her and R8 rolled off the bed. V2 said R8 went to the hospital and suffered a closed hematoma on her forehead and a right acromion process dislocation. V2 said did not report to IDPH because she had just started and she "assumed it was reported." V2 said I was here 5 or 6 days and at the time she had not been shown how to do a reportable.

During an interview on 8/13/20 at 3:05PM V1, Administrator, said R8's fall should have been reported to IDPH. V1 said I don't report nursing things, I report Abuse. V1 said the fall reporting was loss due to miscommunication. V1 said the time frame to report an injury is within 24 hours. V1 said R8 was sent to the hospital and then diagnosed with ac (acromioclavicular) separation and hematoma.

Record review on 8/14/20 of R8's Emergency Department Chart Report dated 7/12/20 notes chief complaint fall. Diagnosis: Injury of head, AC (acromioclavicular) separation, and scalp hematoma.

On 8/14/20 at 11:03AM the facility notified the department of R8's fall with injury (34 days after the injury.)

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S9999	Continued From page 11 The facility's undated policy for Incidents and Actions states in section b. The facility shall notify the department of any serious incident or accident. For purposes of the section "serious" means any incident or accident that causes physical har, or injury to the resident. Section c. The facility shall notify the Regional Office within 24 hours after each reportable incident or accident. (C)	S9999		