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 03/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Facility Reported Incident of 2/18/2023/IL00157028	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) 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 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 resident to meet the total nursing and personal care needs of the resident. 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. These regulations were not met as evidenced by: Based on interviews and records review, the facility failed to follow their fall prevention policy by failing to provide adequate monitoring and fall prevention for 1 resident(R2) of 4 residents reviewed. This failure resulted in R2 sustaining head injury. Findings include: R2 is a 65-year-old individua with multiple admissions to the facility, and last admission is documented as 12/2/2022. R2's MDS (Minimum Data Set) Section C (Cognitive Patterns) dated 3/2/ 2023, document R2 has a BIMS (Brief Interview for Mental Status) score of 9/15, indicating R2 has some cognitive deficits. R2's MDS section G, ADL (Activities of Daily Living-Assistance), dated 3/2/2023, documents R2	S9999		

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S9999	Continued From page 2 needs extensive assistance, two persons plus assistance with Bed mobility, transfer, and toilet use. R2 needs extensive assistance with one person assist with locomotion on and off unit, dressing, eating and personal hygiene. For balance during transitions and walking, R2 is documented as not steady moving from seated to standing position, not steady, able to stabilize with staff assistance for surface-to-surface transfer (Transfer between bed and chair or wheelchair). Walking is documented as "Activity did not occur. Functional Limitation in Range of Motion; Impairment on one side, lower extremity (hip, knee, ankle, foot)-impairment on one side. Mobility Devices, R2 uses manual wheelchair. On 3/11/2023 at 10:07am, R1 was observed in bed with bed in low position and fall mattresses in place. R2's call light was near R2, and his room is near the nurse's station. R2 answered questions with "yes" and "no" answers. On 3/11/2023 at 11:34am, V2(Director of Nursing) said on 2/18/2023, V3(Registered Nurse -RN) reported to V2 that R2 was in the hallway sitting in his wheelchair and V3 said when she turned her back away from R2 that R2 fell in the hallway and was found in facing up position, R2 had a small open area on right eyebrow. V2 said V3 applied pressure and ice to the area, and the bleeding stopped. R2 was sent to the local hospital for further evaluation. V2 said all residents are fall risks and must be monitored. V2 said, at that time, R2's room was not close to the nursing station when R2 fell. V2 said high fall risk residents like R2, should be near the nursing station when in wheelchair so that if resident slides or turns to the side, the nurse can see and reposition the resident before the resident falls. V2 said R2 should have been always monitored	S9999		

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S9999	Continued From page 3 to prevent falls, because R2 has had many falls in the past. On 3/11/2023 at 12:36AM, V3(Registered Nurse) said that on 2/18/2023 in the morning about 10:30am, V4(Certified Nurses' Assistant-CNA) came running to V3 saying that R2 was on the floor in the hallway after falling and was bleeding on the face. V3 said V4 was in a resident room performing her daily duties and when she come out a resident room, V4 found R2 in the hallway on the floor, face up and bleeding from the face. V3 said she run to R2 to assess R2 and provide care, and V3 found R2 on the floor and he(R2) was bleeding to the right brow and had moderate bleeding to oral cavity. V3 said V3 applied pressure to R2's bleeding right brow and the bleeding subsided. V3 said she assessed R2 and R2 was not in pain, and R2 did not lose consciousness. V3 said V3 got an order to send R2 out to the hospital for further evaluation especially because R3 was on blood thinner medications. V3 said high risk fall residents are supposed to be always monitored. they are supposed to be in the day room with staff, or in activities room on the first floor or at nursing station where they can be monitored by nurses if the CNAs are busy taking care of other residents. V3 said monitoring the residents always helps maintain safety. V3 said high risk residents have star/leaf on the door to alert staff that a resident is a fall risk. V3 said R2 is a high fall risk because he is a stoke patient and has right Hemiplegia(paralysis). V3 said staff are supposed to always monitor R2 because he a high fall risk and has a history of falls before this fall. On 3/11/2023 at 1:22pm, V4(Certified Nurse's Assistant -CNA) said she was in a resident room doing patient care and as she was coming out of	S9999		

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S9999	Continued From page 4 the other resident room, V4 saw R2 lying on his right side by his room, just outside the room. V4 said she went and got the nurse(V3) who come and assessed R2. V4 said R2 is a high falls risk resident. V4 said fall risk residents are not supposed to be left alone because "anything can happen. They might try to get up and fall." V4 said to prevent R2 from falling, staff should have taken R2 to activities room on the first-floor main dining room where he could have been monitored, or in the day room with staff, or put him(R2) by the nursing station so that R2 could have been always monitored. V4 said fall risk residents who are fall risk have a leaf on their doors to alert staff of their fall risks, and R2 is one of the high-risk residents. R2's hospital records with encounter date of 2/19/2023 document: -Date of Admission: 2/19/2023 -Primary diagnosis: ICH (Intracerebral hemorrhage) -History of Present Illness (HPI) documents: R2 has a fall from wheelchair on 2/18/2023 at the nursing home where R2 resides, was taken to (ED)Emergency Room and was admitted to trauma service, CTH (Computed Tomography Head) and at that time per report, was found to demonstrate L(Left) frontal traumatic: ICH (Intracerebral hemorrhage). Hospital notes further document: R2 admitted to NSICU (Neuroscience Intensive Care Unit) on 2/19. R2 transferred to another hospital for further work up of suspected aneurysm in setting of expanded L(Left frontal ICH (Intracerebral hemorrhage) with SAH(subarachnoid hemorrhage) S/P(Status Post) fall at nursing home. R2's care plan with initiated date of 10/6/2021,	S9999		

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S9999	Continued From page 5 Revised 11/10/2022 documents R2 has had multiple falls on: 10/5/2021, 3/9/2022, 3/17/2022, 3/25/2022, 411/2022, 12/0/2022, 12/15, 2022, 2/18/2023. Facility Policy titled: Fall Prevention Policy, no date documents: -It is the policy of Mayfield to identify residents at risk for falls and to implement a fall prevention approach to reduce the risk for falls and possible injuries. -Direct Care Providers will be instructed regarding approaches and goals for the management of the resident falls risk -Any resident experiencing a pattern of falls (two or more during a 30-day period) or an injury from a fall will be referred for a falls assessment to be completed by the nurse or therapist. R2's Fall Risk Assessment dated 2/18/2023 documents -R2 is a falls risk related to having fallen before, has more than one diagnosis on the chart, has an impaired gait, overestimates, or forgets limits. For ambulatory aids, R2 is documented as: None/bedrest/wheelchair/nurse assist. (A)	S9999		