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 04/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYFIELD HEALTH CENTER	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
S9999	Final Observations Statement of Licensure Violation: 1 of 1 violation 300.610a) 300.1210b)5) 300.1210d)3)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 well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing	S9999	Attachment A Statement of Licensure Violations	

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 04/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYFIELD HEALTH CENTER	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
S9999	Continued From page 1	S9999		

care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

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:

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

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

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

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 04/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYFIELD HEALTH CENTER	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
S9999	Continued From page 2 Act)	S9999		

These Requirements are not met as evidenced by:

Based on interview and record review the facility failed to follow care plan interventions to ensure a consistent and safe transfer utilizing two person transfers with the gait belt and the mechanical lift for 1 of 3 residents (R1) reviewed for avoidable accidents. Facility failed to assess and address escalating complaints of leg pain for (R1) resulting in (R1) complaining of pain to staff for at least 2 days.These failures resulted in R1 being in pain and sent to local hospital and treated for a left proximal non-displaced tibial fracture.

Findings Include:

R1's admitting diagnosis includes but not limited to hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side.

R1's Minimum Data Set (MDS) dated 2/12/18 documents a brief interview for mental status (BIMS) score of 15. The BIMS is a brief screener that aids in detecting cognitive impairment. Scores from a conducted BIMS assessment suggest the following distributions: 13-15: cognitively intact, 8-12: moderately impaired, 0-7: severe impairment.

R 1's progress note dated 4/6/18 at 8:02 AM, documents R 1 is Alert and oriented x3. Complaints of left leg pain 10/10. Doctor called

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 04/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYFIELD HEALTH CENTER	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
S9999	Continued From page 3	S9999		

for x-ray orders awaiting call back.

R 1's Physician's progress note dated 4/6/18 at 10:22 AM documents R1 was observed in bed and complained of left calf pain that began last night and got worse. Pain 8/10 localized to calf only. R1 is alert and oriented x3.

On 4/20/18 at 4:00pm via telephone V15 (Physician) said that he was told by nursing staff at the facility that R1 was not involved in a fall. V15 said he didn't ask R1 what happened when he assessed her on 4/6/218. V15 said he didn't know what type of fracture R1 sustained and said he would have to review R1's clinical record and further discuss R1's occurance. Several attempts were made to speak with V15 again before the exit of 4/27/218 with no response.

R'1 progress note dated 4/6/18 at 14:23PM documents contracted x-ray Company called for left leg x-ray and Doppler.

R1's facility contracted x-ray report dated 4/6/18 at 15:45 documents impression of suspected proximal tibial fracture, recommend dedicated Multiview imaging.

R 1's progress note dated 4/6/18 at 22:32, documents R1's x-ray results relied to V15 (Physician) V15 gave orders to send R1 to local hospital and Ambulance Company called for transfer.

Local hospital records documents arrival date 04/06/18 at 23:34 to emergency department. Under triage; documents R1 has no mental status changes. R1 is alert and awake. Oriented to person, place and time. R1 states she had been "dropped when they were putting me in bed" on

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 04/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYFIELD HEALTH CENTER	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
S9999	Continued From page 4	S9999		

Wednesday night around 7 pm. (R1) has some swelling to left lower leg; complains of pain 8/10. Local Hospital Records under Clinician history dated 4/6/18 documents R1 reports she was being transferred to bed 2 days ago and had a pop in her left leg.

Hospital consultant request/report dated 4/7/18 documents R1 is alert and Oriented x3 and presented to emergency room after being dropped during a transfer at nursing home on Wednesday 4/4/18.
Hospital Consultation report dated 4/8/18, documents that while transferring with nursing home staff, fell on 4/4/18. Generally this is an alert lady who is conversant and follows commands.

Reviewed facility's initial incident report form dated 4/7/18 documents that R1's incident was immediately reported to nurse. Immediate action taken body assessment done, pain medication given, area immobilized.

Review of the facility's Final Investigation Report dated 4/12/18 for R1 documents under brief description of incident at approximately 10:00AM, writer was called to floor to further evaluate R1 who was complaining of pain after attempting to ambulate with assistance (Resident is one person assist) stated I heard a pop when I stood up, then there was pain in my left leg and they laid me back in bed, writer asked resident who is alert if she had fallen or hit anything and she stated no.

On 4/20/18 approximately 11:10 AM, V5 (Certified Nursing Assistant, CNA) stated R1 is Alert and oriented. V5 said that on Thursday 4/5/18, R1 said that one girl was transferring me back to bed yesterday evening and then my leg started

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 04/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYFIELD HEALTH CENTER	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
S9999	Continued From page 5	S9999		

hurting. V5 said that on 4/5/18 he observed R1's left leg to be swollen and warm to the touch. V5 stated R1 gets up out of bed to her wheelchair on Mondays, Wednesdays, and Fridays. V5 stated he informed V8 (Nurse). V5 said, R1 is a 2 person assist for transferring and that R1 would stand and bear weight to legs and then be able transfer to chair.

On 4/20/18 11:41 AM, V8 (Nurse) stated R1 was alert and oriented x3. On Friday 4/6/18, a CNA informed her that R1 was complaining of pain. V8 cannot recall if any pain medication was given. V8 stated R1 leg was swollen. R 1 stated her leg had started hurting on Wednesday after she went back to bed. V8 unable to find completed pain assessment in R1's medical chart. I called doctor for x-ray's and awaited a call back. MD was in building and ordered x-ray and Doppler.

On 4/20/18 12:45PM, V10 (Nurse) stated R1 is alert and oriented x3. V10 overheard from another nurse saying R1 stated she heard a pop in her leg when being transferred and said that R1 had a fracture and was sent out to hospital later.

A review of R1's Minimum Data Set (MDS) dated 2/12/18 under Section G documents; transfer 3/3 -extensive assistance, 2 person assist.

R1's Care plan initiated 4/16/16 documents, R1 is at risk for falls related to hemiplegia, need for staff for transfers and mobility. Care plan interventions dated 7/19/16 documents staff to assist x2 with gait belt and mechanical lift with all transfers.

On 4/18/18 approximately 1230 PM V3 (CNA) stated R1 is alert and oriented. V3 stated she was

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 04/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYFIELD HEALTH CENTER	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
S9999	Continued From page 6	S9999		

assigned to take care of R1 at times but unable to recall specific date and time. V3 would get V4 (CNA) to assist with transferring R1 to high back wheelchair. V3 said R1 is 2 person assisted and had contractures in both of her legs. V3 said R1 would be lying in bed and one person would have the top portion and the other person would have her legs and they would lift her into the chair. V3 said they did not use a gait belt for transfer. V3 stated she assisted R1 with her legs and that she was complaining of pain in her legs prior to transfer but not specific to which one. R1 said she was waiting for MD. V3 informed V8 (nurse) of pain. V3 unable to recall exact date/time of transfer.

A review of the Electronic kiosk (daily charting system for certified nurse aide) documents Activities of daily living legend report documents on 4/4/18 and 4/6/18, V3 (CNA) documents assisting R1 with eating, dressing, and bathing.

On 4/18/18 approximately 12:50 PM, V4 (CNA) stated R1 is alert and oriented. V4 said she would sometimes assist other staff with transfer for R1. V4 said she assisted V3 with transferring R1. V4 said they used a gait belt to assist R1 out of bed to wheelchair. V4 said there would be one person on each side of the residents with the wheelchair in front of R1 and then use gait belt to transfer R1 to chair.

On 4/20/18 12:50PM, V11 (Certified Nursing Assistant, CNA), said R1 is alert and oriented x 3. R1 is a 2 person assist with transfers. V11 (CNA), said she uses a gait belt, with one person on each side of R1 and then lift R1 into the wheelchair. V11 stated R1 cannot stand and can't put weight on her leg.

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 04/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYFIELD HEALTH CENTER	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
S9999	Continued From page 7 On 4/20/18 1:30PM, V9 (Certified Nursing Assistant, CNA), said R1 is alert and oriented, R1 was complaining of pain Thursday 4/5/18 day shift. V9 said she was providing incontinence care and R1 said her hips were hurting. V9 informed V8 (nurse) of R1's complaint of pain. On 4/20/18 1:50 PM V12 (Certified Nursing Assistant, CNA), stated she heard R1 leg was swollen and possibly fractured on Friday (4/6/18). I was not assigned to R1. A review of the Electronic kiosk (daily charting system for certified nurse aide) documents Activities of daily living legend report documents on 4/4/18 V3 (CNA) and V12 (CNA) provided care to R1. On 4/4/18 at 19:16 V 12 assisted R1 with transferring. At 19:17, V12 (CNA) assisted R1 with bed mobility. A review of the Electronic kiosk Activities of daily living log documents on 4/5/18 at 11:20 V9 (CNA) assisted R1 with toilet use. On 4/20/18 2:54PM, V9 (CNA) reviewed electronic documentation and confirmed that R1 complained of pain to her leg on Thursday 4/5/18 and V9 said that she notified V8 (LPN) of R1's complaint of leg pain. On 4/20/18 3:10 PM V3 (CNA), stated she did not put R1 back to bed prior to leaving her shift on 4/4/18. At 3:00 PM. Reviewed R1's Medication Administration Record (MAR) for April 2018, no record of Tylenol being administered to R1 in April. No record of any pain medication being administered to R1. Reviewed R1's progress notes and no	S9999		

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 04/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYFIELD HEALTH CENTER	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
S9999	Continued From page 8	S9999		

documentation of any pain assessment done on 4/5/18. No documentation noted for R1 on 4/5/18.

A review of local hospital records radiology report dated 4/7/2018 documents R1 was assessed with a left proximal non-displaced tibial fracture.

A review of Facility's education/meeting attendance record titled Resident Transfer, The Safe Way was presented to staff on 4/8/18.

On 4/25/18 approximately 9:55 AM, V2 (Director of Nursing, DON) said if a resident complains of pain 8-10 is considered moderate pain, the nurse assigned to the resident should administer and document pain medication. a comprehensive pain assessment should be completed and a call placed to the doctor. The nurse is expected to reassess pain after medication given. If Medication administration record is blank, that indicates no medication was given.

Facility's Pain Management policy dated 4/2017 documents that pain will be monitored daily and effectiveness of intervention will be documented in the medical record. An intensity scale will be utilized to record pain levels prior to and after responses when necessary. Pain will be assessed and documented when warranted by changes in the resident's condition. Subjective pain scale with ratings from 1 to 10 provided documents 0 to 3 minor pain able to adapt to pain, 4 to 7 moderate pain that interferes with many activities, and 8 to 10 severe pain that patient is disabled and unable to function independently. A pain rated 8 documents utterly horrible comparable to child birth or a real bad migraine headache. A pain rated 9 documents excruciating unbearable, pain so intense you cannot tolerate it and demand pain killers. A pain

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 04/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYFIELD HEALTH CENTER	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
S9999	Continued From page 9 rated 10 documents unimaginable unspeakable pain that is so intense you will go unconscious shortly. According to the American Academy of Orthopaedic surgeons documents that a proximal tibia fracture causes are mostly from the result of trauma. Older persons with poorer quality bone often require only low-energy injury (fall from a standing position) to create these fractures. (B)	S9999		