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 02/29/2024

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 Investigation 2480735/IL169198	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.3210t) 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. 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 resident to meet the total nursing and personal care needs of the resident. Section 300.3210 General	S9999		

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S9999	Continued From page 1 t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. These requirements were not met as evidenced by: Based on interview and record review, the facility failed to ensure a resident was free from physical abuse. This failure affected R5 who was physically pushed by R1, causing R5 to fall and sustained a left hip fracture required emergency transfer to the hospital with surgical repair of the left hip fracture and affected R7 who was physically punched in the face by R1 causing a periorbital contusion when reviewed for resident to resident, physical assault, in the sample of 4 residents (R1, R3, R5 and R7). Findings include: 1. On 2/22/24 at 1:23 pm, R5 observed lying in bed with a left arm mold cast wrapped with bandage. R5 stated R5 just got back from hospital. R5 stated R5 had surgery on left hip and elbow due to being "hurt real bad" while showing surveyor R5's left hip surgical bandage. When asked how R5 injured left hip and elbow, R5 stated, "Someone (R1) punched me on the elevator, and I fell down." When asked the name of the "someone," R5 said R5 didn't know the name, but it was another resident with a physical description matched by R1. When this surveyor stated R1's first name, R1 stated, "Yes, it was (R1)." R5 stated this occurred "days ago." R5's Admission Record, documents, in part,	S9999		

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diagnoses of chronic obstructive pulmonary disease, anemia, pain, hyperlipidemia, vitamin D deficiency, major depressive disorder, dementia, cognitive communication deficit, and hypertension.

R5's emergency ambulance records, dated 2/19/24, V35 (Emergency Medical Services, EMS/Fire Department Paramedic) documents, in part, upon EMS staffs' arrival at the facility, R5 was found "laying supine in the elevator complaining of left leg pain" with R5 "alert and oriented x 4." Trauma assessment found "obvious deformity of the high left femur, shortening of the left leg and rotation outwards of the left leg. Nursing home staff stated, (R5) stated, (R5) was pushed by another resident (R1)" and "that's how (R5) fell." V35 documented R5's cause of injury was "assault."

R5's emergency hospital records, document, in part, R5 was brought in by ambulance after being pushed to the ground by another resident (R1) at the facility. R5's hospital radiology report for left hip X-ray (2-3 views), dated 2/17/24, documents, in part, the results of "acute, complete obliquely oriented fracture involving the left proximal femoral diaphysis."

In R5's hospital operative report, dated 2/18/24, V36 (Orthopedic Surgeon) documents, in part, in discussion with R5 prior to surgery, R5 was "able to tell (V36) (R5) is admitted for (R5's) hip fracture after being pushed at the nursing home." V36 documented, in part, V36 performed R5's surgery of a "left hip cephalomedullary nail for intertrochanteric hip fracture."

On 2/27/24 at 12:21 pm, V12 (Front Desk Receptionist) stated V12 was working on 2/17/24

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from 3:00 pm to 11:00 pm. V12 stated V12 was seated at the facility's front lobby receptionist's desk shortly after 3:00 pm. V12 heard R1 yelling, "Hurry up or I am going to push you." V12 stated, "I (V12) don't think a second went by and I heard the fall." V12 stated despite a door separating the front lobby receptionist's desk from the 1st floor elevator area, which is very close in proximity, R1 yelled "loud enough for me to hear it." V12 stated when V12 immediately got up to see what happened, V12 saw R5 on the elevator floor. R5 was screaming, "Oh, my leg, my leg." V12 stated R1 standing outside the elevator looking at R5. V12 stated nursing staff responded from the dining room which is located on the east side of the elevators. V12 ran back to the receptionist desk to call an emergency overpage code for further staff assistance. When asked how V12 recognized it was R1's voice yelling, "Hurry up or I am going to push you!", V12 stated V12 "definitely" knew R1's voice and recognized it right away. V12 stated R5's fall sound in the elevator was a "loud thud". V12 stated V12 reported this information about R1 pushing R5 to V3 (Assistant Administrator) on 2/17/24.

Facility document titled "Statement," dated 2/18/24, V12 documents, in part, "I (V12) heard (R1) screaming and saying, 'Hurry up or I'll push you.' Then I heard a loud noise. I got up and saw (R1) standing in front of the elevator and (R5) screaming on the elevator floor."

On 2/28/24 12:46 pm, V20 (Escort) stated on 2/17/24, V20 was working as activities staff in the 1st floor dining room. V20 stated R1 and R5, amongst other residents, were in the 1st floor dining room on 2/17/24 afternoon. V20 heard residents saying R5 was on the floor in the elevator. V20 stated V20 immediately responded

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to see R5 was laying on R5's back, somewhat on left side with R5's walker on its side on the elevator floor next to R5. V20 stated R1 was standing directly outside the elevator.

R1's Admission Record, documents, in part, diagnoses of paranoid schizophrenia, psychosis, restlessness and agitation, hypertension, gastro-esophageal reflux disease, vitamin D deficiency, depression, and cocaine abuse with intoxication.

R1's MDS, dated 12/23/23, documents, in part, a BIMS score of 13 which indicates R1 is cognitively intact. R1 no longer resides in the facility and was unable to be interviewed.

On 2/22/24 at 3:17 pm, V3 (Assistant Administrator) stated V3 was informed by V12 that R5 had fallen in the elevator and V12 heard R1 yelling if you don't hurry, I will push you with a few seconds later hearing a noise like a fall.

On 2/28/24 at 11:35 am, V3 stated V3 interviewed R5 on 2/22/24 and R5 stated another resident pushed R5 in the elevator. V3 stated R5 provided a physical description matched R1 with a first name very similar to R1. When asked for the conclusion of R1/R5's allegation of physical abuse on 2/17/24, V3 stated, "(R1) pushed (R5)," and R1 didn't think R1 wanted to get on the elevator with R5. When asked with the allegation of physical abuse of R1 towards R5 on 2/17/24, was this allegation substantiated, V3 stated, "Yes. (R1) did push (R5) on purpose."

On 2/28/24 at 11:49 am, V1 (Administrator) stated V1 is the abuse coordinator for the facility and has a duty "to protect all the residents in the facility." V1 stated after conducting the

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investigation with V3 about R1/R5's incident on 2/17/24, V1 can see R5 was "very sharp". V1 concluded R5 provided a "clear description" of what occurred with R1. When asked if physical abuse is substantiated, V1 stated, "That's really hard. I (V1) can substantiate the incident occurred." V1 stated V1 knows abuse is the intent to cause harm.

2. On 2/27/24 at 3:05 pm, R7 observed sitting at a table in the 1st floor dining room with other residents present at other tables. R7 stated R7 was agreeable with an interview. This surveyor observed R7's speech very slow and pronounced. R7 stated R7 doesn't remember what happened when asked about a physical incident involving R1 where R7 was hit in face in November 2023.

R7's Admission Record, documents, in part, diagnoses of chronic obstructive pulmonary disease, type 2 diabetes mellitus, epilepsy, anemia, hypertension, hyperlipidemia, osteoporosis, thyrotoxicosis, schizoaffective disorder, dementia, chronic atrial fibrillation, mild cognitive impairment, dysphagia, tachycardia, and mood disorder.

R7's MDS, dated 9/21/23, documents, in part, a BIMS score of 9 which indicates R7's cognition is moderately intact.

On 2/28/24 at 1:04 pm, V21 (Activities Aide) stated on 11/18/23 around 9:30 am, during activities program in the 1st floor dining room, V21 observed R1 walking into the dining room, talking to V21. V21 stated R7 was sitting at a table for the activities. V21 stated R1 was walking past R7 when R1 "swung and hit (R7) in the eye" with a closed fist. V21 stated V21 immediately intervened and separated R1 from

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S9999	Continued From page 6 R7. On 2/27/24 at 11:01 am, V10 (PRSA, Psychiatry Rehabilitation Services Assistant) stated on 11/18/23, V10 was walking with R1 from the 1st floor dining room. R1 heard R7's voice from a conversation with another resident, and R1 turned, going back to R7 (who was in a seated position) and punched R7 in the side of the head. When asked what did R7 do, V10 stated R7 sat there and didn't say anything. V10 stated an emergency code was paged overhead for staff assistance. On 2/27/24 at 1:21 pm, V15 (LPN) stated V15 responded to the emergency code in the 1st floor dining room on 11/18/23 due to R1 hitting R7 with a closed fist. V15 stated V15 brought R7 upstairs, performed assessment with R7 having redness to right side of face. V15 notified V37 (Attending Physician) who ordered for monitoring R7. V15 stated on 11/20/23, R7 continued to have redness on R7's right side of face with no complaints of pain from R7. V15 stated on 11/21/23, V15 noted R7's right side of face with increased redness. V15 notified V37 who ordered for R7 to be transferred to the hospital for further evaluation. R7's hospital discharge instructions, dated 11/21/23, document, in part diagnoses from R7's hospital visit as "periorbital contusion, eye injury," and "contusions are the result of a blunt injury to tissues and muscle fibers under the skin." Facility policy dated January 2023 and titled "Abuse Policy," documents, in part, "Each resident has the right to be free from abuse. Residents must not be subject to abuse by anyone, including, but not limited to ... other	S9999		

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S9999	Continued From page 7 residents ... 'Abuse" means the willful infliction of injury ... 3. 'Physical Abuse' includes, but not limited to hitting." Facility policy dated August 2022 and titled "Resident's Rights," documents, in part, "Purpose: No resident shall be deprived of any rights, benefits, or privileges guaranteed by law, the constitution of the State of Illinois, or the Constitution of the United States solely on account of his or her status as a resident of this Community, nor shall the resident forfeit any of the following rights: ... 14. The right to be free of abuse." (A)	S9999		