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 12/09/2024

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 2489127 /IL00180547	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.610a) 300.1210b) 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 care and personal care shall be provided to each	S9999		

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resident to meet the total nursing and personal care needs of the 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. (Section 2-107 of the Act)

These regulations were not met as evidence by:

Based on interview and record review, the facility failed to protect a resident's right to be free from physical abuse and mental anguish by staff and also failed to appropriately identify incident(s) of abuse. This failure affected one resident (R2) whose wrists were tied to their bed side rails using pillowcases by a facility nurse as an attempt to confine R2 in bed for the nurse's convenience. As a result, R2 experienced feelings of humiliation and despair as evidenced by being tearful as well as physical pain and discomfort in both wrists. Any reasonable person in this situation would feel humiliated and ashamed.

Findings include:

R2 is a 63-year-old, cognitively impaired resident with diagnosis that includes but not limited to restlessness and agitation, tracheostomy, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, aphasia, muscle wasting and atrophy and repeated falls.

On 11/14/24 at 2:43 pm, V6 RN (Registered Nurse) stated that the shortage (referring to facility staffing) started at the beginning of the shift (referring to CNA shift 3:00 pm to 11:00 pm). V6 stated normally the second-floor staffing is to

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have three CNAs (Certified Nurse's Aide) but only two were working. V6 stated because R2 is known for climbing out of bed and falling and the RN (V6) was busy passing medication, V6 decided to tie R2's wrists to the bedrail with a pillowcase. V6 stated R2 had become agitated when the family member who came to visit R2 left. V6 stated that they (V6) knew what they did was wrong, but it was done so R2 would not fall when there was not enough staff (referring to CNAs). V6 stated that there was no other staff involved in tying R2 down. When the surveyor asked if R2 was willing to be tied down V6 stated that R2 was not cooperative with the tying down, but V6 was busy and could not stay with R2 and supervise them. V6 acknowledge that there was no physician order in R2s chart to restraint R2 with a pillowcase or any other restraint. When asked if that is a form of abuse V6 stated "Yes, it can be abuse." The surveyor asked V6 if R2 is able to easily remove a pillowcase tied to their wrist and V6 stated "No, because both hands were tied."
On 11/14/25 at 2:51 pm, V20 CNA (Certified Nurse's Aide) stated "On 10/12/24 I (V20) was not in the building, but V21 (CNA) called me at home very upset and told me how she found R2 tied down like a dog with a pillowcase in the bed. So, I called V2 (Director of Nursing).

On 11/14/24 at 2:58 pm, V21 (CNA) stated that she witnessed R2's wrists tied to the bed side rails by use of pillowcases on 10/12/24. V21 stated she called V8 (Registered Nurse) working on the floor to see what was going on. V21 then stated that tying a resident to the bedrail with a pillowcase was a form of abuse. V21 confirmed that when she found R2, they were tearful, showing gestures for help and when she released R2's wrists from the pillowcase, R2 began

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rubbing their wrists and gesturing to pain and discomfort by use of mouth gestures. V21 also stated that R2 was grateful for V21's help and began blowing kisses and mouthing "thank you". V21 acknowledged that a reasonable person would not want to be tied down like R2 was.
V21 said, "I could not believe what I saw so I walked out and called the other nurse V8 (RN) and V25 (CNA). I also called a union representative because this traumatized me, and I was not allowed to go home because we (facility) were short of working CNAs. I had to go off the floor for a short period in the staffing lounge." V21 confirmed that she called V20 at home to talk about what happened and at that time, V20 called V2 (Director of Nursing) to report what had happened.
On 11/14/24 at 3:28 pm, V1 (Administrator) stated that the incident was marked as abuse but it was not founded to be abuse an applying the pillowcase was for safety of R2 and no injury was discovered. V1 attributed V6's action to V6 being busy with another resident and did not have other staff available to assist them (V6) in making sure R2 was supervised. Present during the interview with V1 was V22 (Nurse Consultant) who stated, "it is a form of abuse, and it should absolutely be reported to IDPH (Illinois Department of Public Health)."
On 11/18/24 at 10:42 am, V19 (Restorative Director) stated that it is not appropriate to use a pillowcase as a restraint device because it can cause psychological and emotional anguish. V19 stated, "This can cause the resident to be sad and feel isolated .....a pillowcase can block flow of blood circulation due to it not being designed for use as a restraint device." The surveyor asked V19 that in his own professional opinion can this be a form of abuse and V19 stated "Yes, it can be a form of abuse that should be reported."

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On 11/18/24 the facility staffing schedule dated 10/12/24, showed documentation that V21 was pulled from the 3rd floor to work on the 2nd floor because there was only one CNA present with two nurses at 3:00 pm.
On 11/25/24 at 2:04 pm, V1 stated that V6's action did not constitute a form of abuse because it was not unreasonable confinement. V2 (DON) who was present at the time of V1 interview stated that it was a form of abuse because the effect can be psychological/ mental anguish.
Record review of R2's medical record showed that the only way R2 can communicate with facility staff is by using R2's hands, either by writing or using hand gestures.
R2's MDS (Minimum Data Set) dated 10/18/2024 section C-cognitive patterns did not score R2's BIMS (Brief Interview for Mental Status) indicating that R2 was unable to complete the interview.
R2's medical record did not show any Plan of Care stating R2 was susceptible to abuse.
On 11/18/24 at 1:30 pm, R2 was observed in the room sitting in a recliner chair using the right hand to wipe saliva from the mouth. R2's left hand was noted with weakness; R2 was using their right hand to lift their left hand onto their lap. When asked about the incident on 10/12/24, R2 answered with thumbs down while shaking their head back and forth in a "No" gesture. The surveyor asked R2 whether R2 wanted to be tied down R2 shook the head back and forth in a "No" gesture and mouthed "NO". When asked if R2 experienced pain, R2 shook their head "Yes".
On 11/18/24 at 3:21 pm, V23 (Physician) stated that he has never heard of staff tying down a resident and will never give an order to do so. V23 stated "How can anyone do that? In 28 years of being in medicine, I know that it is not professional, and it is not right."
On 11/18/24 at 3:46 pm, V24 (Psychiatrist)

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stated, "I will never give such order. The nurse (V6) acted on their own." V24 stated "Use of mitten may be used, not a use of pillowcase. It is not good, and it should not be done, and no physician should give that kind of order. That kind of abuse it is unheard of." When asked about what can happen to a resident who is inappropriately restrained, V24 stated that it can compromise their breathing.
On the 11/25/24 facility census report for 10/12/24 presented for the 2nd floor showed that 41-residents were residing on the 2nd floor and 110 total residents residing in the facility.
On 12/04/24 at 10:14 am, V29 (PRSD/Psychiatrist Rehabilitation Services Director) stated that she is new to the facility and was not sure what happened for the nurse to tie down R2. When the surveyor asked about the 10/12/24 incident in which V6 restrained R2 with a pillowcase when the facility was short-staffed and if that can be a form of abuse, V29 stated "In my own professional opinion, yes, it will be considered abuse, and it should have been reported."
On 12/05/24 at 1:12 pm V6's time sheet presented showed that on 10 /12/24 V6 clocked in at 7:11 am and clocked out at 7:26 pm, showing that V6 worked the whole shift.

The facility Abuse Prevention Program policy presented with revised date 04 January 2018 documented that definition of abuse includes but not limited to willful infliction of injury, unreasonable confinement, pain and mental anguish. Willful as used in the definition of abuse means the individual must have deliberately, or that the individual must have intended to inflict injury or harm. The policy under external reporting documented that initial reporting of allegations documented that when an allegation

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S9999	Continued From page 6 of abuse occurred the department of Public Health's regional office shall be informed by telephone or fax. The facility policy presented titled Abuse Prevention Program Facility Policy and Procedure with revised date January 4, 2018, documented that abuse is defined as the willful infliction of injury that includes but not limited to unreasonable confinement, or punishment that is resulting in pain or mental anguish. The policy documented that Willful as used in this definition of abuse, means the individual must acted deliberately not that the individual must have intended to inflict injury or harm. (B)	S9999		