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	IL6005896	A. BUILDING: _____ B. WING _____	C 03/09/2025

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: 258198/IL186676	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the	S9999		

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resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable

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. Restorative measures shall include, at a minimum, the following procedures:

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 requirements were not met as evidenced by:

Based on observation, interview and record review, the facility failed to notify the physician of one (R1) resident of change in condition of three

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residents reviewed. This failure resulted in delaying R1's transfer to the hospital for further evaluation for a contusion and bruised right eye in a total sample of three residents.

Findings include:

R1 is a 78-year-old individual whose medical diagnosis include but not limited to: dementia in other diseases classified elsewhere, mild, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, mild intellectual disabilities, chronic obstructive pulmonary disease, unspecified, disorganized schizophrenia. MDS (Minimum Data Set) section C Cognitive function, dated Jan 8, 2025, documents R1's Brief Interview for Mental Status (BIMS) as 99/15 indicating R1 has severe cognitive impairment.

R1's MDS section GG -Functional Abilities documents R1 requires supervision or touching assistance while eating, partial/moderate assistance with oral hygiene and upper body dressing, substantial/maximal assistance with toileting hygiene, shower/bathe self, lower body dressing, putting on/taking off footwear, and personal hygiene.

Nursing progress notes dated 02/24/2025, documents:
Summary of the Fall: observes resident (R1) with raised area over right eyebrow with discoloration. R1 has raised area to right eye and broken blood vessel to right eye.

Nursing progress notes dated 02/19/2025, documents nurse to nurse report with admitting hospital stated R1 had CT(Computed Tomography) scan showed edema and hematoma and R1 was going to be admitted for

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S9999	Continued From page 3 fall and head contusion. R1's hospital record dated 2/22/2025, documents: A contusion is a deep bruise. Contusions are the result of a blunt injury to tissues and muscle fibers under the skin. The injury causes bleeding under the skin.R1 presented to the hospital with bruised or swollen eye. Fall with right sided periorbital edema. Head CT shows there is hemorrhage and edema throughout the right supraorbital and periorbital region. On 03/08/2025, at 10:43 AM, V5 (Licensed Practical Nurse-LPN) and surveyor observed R1 laying in bed. R1 was observed with a bruise on the right eye above and below the eyebrow. The bruise was below the eye and it was covering the whole lower part of the right eye from side to side. V5 described the bruise as black/reddish/purplish in color. V5 stated R1 does not get out of bed or try to get out of bed by herself and needs two staff when performing ADL (Activities of Living) care. V5 stated R1 is not able to hold the bedside grab bars to move herself and two staff move R1 from the bed to the wheelchair because R1 cannot assist with transfers. On 03/08/2025, at 2:10 PM, V8 (Licensed Practical Nurse-LPN [Former]) via phone stated she worked with R1 on 2/18/2025, on the 11:00 PM-7:00 AM shift. She was not aware R1 had a fall that day. But in the morning on 2/19/2025, before the end of her (V8) shift, she observed R1 with a bruising above and below her (R1) right eye. The bruise below R1's eye was a long line running the length of the right eye. V8 stated she did not notify R1's physician or V2(Director of Nursing) about R1's change in condition. This delayed R1's care and that is why V8 was terminated because she is supposed to notify the	S9999		

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physician as soon as a resident has a change in condition.

On 03/08/2025, at 3:00 PM, V10 (Certified Nursing Assistant- CNA [Former]) via phone V10 worked on 2/18/2025, on the 3:00 PM-11:00 PM shift but he was not assigned to R1 when R1 fell. V10 stated V9 (Former Certified Nursing Assistant) came and got V10 to come help V9 to transfer R1 back to bed. Upon reaching R1's room, R1 was sitting on the floor on her bottom. V10 stated he did not know V9 had not informed the nurse on duty that R1 had fallen and was on the floor. The facility protocol is to let the nurse know first if a resident falls before touching the resident. V10 stated he was terminated for not informing the nurse about R1's fall.

On 03/08/2025, at 3:31 PM, V4 (Licensed Practical Nurse-LPN) via phone stated she worked with R1 on 2/19/2025 on the 7:00 AM-3:00 PM shift. She went to R1's room to take her vitals around 9:00 AM and to give R1 her medications. She noticed R1's right side of the face by her eyebrow had a big knot. V4 stated she notified V2 who went and saw R1's bruise and told V4 to call 911, V13 (Nurse Practitioner) and R1's family and notify them. V4 stated 911 came, took report, and took R1 to the hospital. V4 stated during change of shift that morning, V8 did not report R1 had a knot below and above her right eye. V4 stated if a resident has a change in condition and a staff does not report it, that is neglect which is a form of abuse.

On 03/08/2025, at 4:48 PM, V1 (Administrator) stated on 2/18/2025, V9 was doing ADL (Activities of Daily Living) care for R1, and R1 fell out of the bed. V1 stated V9 ran out of the room and went to get help from V10, and V9 and V10 rushed to

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R1's room past V8 who was at the nursing station. V9 did not notify V8 that R1 fell. V1 stated on 2/19/2025, about 5:30 AM, V14 (CNA) noticed a swelling on R1's face and notified V8 but V8 did not do anything about it including notifying the physician, V2 or V13 (Nurse Practitioner). V9 left at the end of her shift at 7:30 AM.V1 stated V9 and V10 neglected R1 when they failed to notify V8 that R1 had fallen therefore V9 and V10 were terminated for failure to follow facility policy and protocol. V8 was also terminated for failure to follow facility policy when a resident has a change in condition which states the nurse notifies the physician right away. V1 stated on 2/19/2025, around 9:00 AM or 10:00 AM, V4, who was assigned to R1, noticed R1 had a swelling on the right eye. V4 competed an assessment of R1, applied a cold pack, notified V2 and V13 and called 911 to take R1 to the hospital for further evaluation.

On 03/08/2025, at 5:44 PM, V2 (Director of Nursing-DON) stated on 2/19/2025, about 10:00 AM, V4 called V2 to R1's room. When she got to R1's room, she (V2) stated "wow! what happened" because R1 had a big knot on the right forehead area. V2 stated she assisted V4 to assess R1 and put an ice pack on R1's forehead. V4 called 911, V13 and R1's family. R1 was taken to the nearest hospital and was admitted with head edema, hematoma, fall, and head contusion. V2 stated on 2/21/2025, after she completed her investigation regarding R1's injury, she notified V1 of her findings. After discussing with V1, he gave ok to terminate V8, V9, and V10 for failure to follow facility's policies and procedures on reporting falls and notifying physicians of resident change in condition. V2 stated not notifying the physician when R1 was noted to have a swelling on the forehead caused

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a delay in care and R1 could have died of the head injuries sustained during the fall. R1 is on blood thinner medications which could cause bleeding in the brain and death. V2 stated R1 did not receive the care she needed in a timely manner and could have resulted in her death.

On 03/08/2025, at 6:45 PM, V15 (Restorative Manager) stated R1 is a two person assist for transfer and for bed mobility. R1 requires a two person assist during ADLs and incontinence care for safety to prevent falls.

On 03/08/2025, at 12:45 PM, V11 (Human Resources Manager-HR) stated HR does a background check before employing a perspective employee and annually thereafter. V11 stated the supervisors/administrator lets V11 know which staff has an offence. V11 and the manager who reported the offence go through the facility's policies and procedures to determine which policy the staff violated and if the employee will be terminated. V11 stated V8, V9, V10 were terminated because they did not follow policies and procedures of the facility.

Policy titled Change in Condition dated 1/14 documents:
-Residents will receive full assessment of status change with notification to physician and immediate medical emergency care via 911 if indicated.
-Resident will be assessed by the charge nurse or nursing supervisor in response to any changes or deterioration in condition upon notification. Family and physician will be notified.

Facility Reported Incident Report -Final, dated 2/21/2025, 4:23 PM documents:
-R1 was transferred to a nearby hospital after a

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S9999	Continued From page 7 fall with "an above right eye raised area". R1 was unable to communicate what happened to her -R1's roommate (R2) was unable to state what happened to R1 -According to hospital report, R1 was admitted to hospital for fall and head contusion. -V8 (Licensed Practical Nurse-LPN), and V9, V10(Certified Nursing Assistants-CNAs) were terminated for not reporting the incident. V8's HR (Human Recourses) File documents: (A)	S9999		