

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145885	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024
NAME OF PROVIDER OR SUPPLIER Mayfield Care and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 5905 West Washington Chicago, IL 60644	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 02569</p> <p>Based on interview and record review, the facility failed to ensure a resident was free from physical and verbal abuse. This failure affected 2 (R1, R2) residents of 4 reviewed for abuse.</p> <p>Findings include:</p> <p>1. R1 is a [AGE] year old female with a diagnosis including Heart Disease, Chronic Kidney Disease, Alzheimer's, Anxiety Disorder and Repeated Falls. R1 was first admitted to the facility on [DATE]. R1 has a BIMS (Brief Interview of Mental Status) score of 2/15. R1 is non interviewable.</p> <p>Progress note dated 6/13/24 states: It was reported to Nurse that during ADL Care, V3 (CNA), was in the room assisting V4 (CNA). R1 was confused, and combative. R1 scratched V3 (CNA) and out of reflex he (V3) slapped her (R1). Notified MD, notified Abuse Coordinator/Administrator, notified Nursing Management. Sister, POA, aware of incident. Police notified/Report # JH 305102. Resident assessed for injury. Resident with no injury. Resident during assessment with no s/s to indicate pain. V/S Taken: T-97.8 P-72 R-18 B/P 122/76. Resident stable. Will continue to monitor.</p> <p>Facility abuse allegation incident report dated 6/20/24 shows that on 6/13 24 charge nurse informed administrator that there was an altercation between staff and resident. During ADL care, resident (R1) became physically combative with CNA (V3) and scratched him (V3) on his right arm. V3 inadvertently slapped R1 on the right side of her face. Nurse intervened immediately. Nurse did a full assessment with no injury noted. MD, family, and police notified. V3 sent home immediately.</p> <p>On 8/26/24 at 11:55AM V1 (Administrator / Abuse Prevention Coordinator) stated, I am the Abuse Prevention Coordinator. Per investigation and interview V3 (CNA) stated he was asked to turn R1 by V4 (CNA). V4 claimed that R1 kicked V3. Then V3 raised his hand then slapped her. When I interviewed V3 he said he was on his way home and asked to assist V4 to turn R1. R1 scratched and kicked him. V3 stated he never touched R1. I got these statements. I talked to R1. R1 has Alzheimer's and Dementia and could not be interviewed. For that reason, I went with the fact that it happened and terminated V3. I followed the Abuse Prevention Policy. R3 (roommate) was also interviewed and stated V3 did slap R1.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/28/24 at 3:30PM V4 (CNA) stated per phone, I was in the room on the other side of R1. V3 was on the other side of bed from me attempting to care for R1. R1 was combative and kicked V3. V3 then lifted up his hand and smacked her on the side of head. R1 was confused. R1 said oh he slapped me. I asked if she was ok, and she said yes. V3 was removed from the room and sent home immediately.</p> <p>On 8/26/24 at 11:41AM R3 (R1's roommate at the time of incident) stated in June I was in the room with R1. I sat up and was going to watch TV. V3 (CNA) came into the room to care for R1. R1 was kicking and kicked V3. V3 then hit the side of R1's face with his hand.</p> <p>2. R2 is a [AGE] year old female with a diagnosis including COPD, Paraplegia, Diabetes 2, heart disease and Neuralgia and Neuritis. R2 was first admitted to the facility on [DATE]. R2 was discharged home on 8/15/24. R2's BIMS (Brief Interview for Mental Status) score is 12/15.</p> <p>Progress note dated 6/19/24 states; During rounds this shift, charge nurse observed resident and male staff member having a conversation in which staff member (V6, CNA) and resident (R2) began to raise their voices. At this time charge nurse attempted to separate resident and staff member. Staff member (V6) refused to separate from resident (R2). Charge nurse called to secondary floor nurse in an attempt to diffuse the situation, both nurses attempts were unsuccessful. Staff member (V6) finally walked away to go down the hallway and resident (R2) continued to attempt to engage staff member (V6) in an argument. Attempts to inform administrator unsuccessful. DON made aware and staff member informed he needs to gather his belongings immediately and leave facility. Staff member (V6) complied and left facility without incident.</p> <p>Facility abuse investigation dated 6/20/24 shows that on 6/20/24 V6 (CNA) was accused by R2 that he came up to her and whispered into her ear and said why the f-k did you tell the V1 (Administrator) and state that I left you wet? V6 was immediately sent home. V6 was terminated on 6/20/24 related to inappropriate behavior toward a resident related to a live video recording on fxx bxx (social media) where he was observed using profanity in the discussion, he was having with R2. (According to V1, R2 was recording the conversation but it has since been erased). The conversation was inappropriate in nature because he conversed with the resident as though they were family members. They both were using profanity. However, they were not cursing each other out. It was a conversation that one would have with someone that they were familiar with. The facility concluded no abuse took place to R2. The profanity wasn't directed towards R2. The facility terminated V6 because the profane language was inappropriate.</p> <p>On 8/26/24 at 12:10PM V1 (Administrator / Abuse Prevention Coordinator) stated, On 6/20/24 staff came to me and stated you need to hear this. I opened my phone with fxx bxx (social media) and that is when I heard the evidence of profanity. V6 (CNA) approached R2 and said why the f-k did you tell the Administrator and state that I left you wet. There was an exchange between R2 and V6. A lot of profanity was being voiced by V6. I interviewed R2, she said she didn't want V6 terminated. R2 stated he always talks like that to me. This exchange was recorded on R2's phone. I told her that is not policy of the facility to allow the use of profanity in front of residents. The conversation was inappropriate in nature because he conversed with resident like they were family members. I determined this to be verbal abuse.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/26/24 at 12:14PM V7 (CNA) stated, I heard R2 and V6 (CNA) talking at R2's room. R2 was just outside her room. I heard V6 (CNA) say to R2 that he didn't do anything to her. What's wrong with her. A few minutes earlier R2 recorded on her phone the profane language used towards R2 from V6. We reported to the Administrator the incident. An abuse investigation was done and V6 was terminated for verbal abuse to R2.</p> <p>On 8/27/24 at 1:18PM V14 (LPN) stated, R2 was up around 5 in the evening around dinner time. I was passing meds. I started to hear V6 (CNA) and R2 in a verbally loud argument. I tried to separate them. V6 wouldn't listen to me. I got another nurse. She also tried to calm him down. She could not. R2 was visibly upset from V6. The DON (DON at time of incident is no longer employed at facility) arrived. The DON also could not calm V6 down. Finally, it ended and V6 was sent home immediately. I considered this verbal abuse to R2. We followed the facility Abuse Prevention Protocol. R2 was monitored for three days as a follow up. V6 is no longer employed here.</p> <p>Facility policy titled Abuse Prevention Program includes the statement, This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. To do so, the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property and mistreatment of residents.</p>		