STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145885	A. Building B. Wing	10/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mayfield Care and Rehab	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)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47304 Based on interview and record review, the facility failed to provide wound treatments for 2 (R1,R4) of 3 residents who were reviewed for wounds. The facility failed to : 1. Provide wound treatment for R1's surgical site. 2. Develop skin care plan interventions for R1. 3. Ensure wound skin assessment and Braden scale assessment completed on weekly basis for R1. 4 Provide wound treatment as ordered by physician for R4. These failures resulted in R1 being admitted to the hospital on 9/4/24 for dehiscence of the wound to groin area and R4's wound dressing not being changed daily. The findings include: R1's admission record documented admitted on 8/20/24 with diagnoses not limited to Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, Type 2 diabetes mellitus, Other obesity due to excess calories, Essential (primary) hypertension, Hyperlipidemia, Angina pectoris, Other specified anemia, Atherosclerotic heart disease of native coronary artery, Peripheral vascular disease, Encounter for other specified surgical aftercare, Depression, Other abnormalities of gait and mobility, Other lack of coordination. R4's admission record documented admitted on 3/14/23 with diagnoses not limited to Central Cord syndrome at C5 level of cervical spina cord, Chronic Obstructive Pulmonary Disease, Retention Of Urine, Mild Protein-Calorie Malnutrition, Pressure Ulcer Of Right Hip Stage 4, Pressure Ulcer Of Right Heel Stage 3, Pressure Ulcer Of Other Site Stage 4, Non-Pressure Chronic Ulcer Of Skin Of Other Sites With Unspecified Severity, Anemia Due To Enzyme Disorder, Peripheral Vascular Disease, Acquired Absence Of Left Leg Above Knee, Atherosclerosis Of Native Arteries Of Left Leg With Ulceration Of Other Part Of Foot, Non-pressure Chronic Ulcer Of Other Part Of Left Foot With Fat Layer Exposed. R1's progress notes dated 9/4/2024 documented in part: Resident went out on appointment with escort. Resident was being admitted for dehiscence of the wound to groin area. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145885	A. Building B. Wing	10/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mayfield Care and Rehab	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)
F 0684 Level of Harm - Actual harm Residents Affected - Few	MDS (Minimum Data Set) dated 8/27/24 showed R1's cognition was moderately impaired. She needed set up or clean up assistance with upper body dressing; Supervision or touching assistance with toileting and personal hygiene, shower / bathe self; Partial / moderate assistance with lower body dressing, chair / bed, and toilet transfer. MDS showed R1 had surgical wound. R1's wound / skin assessment dated [DATE] documented in part: Lt Inner Thigh measuring 4.5 x 1.5 x 0.1cm with light serosanguinous drainage. R1's Admission History and Physical notes dated 8/21/24 documented in part: Patient underwent Left femoral above to the knee popliteal bypass with Graft. ENCOUNTER FOR OTHER SPECIFIED SURGICAL AFTERCARE - Monitor and change surgical site as per facility protocol. On 10/06/24 at 10:11am Interview with V3 (Wound care nurse, Licensed Practical Nurse / LPN) stated she started working in the facility in July 2024. She said resident's skin condition is checked upon admission and if there is skin alteration such as pressure, non-pressure or surgical wounds, assessment and documentation should be done weekly as it would give information about the wound that include drainage, measurement, treatment, and status of the wound. Any skin alteration, need to have a treatment in place. Treatment will make the wound healed and prevent infection. If there is no wound treatment, could lead to infection, necrosis, worsening of wound. Braden scale assessment is to identify if the resident is at risk for skin breakdown. It is done upon admission / readmission x 4 weeks then quarterly and significant change. Reviewed R1's electronic health record (EHR) with V3 and stated R1 was admitted with surgical site to her left inner thigh related to poor circulation. R1 had stent placement - Left femoral popliteal bypass. She said assessment was done on 8/21/24, showed surgical site on left inner thigh with sutures in place with moderate serosanguinous drainage. She said Treatment: Border gauze dry dressing every Monday, Wednesday, Friday and as needed. Upper part of the left groin area site was closed. She said surgical sutures are dissolvable. Stated standard of practice, treatment order should be in the POS (physician order sheet) and reflected in the TAR (treatment administration record), should be signed after each treatment. If not documented, treatment was not done or provided. R1 went out for a doctor's appointment and was directly admitted to the hospital. Diagnosis: Worsening / Dehisce of the wound on the left groin area. V3 said, she was not aware that wound on left groin area re opened. It was a closed wound that re open. Reviewed R1's POS and TAR with V3 and said did not see treatment order for left groin and left inner thigh surgical wound. Weekly skin wound assessment completed on 8/21/24. She said there should have another documentation on 8/28/24 but was not completed. On 9/4/24, R1 went to the hospital so weekly skin wound assessment was not completed. She said surgical wound should have a care plan that would include interventions to provide guidance for the staff on how to care for the resident. Reviewed R1's skin care plan with V3, no intervention found. Braden scale was completed upon admission on 8/20/24. None for 8/27/24 and 9/3/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145885	A. Building B. Wing	10/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mayfield Care and Rehab	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)
F 0684 Level of Harm - Actual harm Residents Affected - Few	At 12:19am Interview with V2 (DON) stated if resident has a surgical wound, assessment and documentation should be done weekly, it is a reference regarding the status of the wound. Care plan should include interventions and goals to help staff how to care for resident. There should be a treatment order for every wound and can be found in POS (Physician Order Sheet), TAR (Treatment Administration Record), or MAR (Medication Administration Record). After treatment was provided TAR should be signed or documented. Nursing standard practice, if it was not documented then it was not done. If treatment is not done or provided could possibly lead to wound deterioration / worsening / decline in the status / wound infection. She said on 9/4/24, R1 went out for doctor's appointment and was directly admitted to the hospital due to wound on groin area. She said there was an odor in the room. Not sure where the odor was coming from. Did not see R1's wound. She said the wound nurse saw R1 and odor was not from the wound. Stated R1 has a sister working as a CNA (V18) in the facility. On 10/7/24 at 9:07am Interview with V18 (CNA/Certified Nursing Assistant) stated she has been working in the facility for over a year. She said R1 is her sister who had a surgery, stent was placed on her left leg. It was inserted to the groin down to the leg. R1 has 2 surgical sites, on left groin and left inner leg. She said R1's surgical wound was not properly taking care of. She escorted R1 on 9/4/24 for Doctor's appointment and she could smell the odor. She said the doctor checked the surgical sites on left groin area and it got infected. The doctor said that R1 needed to go back to the hospital to clean up the infection. She said from appointment, R1 was directly admitted to the hospital. She said R1 was placed in ICU (Intensive Care Unit), tracheostomy tube and G-tube were inserted. R1 is still admitted in the hospital. At 9:33am Interview with V17 (Nurse Practitioner / NP) stated he was not able to fully recall R1 and reviewed R1's EHR and stated patient underwent Left femoral above to the knee popliteal bypass with Graft. V17 stated he did not see the surgical sites. He assumes that there would be a surgical incision on left groin area where stent was inserted and should be monitored. Wound care should notify the wound specialist for any changes. Treatment care would depend on the assessment of would care. He said any surgical site, nursing should make sure that a daily skin check is done. He said surgical site is a vulnerable area - it would not expect any dehiscing process. Never seen dehisce surgical wound before from stent placement. V17 stated he does not know the events that happened why the surgical wound had dehisced. No wound assessment found for Left groin surgical incision in R1's EHR. No weekly skin assessment found on 8/28/24 and 9/4/24 for R1's left inner thigh surgical site. R1's POS, MAR and TAR for August and September 2024 reviewed, no treatment order for left inner thigh / left groin surgical site. R1's care plan dated 8/21/24 documented in part: The resident has potential / actual impairment to skin integrity. No interventions documented / found. R1's Braden assessment dated [DATE] and 9/4/24 with lock date on 9/8/24 and 9/9/24 respectively showed low risk for skin breakdown. No Braden assessment found on 8/27/24 and 9/3/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145885	A. Building B. Wing	10/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mayfield Care and Rehab	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)
F 0684 Level of Harm - Actual harm Residents Affected - Few	On 10/6/24 at 11:54am R4 was observed lying in bed, alert, and oriented x 3, verbally responsive, no odor. Air mattress in placed. R4 stated his wound dressings should be changed daily, but they are not being done. He said wound treatment is done thoroughly every Wednesday when the wound doctor is here in the facility. R4's TAR: Right hip and buttock: Cleanse with Dakins then pack wound loosely with dakins wet to dry, cover with border gauze one time a day and as needed. Treatment was not signed as provided on 8/16/24, 9/24/24 and 9/25/24. MDS dated [DATE] showed R4 was cognitively Intact. Dependent with ADLs. MDS showed 2 Stage IV pressure ulcers, 2 venous and arterial ulcers present. R4 Care plan Update Review on 9/11/24 showed: Treatment to wounds as directed. Facility's surgical wound care policy dated 4/2023 documented in part: To establish clear guidelines for the care, management, and monitoring of surgical wounds to minimize the risk of infection, promote optimal healing and ensure patient safety. All surgical wounds must be assessed and documented upon admission, after surgery and during each dressing change. Comprehensive wound documentation must be completed after each assessment and dressing change. In patients with co-morbidities such as diabetes, obesity or immune-compromised states, more frequent wound assessment and specialized care may be required. R4's TAR: Right hip and buttock: Cleanse with Dakins then pack wound loosely with dakins wet to dry, cover with border gauze one time a day and as needed. Treatment was not signed as provided on 8/16/24, 9/24/24 and 9/25/24. MDS dated [DATE] showed R4 was cognitively Intact. Dependent with ADLs. MDS showed 2 Stage IV pressure ulcers, 2 venous and arterial ulcers present. R4 Care plan Update Review on 9/11/24 showed: Treatment to wounds as directed. Facility's surgical wound care policy dated 4/2023 documented in part: To establish clear guidelines for the care, management, and monitoring of surgical wounds to minimize the risk of infection, promote optimal healing and ensure patient safety. All surgical wounds must be assessed and documented upon admission, after surgery and during each dressing change. Comprehensive wound documentation must be completed after each assessment and dressing change. In patients with co-morbidities such as diabetes, obesity or immune-compromised states, more frequent wound assessment and specialized care may be required. Facility wound treatment procedure (undated) documented in part: Apply treatment as ordered. Document. Facility's skin inspection and reporting policy dated September 2024 documented in part: All changes in resident's skin must be documented in the EHR (electronic health record) care will be updated.