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	12/09/2024

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30279 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. This was identified as an immediate jeopardy which begin on 10/12/24 at 3:00pm when V6 RN (Registered Nurse) tied R2 with pillowcase to the bed side rails. V1 (Administrator) was informed of the immediate jeopardy and template was presented 11/25/24 at 2:17 pm. The immediate jeopardy was removed on 11/28/24 at 3:36 pm. However, the deficiency remains at the second level of harm until the facility determine the effectiveness of the implementation of the removal plan. Findings include: R2 is a [AGE] 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. (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: 145885	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/09/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0600

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

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 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 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.

(continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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 [AGE] 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) 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. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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 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. The surveyor confirmed on 12/04/24 and 12/05/24 through observation, interview, and record review that the facility took the following actions to remove the Immediate Jeopardy: the facility completed all measures on the abatement plan. Therefore, the abatement plan could be approved on 11/18/24. 1. R2 screened, reassessed for risk for abuse with care plan interventions. 2. All staff in-serviced training completed on 11/26/24 by V1, V2 and V29. 3. Documentation showed that all residents were re-educated on abuse with completion date of 11/26/24. 4. R2, R14, R15, R16, R17, R18, R19 and R20 were screened for potential abuse with care plan reviewed and initiated. 5. All staff will be responsible for monitoring residents for behavior that can make them vulnerable for abuse. 6. All residents determined to be vulnerable or those that will be affected by this deficiency citation R2, R14, R15, R16, R17, R18, R19 and R20 were identified, and plan of care initiated, with ongoing, on admission, quarterly and annually. 7. Review Quality Assurance audit tool started on 11/27/24 weekly ongoing to ensure compliance.

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30279 Based on interview and record review, the facility failed to assure that residents are free of unnecessary physical restraint(s), failed to identify the specific medical symptoms warranting the use of physical restraint(s) and failed to obtain physician orders with medical justification for physical restraint(s). This failure affected R2 whose wrists were tied to the bed side by a pillowcase by a nurse with no physician order, no consent or resident permission, and no medical justification. Any reasonable person in this situation would feel humiliated and ashamed. This was identified as an immediate jeopardy which begin on 10/12/24 at 3:00pm when V6 (Registered Nurse) tied R2 to their bedside rails with a pillowcase. V1 (Administrator) was informed of the immediate jeopardy and template was presented 11/25/24 at 2:17pm. The immediate jeopardy was removed on 12/3/24 at 3:29 pm. However, the deficiency remains at the second level of harm until the facility determine the effectiveness of the implementation of the removal plan. Findings include: R2's medical record Admission Record showed documented that R2 was admitted originally to the facility on [DATE] with latest admission on 11/14/24. Listed diagnosis includes but not limited to Tracheotomy status, restlessness and agitation, hematemesis, Type 2 diabetes mellitus with hyperglycemia, hemiplegia and hemiparesis following cerebral infarction affecting left dominant side, acute and chronic obstructive pulmonary disease, acute and chronic respiratory failure with hypoxia, and repeated falls. 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 documentation of medical symptoms or behavior that would justify the use of restraint, no physician order for restraint usage, no restraint assessment, no consent, and no plan of care for restraint usage. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 11/14/24 at 2:43pm, V6 (Registered Nurse) stated that there was staffing shortage for CNAs that started at the beginning of the shift (referring to 3:00pm to 11:00pm shift on 10/12/24). V6 stated that normally the second-floor staffing is to have three CNAs, but only two were working. V6 stated Because R2 is known for climbing out of bed and falling and I (V6) was busy passing medication and taking care of other residents that were screaming and yelling, I (V6) decided to tie R2's hands with a pillowcase to prevent R2 from falling. I know what I've done is wrong, but it was done so R2 will not fall when there was not enough staff . When asked about the daily staffing for 2nd floor, V6 stated there should be two nurses and three CNAs (3pm to 11pm shift). When the surveyor asked for any medical justification like R2 trying to remove the tracheostomy tube or the oxygen, V6 stated that R2 was not trying to remove the tracheostomy tube or the oxygen, but was just trying to climb out of bed. V6 stated, R2 became restless and agitated because the family (V41) came to visit R2, and V41 (family member) had just left. V6 confirmed that R2 did not have any physician order(s) for restraint and that R2 was tied at the beginning of the shift. V6 also confirmed that before V6 could return to check on R2, V21 (CNA) discovered that R2 has been tied down. When the surveyor asked whether 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 and supervise R2. V6 stated, I know that is not a restraint device but tying R2 down is a form of restraint that was not ordered. V6 stated, I did not want R2 to fall. The surveyor then asked whether restraints is a part facility intervention for falls and can R2 free self from the restraints without injury. V6 stated I should not have tied R2 down, and it is not part of intervention for fall prevention. On 11/14/24 at 3:28pm, when this was brought to V1 (Administrator) attention, V1 stated that applying the pillowcase was for safety of R2 and no injury was founded. V1 attributed V6's action to V6 being busy with another resident and did not have other staff available to assist him (V6) in making sure R2 is stabilized not fall. On 11/25/24 at 2:26 pm, V2 DON (Director Of Nursing) stated that the nurse (V6) should not have used a restraint on R2 and if this was left to her she would have terminated V6 but V1 (Administrator) prefers for this situation to go through them first. V2 confirmed that the situation with R2 was an unnecessary use of restraint. R2's medical record showed no recorded documentation that R2 had prior to 10/12/24, or after, any physical restraint assessment performed by the facility. There also was not any consent obtained from R2 or a resident representative, either written or verbal for the use of physical restraints. There was also no medical justification for physical restraints documented in R2's medical record. R2's care plan for communication initiated 07/15/2024 and revised on 08/05/2024 showed that R2 is non-verbal and can only communicate with staff using a writing pad and pen as well as using hand or mouth gestures. When the surveyor asked R2 about how R2 feels about being tied with pillowcase. R2 responded with hand gestures showing a thumbs down and shaking the head to gesture No. R2's medical record, Risk for Falls assessment dated [DATE] showed that R2 scored 18 and under category deemed to be at a moderate risk for falls. (continued on next page)

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Facility in-house investigation report on 10/12/24 documents in part: Staff witnessed R2 tied up to the bed side rails with a pillowcase by V6 (Registered Nurse). As a result, R2 experienced psychosocial impact that was described as crying for help and tearful. V6 stated R2 was agitated and restless and because there was not enough staff working at the time of the incident he tied R2 with the pillowcase. V6 stated that he was busy with other residents and could not supervise R2. V42 (Director of Rehabilitation services) statement dated 10/16/24 with no date of incident and interview. V42 wrote I (V42) was not present at the time of incident but R2 was in therapy due to having multiple falls out of bed. V42 documented in part in the statement that whenever R2 is trying to get out of bed he can usually redirect R2 and that R2 can usually tell of the needs through on-verbal communication. V42 further stated that R2 likes to have a towel to clean up saliva the mouth/trach (Tracheostomy) and R2 can become anxious if (R2) does not have one. V8's statement documentation dated 10/12/24 documented that on 10/12/24 at 6:10 pm when (V21 CNA) called her (V8 RN) to R2's room the room was dark and when the light was turned on, she (V8) observed R2's left, and right wrist tied with pillowcase. On 11/18/24 at 10:40 am, V19 (Restorative Director) stated that the facility is a restraint free facility therefore no physical restraint should be used on any of the resident and if there is justification for emergency usage for the restraint there must be a physician order immediately after or within eight hours of use. V19 stated that the resident must be placed on 1:1 staff supervision for safety reasons and it is not appropriate to use a pillowcase as a restraint devise because it can cause psychological/ psychological emotional anguish. V19 stated that this can cause the resident to be sad and isolated. And a pillowcase can cause flow of blood circulation due to it not designed to be used as a restraint device. R2's medical record did not show any documentation of medical symptoms or behavior that justify use of restraint, no physician order for restraint usage, no restraint assessment, no consent, and no plan of care for restraint usage. R2's medical record review showed that the only way of R2 communicating with facility staff is by using writing or using mouth and hand gestures. R2's medical record showed no recorded documentation that R2 before 10/12/24 and after had any physical restraint assessment done. There was no consent obtained either written or verbal. R2 was not informed. No physician order, no psych-evaluation and no medical justification for the use of restraints. 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 while R2 was using the right hand to lift the left hand unto the lap. When asked about the incident on (10/12/24). R2 answered with thumbs down and shaking the head that it was bad. The surveyor asked R2 whether R2 wanted to be tied down R2 shook the head and with lip movement to gesture NO. R2 indicate with yes that it was painful. R2's medical record risk for Falls assessment dated [DATE] record that R2 scored 18 and under category deemed to be at a moderate risk for falls. On 11/18/24 at 3:21 pm, V23 (Physician) stated that he has never heard of staff tying down a resident with a pillowcase and will never give an order to do so. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 11/18/24 at 3:46 pm, V24 (Psychiatrist) stated, I will never give such order, V6 acted on their own. V24 stated that use of mitten may be used in a hospital but not a use of pillowcase. V23 stated it is not good and it should not be done, and no physician should give that kind of order, it is a kind of abuse it is un-heard off. When asked about what can happen to the resident. V24 stated that it can compromise R2's breathing. V24 stated, No, I did not give that order because there is no such thing in physician book for a staff to tie up a resident with a pillowcase. On 12/04/24 at 10:36 am, interview conducted with V8 (Registered Nurse) regarding the incident of 10/12/24 where R2 was tied down to the bedside rails with pillowcase. The surveyor asked if R2 was able to remove the pillowcase if R2 wanted to and if it was easily removable. V8 stated No, R2 would not be able to remove the pillowcase. I reported it to V2 (Director of Nursing). Surveyor asked why did V8 report the incident, V8 said that they did because it was wrong and it was abuse. Surveyor asked if V8 ever tied any of the resident up like that, V8 said No, that will be abusive. With any restraint use, we must get a doctor's order and monitor the resident. The restraint is not necessary and the purpose of pillowcases is to be used for pillows, it should not be used as a restraint. The incident happened around 5:30 pm and R2 was happy to be released. This is restraint free facility. When asked what was R2's reaction to what happened. V8 stated that R2 was using hand gestures to thank us. V8 also said that a reasonable person would not have liked to be tied down and it is wrong to do that and no one would like to be tied down. On 12/04/24 at 1:00pm, V19 (Restorative Director) stated that I V19 returned to work 12/02/24 and is still auditing the residents records. V19 stated that the facility is a restraint free facility and that safety belt, medical recliners, side rails and mittens are forms of restraint devices, but the facility does not use restraints. V19 stated that medical recliners are used for positioning and comfort for poor trunk control All those things listed that V6 (RN) did not follow with R2. On 12/04/24 at 2:06 pm, V25 CNA (Certified Nurse Aide) stated that she worked 3pm to 11pm on 10/12/24. V25 stated, at the beginning of the shift when making rounds, R2 kept trying to get out of bed and the V6 (Registered Nurse) came in R2's room and stated he will stay in the room with R2. V25 stated, I (V25) was doing my rounds. Dinner trays came and the other CNA (V21) was passing the dinner trays when she saw R2's arm restrained to the bed rails. V21 told me to come and look and I saw R2's hands tied with pillowcases to the bed rails. R2 was just lying there on the bed. When V25 was asked about what a reasonable person would like and if would R2 liked to be tied down to the bed rails, V25 stated No. On 12/05/24 at 1:12 pm V6 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 procedure for the use of Physical Restraint:Exception for emergency Situations documented that after less restrictive interventions to prevent the resident from serious harm have proven ineffective, determined the need for an emergency physical restrain. This determination may be made by the nurse. Under emergency authorization documentation documented that approval for the use of emergency physical restraints must be made by attending physician , the medical director or a supervisory nurse.if approval is given by a nurse , a physician's order must be received within eight (8) hours, validating the supervisory nurse's decision. Physician orders regarding emergency physical restraint placement may be taken by telephone or fax machine. (continued on next page)

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility Fall Prevention policy presented with revised date 12/20/22 documented that based on the result of the falls assessment, the Inter disciplinary team will determine the best approach to implement for fall prevention, adjust the care plan, inform the family and resident and implement comprehensive fall prevention management approach. The facility titled Restraints Policy presented with revised date 9/17 documented under policy statement that in accordance with federal and state laws has a stringent policy regarding the use of physical and chemical restraints on resident. Our philosophy (Facility) of providing residents with the highest possible quality of care and life is reflective of our belief that is essential for our residents to maintain their dignity and independence by being permitted to take the normal risks of everyday life. For these reasons and in accordance with federal and state laws, restraint use in our facility will only be considered to treat a medical symptom/condition that endangers the physical safety of the resident. Listed procedures includes but not limited to with a physician order, with consent of the resident (or legal representative); when the benefits of the restraint outweigh the identified risks. If the restraint use is deemed necessary, the goal will be to use the least restrictive type of restraint for the shortest period possible. On 12/04/24 and 12 /05/24, the surveyor made observations, conducted interviews, and received documentation to confirm the following removal plan was initiated. 1. All staff were trained on what constitute proper training, unnecessary use of restraint, with ongoing training scheduled Quarterly by V29 and completed on 11/28/24. 2. All residents have been assessed to ensure that none are restrained improperly or unnecessarily by V19. 3. Assessment will be ongoing and conducted at admission, quarterly and annually 4. Outside consultant and V2 and V29 conducted in-service training on behavior management. On 11/27/24 and 12/05/24. 5. Documentation showed all the facility residents were in-service on abuse and restraints by V29. 6. R2, R14, R15, R16, R17, R18, R19 and R20 were care planned/interventions with potential for abuse and proper restraints related to their diagnoses. 7. A system put in place for audit to be done weekly to ensure compliance with unnecessary use of restraint to be monitored by V1, V2 and V29.

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 12/09/2024
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)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 30279 Based on interview and record review the facility failed to immediately report an alleged abuse for one three residents (R2) in the sample reviewed for abuse. This failure affected R2 who was tied up to the bedside rails with pillowcase and this was not reported to IDPH (Illinois Department of Public Health). This has the potential to affect all 39 residents residing on the 2nd floor of the facility. Finding include: On 11/14/24 the facility in-house investigation documented that on Saturday, October 12, 2024, the writer V1 (Administrator) received a phone call informing (V1) that a Nurse (Referring to V6 RN (Registered Nurse) had tied a resident (R2) to the siderail of the bed with a pillowcase. The DON (Director of Nursing) who reported this alleged incident sent the nurse (V6) home pending investigation. V1, wrote that based on known facts from medical records review and interviews conclusion has been determined about allegation of abuse indicating that there was an alleged abuse. On 11/14/24 at 2:30 pm, when the surveyor asked whether this alleged incident was reported to IDPH, V1 (Administrator) stated this allegation of abuse was not reported because in conclusion the allegation of abuse was un-founded and there was no injury.The surveyor then asked whether any allegation of abuse should be reported V2 stated yes, any allegation of abuse should be reported. During the same conference, V2 DON (Director of Nurse's) and V22 (Nurse consultant) who were present at the time of interview was asked about the incident reporting to IDPH. They both stated that it should have been reported. As at 11/14/24 at 3:30pm, the facility did not present any documentation that this incident has been reported to IDPH. On 11/18/24 at 9:50am, V1 presented documentation that the initial report was sent to IDPH at 6:28pm. Showing that it was reported 32 days after the alleged abuse incident. 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. The facility policy on Abuse Prevention Program documented under external reporting initial reporting of allegations that when an allegation of abuse has occurred the Department of Public Health's regional office shall be informed by telephone or fax and that it is being investigated. This report shall be made immediately but not later than two hours after the allegation is made with injury and within 24 hours if the events that cause the allegation do not involve abuse and did not result in serious bodily injury. Under five -day final investigation the policy documented that after complete written report of conclusion of investigation, including steps the facility has taken in response to the allegation, will be sent to the Department of Public Health. This guideline was not followed.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 30279 Based on observation, interview, and record review the facility failed to ensure that treatment cart and resident medication was not left at the bedside un-attended when not in visual proximity of the nurse and not in use to prevent tampering and accidental hazard. This failure affected R4 whose inhaler was left at bed side over bed-table visible to the hallway and treatment cart left unlocked and un-attended in the hallway. This has the potential to affect all the 39 residents residing on the 2nd floor of the facility. Findings include: On 11/13/24 at 10:32 am R4 was noted sitting on the bed and visible to the hallway, an inhaler was observed on the over-bed side table. R4 stated that's mine, I use it. It helps me to breath. The inhaler Symbicort 160mcg/4.5 not in manufacturer's container and no pharmacy label. On 11/13/24 at 10:35 am, when shown to V8 RN (Registered Nurse). V8 stated the inhaler is for R4 and R4 can self-medicate. The surveyor asked V8 whether R4 has an order to do so. V8 said let me check. On 11/13/24 at 10:40 am, V8 checked and stated I (V8) am supposed to give it to R4. When asked to show the surveyor the physician order in the EMAR (Electronic Medication Administration Record) and the EPOS (Electronic Physician Order Sheet). R4 has an order for Symbicort 80mcg/4.5 and no order for the 160mcg/4.5. V8 could not provide any physician order for R4 to keep the inhaler at bedside and self-administration. V8 stated, R4 is not in any self-administration program. When asked if R4 got the inhaler this morning as scheduled, V8 stated I did not give (R4) any inhaler yet. MAR showed the medication has been administered. On 11/13/24 at 11:00 am, when this observation was brought to V2 DON (Director of Nurse's) and was asked about the facility policy on medication administration and self-administration program. V2 stated, unless the physician orders the medication it should not be administered or left at bedside. V2 stated, R4 is not in self-administration program because there was no order for it. V2 stated, R4 should not be self-administering any medication, the medication found is at a stronger dose and side-effects can include tachycardia or respiratory distress. V2 stated, any medication ordered to be kept at bedside are kept locked in the drawer. V2 stated, that the staff are to make rounds every two hours, but it ended up been every hour because the nurses and the CNAs alternate the hours. The staff are to check for anything abnormal and if any medication is found at the bedside, I am expecting them to bring it to the nurses. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/13/24 at 2:00pm, on the 2nd floor the treatment cart noted un-locked un-attended and not in visual proximity of the nurses. When this observation was shown to V8 RN (Registered Nurse) V8 stated we just forgot to lock it. When the surveyor asked about the facility policy on medication/treatment cart storage, V8 stated, it should be locked (referring to the treatment cart) period. At 2:12 pm, When V2 was made aware of the surveyors' observation and was asked about the facility policy on medication storage and treatment cart. V2 stated that if the treatment cart or the medication cart is not with the nurses or in view of the nurse, it must be locked. V2 stated, only the nurses should have access to the key and should go into the cart and by leaving it un-locked the residents can get into the cart. V2 stated that it is a safety issue. The facility policy for self-administration of medication presented with revised date 4/24 documented that each resident has a right to self-administer drugs unless the interdisciplinary team and the resident's physician have determined for each resident that this practice is safe. The facility Medication Administration and storage policy presented with revised date 07/02/18 documented that the policy is to ensure medications are administered and stored in accordance with Standard of Practice. Listed procedures includes but not limited to no medication may be given without a physician's order. A nurse may not write the name and/or strength of the medication on the label. Should the pharmacy fail to label it properly, the drug should be returned to the pharmacy for proper labeling. Self-administration of medications by resident is permitted only when the resident has been assessed and is capable of self-medication administration and a physician order has been written for self-administration.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 30279 Based on interview and record review the facility failed to ensure that there was sufficient staff on duty to meet resident's needs. This failure affected R2 was known to need adequate supervision for trying to get out of bed without help and who was tied to bed rails due to facility short staffing. This failure has the potential to affect all 39 resident residing on the 2nd floor of the facility. Findings include: The facility in-house investigation documented that on Saturday, October 12, 2024, the writer V1 (Administrator) received a phone call informing (V1) that a Nurse (Referring to V6 RN (Registered Nurse) had tied a resident (R2) to the siderail of the bed with a pillowcase. The DON (Director of Nursing) who reported this alleged incident sent the nurse (V6) home pending investigation. V1, wrote that based on known facts from medical records review and interviews conclusion has been determined about allegation of abuse indicating that there was an alleged abuse. 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 floor and 110 total residents residing in the facility. On 11/14/24 at 2:43pm, V6 stated that the shortage started at the beginning of the shift. V6 stated normally the second-floor staffing is to have three CNAs (Certified Nurse's Aide) but only two were working. V6 stated, because R2 is known for climbing out of bed and fall and he (V6) was busy passing medication and taking care of other residents that were screaming and yelling. V6 stated, he decided to tie R2's hands with a pillowcase. V6 stated, I know what I've done is wrong, but it was done so R2 will not fall when there was not enough staff (referring to CNAs). When asked about the normal daily staffing for 2nd floor, V6 stated that there should be two nurses and three CNAs, but it was two nurses and one CNA at the beginning of the 3 pm to 11 pm shift because the CNAs works 3 pm to 11 pm and the nurses shift is 7 am to 7 pm. On 11/18/24 at 3:55 pm, the facility daily staffing sheet and assignment sheet presented showed that two nurses and two CNAs were scheduled to work on the 2nd floor. V2 DON (Director of Nurse's) stated that normally there should be five staff, two nurses and three CNAs but there was a call off. When V2 was asked about the facility preparation in anticipation for call offs. V2 states, the facility staff will be asked to volunteer to work overtime or call the agency services, but this happened on a weekend shift. V2 stated, on a weekend it is difficult to get replacement. The facility Staffing policy for nursing department documented that the purpose of the policy is to ensure adequate staffing levels and skills mix to deliver high-quality, person-centered care in compliance with federal and state regulations. This policy applies to all nursing staff, including RNs (Registered Nurse, LPN (Licensed Practical Nurse), and CNAs (Certified Nursing Assistants). Under scheduling the policy documented that a designated nurse will be on-call for emergencies when additional staffing is required.