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	03/09/2025

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** 45111 Based on observation, interview and record review, the facility failed to notify the physician of one (R1) resident of change in condition of three 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 [AGE] 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 [DATE], documents R1's Brief Interview for Mental Status (BIMS) as ,d+[DATE] 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 [DATE], 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 [DATE], 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 fall and head contusion. R1's hospital record dated [DATE], 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. (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

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On [DATE], 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 [DATE], at 2:10 PM, V8 (Licensed Practical Nurse-LPN [Former]) via phone stated she worked with R1 on [DATE], on the 11:00 PM-7:00 AM shift. She was not aware R1 had a fall that day. But in the morning on [DATE], 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 physician as soon as a resident has a change in condition. On [DATE], at 3:00 PM, V10 (Certified Nursing Assistant- CNA [Former]) via phone V10 worked on [DATE], 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 [DATE], at 3:31 PM, V4 (Licensed Practical Nurse-LPN) via phone stated she worked with R1 on [DATE] 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 [DATE], at 4:48 PM, V1 (Administrator) stated on [DATE], 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 R1's room past V8 who was at the nursing station. V9 did not notify V8 that R1 fell . V1 stated on [DATE], 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 [DATE], 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. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On [DATE], at 5:44 PM, V2 (Director of Nursing-DON) stated on [DATE], 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 [DATE], 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 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 [DATE], 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 [DATE], 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 ,d+[DATE] 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 [DATE], 4:23 PM documents: -R1 was transferred to a nearby hospital after a 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: (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	V8's Employee Termination Form dated [DATE], documents: -V8 was terminated for gross misconduct, not reporting a resident (R1 change in condition). R8's Employee Report dated [DATE] documents: -V8 failed to follow facility policy and procedures by not notifying provider of resident's change in condition. V9's HR (Human Recourses) File documents: V9's Employee Termination Form dated [DATE], documents: -V9-Gross misconduct- not reporting a fall, dishonesty, or theft V9's Employee Report dated [DATE] documents: -V9 failed to follow facility policy and procedure; did not report a resident (R1) fall to supervisor. V10's HR (Human Recourses) File documents: V10's Employee Termination Form dated [DATE], documents: -V10-Gross misconduct- not reporting a fall, dishonesty, or theft V10's Employee Report dated [DATE] documents: -V10 failed to follow facility policy and procedure; did not report a resident (R1) fall to supervisor. Facility policy titled -Fall Prevention Policy dated [DATE], documents: -If a resident experiences a fall, nursed will complete an incident report and document the fall in the resident record as well as the 24-hour report. Facility policy titled Change in Condition dated ,d+[DATE], documents: -Resident will receive full assessment of stats change with notification to physician and immediate medical emergency care via 911 in 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.