### Statement of Deficiencies and Plan of Correction

**NAME OF PROVIDER OR SUPPLIER**

**MAYFIELD HEALTH CENTER**

**STREET ADDRESS, CITY, STATE, ZIP CODE**

**5905 WEST WASHINGTON**

**CHICAGO, IL 60644**

**DATE SURVEY COMPLETED**

<table>
<thead>
<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<tbody>
<tr>
<td>F 000</td>
<td><strong>INITIAL COMMENTS</strong></td>
<td>F 000</td>
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<td>Annual Recertification</td>
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<td>Complaints Investigation:</td>
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<td></td>
<td>1989450 / IL118671 - No deficiency</td>
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<td>2080253 / IL119093 - No deficiency</td>
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<tr>
<td>F 550</td>
<td><strong>Resident Rights/Exercise of Rights</strong></td>
<td>F 550</td>
<td></td>
<td>1/31/20</td>
</tr>
<tr>
<td>SS=D</td>
<td>CFR(s): 483.10(a)(1)(2)(b)(1)(2)</td>
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<td></td>
<td>§483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.</td>
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<td>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.</td>
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<td>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.</td>
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<td>§483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.</td>
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<td>§483.10(b)(1) The facility must ensure that the</td>
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**LABORATORY DIRECTOR’S OR PROVIDER/SUPPLIER REPRESENTATIVE’S SIGNATURE**

**TITLE**

**DATE**

Electronic Signed

01/31/2020

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.
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<tr>
<td>F 550</td>
<td>Continued From page 1 resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.</td>
<td>F 550</td>
<td>Combined Plan of Correction and Allegation of Compliance:</td>
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<td></td>
<td>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to knock at the door, in order to maintain dignity and respect, before entering the room for 1 of 1 (R41) residents in a sample of 32. Findings include: On 1/14/2020 at 2:10pm an observation of (V10) Licensed practical nurse entered R41 to flush feeding tube and hang feeding and did not knock on the door, state her name or why she was entering. At 2:25pm (V10) said I should of knocked before entering and said hi. On 1/16/2020 at 12:30pm (V3) Director of nursing said the staff should knock and announce themselves before entering any resident's room. Facility Policy: Residents Privacy and Dignity Policy: Staff is to knock on resident's door prior to entering the resident's room. Staff will be invited into the resident's room if the resident is capable of the invitation.</td>
<td></td>
<td>The following plan of correction constitutes the facilities allegation of compliance such that all alleged deficiencies cited have been and will be corrected by the date indicated. The statement made on the plan of correction are not an admission to and does not constitute an agreement with alleged deficiencies herein. We respectfully submit that these deficiencies do not exist. To remain in compliance with all State and Federal regulations, the facility has taken or will take the actions set forth in the following plan of correction:</td>
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<td></td>
<td>F550 Resident Rights/Exercise of Rights R41 is being treated with respect and dignity in a manner and in an environment that promotes maintenance or enhancement of his quality of life. No other residents were affected by this alleged deficiency.</td>
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| 145885 | |

NAME OF PROVIDER OR SUPPLIER

MAYFIELD HEALTH CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
5905 WEST WASHINGTON
CHICAGO, IL 60644

01/16/2020
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<td>Continued From page 2</td>
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<td>V10 and all staff were reeducated on resident dignity to ensure they knock before entering a residents room.</td>
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<td>The administrator or designee will monitor 5 times a week for the next month and on-going if any trend is noted to ensure compliance with this alleged deficiency. See attached audit tool.</td>
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<tr>
<td>F 676</td>
<td>Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)(5)(i)-(iii)</td>
<td>F 676</td>
<td></td>
<td>1/31/20</td>
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§483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that:

§483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ...

§483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living:

§483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care,

§483.24(b)(2) Mobility-transfer and ambulation,
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**ID**

| F 676 | Continued From page 3 including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure that one of three residents (R91) reviewed for communication in the sample of 32, has the means to communicate needs. Findings include: On 1/14/2020 at 2:15pm V5 (nursing assistant) stated that R91 communicates through facial expression. V5 stated that, she has not been given any communication tool to use with R91. V6 (Restorative Supervisor) stated that R91 understands familiar faces but can be combative sometimes. She stated that no communication board is used to communicate with R91. On 1/17/2020 at 2:00pm V7 (Restorative Director) stated that R91 communicates by using body language and eye contact. V7 also stated that R91 is not able to communicate with a communication board. Facility care plan goal revision dated 11/25/19 reads: will maintain current level of communication...using communication board. |

**ID**

| F 676 | Combined Plan of Correction and Allegation of Compliance: The following plan of correction constitutes the facilities allegation of compliance such that all alleged deficiencies cited have been and will be corrected by the date indicated. The statement made on the plan of correction are not an admission to and does not constitute an agreement with alleged deficiencies herein. We respectfully submit that these deficiencies do not exist. To remain in compliance with all State and Federal regulations, the facility has taken or will take the actions set forth in the following plan of correction: F676 ADL R91 has a communication tool in his room. See attached note. No other residents were affected by this alleged deficiency. |

**NAME OF PROVIDER OR SUPPLIER**

**MAYFIELD HEALTH CENTER**

**STREET ADDRESS, CITY, STATE, ZIP CODE**

**5905 WEST WASHINGTON CHICAGO, IL 60644**

**DATE SURVEY COMPLETED**

| 01/16/2020 |

**DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES**

**FORM CMS-2567(02-99) Previous Versions Obsolete**

**Event ID:** 45MM11

**If continuation sheet Page 4 of 19**

**Facility ID:** IL6005896
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<td>F 676</td>
<td>Continued From page 4</td>
<td>F 676</td>
<td>The social service staff were in serviced on 1-28-20 to ensure all residents who are not able to communicate have a communication board. The social service director or designee will monitor 3 residents a week for the next month and on-going if any trend is noted to ensure compliance with this alleged deficiency. See attached audit tool.</td>
<td>1/31/20</td>
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<tr>
<td>F 684</td>
<td>Quality of Care</td>
<td>F 684</td>
<td>Combined Plan of Correction and Allegation of Compliance: The following plan of correction constitutes the facilities allegation of compliance such that all alleged deficiencies cited have been and will be corrected by the date indicated. The statement made on the plan of correction are not an admission to and does not constitute an agreement with alleged deficiencies herein. We respectfully submit that these deficiencies do not</td>
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<tr>
<td>SS=D</td>
<td>§ 483.25 Quality of care</td>
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<td>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents’ choices. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to follow physician orders for endocrine appointment for 1 of 1 residents (R138) reviewed for the provision of medical-related social services in a sample of 32. Findings include: R138 was admitted to the facility in 12/23/2019 with a diagnosis of Type 2 Diabetes Mellitus with hyperglycemia. On 1/14/2020 at 11:30am R138 said the nurses</td>
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F 684 Continued From page 5
have not made an appointment for him to see the
doctor to attach his insulin pump and I've been
here since December 23, 2019.

At 12:00 noon (V11) 3rd floor supervisor, said I'm
waiting for the manufacturer to repair his pump
first, then I'll make the appointment. V11 stated all
orders should be carried out when we receive
them.

On 1/16/2020 at 12:00 noon (V3) Director of
nursing said all orders should be carried out as
soon as possible.

On 1/16/2020 at 1:30pm (V13) physician said
"that appointment should have been made ASAP
(as soon as possible) to replace [R138's] pump,
no further harm to the resident would have been
caused without the pump, but he does need it,
that's unacceptable."

Medication Review Report dated 1/14/2020
reads: endocrine appoint at (local hospital) Insulin
pump broken, resident have pump with him in his

Facility Policy:
Physician /Prescriber Authorization and
Communication of orders to pharmacy.
Number 9.1. Once admission orders are verified,
staff should promptly transmit medication orders
to the pharmacy.

F 686 SS=D Treatment/Svcs to Prevent/Heal Pressure Ulcer
CFR(s): 483.25(b)(1)(i)(ii)

§483.25(b) Skin Integrity
§483.25(b)(1) Pressure ulcers.
Based on the comprehensive assessment of a

exist. To remain in compliance with all
State and Federal regulations, the facility
has taken or will take the actions set forth
in the following plan of correction:

F684 Quality of Care

R138 had an appointment made to for his
endocrine appointment. See attached
documentation.

No other residents were affected by this
alleged deficiency.

The Nursing staff were in serviced on
1-28-20 to ensure all residents who have
appointments that the orders are carried
out as soon as possible.

The Director of Nursing or designee will
monitor 5 residents a week for the next
month and on-going if any trend is noted
to ensure compliance with this alleged
deficiency. See attached audit tool.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**MAYFIELD HEALTH CENTER**

**NAME OF PROVIDER OR SUPPLIER:**

**ADDRESS:**

**STREET ADDRESS, CITY, STATE, ZIP CODE:**

**DATE:**

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| F 686 | Continued From page 6 resident, the facility must ensure that-

(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and

(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview and record review the facility failed to ensure interventions were in place for one (R125) with an unstageable pressure ulcer to right heel. The facility also failed to follow professional standards of care for settings of a low air loss mattress for three residents (R55, R77, R100) out of three residents reviewed for pressure ulcers in a sample of 32.

Findings include:

On 1/16/2020 at 10:00am R125 was observed in bed without bilateral heel protectors. (V12) wound care administering a treatment to R125. V12 cleansed the right heel with normal saline, applied hydrogel then wrapped with kerlix and sock applied. V12 said R125 should have on heel protectors in bed.

Facility policy:

Mayfield health Center policy and procedure for the treatment and prevention of skin breakdown Policy: properly identify and assess resident's whose clinical condition's increase the risk for impaired skin integrity, and pressure ulcers, to implement preventive measures and to provide

Combined Plan of Correction and Allegation of Compliance:

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- F686 Treatment/Services to Prevent/Heal Pressure Ulcer
  
- R125 has her bilateral heel protectors in place. See attached note. R77, R55 have their air loss mattresses set at the correct setting. R100 is no longer a resident at the facility. See attached notes.
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: 01/16/2020

NAME OF PROVIDER OR SUPPLIER

MAYFIELD HEALTH CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

5905 WEST WASHINGTON
CHICAGO, IL 60644

(X4) ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETION DATE

F 686 Continued From page 7
appropriate treatment modalities for ulcers according industry standards of care.
Number two prevention of skin breakdown section (b) number viii. Protect elbows and heels as needed, heel protectors/heel pads protect against friction not pressure and used for comfort. On 1/14/2020 at 11:33 AM low air mattress for R100 setting on 350 pounds. At 11:41 AM found R55 low air mattress setting on 320 pounds and at 11:45 AM found R77 low air mattress bed set at 400.

On 01/14/2020 11:34 AM V14 (Nurse) stated "low air mattress is supposed to be set by resident weight."

On 01/16/2020 at 10:15 AM V15 (Nurse) stated "R77 air mattress is supposed to be set on 320 pounds."

On 1/16/2020 review of resident's weights R55 weight taken 01/15/2020 128.8 pounds. R77 weight taken 01/09/2020 119.3 pounds and R100 weight taken 01/08/19 132.1 pounds.

On 1/16/2020 at 2:45 P.M. Review of manufactures user manual for R55's air low mattress reveals; To turn the pressure adjust knob to set a comfortable pressure level using the weight scale as a guide.

Several request was made, the Facility did not provide a policy for low Air Loss mattress or a manufacture guide for R77 and R100.

F 688 Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3)

§483.25(c) Mobility.

F 686 No other residents were affected by this alleged deficiency.

The Nursing staff were in serviced on 1-28-20 to ensure that all residents receive care, consistent with professional standards of practice, to prevent pressure ulcers and doesn't develop pressure ulcers unless the individual clinical condition demonstrates that they were unavoidable.

The Director of Nursing or designee will monitor 5 residents a week for the next month and on-going if any trend is noted to ensure compliance with this alleged deficiency. See attached audit tool.

F 688 1/31/20
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**X1** PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER: 145885

**X2** MULTIPLE CONSTRUCTION
A. BUILDING _______________
B. WING _______________

**X3** DATE SURVEY COMPLETED 01/16/2020

**NAME OF PROVIDER OR SUPPLIER**

MAYFIELD HEALTH CENTER

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<td>§483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and</td>
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<td>§483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</td>
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<td></td>
<td>§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by:</td>
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<td>Based on observation, interview and record review the facility failed to provide range of motion and a splint to one of one resident (R91) with a right wrist contracture in a sample of 32 residents.</td>
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<td>Findings Include:</td>
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<td>On 1/14/2020 at 2:50pm, V5 (nursing assistant) stated that nursing assistants are not responsible to apply hand splint to residents. V5 stated that restorative is responsible for applying and taking off hand splint.</td>
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<td>On 1/14/2020 at 3:00 pm V6 (Restorative supervisor) was asked why R91 was not wearing a right wrist splint as ordered by the physician. V6 stated that R91 has a splint but takes it off.</td>
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<td>V6 also stated that range of motion is provided to</td>
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**X5** COMPLETION DATE

**X6** PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

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<tr>
<td>688</td>
<td>Continued From page 9 R91 by restorative nursing assistants daily. No written documentation was provided to support that R91 receives range of motion exercise daily. The facility was unable to provide a policy on providing care to contracted residents when requested.</td>
</tr>
<tr>
<td>761</td>
<td>Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel access.</td>
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## F 761
Continued From page 10

personnel to have access to the keys.

§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview and record review the facility failed to dispose of expired medication and also failed to properly label open medication for 3 of 3 residents (R88, R113, R135) reviewed for medication storage.

Findings include:

On 1/14/2020 at 9:30am on second floor medication storage observation, wing 2 medicine cart:

A 100 unit/ml vial of Novolog Aspart (insulin) filled by pharmacy on 7/31/2019, open by nurse on 11/27/2019, and expired 12/15/2019 for R135.

A insulin pen (Victoza) filled by pharmacy on 11/23/2019, no open date, expired 12/22/2019 for R88

Haldol Decanoate 100mg/1ml open and used, no open date for R113.

One multi dose vial of tuberculin solution no open date in refrigerator.

On 1/14/2020 at 10:20am on the third-floor medication storage room:

One multi dose vial of tuberculin solution no open

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**Combined Plan of Correction and Allegation of Compliance:**

The following plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been and will be corrected by the date indicated. The statement made on the plan of correction are not an admission to and does not constitute an agreement with alleged deficiencies herein. We respectfully submit that these deficiencies do not exist. To remain in compliance with all State and Federal regulations, the facility has taken or will take the actions set forth in the following plan of correction:

- **F761 Label/Store Drugs and Biologicals.**

The Director OF Nursing on 1-29-20 verified that all items in the med cart, refrigerator and medication storage room that were expired have been properly disposed of. See attached documentation.
## Statement of Deficiencies and Plan of Correction

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<tr>
<td>F 761</td>
<td>Continued From page 11 date in refrigerator. One influenza vaccine in cabinet expired date of 6/22/2019. One angiocath 18 gauge with an expired date of 1/2018. On 1/14/2020 at 9:30am (V3) Director of nursing said pharmacy removes all expired medication or staff send medication back to the pharmacy. At 10:20am (V9) Licensed practical nurse said the charge nurse removes all expired medication. Facility Policy: Storage of medication 12. Insulin products should be stored on the refrigerator until open and the date on the label for insulin vials and pens when first used. 14. Outdated, contaminated, discontinued or deteriorated medications and those in containers should be immediately removed from stock.</td>
<td>F 761</td>
<td>No other residents were affected by this alleged deficiency. V5 and all nursing staff were in serviced on 1-28-20 to ensure that all expired medications will be disposed of properly and all open medications will be labeled properly. The Director of Nursing or designee will monitor 5 residents a week for the next month and on-going if any trend is noted to ensure compliance with this alleged deficiency. See attached audit tool.</td>
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<tr>
<td>F 812 SS=F</td>
<td>Food Procurement, Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.</td>
<td>F 812</td>
<td>1/31/20</td>
<td></td>
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</tr>
</tbody>
</table>

**Department of Health and Human Services**

**Centers for Medicare & Medicaid Services**

**Name of Provider or Supplier**: Mayfield Health Center

**Address**: 5905 West Washington Chicago, IL 60644

**Date Survey Completed**: 01/16/2020
F 812 Continued From page 12

§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, and record review, the facility failed to follow their policy on labeling and dating food, cleaning fresh produce in a sanitary manner, ensure facial hair is covered, air dry blender bowl. This has the potential to affect all 135 residents receiving diets from the kitchen. The facility also failed to follow their policy on resident refrigerators in one resident (R88) out of two reviewed for food storage in a sample of 32.

Finding Include:

On 01/14/2020 09:42 AM in refrigerator found two salads, three sandwiches, twenty pureed bread and nectar milk no date. In pantry found two opened cake mixes, one package of dry potatoes, Butter milk biscuit mix, and two packages of Cane Sugar not dated.

On 11/14/2020 at 10:04 AM V20 stated "everything is dated and labeled using first in first out."

01/14/2020 10:12 AM Garbage in back dumper overflowing with no lid. No beard covers for V18 and V19.

On 01/14/2020 dietary manager stated "they are supposed to have the beard cover on. Housekeeping take care of the garbage."

01/15/2020 09:58 AM Potatoes sitting in the bottom of the prep sink.

Combined Plan of Correction and Allegation of Compliance:

The following plan of correction constitutes the facilities allegation of compliance such that all alleged deficiencies cited have been and will be corrected by the date indicated. The statement made on the plan of correction are not an admission to and does not constitute an agreement with alleged deficiencies herein. We respectfully submit that these deficiencies do not exist. To remain in compliance with all State and Federal regulations, the facility has taken or will take the actions set forth in the following plan of correction:

F812 Food Procurement, Store/Prepare/Serve-Sanitary

The Food Service Supervisor on 1/14/20 dated all items that were opened and not dated. See attached note. Both dietary staff members are wearing hairnets to cover their beards. See attached documentation.

Administrator on 1-14-20 went to the back dumpster and closed the lid so it wasn’t overflowing. See attached statement.

Housekeeping staff on 1-17-20 cleaned
Continued From page 13

On 01/15/2020 10:00 AM V20 (Manager) said "if it was me I would have placed the potatoes in a strainer, but each cook cooks different."

On 01/15/2020 at 11:04 AM R98 personal refrigerator had 1 slice of dried up pie open on paper plate unwrapped no date. Three containers of milk one expired 1/13/2020 no thermometer and the freezer section was packed with ice. Refrigerator had brown stains on the inside of it.

On 01/15/2020 at 1:22 PM V2 stated "Housekeeping is supposed to check the temperatures of the refrigerator and Nursing should date the foods.

Policy Titled Storage of Refrigerated Foods. No date
Food in the refrigerator will be covered labeled and dated.
Policy Titled Storage of Dry Goods/Foods. No date
Open products will be labeled and tightly covered to protect against any contamination including from insects and rodents. Pest control should be in place as needed.
Policy Titled Hair Restraints/Jewelry/Nail Polish No date
Hairnets will be worn all times in the kitchen.
Beard guards or mask will be worn as indicated if hair longer than 2 inches.
Census obtained from federal form 672

Policy Titled Residents Refrigerators dated 1-2020:
All resident refrigerators will be maintained regarding temperature and cleanliness. Each refrigerator will be provided with thermometer to out all the resident refrigerators and anything not dated was disposed of properly. All resident refrigerators have a temperature gauge and daily temps are being done. See attached.

No other residents were affected by this alleged deficiency.

Housekeeping and dietary staff were in-service on 1-28-20 to ensure the dumpster is not overflowing and the lids are always covered. Dietary staff on 1-14-20 were in servied that all food items that are opened have to be dated. Housekeeping staff on 1-27-20 were in organized that all resident refrigerators have to be cleaned and temperatures have to be taken daily to ensure it is at least 40 degrees or less.

The Food Service Supervisor will monitor 3 times a week for the next month and on-going if any trend is noted to ensure compliance that all food items which are opened and dated. The FSS will also monitor weekly for the next month and on-going if any trend is noted to ensure compliance that all staff members who have facial hair of 2 inches or longer are wearing proper hairnets for their beards. The Assistant Administrator or designee will monitor 3 times a week for the next month and on-going if any trend is noted to ensure compliance that all resident refrigerators are cleaned and dated properly. The Assistant Administrator or designee will monitor 3 times a week for the next month and on-going if any trend
| F 812 | Continued From page 14 assure that refrigerators are maintained at least 40 degrees temperature. The resident's refrigerator will be cleaned by the housekeeping department or designee to assure that all stored in the refrigerator is palatable and not beyond expiration date. Refrigerators temperatures will be checked periodically to ensure sanitary conditions. Policy Titled Foods brought by family/visitors Perishable foods must be stored in re-sealable containers with tightly fitting lids in the refrigerator. Containers will be labeled with resident's name, the item and the "use by" date. |
| F 814 | Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4)§483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to dispose of garbage properly. This has the potential to affect all 139 residents residing in the facility. Finding include: On 01/14/2020 at 10:12 AM Garbage in back dumpster overflowing with no lid. On 01/16/2020 at 1:22 PM V2 (Assistance Administrator) stated "Housekeeping placed the garbage in the dumpster, pushed the garbage down inside to close the top. We have no policy for this but we do have a job description." Facility provided no policy |

F 812 is noted to ensure compliance that the back-garbage dumpster isn’t overflowing, and the lid is covered properly. See attached audit tools.

F 814

1/31/20

Combined Plan of Correction and Allegation of Compliance:

The following plan of correction constitutes the facilities allegation of compliance such that all alleged deficiencies cited have been and will be corrected by the date indicated. The statement made on the plan of correction are not an admission to and does not constitute an agreement with alleged deficiencies herein. We respectfully submit that these deficiencies do not exist. To remain in compliance with all State and Federal regulations, the facility has taken or will take the actions set forth in the following plan of correction:
<table>
<thead>
<tr>
<th>ID</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 814</td>
<td>Continued From page 15</td>
<td>Job Description no date: Discard waste/trash into proper containers in accordance with established sanitation procedures and reline trash receptacle and plastic liner. Census obtained from federal form 672</td>
<td>F 814</td>
<td>F814 Dispose Garbage and Refuse Properly Administrator on 1-14-20 went to the back dumpster and closed the lid so it wasn't overflowing. See attached statement. No other residents were affected by this alleged deficiency. Housekeeping and dietary staff were in-service on 1-28-20 to ensure the dumpster is not overflowing and the lids are always covered. The Assistant Administrator or designee will monitor 3 times a week for the next month and on-going if any trend is noted to ensure compliance that the back-garbage dumpster isn't overflowing, and the lid is covered properly. See attached audit tools.</td>
<td>1/31/20</td>
<td></td>
</tr>
<tr>
<td>F 880</td>
<td>Infection Prevention &amp; Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)</td>
<td>§483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</td>
<td>F 880</td>
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</table>

NAME OF PROVIDER OR SUPPLIER

MAYFIELD HEALTH CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

5905 WEST WASHINGTON

CHICAGO, IL, 60644

DATE SURVEY COMPLETED

01/16/2020
F 880  Continued From page 16

$483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to $483.70(e) and following accepted national standards;

$483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv) When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.

F 880
<table>
<thead>
<tr>
<th>(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
<th>(X3) DATE SURVEY COMPLETED</th>
</tr>
</thead>
<tbody>
<tr>
<td>145885</td>
<td>A. BUILDING</td>
<td>01/16/2020</td>
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<td></td>
<td>B. WING</td>
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</tbody>
</table>

**NAME OF PROVIDER OR SUPPLIER**

MAYFIELD HEALTH CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**

5905 WEST WASHINGTON

CHICAGO, IL 60644

<table>
<thead>
<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER’S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 880</td>
<td>Continued From page 17</td>
<td>F 880</td>
<td>Combined Plan of Correction and Allegation of Compliance:</td>
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<tr>
<td></td>
<td>§483.80(a)(4) A system for recording incidents identified under the facility’s IPCP and the corrective actions taken by the facility.</td>
<td></td>
<td>The following plan of correction constitutes the facilities allegation of compliance such that all alleged deficiencies cited have been and will be corrected by the date indicated. The statement made on the plan of correction are not an admission to and does not constitute an agreement with alleged deficiencies herein. We respectfully submit that these deficiencies do not exist. To remain in compliance with all State and Federal regulations, the facility has taken or will take the actions set forth in the following plan of correction:</td>
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<tr>
<td></td>
<td>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</td>
<td></td>
<td>F880 Infection Prevention &amp; Control</td>
<td></td>
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<td></td>
<td>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:</td>
<td></td>
<td>R92’s room has proper signage up showing its an isolation room. See attached picture.</td>
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<td></td>
<td>Based on observations, interviews and record review the facility failed to follow their infection control policy on wearing personal protective equipment. The facility also failed to place signage on the isolation door of one resident (R92) reviewed for isolation. These failures have the potential to affect all 49 residents residing on the second floor.</td>
<td></td>
<td>Staff are using PPE (Personal Protective</td>
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<td></td>
<td>Findings Include:</td>
<td></td>
<td>Protects)</td>
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<tr>
<td></td>
<td>On 1/14/2020 at 10:48 A.M. during initial tour there was no signage on the wall or door of R92’s isolation room.</td>
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<tr>
<td></td>
<td>On 1/14/2020 at approximately 11:10 A.M. V8 (Housekeeping) walked into R92's isolation room without wearing PPE (Personal Protective Equipment).</td>
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<td></td>
<td>On 1/14/2020 at 10:48 AM V15 LPN (Licensed Practical Nurse) stated &quot;There is supposed to be a sign on the door.</td>
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<tr>
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<td>On 1/14/2020 approximately 11:00AM V8 stated</td>
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</table>
F 880  Continued From page 18  
"I am supposed to put on the yellow gown and gloves."

On 1/16/2020 at 12:13 AM V3 (Director of Nurses) stated "Absolutely a sign is supposed to be in place for anyone who goes into the room. It depends on the isolation which protective equipment they would use."

Policy Title: Isolation reviewed November 2018

Protective clothing (PPE)
Single use gloves must be worn for direct patient contact, and contact with body fluids potentially infectious material or when touching items in the environment which may be contaminated.

Facility did not provide policy for door signage.

Floor census obtained from second floor roster dated 1/14/2020

<table>
<thead>
<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARIZED STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (Each corrective action should be cross-referenced to the appropriate deficiency)</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 880</td>
<td>Equipment) when entering a resident room who is in isolation.</td>
<td>F 880</td>
<td>No other residents were affected by this alleged deficiency.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>V8 and all staff were in-serviced on 1-28-20 that anyone in an isolation room needs to have a sign on their door stating its an isolation room and anyone entering that room needs to be wearing PPE.</td>
<td></td>
<td>The administrator or designee will monitor 4 days a week for the next month and on-going if any trend is noted that anyone in isolation has proper signage on their door and all staff entering those rooms are wearing PPE.</td>
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<tr>
<td></td>
<td>Facility did not provide policy for door signage.</td>
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<td></td>
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<tr>
<td></td>
<td>Floor census obtained from second floor roster dated 1/14/2020</td>
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