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 _____	C 03/18/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYFIELD CARE CENTER	**5905 WEST WASHINGTON CHICAGO, IL 60644**

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F 000	INITIAL COMMENTS Complaint Investigation 1581074 / IL75338 - F157, F226 and F309 cited 1581210 / IL75510 - F272 cited 1581322 / IL75648 - F322 cited	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 157	Continued From page 1 legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed notify the physician and resident's representative of a change in condition for two of eight residents (R1, R2) reviewed for resident injury in the total sample of 16. Findings include: 1. On 2/21/15, R1 was noted with scratches to the left upper arm and left knee. During an interview on 3/4/15, at 10:00AM, Z1 (family member) who visited R1 on 2/21/15, described the injury as: it appeared as if someone's nails had gone into her skin. 12 (certified nurse aide/C.N.A.) and E13 (nurse) were at the bedside when the injury was observed. There is no evidence that the attending physician was made aware of the injury of unknown origin. On 3/18/15, at 12:00PM, E13 stated:"We were busy that day; we were short." E13 confirmed that the attending physician was not notified of R1's injury on 2/21/15. 2. R2's nurses' notes dated 2/7/15, at 2:45PM states: During patient care, C.N.A. noted that gastrostomy tube had dislodged. At 2:54PM, Z3 (covering physician) ordered for the facility staff to make an appointment for the gastrostomy tube to be inserted at an acute care hospital. There is no evidence that the representative or the family member was made aware of the incident of tube being dislodged and the need for R2 to be sent to the hospital for re-insertion. The facility policy titled, " Change in Condition in a Resident ' s Condition or Status" with a revision date of 4/2011, documents: " Our facility shall promptly notify the resident, his/ her attending	F 157		

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F 157	Continued From page 2 physician and representative (sponsor) of changes in the resident's medical/mental condition and/or status. The Nurse Supervisor /Charge Nurse will notify the attending physician or on-call physician when there has been a discovery of injuries of unknown origin." The same policy also documented regarding notifying the resident's representative of a resident change of condition. The same policy documents in part: "Unless otherwise instructed by the resident, the nurse supervisor/charge nurse will notify the resident ' s family or representative when it is necessary to transfer the resident to a hospital/treatment center. "	F 157		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to conduct pre-employment screening, orientate and train an employee regarding abuse procedures and protect residents during an abuse investigation according to the facility's abuse policy. This failure applies to five of eight residents (R1, R3, R4, R6, R7) reviewed for abuse in a sample of 16 and three of six employees (E3, E11, E13) reviewed for the facility's pre-screening and training requirements. Findings include:	F 226		

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F 226	Continued From page 3	F 226		

1. According to abuse incident report and investigation: On 2/21/15, R1 was noted with a scratch mark to her left upper arm by E13 (nurse). R1 reported an allegation of physical abuse involving E12 (C.N.A./ nursing assistant) to E13. The allegation of physical abuse was not reported immediately to E1 (administrator). E12 was not removed from resident contact until 2/27/15.

According to shower/bath skin check form completed on 2/19/15, R1 did not have any sign of injury as documented. When asked, E2 (director of nursing /DON) validated that the documentation of " None " in the shower/bath skin check signifies that R1 did not have any skin problem during the shower on 2/19/15.

-R3 and R4 were involved in an altercation on 2/17/15. The abuse investigation presented by E1 (administrator) included resident statements According to the statements, R3 kicked R4; R4 threatened R3 to hit with a jar. The facility separated R3 and R4 but there is no evidence of R3 and R4 being monitored and removed from contact with other residents during the course of investigation. The investigation was concluded on 2/22/15, five days later.

-On 3/5/15, at 6:00PM, R6 was threatened by R7 with a butcher knife according to the abuse investigation facility file presented by E1. The investigation was concluded on 3/10/15, which is five days later, but there was no evidence noted that R7 was removed from resident contact to protect all residents for potential abuse/injury.

On 3/18/15, at 11:15AM, E9 PRSC (psychiatric rehabilitation services coordinator) was

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F 226	Continued From page 4	F 226		

interviewed as a part of the abuse prohibition review. E9 stated that a person who allegedly abused a resident should be taken away from all resident contact until the investigation is over. E9 also said that if an employee is the alleged perpetrator, the employee should be sent home pending investigation, and if the alleged perpetrator is a resident, the resident should be placed on one-to-one monitoring until the investigation is completed to protect all residents for potential harm.

2. On 3/4/15, at 12:18PM, E13 (nurse) stated that she did not have any training about abuse since she was hired in 2013.
On 3/17/15 at 12:23pm, E3 (Restorative Nurse) stated that she is new to the facility and E3 denied receiving abuse-related training and orientation upon hiring. E3 confirms that her job involves dealing with residents in a daily basis.
The lack of training upon orientation was validated upon review of E3's personnel file on 3/18/15, with E10 (Human Resources/ HR).

On 3/1815, at 10:13AM, six employee files were reviewed with E10. The following employee files with dates of hire, pre-employment screening, and orientation and training related to abuse prevention, were noted in the files:

E3 (Restorative Nurse) with date of hire 02/25/15 - no evidence of abuse prevention training received during orientation.
E11(C.N.A.) with date of hire 08/06/14 - no background checks done before hiring.
E13 (nurse) with date of hire 10/30/13 - no evidence of abuse training received during orientation

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F 226	Continued From page 5 When asked, E10 stated that she is new in the facility and was not able to describe the hiring process of the previous HR staff. E10 also indicated that the previous HR left on the day E10 started and E10 did not receive orientation from her. The facility's policy titled," Abuse Prevention Program " dated 1/23/15, documents: Orientation and Training of Employees: During orientation of new employees, the facility will cover at least the following topics: what constitutes abuse, neglect and misappropriation of property; staff obligation to prevent and report abuse, neglect and misappropriation of property. -Protection of Residents: Residents who allegedly abused another resident will be removed from contact with other residents during the course of the investigation. Employees of this facility who have been accused of abuse, neglect mistreatment or misappropriation of resident property will be removed from resident contact immediately until the results of the investigation have been reviewed by the administrator.	F 226		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information;	F 272		

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F 272	Continued From page 6 Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based upon interview and record review, the facility failed to accurately assess the feeding status of one of three residents (R2) reviewed for tube feeding in the sample of 16. Findings include; According to a face sheet and admitting nurses' notes, R2 was admitted to the facility on 1/26/15 with diagnosis of dysphagia. R2 was receiving nutrition by enteral feeding. The MDS (Minimum Data Set) assessment with a	F 272		

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F 272	Continued From page 7 ARD (Assessment Reference Date) of 2/2/15, did not document the presence of feeding tube. On 3/18/15, at 11:00AM, E6 stated the look-back review of R2's MDS assessment includes seven days prior to the ARD. According to nurses' notes, R2 was receiving nutrition via G-tube (gastrostomy tube) during the look-back review. The accurate feeding status of R2 was not captured in the assessment.	F 272		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to informed a resident's physician of a resident's injury to obtain orders for treatment of the wound. This failure applies to one of eight residents (R1) reviewed for injury in the sample of 16 residents. Findings include: According to an accident report on 2/21/15, R1 was noted with scratches to the left upper arm and left knee. During an interview on 3/4/15, at 10:00AM, Z1 (family member) who was visiting R1 during that time described the injury as, " It appeared as if someone ' s nails had gone into her skin. " Per review of the POS (physician order sheet)	F 309		

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F 309	Continued From page 8 dated 2/2015 and nurses ' notes on 2/21/15, there is no evidence that the attending physician was made aware of the injury of unknown origin and there is no evidence that a treatment order was obtained to treat the injury. There was no nurses' note entry between 2/21/15 and 2/15/15. On 3/18/15, at 12:00PM, E13 (Nurse) stated that she was the nurse of R1 on 2/21/15 and the injury was noted while E12 C.N.A. (nursing assistant) was providing ADL (activities of daily living) care. E13 confirmed the lack of documentation and treatment. E13 stated, " I did not have time to call the doctor for treatment; we were very busy; we were short of C.N.A.s that shift "	F 309		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.	F 322		

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F 322	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to provide enteral feeding and care plan for services for the use of a gastrostomy tube (G-tube) for one of three residents (R2) reviewed for G-tube feeding, in the sample of 16 residents. Findings include: According to R2's face sheet, R2 was admitted to the facility on 1/26/15 with diagnoses of dysphagia and was receiving nutrition via G-tube. According to nurses' notes, on 2/7/15, R2's G-tube was dislodged during patient care. The facility staff obtained a physician order to insert a catheter and make an appointment for re-insertion of the G-tube at the hospital. R2's nurses' note entry dated 2/10/15, at 7:57AM, documents: "(R2) did not have (diabetic enteral feeding formula) overnight due to waiting for a confirmation from a supervisor on how to proceed with feeding." The facility did not follow the care plan created for R2 to administer feeding formula as a part of R2's diet. According to nurses' notes, R2 was sent to the hospital on 2/10/15 and was admitted with diagnoses of: G-tube malfunction and hypoglycemia. On 3/18/15, at 1:30PM, E7 (Nursing Administrative Assistant) was interviewed regarding G-tube feeding supplies and availability. E7 stated if a resident is admitted with enteral feeding order that is not currently	F 322		

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available in the facility, the staff will use "whatever is available in the facility." E7 also said that supply orders that include enteral feeding supplies and syringes are placed on Mondays. During the interview, E3 was unable to describe the facility system or process of ensuring enteral feeding supplies that include feeding formulas are ordered to meet the needs of the residents in the facility. E3 stated, " I just started doing this job; I am also doing nursing schedules. " When asked for evidence that enteral feeding and related supplies were ordered, E3 presented order sheets dated 3/10/15 and 3/16/15. There was no evidence of enteral feeding supplies being ordered upon review of the order sheets presented by the staff.

Upon review of R2's care plans, there was no evidence that the facility created a care plan for R2 to address the complications and injury related to the use of G-tube. There was no evidence that a care plan was created to address the G-tube being dislodged and the use of a urinary catheter before the facility can make an appointment for re-insertion of the G-tube. R2's care plan documented a problem which reads: (R2) is at risk for fluid deficit related to Gastrostomy tube status. One of the intervention documented stated, " Administer tube feeding as ordered. "

The facility policy titled, " Enteral Nutrition " dated 12/2011, documents in part: " Enteral nutrition will be ordered by the physician based on the recommendation of the dietician. "