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	145885	A. BUILDING _____ B. WING _____	04/22/2013

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F 000	INITIAL COMMENTS Annual Licensure and Recertification Complaint Investigation: 1283632/IL59917 - No deficiencies cited 1381340/IL62480 - F323 cited	F 000		
F 159 SS=E	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of	F 159		

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

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resident funds with facility funds or with the funds of any person other than another resident.

The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.

The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to provide notification of trust fund account reaching maximum limits involving one resident(R4) in the sample of twenty four and five residents in the supplemental sample (R25,R30, R31, R32 and R33) and the facility failed to provide quarterly balance reports for 136 residents in the facility which the facility handles trust funds.
Findings include:
On 4/16/13, the facility provided the list of residents whose funds are being managed. R30 has a balance of two thousand dollars and fifty cents which is over the SS (Social Security) resource limit. R4 has a balance of two thousand nine hundred twenty two dollars and fifty five cents. R31 has a balance of two thousand one hundred sixty nine dollars and sixty

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F 159	Continued From page 2 cents. R32 has a balance of two thousand, five hundred forty five dollars and fifty two cents. R33 has a balance of four thousand, one hundred two dollars and thirty six cents. On 4/16/13 at 10:40am E1 stated in part that E13 is responsible for taking care of the trust fund. At 11:00am, E13 (Social Services Director), in charge of trust fund, acknowledges that she was aware of the resident trust fund balances but was unsure of what to do, because she believes the book keeper is in charge of notification. E13 could not provide any documentation that indicates that either the resident/legal guardian was provided with quarterly statement report for any of the residents. On 4/17/13 at 10:35am, According to facility Quarterly Statements for resident funds policy statement presented by E1 (Administrator) indicated that " Our facility provides each resident who has funds managed by the facility on his or her behalf with a quarterly statements. " This policy was not followed. E1 was also unable to provide any notification documentation regarding trust fund given to either the resident or the legal guardian. R25 stated 4/16/13 at 2:20pm that she has never received quarterly statements of her facility trust fund account, has no idea what the balance is, and would like to have that information. E1 (Administrator) was notified of R25's request 4/16/13 at 4:00pm. R25 stated 4/17/13 at 3pm that she still hasn't received any information on her facility account.	F 159		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have	F 225		

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F 225	Continued From page 3 been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility	F 225		

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failed to investigate four injuries of unknown origin for one of 24 sampled residents (R4) and failed to immediately report an alleged violation involving staff to resident abuse to the State survey and certification agency; the facility also failed to complete a timely and thorough investigation for suspected staff to resident abuse for 1 (R26) resident in the supplemental sample, reviewed for abuse/neglect.

Findings include:

1) R4 is a 106 year old resident with several diagnoses including Senile Dementia with Psychosis, degenerative joint disease and Osteoporosis. R4 relies on staff for all of her care needs.

On 4/15/13 during the initial tour of the 2nd floor surveyor was accompanied by E2 (director of nursing). R4 was noted in the day room seated in a wheel chair. R4's left hand was noted with a dressing on it. Both of R4's legs were slightly elevated. R4 was wearing white socks in which the right foot was larger than the left. When surveyor asked why R4's right foot was so large, E2 stated, "she has a cast."

The nurse's notes dated 11/21/12 (7:03pm) indicate a change in condition, abrasion/bruises, resident noted with bruises to back of right hand and right forearm. Areas are purplish black in color and are fading. Resident also has some redness to knuckle on the right index finger. Z4 was notified, no new orders received.

On 2/22/13 resident observed with an open area

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to her right elbow. Area is the size of a quarter.

On 3/8/13 resident has an open area on her left thumb. Doctor gave orders to have wound care evaluate. The re-admission skin assessment is dated 3/20/13.

On 3/11/13 E4 (licensed practical nurse) documented that she was informed by the CNA (certified nurse aide/CNA) that resident had a small spot of blood on her left sock. When E4 took the sock off, E4 noticed R4 had a small skin tear on the second left digit. E4 also noticed R4 had swelling to both feet.

On 4/18/13 at 12:20 in the conference room E4 stated, "I was informed by the CNA but I don't remember which one. I initiated the treatment to the toe. Yes the feet were swollen."

There is no documentation to show these injuries were witnessed and the source of the injuries could not be explained by R4.

On 3/14/13 R4 was transferred to the hospital emergency room for evaluation due to edema in the right leg and foot, firmness in calf and pain in right leg.

The nurse's note dated 3/15/13 indicates the hospital admitting diagnosis was DVT (deep vein thrombosis) and fracture of right tibia.

During the daily status meeting on 4/16/13 the concern of injuries of unknown origin were presented to the facility. On 4/17/13, E5 (nurse consultant) presented incident reports that had "Confidential QA/QI" (Quality Assurance/Quality

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Indicator) stamped on them. When asked for incident reports that were not confidential and that the survey team could review copies of, E5 indicated the facility has that and would present them.

On 4/18/13 during the facility's presentation, E5 presented the same documents that had "Confidential QA/QI" (Quality Assurance/Quality Indicator) stamped on them. The facility was not able to present documentation of R4's injuries of unknown origin were investigated and that an investigation was reported to the state agency.

The Accidents and Incidents - Investigating and Reporting Policy indicates in part:

All accidents or incidents involving resident shall be investigated and reported to the Administrator and/or DON.

Policy Interpretation and Implementation
1. The Nurse Supervisor/Charge Nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident or incident. The investigation will continue via the QA process, as the interdisciplinary team discuss all incidents and accidents, to come to a conclusion and proceed to the care plan for interventions.

The facility's Accident and Incident policy does not indicate if or when the investigation will be reported to the state agency.

2) The facility ' s 24 hour Incident Investigation Report for R26 that was faxed to IDPH (Illinois

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Department of Public Health) on 4/24/12 documents:

(Pg 1) that R26 ' s daughter complained to the facility that her hand was swollen as a result of contact with the staff. The report also documents: Any obvious injuries or complaints of injury- right hand swollen. The facility ' s investigation summary documents that 4 days earlier, on 4/20/12, R26 was in the dining room and was agitated. The report further documents that R26 had a pen in her right hand and was waving it close to her face while yelling. The report adds that E6 CNA (Certified Nursing Assistant) attempted to remove the pen with no success. E6 then asked E7 (CNA) to remove the pen in which he did, while R26 continued screaming. The report then documents that on 4/23/12 (3 days after the incident) Z1 (R26 ' s mother) reported that R26 ' s hand was swollen and that R26 informed her that a facility employee bent her fingers back. The report added that E8 (Licensed Practical Nurse/LPN) examined R26 ' s hand and noted swelling, redness and pain and obtained an order for a radiology report.

(Pg 2) E6 stated that the pen broke while E7 attempted to take it from R26.

(Pg3) The report documents: " E7 heard screaming from R26 and looked in her hand and she had an ink pen. She had a locked grip on it. E6 stated that they had to get the pen from her. E7 asked R26 for the pen and she stated no. When R26 made a turn with the pen, E7 placed his hand in her palm to get the pen. R26 started escalating telling E7 to let her hand go. The pen was in both R26 and E7 ' s hands and E7 was

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able to retain the pen. R26 was still screaming for over an hour. "

The Incident Investigation Report goes on to document that on 4/20/13 E9 (CNA) stepped off the elevator and heard R26 screaming and crying. E9 then asked R26 what happened, and R26 stated " he hurt my hand. " E7 informed E9 that he removed a pen from R26 ' s hand. E9 stated that she informed E7 " it was rough and E7 needs to apologize. E7 stated I see no reason to apologize. " The report documents that E9 left the unit after R26 stopped yelling.

The report further documents that E10 (LPN) was in another resident ' s room when she heard R26 in the dining room crying. E10 went to see what happened and E7 and E6 approached her and explained what had happened. The report documents that E7 grasped R26 ' s wrist and removed the pen. The report documents that E10 did not notice any swelling or skin tears, informed R26 that she could have injured herself, and took R26 in her room and turned the radio on. The report did not document that E10 assessed R26 for pain.

(Pg 4) On Monday 4/23/12, Z1 informed E8 that an employee had bent R26 ' s fingers back and her wrist has been swollen since Saturday. E8 stated 4/23/13 was the first time she had been informed of R26 ' s change in condition. Upon examination, R26 had swelling, redness and pain on her right hand. The report documents that E7 was suspended and later terminated for reasons other than the manner in which he provided care to R26.

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E7 ' s personnel file contained a letter dated 4/27/12, addressed to him documenting: " At about 2:15pm today, you were being interviewed by telephone by E11. E11 asked you whether you told a specific individual about a specific incident at the time it occurred. You evaded the question and did not provide a clear answer. When E11 demanded a clear answer you hung up the phone. " The report further documents " you have been discharged from your employment effective as of your last day of work. E7 ' s employee time sheet documents that he last worked on 4/22/13 (2 days after the incident).

R26 ' s radiology report was dated 4/24/13 (4 days after the incident) with the following finding: Right hand and Fingers- examination reveals oblique and slightly comminuted fractures of the distal shafts of the third and fourth metacarpals and possible fracture of the neck of the fifth metacarpal with no significant displacement. Written on the report was: Medical Doctor aware, send to local hospital.

The facility was asked to provide all of R26 ' s nursing documentation and assessment for the months of 04/12- 06/12. There were no entries in R26 ' s nursing notes for 4/20/12 - 4/24/12. There was an entry for 4/5/12 documenting R26 ' s VS (vital signs) and the next entry was 4/25/12 at 11:57am documenting that R26 had a change in condition and returned from the hospital. The nursing notes further documents: 4/25/12 at 2:58pm: " Change in condition- Late entry for 4/22/12; 7:27pm Change in condition- right wrist swollen, right hand splint. "

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On 4/16/13 at 2:52pm, E3 (Assistant Director of Nursing) was asked what would make her suspect a resident is being abused? E3 stated " changes in behavior. " E3 also stated that if the facility is informed that a resident is being abused by a staff the policy is to send the staff home immediately. E3 also stated the facility ' s policy is to assess and interview the resident and notify the resident ' s family.

On 4/17/13 at 12:09pm, E13 (Abuse Coordinator/Social Service Director) stated that E14 (Former Social Services Director) investigated the incident with R26. E13 further stated that the facility ' s policy is to notify the Division of Long Term Care, Public Health and Authorities if abuse is substantiated. E13 also stated " We have not had any abuse cases substantiated, all of them have been unfounded in 1 ½ years. So the facility hasn ' t had to notify the authorities. "

On 4/17/13 at 12:55pm E2 (Director of Nursing) stated that E7 and E9 are no longer employees at the facility.

On 4/17/13 at 1:38pm along with E2 (Director of Nursing), E6 stated that on 4/20/13 she was in the dining room with R26 who grabbed a pen off the table and was waving it up and down towards her face. E6 stated that E7 came over and all she could see was that E7 grabbed R26 ' s wrist. According to E6, E7 went to grab the pen and the spring broke. E6 stated that E7 was holding the top part of the pen while R26 had the rest in her hand. E6 stated she exited the dining room, leaving only E6 in there with the residents. E6 stated that if a resident was physically harmed by

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F 225	Continued From page 11 a staff the protocol is to stay with the resident and tell the nurse immediately. On 4/17/13 at 2:15pm, E12 (Human Resources Director) stated that E7 was terminated after E11 contacted him to discuss the incident with R26. E12 stated that the facility ' s policy when abuse is suspected is for the nursing department and social services to notify the resident ' s family and to call the department of aging and the police. E12 also stated that said documentation of police notification should be kept in the employee ' s file. E12 looked in E7 ' s file and stated " he does not have anything reference calling the police or the department of aging, only the termination. " On 4/17/13 at 2:50pm, E10 stated that she was the nurse for R26 on 4/20/13. E10 stated she was down the hall and she heard R26 crying. E10 then stated that E6 informed her that R26 was crying because E7 took a pen from her. E10 stated she did not complete any pain assessment documentation for R26. E10 stated " we just had a conversation. " E10 stated she did not complete an incident report because it was not considered an incident at the time. R26 ' s medical record contained a criminal background check sheet in which R26 documented a criminal history of battery.	F 225		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		

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This REQUIREMENT is not met as evidenced by:
Based on interview and record review the facility failed to investigate and determine the cause of falls and revise a care plan with updated interventions after a fall incident for one resident (R15) of 9 residents reviewed for falls from a total a sample of 24.

Findings include:

R15 admitted to the facility with the diagnoses of hypothyroidism, schizophrenia, hypertension, depressive disorder, coronary artery disease and anxiety. R15 ' s MDS (Minimum Data Sheet) documents that R15 required extensive assistance from the staff for bed mobility, transfers, locomotion, dressing, toilet use, personal hygiene and bathing. Incident report review indicates the following occurrences involving R15:
5/12/12 fall - 2nd floor dining room, Injury- raised area to right forehead
7/28/12 fall - Resident bedroom
7/31/12 fall - Resident room
8/13/12 fall - clinic appointment (out of facility)
9/16/12 fall - Resident room
9/25/12 fall - Resident ' s room

On 4/15/13, there was a care plan in R15 ' s medical record dated 5/8/12. When R15 sustained a fall on 5/12/12 in the dining room the care plan did not contain new interventions. The QA report sheet documents that R15 sustained a

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raised area to her right forehead. R15 ' s nurse ' s notes documents that she sustained no injury. R15 ' s care plan was not updated related to this fall until 8/13/12.

R15 ' s nurse ' s notes documents that R15 sustained a fall on 6/21/13. This fall report was not provided by the facility. According to R15 ' s nurse ' s notes, she sustained a hematoma to her forehead and was sent to the local emergency room. There were no updated care plan interventions for this fall. This fall was not noted on R15 ' s care plan until 11/12/12.

R15 sustained a fall in her bedroom on 7/28/12 and again on 7/31/12. There were no new interventions on R15 ' s care plan on these dates. R15 ' s care plan noted the fall on 7/31/12 on the care plan dated 8/13/12. There was no documentation of the fall R15 sustained on 7/28/12 on this care plan. The approaches on R15 ' s care plan does not list which intervention pertains to which fall. R15 ' s nurse ' s notes also did not contain documentation of the fall on 7/28/12. R15 ' s medical record did not contain documentation of an investigation, vital signs or whether the physician or family was notified of the fall on 7/28/12.

R15 sustained a fall on 8/13/12 while out of the facility. This fall was not updated on R15 ' s care plan until 11/12/12. R15 then fell in her room 2 more times on 9/16/12 and 9/25/12 neither of these falls was updated on R15 ' s care plan until 11/12/12. The care plan also documented that R15 fell on 8/31/12 even though the report documents 8/13/12.

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 _____	04/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYFIELD CARE CENTER	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 323	Continued From page 14 On 4/16/13 at 2:50pm, E15 (Restorative Director) stated that she does not update care plan interventions. E15 stated that E16 (MDS Coordinator) is responsible for updating care plan interventions. On 4/16/13 at 3:05pm, E16 stated he is responsible for updating care plan interventions when a resident sustains a fall. E16 stated he does not add interventions every time a resident sustains a fall. E16 stated he only updates the care plan quarterly. E16 stated that when R15 sustained a fall on 5/12/12, he didn ' t update the care plan until 8/13/2012. The approaches on R15 ' s care plans does not document which approach pertains to which fall. When asked which interventions pertain to the fall R15 sustained on 5/12/13, E16 looked at the care plan and stated " do not leave her alone on the toilet." When asked, what interventions pertained to the fall R15 sustained on 7/31/12, E16 replied " low bed, floor matt and call light. " However, these were not new interventions, as they were already added to R15 ' s care plan dated 5/8/12. E16 also stated that he updated R15 ' s care plan on 11/12/13 for the fall she sustained on 9/16/12. When asked what interventions plan pertained to the fall, E16 stated " keep dry and comfortable and we kept the same low bed. " However, these interventions were already documented on R15 ' s care plan dated 8/13/12.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 329	Continued From page 15 duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to have adequate monitoring in place for possible side effects for one resident (R22) out of 5 residents in the sample of 24, reviewed for psychoactive medications. Findings include: R22 is a 65 year old resident with diagnoses including Schizophrenia and Depression. The 4/15/13 through 5/14/13 indicates R22 is to receive Quetiapine (for Seroquel) 200mg, one	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 329	Continued From page 16 tablet by mouth every morning (9am). Start date 5/3/12. Further review of the physician's order sheet does not show a specific order for a initial slit eye exam and one every six months thereafter while taking Quetiapine (Seroquel). The active clinical record does not show a base line or that an every six month eye exam was done. On 4/17/13 during the daily status meeting, this concern was presented to the facility. On 4/18/13 during the facility's presentation, R22's physician order sheet was presented. E5 (nurse consultant) stated, "we have all orders for outside services on everyone's POS (physician's order sheet)." The POS presented by the facility did not have orders for a initial or slit eye exam every six months while taking Quetiapine (Seroquel). The facility was not able to show evidence that R22 has had a slit eye exam since receiving the Quetiapine (Seroquel).	F 329		