STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145885	A. BUILDING _____ B. WING _____	**08/18/2020**

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

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F 0638 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Assure that each resident's assessment is updated at least once every 3 months.** Based on interview and record review the facility failed to follow their policy for completing risk assessments in residents previously identified to be at risk for skin impairments for 3(R1, R2 and R3) of 3 residents reviewed for assessments. Findings include: During an interview on 8/12/20 at 2:18PM V2, Director of Nursing, said the plan of care is a collaboration from the assessments. During an interview on 8/13/20 at 8:45AM V15, Wound Nurse, said the Braden Scale is used to see if residents are at risk for wounds. V15 said assessment from the Braden Scale includes nutrition, incontinence, and mobility. V15 said the information obtained is used to determine the resident's care plan. V15 said the purpose of doing the assessments quarterly is to assess for any changes and if any changes are found the care plan will be updated. V15 said the Braden helps determine if care plan interventions are effective. V15 said V2, Director of Nursing, is supposed to ensure that quarterly assessments are being completed. V15 said R1 has no Braden scale for April 2020. V15 said the skin assessment she sees for R1 is The Unit Skilled Review dated July 2019. V15 said R2's last Braden Scale was done in October 2019. V15 said R2 is missing Braden Scales. V15 said R2's last Braden score is 16 and that means he is at risk for skin impairment. V15 said R3's last Braden Scale was done in January 2020, her score is 13 moderate risk. V15 said R3 should have had 2 Braden Scales done since January. During an interview on 8/14/20 at 9:29AM with V26, Nurse Practitioner, she said she expects the facility staff to perform assessments as the policy states. V26 said assessments should be done because if a resident's condition changes the plan is not working and the plan of care may need to be intervened with. During an interview on 8/14/20 at 2:34PM with V28, Minimum Data Set Nurse (MDS), said the formal tool used to code the risk for pressure ulcer / injury section of the MDS assessment is the Braden Scale. Records reviewed on 8/13/20 for R1's skin condition. The only documented skin condition record provided for review is dated 7/31/19. No Braden scale was found in the record or provided by the facility for review. Records reviewed on 8/13/20 for R2's most recent Braden Scale for Predicting Pressure Sore Risk is dated 10/22/19. Records reviewed on 8/13/20 for R3's most recent Braden Scale for Predicting Pressure Sore Risk is dated 1/13/20. Record Review of the Long Term Care Facility Resident Assessment Instrument 3.0 Useres Manual October 2019 on 8/14/20 section M0150 states Steps for Assessment review formal risk assessment tools to determine the resident ' s risk score. Record review of the facility's (undated) Policy and Procedure for the Treatment and Prevention of Skin Breakdown states Complete Braden Scale on admission and weekly for the first 4 weeks post admission, quarterly, and with significant change in status.
F 0689 **Level of harm** - Actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observations, and records reviewed the facility failed to follow their identified care plan interventions to prevent a fall. The facility failed to implement a care plan with interventions related to the contributing factors of a fall and failed to implement care plan interventions implemented after a fall. This failure resulted in R8 sustaining an acromioclavicular separation and scalp hematoma after falling from bed during care.This failure affected 3 of 4 (R8, R1, R2) residents reviewed for falls. Findings include: R8's [DIAGNOSES REDACTED]. During an interview on 8/12/20 at 8:50AM with V3, Unit Manager, she said an initial fall risk assessment is completed on admission and after every fall. V3 said the floor staff is notified of residents at risk for falls in report, during stand-up meetings, with the use falling star symbols, and oral reports given to CNAs daily. During an interview on 8/13/20 2:00PM, V2, Director of Nursing, said a Certified Nursing Assistant improperly rolled R8 on 7/12/20 and walked away and R8 rolled off the bed. V2 said R8 sustained a closed hematoma on her forehead and a right acromion process dislocation. During an interview on 8/13/20 at 2:17PM V16, Certified Nursing Assistant (CNA), said R8's care before the fall included staff to bathe her, 2 persons for transfers, and dependent on staff for incontinent cares. V16 said R2 requires 2 persons to reposition her. V16 said R8 now has a rail for her to grab and pull while in the bed. V16 said R8 did not always have the rail before the fall because it is removable. V16 said if R8 has a pillow or wedge she could be left on her side. V16 said R8 would not be safe left on her side without a device to support her. During an interview on 8/14/20 at 9:29AM with V26, Nurse Practitioner, she said she expects the facility to follow the resident plan of care, so if 2 persons are required for care then they should be using 2 persons. V26 said the fall on 7/12/20 was the cause of R8's shoulder dislocation. V26 said on her assessment prior to the fall R8 was able to move her arms without difficulty. When R8 was sent to the emergency room for evaluation following the fall they found she had the dislocation immediately on 7/12/20. During an interview on 8/14/20 at 11:52AM with V25, CNA, she said she was providing care to R8 on 7/12/20. R8 was in the bed and V25 left her to get more towels. V25 said she was providing care to R8 alone and no other staff was in the room. On 8/13/2020 at 3:06PM R8 observed awake and alert, in her bed eating a snack. Half side rails up, call light on her lap, name tag on her right wrist. No arm sling noted on either arm. There is a #2 posted on the wall above head of bed. R8's name appears as the first name on the list of residents outside of the room, but there is no star next to her name. During an interview on 8/14/20 at 9:25AM V29, Nurse, said R8 is cooperative with wearing her sling. V8 was a 2 person assist because she is heavy weight for one person to turn and reposition while in the bed. 8/14/20 Record review of R8's care plan for self-care performance deficient dated 2/22/20 intervention for bed mobility dated 2/22/19 states 2 staff to turn and reposition. Record review of R8's Fall Report on 8/14/20 dated 7/12/20 written by V24, Nurse, notes when asked what happened CNA reported that she attempted to roll resident to one side and went to go pick up materials, resident rolled out of bed. Evaluation noted to have a hematoma to forehead with swelling and bleeding. Record review of R8's care plan on 8/14/20 note date initiated 7/12/20 R8 had an actual fall with injury. CT scan performed positive for right acromion dislocation. Interventions dated 7/13/20 note CNA in service on how to do an Activity of Daily Living care regarding proper placement, repositioning and gathering material prior to attending to residents. Right arm sling to wear at all times except during ADL care. Review of Occupational Therapy Plan of Care dated 7/20/20 notes R8's Functional Deficits for Activity of Daily Living for hygiene required maximum assistance prior to the fall and her current level is dependent. R8's prior Functional Deficits for Activity of Daily Living for upper body dressing was moderate assistance and her current level of assistance is dependent. Record review of R8's physician orders [REDACTED]. [MEDICATION NAME] HCL tablet 50mg as needed for pain. Record review on 8/14/20 of R8's Emergency Department Chart Report dated 7/12/20 notes chief complaint fall. Diagnosis: [REDACTED]. 2). R1's [DIAGNOSES REDACTED]. R1's most recent admitted listed on the face sheet is 12/18/17. R1 is no longer in the facility. During an interview on 8/12/20 at 1:43PM V12, Nurse, said during her rounds on 4/13/20 she saw R1 sitting on the floor. R1 told her he did not know how he got to the floor. V12 said following a fall the department heads will discuss the fall the next day and discuss new interventions. V12 said prior to the fall she can not recall if R1 has any fall precautions in place. During an interview with V14, Nurse, on 8/12/20 at 3:15PM, he said Fall Risk Assessments should be done on

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

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F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) admission. V14 said the purpose of a Fall Risk Assessment is plan interventions to prevent falls. During an interview on 8/13/20 at 9:17AM V2 said if she would have done the fall follow up for R1 she would have a care plan entry for each fall dated 4/13/20 and 4/15/20. Surveyor asked V2 for the care plan following R1's 4/13/20 fall and V2 said It's not there that is why I didn't bring it. During an interview on 8/13/20 at 11:30AM V20, CNA, said she didn't think R1 was a fall risk. V20 said if a resident is a fall risk, she is made aware by the resident's gait and walking ability and the nurses will tell you who is a fall risk. V20 said the nurses never said R1 was a fall risk. V20 said someone who falls twice within a couple of days should be a fall risk. During an interview on 8/13/20 at 2:31PM with V21, Nurse, she said on 4/15/20 during rounds she saw R1 was on the floor. V21 said she was not familiar with R1 because she is a float nurse. V21 said she received report from the prior shift's nurse on 4/15/20. V21 said she was not made aware during report that R1 had a fall on 4/13/20. Record review on 8/12/20 of R1's Fall reports include fall on 4/13/20 and a fall on 4/15/20. Record review on 8/13/20 of Fall Risk Assessments dated 4/13/20 and 4/15/20. No other Fall Risk Assessments are present in R1's electronic record for review. Record review on 8/13/20 of R1's care plan includes a fall focus dated 4/15/20. Interventions to monitor the resident and neurological checks are both dated 4/15/20. No other interventions are on the care plan. 3). R2's [DIAGNOSES REDACTED]. During an interview with R2 on 8/12/20 at 12:40PM he said he fell a few weeks ago. R2 said he fell trying to change his brief while in bed because no one had changed him and he was wet. During an interview on 8/13/20 at 11:50AM with V18, Nurse, said on 7/24/20 R2 told her he was sitting at the edge of the bed and he slid to the floor. V18 said all residents are at risk for falls. V18 said the care plan interventions added should be something that address the situation related to the resident's fall. V18 said R2's wheel chair was not involved in this fall. V18 said the nonskid pad intervention will help when the resident is in the wheel chair, but if the resident is not in the wheel chair it won't help. During an interview on 8/13/20 at 11:18AM V19, Director of Rehab, said we had added R2 to case load on 7/22/20, before he fell , for decline involving problems with transfers and bed mobility. We screened him and noticed he had changed. V19 said after the fall R2 had told her he was trying to get his balance while sitting on the bed and he said he lowered himself to the floor. V19 said R2 is alert, oriented, and credible. V19 said she discovered R2 was on the floor and the wheel chair was nowhere near him when she saw him on the floor. On 8/13/20 at 10:48AM During an observation of R2 with V27, CNA, present R2 stood up from his wheel chair with assistance of V27. While standing surveyor observed wheel chair cushion in wheel chair. No non-skid device was on top of the cushion. Surveyor asked V27 if the nonskid is present under the cushion. V27 lifted the cushion and said no nonskid is present under the cushion. V27 said she had gotten R2 ready and into his chair in the morning. Record review on 8/12/20 of R2's Fall report dated 7/24/20 written by V18, Nurse, reads resident statement I slid while sitting at the edge of my bed. On the same report mental status documented as oriented to person, place, and situation. Record review on 8/12/20 of R2's Progress Notes dated 7/24/20 written by V18 read when resident was asked what happened verbally told slid while sitting at the edge of my bed. Record review on 8/12/20 of R2's Care Plan date initiated 3/3/20 notes the resident had an actual fall with no injury. Intervention dated 7/24/20 reads continue interventions, nonskid pad to wheel chair cushion, and rehabilitation to evaluate and treat as orders post fall. (Rehab had already been initiated on 7/22/20.) R2's Order Summary Report includes an order dated 7/20/20 for Occupational therapy to evaluate and treat. an order for [REDACTED]. The 3 orders are prior to the date of the fall on 7/24/20. R2's assessment for Functional Status dated 7/30/20 stated R2 requires extensive assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene. assessment dated [DATE] for Balance During Transitions and Walking is assessed as activity did not occur. Record review on 8/14/20 of the facility's undated Incident / Accident Facility Responsibility List states fall care plan interventions updated with date. The facility's undated Fall Program Guidelines reviewed on 8/18/20 states: Purpose to define guidelines in implementing a falls program to promote resident safety and prevent or reduce falls. Enroll resident's in Falling Star Program and communicate interventions to staff. Resident's identified as a fall risk will have an individualized care plan to address the contributing factors that place them at risk, goals to prevent falls / injuries, and interventions / approaches to promote safety of the resident.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observations, and records reviewed the facility failed to follow their facility policy to perform hand hygiene when exiting resident rooms; after direct contact with a resident' s skin; before and after handling a medication and did not follow their policy to wear proper Personal Protective Equipment (PPE) for contact/droplet isolation rooms and when potential exposure to blood/body fluids is anticipated. This failure affected 3 of 8 residents reviewed for infection control. Findings include: On 8/12/2020 at 10:23 AM Surveyor observed V6, Nurse, take blood pressure cuff to R5' s room and proceeded to take R5's blood pressure. V6 finished taking blood pressure, left the room, did not hand sanitize in or outside of the room. V6 passed hand sanitizer outside of room and at nurse' s station by the elevator. V6 put blood pressure cuff on the medication cart and proceeded to touch the top of the cart and other items on the cart. During an interview on 8/12/2020 at 10:40AM V6, said he is an agency nurse and he hand sanitizes when giving medication before going in and out of the resident' s room. V6 said if the resident is on contact / droplet isolation then he would wear PPE, goggles, gloves, face mask and gown. On 8/12/2020 at 12:06 PM surveyor heard R6 moaning and saw R6 squirming in bed through the open door. Surveyor knocked on the door and entered into room. Observed V6 standing straight up from bent position over the resident. R6 was squirming in the bed and sheets were bundled beneath her. V6 stated he was giving R6 medicine. V6 left room with medication in hand and returned to medication cart at the nurse' s station. V6 did not use hand sanitizer or wash his hands after leaving R6's room. Hand sanitizer located at nurses station by the elevator near R6's room on the wall. V6 placed medication on top of the cart and touched cart drawer. On 8/12/2020 at 12:20 PM surveyor observed V9, CNA, enter R4's room with another staff. R4' s room is located in the blue zone. There is a stop sign on the door that states: Please follow Personal Protective Equipment (PPE) Procedures. V9 entered R4's room wearing a mask and face shield and closed the door. PPE cart is located in the hall. At 12:24 PM V9 exited R4' s room no hand sanitizing observed. During an interview V9 said she went in R4's room to change and reposition R4. During an interview at 12:39 PM V9 said as far as she knows she did not have to wear a gown in R4 ' s room. During an interview on 8/12/2020 at 1:55 PM V1, Administrator, said blue zone is on the 4th floor and those residents are Persons Under Investigation (PUI) and quarantined for 14 days. V1 states the facility is following recommendations by Chicago Department of Health procedure. On 8/12/2020 at 12:34 PM surveyor observed V5, CNA, feeding R4 and wearing mask and face shield. There is a stop sign on the door that states: Please follow Personal Protective Equipment (PPE) Procedures. V11 referred to a piece of paper and stated that R4 is on 14 day quarantine for Covid-19. R4 is a new admission is a person under investigation (PUI). At 12:35 PM V11 states that V5 should be wearing gloves, but a gown is not required. During an interview on 8/12/20 12:37 PM V3, 4th floor manager, said when someone is on 14 day quarantine anyone that goes into the room should be wearing gloves, face shield, mask and gown. During an interview on 8/12/20 at 12:41 PM V5 said there was no need to wear a gown. V5 said only need to wear a gown if the resident has Covid. V5 states she didn't wear gloves while feeding R4 for dignity issues so the resident doesn't feel bad. Surveyor asked if resident ever expressed to her that she did not want her to wear gloves in her room and V5 said, no. During an interview on 8/12/20 at 1:07 PM V3, Unit Manager, said staff has had in-service on when to wear PPE and will have another one soon. During an interview on 8/12/20 at 3:00 PM V2, Director of Nursing, said to enter contact/droplet isolation room one should be wearing gown, gloves, mask, and face shield. The facility's Infection Prevention Manual vr 7, section 5 Hand Hygiene Program, page 13 states: Hand hygiene should be performed if there has been any contact with a resident, resident' s environment. III. Recommended opportunities for hand hygiene with alcohol based hand rubs include routine decontamination: a. Before direct contact with residents b. Before application of gloves c. After direct contact with a resident ' s skin. The facilities Medication administration policies and procedures manual effective 10/25/2014 states, Section A, #2: Handwashing and hand Sanitization: The person administering medications adheres to good hand hygiene, which includes washing hands thoroughly before beginning a medication pass, prior to handling any medication, after coming into direct contact with a resident, and before and after administration of ophthalmic, topical, vaginal, rectal and [MEDICATION NAME] preparations and medications given via enteral tubes. Examination gloves are worn when necessary (refer to specific administration procedures for each route in Sections IIA and IIB of this manual). Hand sanitization is done with an approved sanitizer between handwashings, when returning to the medication cart or preparation area (assuming hands have not touched a resident or potentially contaminated surface). Sanitization can be done at regular intervals during the medication ass such as after each room, again assuming handwashing is not indicated. Sanitization is not a substitute for proper handwashing, and washing should be done if there is any question. Review of the facilities Infection Prevention Policy: Standard precautions located within the ECG infection Prevention Manual 2020. Page 4 Section C: PPE available

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) includes gloves, gowns or aprons, masks, and eye protection (or face shields), and resuscitation devices. (See Figure1, Donning and Removing PPE.) 1) Gloves - gloves should be worn whenever exposure to the following is planned or anticipated. a. Blood/blood products/body fluids with visible blood, excretions. Secretions b. Performing venipuncture or invasive procedures c. Urine d. Feces e. Saliva f. Mucous membranes g. Wound drainage h. Drainage tubes i. Non-intact skin 2) Masks and/or eyewear - should be worn during procedures that are likely to generate droplets/splashing of blood/body fluids. 3) Gown/Aprons - should be worn when there is potential for soiling clothing with blood/body fluids. Record review of the of the policy, V1 said the facility is following, Chicago Department of Health procedure dated 7/20/2020, provided by the facility, states: Blue zone: New and readmitted residents. These residents should be placed in private rooms and quarantined from the date or (re)admission. If no symptoms develop within the 14 day quarantine period, these residents can move to the green zone.