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	IL6005177	A. BUILDING: _____ B. WING _____	C 10/05/2018

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MOSAIC OF LAKESHORE, THE	7200 NORTH SHERIDAN ROAD CHICAGO, IL 60626

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S 000	Initial Comments Complaint Investigation 1882768/IL102231 1883206/IL102697 1884049/IL103594 1885158/IL104788 1886280/IL106034	S 000		
S9999	Final Observations Statement of Licensure Violations (Violation 1 of 2) 300.610a) 300.1210b) 300.1210c) 300.1210d)6) 300.1220b)3) 300.3240a) 300.2900d)2) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as	S9999		

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S9999	Continued From page 2 nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) Section 300.2900 General Building Requirements d) Doors and Windows 2) All exterior doors shall be equipped with a signal that will alert the staff if a resident leaves the building. Any exterior door that is supervised during certain periods may have a disconnect device for part-time use. If there is constant 24 hour a day supervision of the door, a signal is not required. These requirements were not met as evidenced by: Based on observation, interview, and record review the facility failed to monitor and supervise two residents (R7, R8) to prevent the elopement of the resident. The facility failed to follow a resident's fall care plan and fall management policy by not frequently monitoring and evaluating one resident (R23) resulting in a hospitalization with fracture. The facility also failed to implement fall interventions to prevent one resident (R17) from frequently falling. These failures affect 4 (R7, R8, R23, R17) of 9 residents reviewed for accidents/incidents &supervision, in a sample of	S9999		

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S9999	Continued From page 3 23. These failures resulted in R23 sustaining a right femur fracture requiring hospitalization and treatment. Findings include: 1. R23 is a 74-year old male admitted to the facility on 4/18/18 from local acute care hospital with admission diagnoses including: Mild cognitive impairment, CVA (Cerebrovascular Accident), unspecified dementia and muscle weakness. MDS (Minimum Data Set) dated 7/18/18 reads ...Section C: Cognitive Patterns, Brief Interview for Mental Status (BIMS) ...C0500. Summary Score: 05 (indicated cognitively impaired) ...Section G. Functional Status: G0110. Activities of Daily Living (ADL) Assistance: ...B. Transfer: 3 (Extensive Assistance)/2 (One person physical Assist), C. Walk in room: 2 (Limited Assistance)/2, D. Walk in Corridor:2/2 ...G. Dressing: 3/2 ...I. Toilet use: 3/2 ...G0300. Balance During Transitions and Walking: 2 (Not steady, only able to stabilize with staff assistance)... "Care Plan Report" effective 4/19/18 - Present reads, Problems: Resident is at risk for falls: (resident had a fall on 8/10/18... on 9/3/18... Effective: 4/19/18 - Present ...Interventions: ...Monitor resident toileting patterns... Frequently check resident for toileting need ... "Care Plan Report" effective 4/21/18 reads, Problems: The resident is disoriented to place and time...this resident has problems with decision making, insight, logic, calculation reason, planning and judgment. This problem is related to a diagnosis of dementia...	S9999		

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Interventions: ...Provide reality based orientation information throughout the day to help the resident increase his/her comfort level and awareness of the environment...

"Care Plan Report" effective 6/4/18 to present reads, Problems: Resident is at potential risk for exit seeking... Interventions: ...Staff will monitor resident...

A record review indicates the following:

R23 was hospitalized from 8/10/18 - 8/15/18 as a result of an unwitnessed fall which occurred in the facility. R23 returned to the facility on 8/15/18 with a new diagnosis of closed displaced intertrochanteric fracture of right femur. "Quality assurance review" dated 8/10/18 reads, ...Root-Cause Analysis: Resident wandering in his room...

R3 was hospitalized from 9/24/18 - 10/2/18. R23 returned to the facility on 10/2/18. Hospital record dated 9/24/18 reads, "...History and Physical Note: ...Discussed with another RN (Registered Nurse) who was able to provide limited information per chart review - patient's nurse found him laying in bed "grimacing" and unable to respond to questions. He was unable to move his right leg. Significant deformity of right leg was noticed at the time. There is no documentation of a fall ...Of note, patient recently had ORIF (Open Reduction Internal Fixation) of right leg on 8/15/18 after resulting in minimally displaced intertrochanteric fracture of the right femur... He has presented to the ED (Emergency Department) several times with falls unwitnessed per NH - most recently on 9/3/18 with laceration to right forehead... In the ED, X-ray of right femur showed spiral fracture shaft of right femur with

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lateral displacement of distal fragment. CXR (Chest X-Ray) showed several acute left-sided rib fractures...orthopedic surgery was consulted with plan for ORIF of right femur this afternoon... MD (Medical Doctor) note dated 9/24/18 reads, ...This patient has sustained a right hip periprosthetic midshaft femur fracture at the level below a previous cephalo-medullary short nail that was placed about two months ago. The patient is non-verbal and it is not clear how long he has had this fracture for. Certainly he has sustained serious life-threatening injury and has experienced substantial blood loss from the fracture...he is becoming hypothermic and will need blood..."

"State Report" faxed to state agency dated 10/3/18 reads, ...Analysis/Conclusion: ...After staff were questioned, it was determined that the resident had a previous right hip fracture which may have caused the right hip to be weakened in nature and not completely healed thus during routine care the right hip broke again...

"Quality Assurance Review" dated 9/23/18 reads, ...Root-Cause Analysis: ...resident sometimes does attempt to walk with unsteady gait or sitting on the edge of the bed...

On 10/3/18 at 10:30am, V3 (DON/Director of Nursing) stated, "On 9/23/18 around 5:30am, the nurse noticed the resident going in/out of bed and put resident in a geriatric chair by the nursing station. At 6:30am, the resident was transferred back to bed, ADL (Activities Daily Living) provided and breakfast given. On 9/23/18 at about 11pm, the nurse noted the resident has a swollen right thigh. MD (Medical Doctor) and nurse supervisor were notified. The resident was transferred to the hospital on 9/24/18 and was discharged on 10/2.

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The resident had a previous fracture on 8/10/18 from a fall and was hospitalized from 8/10/18 to 8/15/18. My conclusion from my investigation is the resident's hip was re-fractured during routine care due to resident's fractured hip is not totally mended from the last fall."

On 10/5/18 at 9:45am, V17 (R23's attending physician) stated, "Based on the chest x-ray result of multiple acute rib fractures and right femur fracture, the resident might have had a fall in the facility. Normally routine care won't cause that kind of injury unless the resident is non-compliant and gets up suddenly during the delivery of routine care. Only a fall can cause that kind of injury."

On 10/5/18 at 11:50am, this writer noted R23 in bed wearing only an incontinence brief. R23 is alert and oriented to self only. V23 (CNA/Certified Nursing Aide) stated, "The resident removed his blanket every time I tried putting it on him." This writer requested V23 to make another attempt to place a blanket over R23. R23 did not resist and soon fell asleep.

On 10/5/18 at 11:55am, V23 stated, "The resident is a one-person assist in ADL care and in transferring and walking; his gait is not steady. He held onto his side rail when I changed him but he released his hand and allowed me to change him once I gently rubbed his hand and explained to him what I am doing. He was not fighting or trying to get up."

On 10/5/18 at 12:25pm, V24 (CNA) stated, "I took care of R23 on 9/22/18 from 3p -11p. I changed his incontinence brief twice with the help from another CNA. The resident was cooperative, not combative or trying to get up in the middle of the

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S9999	Continued From page 7 care." On 10/5/18 at 2:42pm, V3 stated, "After reviewing the hospital record from 9/24 to 10/2, I agreed that the resident had a new fracture from the last incident. The resident has low safety awareness due to his dementia. Nursing staff keep residents under observation and watch for behaviors such as exiting bed and unsteady gait, but I have no tool of frequent monitoring." "Fall Management Guidelines" issued 10/2014 reads, ...Fall occurrence: ...Frequent monitoring and evaluating of the resident is important to evaluate response to intervention and identification of any changes...these evaluation findings are recorded in the clinical record... 2. The facility presented fall log document that R17 had a fall happen on 2/4/18 with scratch, 6/14/18 with no apparent injury, and 9/18/18 with skin abrasion. Record review of facility fall log documents that R17 had unknown injury of bruise/skin tear documented on 2/4/18, 2/25/18, 3/1/18, 3/13/18, 4/4/18, 5/1/18, 5/10/18, and 7/22/18. Record review on care plan documents care plan was revised after each fall. On 9/28/18 at 9:50 AM V3 stated, "The purpose of revising care plan after fall incident is to implement new interventions to prevent future falls. If the patient is falling again, that means interventions are not effective to prevent fall." On 9/27/18 at 1:15 PM, surveyor observed R17 moved to second floor and no floor mattress was in place at bedside as per fall care plan.	S9999		

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On 9/28/18 at 10:10 AM, observed R17 with healing brown marks with right thigh and left small finger swollen.

Record review on clinical record indicates that these injuries were recorded as self-inflicted.

Record review on facility presented Fall Management Guidelines dated on 10/2014 document: The resident's plan of care is revised to identify intervention/changes based on initial evaluation and possible cause of fall. Frequent monitoring and evaluation of the resident is important to evaluate response to interventions and identification of any changes.

3. R7's care plan, undated, documents that R7 has dementia and wandering behaviors. R7 is an elopement risk and the facility is to provide a wander guard. R7 has the physical and mental capability to find the way out of the facility, but evaluation indicates that R7 cannot thrive safely outside of the facility unescorted.

Incident report dated 05/21/2018 documents R7's elopement from the facility. Event description dated 05/21/2018 documents that R7 (a resident with frequent wandering behavior, verbalizations of wanting to return home, and prior attempts to leave the facility unescorted) was sitting in the theater area on the first floor. The nurse on duty notified V27 (former facility receptionist) that R7 was at risk for elopement and not to let R7 come near the front door. V27 stated that R7 would not come near the front door if she was at the front desk. At 10:30PM, R7 was not able to be located in the facility. An elopement code was called. Staff began search internally and externally for R7. The physician, V1 (Executive Director), and

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state guardian were notified. A police report was filed. After review of the facility security video system, it was discovered that at 7:34PM, R7 left his room with a checkered coat and hat on. At 8:07PM, R7 exited the theater area and went to the patio. At 9:16PM, R7 climbed over the patio fence and took off walking down the street. It was determined that the patio exit was not armed with a wander guard transmitter. R7 returned to the facility and expired under hospice care 08/15/2018.

Statement dated 05/21/2018 notes that V27 stated, "R7 went missing last night. I was notified by nursing staff that R7 had left the floor and I was not supposed to let him leave. I did not see R7 physically approach the desk area. To my knowledge, R7 was in the theater room and I never saw him approach the patio."

On 09/26/2018, at 10:49AM, V1 stated, "R7 has behaviors before he eloped. If staff was out on the patio, R7 would not have eloped."

On 10/05/2018 at 11:34AM, V1 stated, "If a wander guard system was by the patio door, R7 could have been monitored. There was no wander guard system in place. The facility relies on reception or staff to monitor residents. R7 had dementia. R7 stayed in the dining room and then sat on the patio for almost an hour or less. R7 then decided to jump over the fence. There is a camera on the patio that is monitored by the receptionist. V27 was given instruction that R27 was down in the dining room and he needed to be monitored. V27 said she did not see R7 go to the patio door. Residents can be physically and mentally harmed if/when they elope."

Root cause analysis documents, undated, note

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that that nursing staff should not have allowed R7, who was an at-risk resident, to be left unsupervised. There was a lack of communication between staff as to where R7 went and if he had left the building. V27 should have not been left in charge of monitoring R7 due to the high activity at the reception desk. It was noted that the wander guard system is inconsistent in sensing the transponders. There was not a wander guard transmitter on the exit door of the patio. Staff did not follow the policy in regard to elopement search and procedures. There was a breakdown in communication and verification of residents, which caused the initial search procedures/codes to be delayed. The nurse assigned did not follow facility procedures to account for all of her residents at the start of the shift. Communication among staff about R7's location was not adequate. R7 was at high risk for elopement and should not be left in an environment that was not frequently monitored.

Event description documentation dated 04/02/2018 documents that at 8:40AM, R8 was not found in her room. A search was initiated. A code yellow was called. The physician was notified and staff initiated a community search with no findings. At 10:50PM, R8 returned to the facility. R8 was very confused during the interview, but was able to recall some of the elopement.

On 09/25/2018, AT 1:19PM, R8 stated, "I do remember leaving the building for pizza."

On 09/26/2018 at 11:24AM, V28 (Maintenance) stated, "I did not notice R8. R8's wander guard did not go off. I was talking with someone else at the receptionist desk. R8 went out with another resident who can leave the facility. I opened the

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door for that resident sometime in the afternoon. I did not notice that R8 had left. The wander guard was not working. I should have been more alert and should have made sure the wander guard was working."

Care plan for R8, undated, documents that R8 is at increased risk for exit seeking. Community Pass Privilege Assessment dated 04/12/2018, documents that R8 is at risk for elopement. R8 experiences cognitive deficits that would make it necessary for R8 to use an escort in the community at all times. Exit Seeking Risk Screen, dated 04/12/2018 notes that R8 has a diagnosis of dementia/Alzheimer's confusion.

Root cause analysis documents, undated, note that there was a lack of communication between staff as to where R8 went and if she had left the building. Reception should not have been left in charge of the monitoring of R8 due to the high activity at the reception desk. Staff did not follow the policy in regard to elopement search and procedures. There was a breakdown in communication and verification of residents, which caused the initial search procedures/code to be delayed. Communication among staff about R8's location was not adequate.

Facility policy dated December 2008, documents that staff shall promptly report any resident who tries to leave the premises or is suspected of being missing to the Charge Nurse or Director of Nursing. If an employee observed a resident leaving the premises, he/should attempt to prevent the departure in a courteous manner.

(A)

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(Violation 2 of 2)

300.610a)
300.1210b)
300.1210d)1)
300.1210d)2)
300.1210d)3)
300.3240a)

Section 300.610 Resident Care Policies
a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

Section 300.1210 General Requirements for Nursing and Personal Care
b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

d) Pursuant to subsection (a), general nursing

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MOSAIC OF LAKESHORE, THE	7200 NORTH SHERIDAN ROAD CHICAGO, IL 60626

(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) COMPLETE DATE
S9999	Continued From page 13 care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. 2) All treatments and procedures shall be administered as ordered by the physician. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These requirements were not met as evidenced by: Based on observation, interview and record review, the facility failed to follow its pain assessment policy by not ensuring a resident was assessed for pain at least each shift for acute pain. The facility also failed to follow its medication management policy by not providing scheduled pain medication to a resident. These failures affect one of three residents (R3) reviewed for pain in a total sample of 23. As a result, R3 was allowed to have a self-reported pain level of "30" on a 1-10 pain scale. Findings include:	S9999		

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R3 is a 56-year old male admitted on 1/25/18 from a long-term care facility with diagnoses which include spinal stenosis, major depressive disorder, anxiety disorder and morbid obesity.

R3's "Physician Order Sheet" reads (in part), Oxycodone HCL 10mg (milligram), (1 tablet) TABLET Oral, Related Diagnoses: Spinal Stenosis, Lumbosacral Region, As needed Every Six Hours, starting 2/2/18, traMADol ER mg (milligram) tablet, extended release 24 hr (a tab) TABLET, EXTENDED RELEASE 24 HR Oral, Related Diagnoses: Spinal Stenosis, Lumbosacral Region, Two times daily, starting 3/11/18.

On 9/25/18 at 10:45am, R3 stated, "I have not been given the Tramadol Extended Release for the last few days. I was told by the nurse they have not received the pain medication from Pharmacy because of problems between them and the Pharmacy. On a scale of 1-10, my pain level is at 30. I am constantly in pain due to my spinal stenosis from a car accident. The nurse gives me Oxycodone when I ask for it. The Oxycodone relieves my pain for only about three hours; I have to wait for another three hours to have another Oxycodone because it is given every six hours. The nurse does not come in often to ask about my pain. I need the Tramadol Extended Release to be medicated on a constant level."

On 9/25/18 at 12:05pm, V11 (LPN/Licensed Practical Nurse) stated, "The resident has a medical condition that causes him pain. He is on Oxycodone PRN (as needed) every 6 hours and on Tramadol ER. The policy is to ask him about his pain in the morning and check with him every

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two hours after that. When I came to work yesterday from being off a few days, I noticed there is no Tramadol ER left for the resident. I notified the Director of Nursing and followed up with Pharmacy. I was told by Pharmacy that they needed the script. I made the script and had the Nurse Practitioner sign it and faxed it to Pharmacy."

On 9/26/18 at 12:10pm, R3 stated, "I still have not received the Tramadol ER. This is the 4th time they ran out of it since February. During the last few days, the pain has affected me both physically and mentally. I have lost my appetite and feel edgy and bitchy; I don't like how I feel." This writer noted R3 becoming tearful while describing how the constant pain is affecting him.

On 9/27/18 at 11: 45am, V3 (DON/Director of Nursing) stated, "I was informed on the 24th by V11 about not having the Tramadol ER for the resident. The resident is prescribed to have the Tramadol ER twice a day, at 9am and 9pm. The extended release pain medication acts for an extended period of time. We normally received 60 tablets but because of insurance problems, we only received 14 tablets on 9/10/18. The nurse who signed off on the medication on the 10th should have contacted the supervisor or myself. We would have communicated with Pharmacy and the attending physician earlier. I believe the resident has experienced pain because he did not get the pain medication he needs. Before administering pain medication, the nurse must complete a pain assessment. Nurses should be checking every two hours and PRN for pain."

On 9/27/18 on 1:30pm, R3 stated, "I received the Tramadol ER last night around 9:30pm and this morning. I feel a lot better and have gained my

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S9999	Continued From page 16 appetite back." This writer noted R3 ate 100% of his lunch. A review of "Resident Vital Sign Reports" indicates pain assessment not completed on the following dates/shifts: 9/22/18 am shift, 9/22/18 pm shift, 9/23/18 am shift, 9/23/18 pm, 9/25/18 pm shift. A review of "Controlled Substances Proof of Use" records indicates R3 was not provided with the prescribed Tramadol ER on the following dates/times: 4/19 am, 4/19/18 pm, 5/15/18 pm, 5/16/18 am, 7/11/18 pm, 8/21/18 pm, 9//22 am, 9/22/18 pm, 9/23/18 am, 9/23/18 pm. 9/24/18 am, 9/24/18 pm, 9/25/18 am, 9/25/18 pm, 9/26/18 am. "Care Plan report" reads, Problems: (resident has alteration in comfort: pain r/t (related to) musculoskeletal impairment secondary to diagnosis of spinal stenosis as evidenced by chronic back pain... Goal Date: 10/30/18... Interventions: Assess and Monitor for nonverbal indicators of pain... Administer and monitor for effectiveness and for possible side effects from medication... "Pain Assessment and Management" policy revised October 2010 reads, General Guidelines: ...6. Assess the resident's pain and consequences of pain at least each shift for acute pain. "Medication Management Orders Management: Medication and Treatment Orders" dated 3/17/2016 reads, Guideline: ...Complete medication orders are obtained for medication(s) and/or treatment(s).	S9999		

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