STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005177	A. BUILDING: _____ B. WING _____	C 04/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOSAIC OF LAKESHORE, THE	7200 NORTH SHERIDAN ROAD CHICAGO, IL 60626

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S 000	Initial Comments Complaint Investigation 1881927/IL101310 1882098/IL101506	S 000		
S9999	Final Observations Statement of Licensure Violations 300.1010h) 300.1210b) 300.1210d)3) 300.1210d)5) 300.3240a) Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. 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	S9999	Attachment A Statement of Licensure Violations	

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care needs of the resident.
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:
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.
5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

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 are not met as evidenced by:

Based on interview and record review, the facility failed to assess and identify a deep tissue injury and failed to follow their care plan interventions by not notifying Nurse or Physician of skin changes for 1 of 3 residents (R2) reviewed for pressure sore development. This failure resulted in one resident (R2) acquiring a deep tissue injury

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S9999	Continued From page 2 developing into a stage 4 pressure ulcer that became infected and required hospitalization. Findings Include: The medical record documents R2 as a 46 year old admitted to the facility on 6/7/2017 with diagnoses that include dysphagia, anoxic brain damage, hypertension, hepatitis C, substance abuse and muscle weakness. R2 was discharged to a local hospital on 11/8/17 and no longer resides at the facility. The first progress note addressing the sacrum wound for R2 is 9/1/17 by V5 RN (Registered Nurse) documents: Staff attention was called the resident's sacrum, when assessed no dressing was in place, staff cleaned the wound with NS (normal saline) dressing applied. Will continue to monitor. Endorse to the next shift to notify wound nurse. Progress Note for R2 dated 9/1/17 by V9 Wound Care LPN (Licensed Practical Nurse) documents: unstageable ulcer noted to sacrum/coccyx. Foul smell noted. Per MD (Medical Doctor) stat (immediate) wound culture, stat CBC (complete blood count), cmp (comprehensive metabolic panel), start IV (intravenous) ABT (antibiotic therapy) Vanco (vancomycin) 1 gram x 1 dose, then Zosyn 3.37 gm Q8H (every 8 hours) X 10 days, 0.9 NS (normal saline) 100 cc (centimeter) per hour x 2 bags. Air mattress ordered and in place. Order Dakins solution moist gauze BID (twice a day). Education provided regarding the importance of turning and repositioning. Resident's family was notified of wound and new orders and gave verbal consent for orders. Family gave consent for PICC line (peripherally inserted central catheter) if needed.	S9999		

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The Weekly Pressure Ulcer Evaluation report dated 9/1/18 for R2 documents suspected deep tissue injury sacrum/coccyx measurements length 7.00 cm (centimeter) by width 8.00 cm by depth 1.60 cm.

On 4/17/18 at 11:00 AM V9 Wound Care LPN stated, "9/1/17 was the first time I saw the wound (R2's sacrum/coccyx). It had not been reported to the wound team. It looked bad and it smelled bad. I notified V13 PCP (Primary Care Physician) at once and was given orders. The wound had to be there awhile. I remember the 11:00 PM to 7:00 AM Nurse reported to the 7:00 AM to 3:00 PM Nurse, who reported it to me. This wound was upsetting to me. The CNA (Certified Nursing Assistant) or Nurse should notify the wound care team immediately when there is a wound."

On 4/17/18 at 3:00 PM V5 RN stated, "R2's wound had an odor, slightly open. I only worked that day, I'm not a regular. I didn't see that patient (R2) before."

On 4/17/18 at 10:30 AM V8 Wound Care Coordinator LPN stated, "My understanding is the nurse and CNA didn't report the wound to the wound care team. I believe there was an investigation concerning R2's wound. I was not involved in the investigation. I don't know how a wound gets that big unnoticed."

On 4/19/18 at 1:10 PM V1 Administrator stated, "We did do an investigation concerning R2's pressure ulcer. We terminated a (V16) CNA (Certified Nursing Assistant). V16 stated he/she saw a blister on R2's sacrum about two weeks before 9/1/17 and did not report it to anyone. V16 stated he/she didn't think it was anything. That is

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why V16 was terminated, because the skin condition was not reported. The CNAs have been instructed to report all skin changes to the Nurse."

Progress Note dated 9/4/17 for R2 documents, relayed lab results to MD (Medical Doctor) with orders to send resident to hospital.

Laboratory results dated 9/1/17 for R2 document white blood cells 19.7 H (high) normal range 4.8-10.8.

Wound Culture result dated 9/5/17 for R2 documents specimen sacral proteus mirabilis moderate growth, enterbacter cloacae light growth.

On 4/18/18 at 11:15 AM V13 PCP stated, "It's hard to believe an unstageable wound gets that big overnight. There had to be something there before, especially if it was infected. The wound may have been the cause of the acute kidney injury (dehydration); infection is usually the cause. I had heard there was an inquiry into this wound."

Local hospital V17 admission medical records document on 9/4/17 R2 had a stage 4 sacral pressure ulcer. Laboratory creatinine (kidney function) value of 0.3 low, normal range 0.7 - 1.3. white blood count 14.54 high. The admitting diagnosis was sepsis, secondary dehydration.

R2's Care Plan dated 6/25/17 documents: R2 is at risk for impaired skin integrity related to incontinence of bowel and bladder. Interventions include: Report changes in skin status to physician. Notify nurse immediately of any new areas of skin breakdown, redness, blisters, bruises, discoloration noted during bathing and

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S9999	Continued From page 5 daily care. The MD'S (Minimum Data Set) for R 2 dated 9/12/17 documents Section C Cognitive, decision Making as severely impaired. Section G Functional Status, bed mobility as total dependence with a two person assist, transfer as total dependence with a two person assist. (B)	S9999		

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F 000	INITIAL COMMENTS Complaint Investigation 1881529/IL100895 - No deficiency 1881927/IL101310 - F686 1882098/IL101506 - F693, F686 1882342/IL101766 - No deficiency	F 000		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to assess and identify a deep tissue injury and failed to follow their care plan interventions by not notifying Nurse or Physician of skin changes for 1 of 3 residents (R2) reviewed for pressure sore development. This failure resulted in one resident (R2) acquiring a deep tissue injury developing into a stage 4 pressure ulcer that became infected and required hospitalization. Findings Include:	F 686		5/15/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 05/11/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 686	Continued From page 1 The medical record documents R2 as a 46 year old admitted to the facility on 6/7/2017 with diagnoses that include dysphagia, anoxic brain damage, hypertension, hepatitis C, substance abuse and muscle weakness. R2 was discharged to a local hospital on 11/8/17 and no longer resides at the facility. The first progress note addressing the sacrum wound for R2 is 9/1/17 by V5 RN (Registered Nurse) documents: Staff attention was called the resident's sacrum, when assessed no dressing was in place, staff cleaned the wound with NS (normal saline) dressing applied. Will continue to monitor. Endorse to the next shift to notify wound nurse. Progress Note for R2 dated 9/1/17 by V9 Wound Care LPN (Licensed Practical Nurse) documents: unstageable ulcer noted to sacrum/coccyx. Foul smell noted. Per MD (Medical Doctor) stat (immediate) wound culture, stat CBC (complete blood count), cmp (comprehensive metabolic panel), start IV (intravenous) ABT (antibiotic therapy) Vanco (vancomycin) 1 gram x 1 dose, then Zosyn 3.37 gm Q8H (every 8 hours) X 10 days, 0.9 NS (normal saline) 100 cc (centimeter) per hour x 2 bags. Air mattress ordered and in place. Order Dakins solution moist gauze BID (twice a day). Education provided regarding the importance of turning and repositioning. Resident's family was notified of wound and new orders and gave verbal consent for orders. Family gave consent for PICC line (peripherally inserted central catheter) if needed. The Weekly Pressure Ulcer Evaluation report dated 9/1/18 for R2 documents suspected deep tissue injury sacrum/coccyx measurements	F 686		

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F 686	Continued From page 2	F 686		

length 7.00 cm (centimeter) by width 8.00 cm by depth 1.60 cm.

On 4/17/18 at 11:00 AM V9 Wound Care LPN stated, "9/1/17 was the first time I saw the wound (R2's sacrum/coccyx). It had not been reported to the wound team. It looked bad and it smelled bad. I notified V13 PCP (Primary Care Physician) at once and was given orders. The wound had to be there awhile. I remember the 11:00 PM to 7:00 AM Nurse reported to the 7:00 AM to 3:00 PM Nurse, who reported it to me. This wound was upsetting to me. The CNA (Certified Nursing Assistant) or Nurse should notify the wound care team immediately when there is a wound."

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F 686	Continued From page 3 Nurse." Progress Note dated 9/4/17 for R2 documents, relayed lab results to MD (Medical Doctor) with orders to send resident to hospital. Laboratory results dated 9/1/17 for R2 document white blood cells 19.7 H (high) normal range 4.8-10.8. Wound Culture result dated 9/5/17 for R2 documents specimen sacral proteus mirabilis moderate growth, enterbacter cloacae light growth. On 4/18/18 at 11:15 AM V13 PCP stated, "It's hard to believe an unstageable wound gets that big overnight. There had to be something there before, especially if it was infected. The wound may have been the cause of the acute kidney injury (dehydration); infection is usually the cause. I had heard there was an inquiry into this wound." Local hospital V17 admission medical records document on 9/4/17 R2 had a stage 4 sacral pressure ulcer. Laboratory creatinine (kidney function) value of 0.3 low, normal range 0.7 - 1.3. white blood count 14.54 high. The admitting diagnosis was sepsis, secondary dehydration. R2's Care Plan dated 6/25/17 documents: R2 is at risk for impaired skin integrity related to incontinence of bowel and bladder. Interventions include: Report changes in skin status to physician. Notify nurse immediately of any new areas of skin breakdown, redness, blisters, bruises, discoloration noted during bathing and daily care.	F 686		

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F 686	Continued From page 4 The MD'S (Minimum Data Set) for R 2 dated 9/12/17 documents Section C Cognitive, decision Making as severely impaired. Section G Functional Status, bed mobility as total dependence with a two person assist, transfer as total dependence with a two person assist.	F 686		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to follow their policy by not checking patency of a gastrostomy tube before beginning a feeding for one resident (R5) of two residents reviewed for gastrostomy tube	F 693		5/15/18

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F 693	Continued From page 5 feeding. Findings Include: On 4/13/18 at 12:00 PM V10 RN (Registered Nurse) flushed R5's g-tube (gastrostomy) with 250 cc (centimeter) of water by gravity and started the g-tube feeding of Nepro 1.8 at 50 cc per hour over 20 hours. V10 did not listen to the abdomen or check residual stomach contents. V10 stated, "I did not do a residual because I did it this morning. I should have. The reason we check every time is to make sure the resident is digesting and to make sure (there is) no distention." On 4/20/18 at 11:45 AM V2 DON (Director of Nursing) stated, "The nurse should always check placement of a g-tube before starting a feeding." The facility policy titled Maintaining Patency of a Feeding Tube (Flushing) dated December 2011 documents: 7. Verify placement g- tube by injecting air into tube while listening to abdomen with a stethoscope for a bubbling sound.	F 693		