STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145244	A. BUILDING _____ B. WING _____	08/27/2020

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0604 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure that a resident was not physically restrained which affected one (R2) of three residents reviewed for restraint usage. Findings include: R2 was a [AGE] year old with [DIAGNOSES REDACTED]. On 8/25/2020 at 4:21 pm, V1 (Administrator) stated that she is the abuse coordinator for the facility. V1 stated that on 11/27/2019, she was informed by V19 (Human Resources Director) of an allegation of R2 being restrained by V10 (Licensed Practical Nurse/LPN). V1 stated that V19 had received this allegation from V11 (Former Employee, Registered Nurse/RN) and wrote her statement. V1 then interviewed V11. V1 stated that on 11/20/2019, during the 11:00 pm to 7:00 am shift, V11 said that R2 was a fall risk and that V10 tied R2 to the wheelchair using a gait belt around R2's waist, then tied R2's wheelchair to the bed. In facility document, titled Statement and dated 11/27/2019, V19 documented V11's statement, which reads, During facility orientation, (V11) informed writer that (V10) used restraints on 11:00 pm to 7:00 am shift because (R2) kept getting up in the middle of the night. Per (V11), (V10) tied (R2) hands to the wheelchair. On 12/2/2019, V1 continued to document V11's statement, which reads, in part, Sitting at nurse's station, (V11) was being oriented. (V10) informed me that (R2) was a fall risk. (R2) was sitting in the wheelchair. Wheelchair was tied to the bed and (R2) was tied to the wheelchair with gait belt. In R2's Illinois Department of Public Health (IDPH) initial report, dated 11/27/2019, V1 documented, in part: Brief Description of Incident: (V11) alleged that another nurse (V10) was restraining a resident (R2). Immediate Action Taken: . (V10) suspended pending investigation. Investigation in progress. On 8/25/2020 at 4:21 pm, V1 stated that she immediately suspended V10 (LPN) during her investigation. V1 stated that she interviewed all staff that were working on 11/20/2019, 11:00 pm to 7:00 am shift, on R2's dementia unit. V1 stated that she interviewed V10 about the allegation of restraining R2. In facility document, titled Statement and dated 12/2/2019, V1 documented V10's statement, which reads, When (V10) came to work, (R2) was in wheelchair. (R2) was trying to jump out of wheelchair. I put gait belt around (R2). The wheelchair was tied to the bed. (V10) tied the wheelchair to the bed. No one was is (R2's) room with (R2) when (R2) was up in wheelchair. The door was open. (V10) could see (R2) from nurse station. After one hour, (V10) put (R2) to bed. (R2) sleep all night after (V10) put (R2) to bed. On 8/26/2020 at 3:55 pm, V10 (LPN) stated, I tied (R2's) wheelchair to keep it from moving. I don't want (R2) to roll wheelchair so I tied wheelchair to leg of bed. I should not have done it. It was a mistake. V10 stated that he used a gait belt to tie R2's wheelchair to the leg of the bed so R2's wheelchair brakes wouldn't come loose, and R2 would try to move by R2's self. V10 stated that if he let R2 loose in wheelchair then R2 could already be down on the floor from a fall. V10 further stated that R2 is a fall risk due to unsteady gait and that her primary movement is with R2's wheelchair. V10 added that R2 was confused and would try to get up from the wheelchair or the bed throughout the night. V10 stated that when R2 repeatedly was trying to get up and it got to be too much, a certified nursing assistant (CNA) was assigned one on one monitoring for R2. V10 said that on the night shift on 11/20/2019, there were only two CNA's working on the dementia unit, when there were three scheduled. V10 stated that one on one monitoring of R2 can be done when the dementia unit is staffed with three CNA's, but not with two CNA's. Facility document, titled CNA Daily Schedule 11pm to 7am Shift and dated 11/20/2019, documents, in part, that three CNA's were scheduled and listed as V12, V13 and V14. On 8/26/2020 at 9:08 am, V14 (CNA) stated that he did remember working that night on 11/20/2019. V14 stated that R2 was in R2's wheelchair in R2's room by R2's self and that V10 was looking at R2 from the nurse's station. V14 stated that R2 was not allowed to walk due to unsteady gait and that's why (R2's) in a wheelchair for fall risk. V14 stated that R2's wheelchair is R2's mode of transportation. V14 stated that on nights when R2 wouldn't sleep, R2 would be in wheelchair at the nurse's station for monitoring by staff. V14 said that if R2 would stand up from the wheelchair, V14 would tell R2 to sit down. On 8/26/2020 at 11:43 am, V13 (CNA) stated that due to the incident being quite a while back, she could not recall if she worked night shift on 11/20/2019. V13 stated that when R2 would keep trying to get out of bed at night, R2 would be placed at the nurse's station in R2's wheelchair for close monitoring due to being a fall risk. V13 stated that if R2 was awake in R2's room, then a CNA would be one on one monitoring R2. In facility document, titled Statement and dated 12/4/2019, V13 (CNA) indicates that she worked on the date of the incident, 11/20/2019. On 8/27/2020 at 12:35 pm, V12 (CNA) stated that she did not work on the dementia unit on the night shift of 11/20/2019. In a clinical note, dated 12/3/2019 at 2:57 am, V24 (LPN) documented, in part, (R2) continued to get up and refused to sleep or stay in bed. There are only two CNA for thirty residents who in need of attention every minute. (R2) is in need of 1/1 monitoring throughout this shift. On 8/25/2020 at 4:21 pm, V1 stated that the dementia unit is normally staffed with three CNA's every night shift. On 8/25/2020 at 3:52 pm, V2 (Director of Nursing) stated that restraints are not to be used on any resident in the facility for staff convenience. V2 confirmed that R2's primary mode of transportation was R2's wheelchair. In R2's IDPH final report, dated 12/4/2019, V1 documented, in part: Based on statements obtained from (V10) and (V11). Investigation was able to conclude per (V10) the wheelchair was tied to the bed. The investigation was unable to conclude in fact, if (R2) gait belt was tied to the wheelchair . (V10) was suspended for 5 day, educated on facility restraint policy and removed from (R2) care. V10's Employee Report, dated 12/4/2019, documents, in part: Employee Action/Discipline: Suspension. Procedure/Rule Violation. (V10) tied (R2's) wheelchair to the bed to prevent (R2) from falling . (V10) did not follow facility's policy on restraints. Facility policy, titled Use of Restraints and dated December 2008, documents, in part: Policy Statement: Restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully. Restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience, or for the prevention of falls. Policy Interpretation and Implementation: 1. Physical Restraints are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body.

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

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.