| 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 _____ | 09/24/2020 |

| 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 0609<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview and record review the facility failed to follow their policy and procedures and report all allegations of injury of unknown origin to the State Agency within 2 to 24 hours for one (R1) of 3 residents reviewed for abuse reporting. Findings include: R1 has [DIAGNOSES REDACTED]. Facility's initial report to the Illinois Department of Public Health (dated 9/11/2020) regarding swelling and bruising to left side of R1's face was reviewed. Review of the facility's final report for swelling and bruising to left side of R1's face (dated 9/18/2020) shows the following: Ultrasound venous doppler of bilateral lower extremities were negative for [MEDICAL CONDITION]. CT of facial bones show no evidence of fracture; left peri orbital and maxillary region soft tissue swelling, induration and localization hematoma. CT of head showed no acute changes demonstrated, extensive arthritic changes, small elbow effusion. R1's hospital records dated 9/11/2020 shows, in part: ED Diagnosis: [REDACTED]. Upon asking patient about the bruising patient was not able to recall what happened. Per history obtained from rehab facility, patient is in long term care for management of dementia. At baseline patient is alert and oriented x1, usually unaware of time and place. Rehab facility states that she has had history of recurrent falls in past. This morning the nurse noted bruising on the left face beneath the left eye. Several other bruises on the right arm noted as well. The patient's family was visiting today and requested an X-ray with lab work. Before the X-ray was done, family had called 911 requesting the patient to be brought to the ER for evaluation. R1's progress notes dated 9/12/2020 at 12:45pm documented by V4 (Nurse) show call made to (hospital) for follow up of resident and admitting DX (diagnosis). Per RN (Registered Nurse) resident was admitted for multiple bruises and lower extremity swelling. All responsible parties notified. On 9/22/2020 at 12:52pm V4 (nurse) stated she reported this information to the charge nurse when she received the information. V4 said she did not report this to the administrator. V4 said she does not know where the multiple bruising reported came from. R1's progress notes dated 9/2/2020 show [MEDICAL CONDITION] of BLE (Bilateral Lower Extremities) - stable, X-ray of left foot and ankle, U/S Doppler ordered, restorative therapy, keep leg elevated, compression stockings, and monitor for worsening. Bruise/Swelling of Left Cheek - Stable, Ice pack for swelling/comfort, Tylenol as needed for pain, monitor patient for any neurological changes or injuries, fall precautions. Labs, clinical notes, and assessments reviewed. Moderate complexity due to multiple chronic medical conditions. On 9/23/2020 3:08p.m V2 (Director of Nursing) stated she read R1's progress note on 9 /14/2020 regarding R1 being admitted with multiple bruising and lower extremity swelling. V2 stated when she interviewed V4 (nurse), V4 denied seeing any bruising on R1's arms. V2 stated she did not contact the hospital to inquire about the bruising observed on R1 while R1 was in the ER. Facility presented its' initial investigation dated 9/23/2020 showing on 9/22/2020 the facility learned for the first time that the hospital suspects that the bruises on R1's face and arm suggested elder abuse. On 9/22/2020 at 12:00 V1 (Administrator) stated she was not aware of R1 noted with multiple bruising reported by the hospital. V1 stated the swelling and discoloration to R1's left eye was investigated as injury of unknown origin. V4 was made aware that R1 had multiple bruises by the hospital on [DATE]; V2 read the documentation on 9/14/2020 regarding R1 being admitted to the hospital with [REDACTED]. V2 also did not report the allegation of multiple bruises on R1 to State Agency immediately. The facility did not report this to State Agency until 9/22/2020, 10 days after being made aware that R1 was noted with multiple bruises by the hospital. On 9/22/2020 at 1:31pm V1 (Administrator) stated she should have been made aware of an allegation of multiple bruises noted on R1 immediately. Facility policy titled Abuse Prevention with no date and Abuse Prevention Program shows in part: External reporting: this report shall be made immediately, but no later than two hours and after the allegation is made, if the event that cause the allegation involved abuse or resulted in serious bodily injury, or not less than 24 hours if the event which caused the allegation did not involve abuse and did not result in serious bodily injury. |
| F 0610<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Respond appropriately to all alleged violations.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview and record review the facility failed to follow its' policy and procedure and thoroughly investigate all allegations of unknown injury for one (R1) of 3 residents reviewed for abuse investigation. Findings include: R1 has a [DIAGNOSES REDACTED]. On 9/22/2020 at 12:00 V1 (Administrator) stated she was not aware of R1 noted with multiple bruising reported by the hospital. V1 stated the swelling and discoloration to R1's left eye was investigated as injury of unknown origin. Facility's initial report to Illinois Department of Public Health, dated 9/11/2020, regarding swelling and bruising to left side of R1's face was reviewed. Facility's final report for swelling and bruising to left side of R1's face, dated 9/18/2020, shows review of resident hospital records showed the following: Ultrasound venous doppler of bilateral lower extremities were negative for [MEDICAL CONDITION]. CT of facial bones show no evidence of fracture; left peri orbital and maxillary region soft tissue swelling, induration and localization hematoma. CT of head showed no acute changes demonstrated, extensive arthritic changes, small elbow effusion. R1's hospital records dated 9/11/2020 shows in part: ED Diagnosis: [REDACTED]. Upon asking patient about the bruising, patient was not able to recall what happened. Per history obtained from rehab facility, patient is in long term care for management of dementia. At baseline patient is alert and oriented x1, usually unaware of time and place. Rehab facility states that she has had history of recurrent falls in past. This morning the nurse noted bruising on the left face beneath the left eye. Several other bruises on the right arm noted as well. The patient's family was visiting today and requested an X-ray with lab work. Before the X-ray was done, family had called 911 requesting the patient to be brought to the ER for evaluation. R1's progress notes dated 9/12/2020 at 12:45pm documented by V4 (nurse) shows: Call made to (hospital) for follow up of resident and admitting DX (diagnosis). Per RN (Registered Nurse) resident was admitted for multiple bruises and lower extremity swelling. All responsible parties notified. On 9/22/2020 at 12:52p.m V4 (nurse) stated she reported that R1 was admitted to the hospital with [REDACTED]. V4 stated she did not report this to the administrator. V4 stated she does not know where the multiple bruising came from that was noted on R1. R1's progress notes dated 9/2/2020 show [MEDICAL CONDITION] of BLE (Bilateral Lower Extremeties) - stable, X-ray of left foot and ankle, U/S Doppler ordered, restorative Therapy, keep leg elevated, compression stockings, and monitor for worsening. Bruise/Swelling of Left Cheek - Stable, Ice pack for swelling/comfort, Tylenol as needed for pain, monitor patient for any neurological changes or injuries, fall precautions. Labs, Clinical notes, and assessments reviewed. Moderate complexity due to multiple chronic medical conditions. On 9/23/2020 at 3:08p.m V2 (Director of Nursing) stated she read the progress note on 9/14/2020 regarding R1 admitted with multiple bruising and lower extremity swelling. V2 stated when she interviewed V4 (nurse), V4 denied seeing any bruising on R1's arms. V2 stated she did not contact the hospital to inquire about the bruising observed on R1 in the ER. V4 was made aware that R1 had multiple bruise by the hospital on [DATE]. V2 read the documentation on 9/14/2020 that R1 was admitted to the hospital with [REDACTED]. The |

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.

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| F 0610<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | (continued... from page 1)<br>facility did not initiate an investigation until 9/22/2020, 10 days after being notified that R1 was noted with multiple bruises by the hospital. Facility policy titled Abuse Prevention with no date and Abuse Prevention Program shows in part: Injury of unknown source are injuries for which both of the following conditions are met 1. The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and 2. The injury is suspicious because of the extent or location of the injury, the number of injuries observed at one point in time or the incidence of injuries over time. On 9/22/2020 at 1:31p.m V1 (Administrator) stated she should have been made aware of the allegation of multiple bruises noted on R1 immediately so that she can initiate an investigation. |
| F 0757<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Ensure each resident's drug regimen must be free from unnecessary drugs.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview and record review the facility failed to follow its' policy for [MEDICAL CONDITION] medications and monitor residents (R1, R2, R4) for side effects. Findings include: 1. R1's face sheet shows R1 has [DIAGNOSES REDACTED]. R1's POS (Physician order [REDACTED]. Review of R1's POS and MAR (Medication Administration Record) shows R1 is receiving<br>medication as ordered. R1's care plan with goal date of 11/11/2020 shows R1 is receiving antipsychotics [MEDICATION NAME] and [MEDICATION NAME] drugs on a regular basis. R1 is at risk for side effects and adverse reactions. R1 will not exhibit s/s (signs and symptoms) of SE/AR (Adverse Reaction) from [MEDICAL CONDITION] drugs. On 9/22/2020 at 11:29a.m V2 (Director<br>of Nursing) was asked how facility monitors for side effects for [MEDICAL CONDITION]. V2 did not respond. Surveyor requested to review documentation of monitoring side effects with [MEDICAL CONDITION] use for R1. The facility failed to present documentation of monitoring side effects of [MEDICAL CONDITION] medication for R1 prior to the time of exit. On 9/22/2020 at 1:03p.m V1 (Administrator) stated the facility cannot find a consent for R1's [MEDICATION NAME] medication. On 9/22/2020 at 1:03p.m V2 stated the facility cannot find a consent for R1's [MEDICATION NAME] medication. R1's facility face sheet shows R1 was admitted to the facility on dated 8/2/2017. R1's initial admission record shows R1 was prescribed [MEDICATION NAME] 50mg by her physician prior to being admitted to the facility. Consent for [MEDICATION NAME] dated 8/22/17 was reviewed and showed as signed by R1's daughter. R1's POS shows [MEDICATION NAME] was discontinued on 9/2/2020.<br>On 9/23/2020 at 1:20p.m V2 stated she did not have a consent for [MEDICATION NAME] for R1. V2 stated R1 was on the medication for increased agitation. V2 stated several interventions including redirection and room change were unsuccessful. V2 stated R1's behavior escalated to physical aggression; at that time the provider made adjustments to her (R1) medication and initiated the [MEDICATION NAME] on an as needed basis. 2. On 9/18/2020 at 11:35 am R2 was observed lying in bed, sleeping with episodes of being awake. R2's POS dated September 2020 shows, in part, orders for [MEDICATION NAME] 25 mg 1 tablet every day for [MEDICAL CONDITION] disorder. R2's MAR indicated [REDACTED]. Surveyor requested to<br>review documentation of monitoring side effects with [MEDICAL CONDITION] use for R2. The facility failed to present documentation of monitoring side effects of [MEDICAL CONDITION] medication for R2 prior to the time of exit. Further, the facility failed to present R2's care plan, after multiple requests. 3. On 9/18/2020 at 11:20 am R4 was observed sitting in his room in a chair. R4 appeared to be sleeping. R4 then got up and walked around the room. R4 was later put in bed to rest. R4's POS dated September 2020 shows orders for [MEDICATION NAME] 25mg 1 tablet 3 times daily for unspecific dementia without behavior disturbance, unspecific [MEDICAL CONDITIONS] disorder, and anxiety. R4's face sheet shows R4 has [DIAGNOSES REDACTED]. R4's MAR indicated [REDACTED]. R4's care plan with goal date of 10/16/2020 shows R4 is at risk for<br>potential side effects related to [MEDICAL CONDITION] drug use (antipsychotic [MEDICATION NAME]). Interventions are to attempt gradual dose reduction as per doctor's orders, record behavior and monitor patterns of behavior, initiate non-pharmacological interventions for behaviors and monitor effectiveness; drug regimen review will be conducted as per facility protocol, monitor symptoms of withdrawal during gradual dose reduction and notify doctor of any changes, i.e., [MEDICAL CONDITION], agitation, [MEDICAL CONDITION], motor disorders, nausea, vomiting, anorexia, and tardive dyskinesia.<br>Monitor for adverse side effects of medications. Educate resident and/or family regarding possible side effects of any new [MEDICAL CONDITION] medication. Surveyor requested to review documentation of monitoring side effects with [MEDICAL CONDITION] use for R4. The facility failed to present documentation of monitoring side effects of [MEDICAL CONDITION] medication for R4 prior to the time of exit. On 9/23/2020 at 3:09p.m V5 (Nurse Practitioner) stated R1 was having increased behavior episodes, and [MEDICATION NAME] was started at a small dose. V5 stated when the facility noticed the medication was not effective, the medication was change to [MEDICATION NAME]. V5 stated he ordered the [MEDICATION NAME] on an as<br>needed basis. V5 stated the [MEDICATION NAME] was discontinued because it was not effective. V5 stated it is expected that the facility monitor residents for side effects with use of [MEDICAL CONDITION]. V5 further stated he is not aware of the facility policy on getting consents for [MEDICAL CONDITION]. V5 said R1 is not overly medicated and that her treatment plan is appropriate. Facility policy titled Antipsychotic Medication Use dated 2007 shows in part: Antipsychotic medication therapy shall be used only when it is necessary to treat a specific condition. Nursing staff shall monitor and report any of the following side effects to the attending physician: sedation, orthostatic [MEDICAL CONDITION], lightheadedness, dry mouth, blurred vision, constipation, [MEDICAL CONDITION], increased psychotic symptoms, extrapyramidal effects, akathisia, [DIAGNOSES REDACTED], tremor, and rigidity akinesia or tardive dyskinesia. |