

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6005177</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/07/2019</b>
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NAME OF PROVIDER OR SUPPLIER  <b>MOSAIC OF LAKESHORE, THE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>7200 NORTH SHERIDAN ROAD CHICAGO, IL 60626</b>
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(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
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S 000	Initial Comments  Annual Certification Survey  Complaint Investigation  1985986/IL114865	S 000		
S9999	Final Observations  Statement of Licensure Violations  300.1210b) 300.1210d)6) 300.1220)b)3) 300.3240a)  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 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.	S9999	<h2>Attachment A</h2> <h3>Statement of Licensure Violations</h3>	

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  Electronically Signed	TITLE	(X6) DATE <b>11/30/19</b>
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S9999	<p>Continued From page 1</p> <p>Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including:</p> <p>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 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.</p> <p>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)</p> <p>These requirements were not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to follow the plan of care for a resident by failing to provide an escort while outside for a resident identified as requiring supervision when out of the facility due to known fall risk. This failure resulted in one (R69) resident having a fall with an injury which required five sutures to the forehead.</p> <p>Findings Include:</p>	S9999		
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S9999	<p>Continued From page 2</p> <p>R69 was admitted to the facility on 09/21/2017. R69's diagnoses include: dementia, delusional disorders, muscle weakness, cerebral infarction, major depressive disorder, cognitive communication deficit, and history of falling.</p> <p>R69's hospital records document he had a fall on 07/04/19 with a laceration.</p> <p>The facility's investigation report dated 07/04/19 documents: (R69) attempted to go down the facility's outside ramp without assistance and lost control which resulted in a fall with injury, was sent to the hospital and returned to the facility with 5 sutures; the conclusion of the root cause analysis for R69's fall incident 07/04/19 at 11:30AM was that he "went out of the building without supervision."</p> <p>11/06/19 01:39 PM V25 (Receptionist) stated, "(R69) was sitting on the patio area in front of building by himself and went down the ramp in July." V25 further stated as she noticed him going down the ramp, she called a code and all staff available assisted. V25 stated, "R69 lost control of chair while on ramp. After incident he was not allowed out without an escort."</p> <p>11/06/19 01:17 PM V23 (Social Services Worker) stated, "(R69) can go out with social services or CNAs, nursing, and/or activities. R69's community pass privilege assessment documents due to diagnosis of dementia resident is encouraged to use an escort while out in the community. R69 has periods of confusion at times. For sake of safety we assessed him for use of an escort, as noted by R69 experiencing a fall when out by himself."</p> <p>R69's physician order sheet documents orders</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>effective 02/19/19 for fall precautions.</p> <p>R69's fall risk assessment dated 05/15/19 documents a high-risk score of 40 for falls.</p> <p>R69's fall care plan dated 03/26/19 documents R69 had a history of falls occurring 03/07/19, 03/25/19, and 05/24/19.</p> <p>R69's current care plan effective, 03/07/18 to present, documents interventions including resident will utilize escort while in the community...related to compromised mental health status, neurological disorder, and compromised medical status.</p> <p>R69's current care plan, effective 05/29/18 to present, documents interventions including notify the nurse or social service departments of attempts to leave the building and resident will not leave the facility unescorted by a responsible person in the next 90 days.</p> <p>On 11/07/19 at 11:23 V26 (Nurse Practitioner) confirmed that (R69) received 5 stitches on the left side of his forehead due to injury obtained when he fell outside. V26 stated, "(R69) is a fall risk and should be supervised if outside on his own...somebody should probably be with him."</p> <p>11/07/19 11:58 AM V23 (Social Worker) stated, "(R69) doesn't exhibit exit seeking behavior."</p> <p>The facility's fall management guidelines policy documents: Some risk factors or conditions that may predispose a patient to fall may include but are not limited to: musculoskeletal conditions, history of falls, unsteady gait, muscle weakness, stroke, age over 80 years, cognitive impairment, dementia.</p>	S9999		
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