

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/07/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14E163	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2008
NAME OF PROVIDER OR SUPPLIER SOMERSET PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 5009 NORTH SHERIDAN CHICAGO, IL 60640		
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F 490	Continued From page 18 already in a state of decomposition. Per observation, this motel is about 4 short blocks from the facility. The facility took the following steps to remove the Immediately Jeopardy: 1. The facility will review / revise and monitor all established policies / procedures for compliance. 2. Staff were inserviced on resident elopement. 3. The facility will monitor all residents on probation and follow the Identified Offender Act. 4. The facility will contact the residents' probation officer when inappropriate sexual / substance abuse behavior is observed. 5. Daily resident attendance rounds will be done and monitored by the DON and / or designee. 6. The facility will notify the local police department when a resident does not return to the facility within the designated return curfew hour after signing-out on pass. The QA Committee, Medical Director, and the DON will monitor for compliance.	F 490			
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.695c)1)3) 300.1210a)	F9999			

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F9999	<p>Continued From page 19</p> <p>Section 300.695 Contacting Local Law Enforcement</p> <p>c) The facility shall develop and implement a policy concerning local law enforcement notification, including:</p> <p>1) Ensuring the safety of residents in situations requiring local law enforcement notification;</p> <p>3) Contacting police, fire, ambulance and rescue services in accordance with recommended procedure.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>a) The facility must 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 assessment and plan of care. 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.</p> <p>These REGULATIONS are not met as evidenced by:</p> <p>Based on interview and record review, the facility administration:</p> <p>1. Failed to ensure that 1 resident (R2) with pass restriction was prevented from leaving the facility unsupervised.</p> <p>2. Failed to notify R2's parole officer and the local</p>	F9999			

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F9999	<p>Continued From page 20</p> <p>police authorities of R2's drug use and disappearance after R2 left the facility while on pass restriction on 5/8/08.</p> <p>R2 has diagnoses of Schizophrenia, Schizoaffective Disorder, Seizure, and Bipolar Disorder. R2 was released from jail and was on parole for drug use while at the facility. R2 also had an active cocaine addiction and was documented to abuse drugs when out of the facility, was known to solicit sex for money outside of the facility, had a history of being physically assaulted while out in the community, had a recent seizure attack while in and out of the facility, and had been missing her anti-seizure and psychotropic medication while in and out of the facility.</p> <p>R2 left the facility unsupervised while on pass restriction on 5/8/08 at 9:14 PM. R2's parole officer was never notified of her admission to the facility and of her continued documented cocaine use nor of R2's disappearance after she left the facility unauthorized on 5/8/08.</p> <p>The local police were also not notified of R2's disappearance to file a Missing Persons Report so a search for R2 could be initiated by the local police. R2 was found murdered in a nearby motel room about 4 short blocks from the facility on 5/20/08. When R2's body was found, it was already in a state of decomposition according to the police.</p> <p>Findings include:</p> <p>R2 was admitted to the facility on 1/23/08 with diagnoses of Seizures, Schizoaffective Disorder, Bipolar Disorder, and Schizophrenia. Per R2's</p>	F9999			

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F9999	<p>Continued From page 21</p> <p>PAS Mental Health Initial Screen and Referral Form dated 1/23/08, R2 was "released from Cook County Jail and is in need of placement due to Mental Illness. Resident is unable to take care of self and is a risk to become a danger to herself and others."</p> <p>Review of R2's Clinical record showed that one reason why R2 is unsafe outside of the facility is her being at high risk for recurrence of seizures. Per nurses notes dated 4/21/08, R2 was out of the facility past curfew hour (10 PM to 7 AM) and was documented as having returned to the facility on 4/23/08 at 1:40 AM. Six hours later, R2 had seizures in her room at 6:45 AM. R2 was sent to St Mary of Nazareth Hospital, came back at 2:30 PM, but had another seizure attack while in her bed at 3:30 PM. Phenobarbital 30 mg. was ordered and given to R2 at 5:00 PM per R2's Medication Administration Record (MAR).</p> <p>According to R2's Nurses notes dated 4/24/08 at 11:05 AM, R2 told E5 (Case Worker) that R2 also had a seizure attack at her sister's house while R2 was out on 4/21/08. Further review of R2's record showed that on 2/23/08, R2 was also sent to Weiss Hospital ER for seizures. Added to this, review of R2's MAR also showed that R2 had not taken some of her Dilantin (anti-seizure medication) 300 mg. doses every AM on 2/3/08 and 2/8/078.</p> <p>When R2's Dilantin dose was increased to 400 mg. every AM on 3/29/08, R2 also missed her doses on 4/3/08, 4/8/08, 4/9/08, 4/10/08, 4/11/08, 4/12/08, 4/13/08, 4/15/08, and 5/2/08. Although Phenobarbital (anti-seizure medication) 30 mg 3x/day was ordered on 4/23/08 per Physician Order Sheet (POS), R2 also missed her 9:00 AM</p>	F9999			

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F9999	<p>Continued From page 22</p> <p>dose on 5/2/08 and her 5:00 PM and 9:00 PM dose on 5/3/08.</p> <p>R2 was also documented as actively soliciting sex when R2 is allowed to go outside of the facility. Per R2's Nurses notes dated 4/5/08 6:30 PM, R2 admitted to E5 (Case Worker) that she solicited sex to a man in the alley for \$20. Added to this, per R2's Nurses Notes, R2 admitted later to E4 (Nurse) and E5 that after sex, this same man took back the money and hit her hard in the face and at the back of her head causing her to fall and sustain a laceration above the left eye, edema around the left eye, and a bruise at the back of the right shoulder.</p> <p>During interview with E4, E4 confirmed that R2 indeed admitted to him that R2 solicited sex to a man who later physically assaulted her. E4 said that R2 has been soliciting sex for money and is having access to cocaine outside. E4 added that R2 is known to be a crack cocaine addict and that, if she is placed on a pass restriction, it is for her own protection.</p> <p>E5 is also aware that R2 had been soliciting sex from people outside of the facility and is using cocaine because of her addiction. This was further confirmed when R2's urine drug screen at the facility was reviewed. R2's urine was found positive for Cocaine Metabolites on 3/6/08, 4/16/08, and 5/2/08. Added to this, when R2 was sent to Kindred Hospital on 3/18/08, R2 was also found positive for cocaine 3/20/08, although R2 denied using drugs per 3/18/08 Psychosocial Assessment at the hospital.</p> <p>R2's hospital record also noted that R2 was found positive for cocaine on 3/6/08 and admitted</p>	F9999			

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F9999	<p>Continued From page 23</p> <p>use of cocaine on the night of 3/5/08. Per nurses notes dated 4/12/08 at 1:30 PM, R2 admitted to smoking crack cocaine while out of the facility.</p> <p>Although some of them are missing, R2's Sign In/ Out sheets showed that R2's positive drug tests and admission of drug use coincided with R2's being out of the facility (4/12/08, 4/14/08, 4/15/08, 4/28/08, 4/29/08) prior to the drug test and R2's admission of drug use.</p> <p>R2 was also documented as non-compliant with taking her psychotropic medications for her mental illness. Per her MAR, R2 did not take her 8AM, 1PM, 5 PM, and 9 PM doses of Seroquel 50 mg on 3/16/08 and 3/17/08. R2 also missed her Seroquel 100 mg at bedtime on 4/8, 4/9, 4/10, 4/11, 4/12, 4/13, 4/14, 4/21, 4/22, 4/29, 5/1, 5/3, and 5/8/08.</p> <p>Review of R2's facility and hospital record shows that when R2 became non-compliant with her medications, R2 would exhibit behaviors which could be dangerous outside of the facility. Z2's Initial Psychiatric Hospital Evaluation dated 3/6/08 documented that when R2 does not get her appropriate medication, she gets more agitated, irritable, hostile, can get aggressive, and out of control.</p> <p>Kindred Hospital Psychosocial Assessment dated 3/18/08 documented that "Per N. H. (Nursing Home) report, pt. refusing all psychotropic medication, increased paranoid thought process, increased verbal abuse, increased irrational behavior, threatening to leave the facility, behavior is explosive and unpredictable resulting in danger to self and others."</p>	F9999			

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F9999	<p>Continued From page 24</p> <p>Review of R2's nurses notes on above dates, when R2 had been consistently not taking her psychotropic medications, showed that R2 was still allowed to leave the facility even past curfew hours despite not getting her psych medications. On 5/3/08 at 7:15 PM, R2 was documented by E5 as agitated, refused to give urine sample, aggressive, threatened to leave against medical advice. R2 was also documented as grandiose and hyperverbal after return from leaving the facility on 5/1/08 while on 3 clean urine drop restriction.</p> <p>Review of facility's Sign In /Out Sheet, located at facility's front desk, showed that R2 was allowed to leave the facility on 5/8/08 at 9:14 PM by the front desk security (E6). This was the last time R2 was seen by the facility. Review of facility's Restriction Book showed that R2 was issued a pass restriction on 5/7/08 at 12:41 PM for agitation. Furthermore, on 5/8/08 R2 was again issued another pass restriction by E5 (Case Worker) which was received by Z4 at 10:30 AM.</p> <p>Added to this, per 4/24/08 Nurses Notes, which was verified by E5 during 5/30/08 interview, R2 was issued a 3 Clean Urine Drop Restriction on 4/24/08 by E5 to maintain drug sobriety. Review of R2's medical record showed that since 4/24/08, R2 never had a negative urine test for Cocaine (5/2/08 test was positive for Cocaine) yet was continuously allowed to leave the facility even with a 3 Clean Urine Drop Restriction.</p> <p>Per R2's nurses notes, R2 was allowed to leave the facility on 4/28/08, 5/1/08, and finally 5/8/08. On all of these dates, R2 was on restriction and was unauthorized to leave the facility without a family member. Per interview with Z6, Z6 said</p>	F9999			

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F9999	<p>Continued From page 25</p> <p>that R2's sisters did not pick R2 up from the facility during all of these unauthorized leaves including the one on 5/8/08.</p> <p>Review of facility's Sign In/Out Sheet confirmed that R2 signed herself out on 5/8/08. Per Facility's Restriction/Pass Policy and Procedure, only family member or staff member can take a resident on pass restriction out of the facility.</p> <p>When E6 was interviewed on 6/2/08, E6 said that on 5/8/08, E6 was not aware that R2 was on pass restriction. E6 explained that if R2 was on restriction, R2 should have had an orange sheet in the front desk Sign In/Out indicating that R2 could not leave the facility if not accompanied by staff or family member.</p> <p>E6 said that R2 was allowed to leave the facility that night at 9:14 PM because she had a green Sign In/Out Sheet indicating she could leave the facility without restriction. As noted by the surveyor, R2's 5/8/08 Sign In/Out sheet was indeed colored green (No Restriction) and not orange.</p> <p>Review of the facility's Restriction book showed that R2 was placed on restriction by E5 on 5/8/08. This restriction was received and documented by Z4 who no longer works in the facility.</p> <p>When E5 was interviewed on 5/30/08 at 1:51 PM, E5 said that R2 "is extremely unsafe outside the facility as she's been assaulted outside, used drugs, and had prostituted herself." E5 further explained that when a resident is placed on a 3 Clean Urine Drop Restriction, she is not allowed to leave the facility if she has not submitted 3</p>	F9999			

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F9999	<p>Continued From page 26 drug-free urine results.</p> <p>When asked why R2 was allowed to leave the facility even if she has not submitted any drug-free urine result and sample since 4/24/08, E5 said that in R2's case, her 3 Clean Urine Drop Restriction was too much for R2 and was lowered down to a 24 hour restriction as R2 is unable to meet the 3 Clean Urine drop restriction as evidenced by R2's leaving the facility unauthorized despite the restriction.</p> <p>E5 added that this was discussed with E1 (Administrator) and Case Worker Coordinator. When this was brought up for verification during Daily Status on 5/30/08, E1 did not make a comment.</p> <p>During 6/2/08 interview, Z1 verified that the use of cocaine predisposes a patient to seizure attacks especially if she is also non-compliant with her anti-seizure medications.</p> <p>When Z2 was interviewed over the phone on 6/2/08, Z2 explained that R2 was placed on restriction while at the facility to protect her from her substance abuse and prostitution. Z2 added that it is not safe for R2 to be outside of the facility unmonitored.</p> <p>When Police Special Victims Unit Department was called on 5/30/08 at 10:25 AM, it was verified with Z7 that the facility did not notify the police to file for a Missing Persons Report after R2 left the facility unauthorized on 5/8/08. When another police officer was spoken to on 5/30/08 at the facility front desk, surveyor was told that when a Missing Persons Report is filed, the police will enter that in the computer and that a "Flash" can</p>	F9999			

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F9999	<p>Continued From page 27</p> <p>be done where the police can search for the missing person and can literally stop a person in the street and check if the identity of the person matches that of the reported missing individual.</p> <p>When Z8 (R2's parole officer) was interviewed on 6/3/08, Z8 said that the facility did not notify Z8 that R2 had been found murdered outside of the facility. Z8 also confirmed that the facility did not even notify him of R2's admission on 1/23/08 so that Z8 could tell the facility the parole terms and agreement for R2. Added to this Z8 also confirmed that the facility should have also notified him of R2's continued drug use when R2 was out of the facility as R2 was in jail for possession of drugs.</p> <p>Z8 explained that if the facility had notified Z8 of R2's continued violation of her parole term for drug use, R2 could have been placed in an in-hospital drug treatment center which would not have allowed R2 further access to drugs. Z8 continued that in some instances if R2 would not have cooperated to go to drug treatment, she would have been placed back in jail.</p> <p>During 5/30/08 interview of Z5, Z5 stated R2 was found murdered in the nearby motel. Z5 confirmed that when R2 was found on 5/20/08, R2's body was already in a state of decomposition. Per observation, this motel is about 4 short blocks from the facility.</p> <p>(A)</p>	F9999			