STATE OF ILLINOIS
DEPARTMENT OF PUBLIC HEALTH
STATEMENT OF VIOLATIONS AND PLAN OF CORRECTION

SOMERSET PLACE	0044289
Facility Name	I.D. Number
5009 NORTH SHERIDAN, CHICAGO,ILLINOIS 60640	
Address, City, State, Zip	
13105, 18196	OCTOBER 29, 2009
Reviewed By	Date of Survey
SPECIAL LICENSURE AND CERTIFICATION	05399, 09696, 10128, 12208, 15845, 16746, 16856, 20175
Type of Survey	Surveyed By

As a result of a survey conducted by representative(s) of the department, it has been determined the following violations occurred.

IMPORTANT NOTICE: THE STATE AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED UNDER PUBLIC ACT 83-1530. DISCLOSURE OF THIS INFORMATION IS MANDATORY. THE FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

"A" VIOLATION(S):

300.1210a)
300.1210b)6)

Section 300.1210 General Requirements for Nursing and Personal Care

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.

b) 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.

These REGULATIONS are not met as evidenced by:

Based on record review and interview the facility failed to supervise R21 with known history of physically aggressive behavior from pulling R50 from her wheelchair which resulted in an injury with a fractured hip. The facility failure to monitor and periodically re-assess R21's negative behavior led to this serious preventable injury. R21 had been identified by the facility as having a history of aggression prior to this incident.

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CONT. Findings include:

Review of the most recent MDS (Minimum Data Set) dated 7/17/09 shows that R21 is 48 years old and admitted to the facility 7/21/05 with diagnosis including psychosis, bi-polar, and schizophrenia. R21's cognition is coded as moderately impaired.

The initial screening done on 7/18/05 identified R21 as mentally ill, receiving psychotropic medications and was approved for nursing facility level of care.

Review of medical record during survey of 10/6 through 10/8/09 indicated that R21 has had physically aggressive behaviors toward residents and staff since her admission in 2005, in addition to showing medication non-compliance and "falling" behaviors that have not been thoroughly analyzed as possibly due to medical factors in addition to the attention seeking determined by facility.

A facility incident report shows that on 6/7/09 R21 pulled another resident, R50, from her wheelchair resulting in a fractured hip. The final investigation report completed 6/9/09 states that on 6/7/09 in the 5th floor laundry room, R21 became upset at R50, stating that R50 was taking too long with the dryer and grabbed R50 by her left hand and pulled her from the wheelchair.

Interview with E13 (PRSC / psycho/social rehab coordinator) on 10/8/09 at 10:40am stated that R21 has incidents involving residents "all the time." "She will sit on the floor and when we try to get her up she goes crazing throwing herself all over the place. We have to get the other residents out of the way. Sometimes she sleeps all day-from 3:00am til 7:00pm. She won't even get up to go to the bathroom and will lie in her wet clothes."

There was no treatment plan developed for R21 based on these identified areas of aggression, behavior, impulsiveness and anger. R21 is not participating in any psycho/social programming as stated on facility monthly "Individuals Psychosocial Rehabilitation Program Plans" for June, July and August. The back of this form has an area for resident goals to be written, however R21's is blank except for a brief narrative stating R21 *is not attending programming due to being of lower functioning. R21 is not able to get dressed and receive treatment* ***on a regular basis****....has poor conflict resolution and can become agitated.*

R21's care plan dated 11/8/08 states that R21 has a history of aggressive behavior when asked to perform a task, becomes verbally aggressive toward staff and peers. Has poor conflict resolution skills, becomes verbally aggressive due to being unable to problem solve, which results in violence that leads to hospitalization. The corresponding goal is for R21 to learn to use effective coping skills. However she is not presently on any coping skills program either through group or on individual basis. This goal and the approaches have not been revised or evaluated and the goal has not been achieved. There

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CONT.

has been no treatment program developed to assist R21 in dealing with her behavioral issues.

Two incident reports of resident to resident aggression were reviewed for 8/3/09 and 10/1/09. Even though the injuries were minor, the pattern of behavior by R21 reveals instant frustration and immediate pushing of other residents, and then physical aggression towards the staff attempting to mediate the situation.

Record review shows facility documenting behaviors as they occur, but facility's approach is to monitor and continue to encourage compliance with meds and activities of daily living.

This failure to update and assess and reassess this on-going behavior and non-compliance does not constitute a comprehensive re-assessment, nor have existing approaches been analyzed for its effectiveness in changing R21's aggressive behaviors towards residents and staff.

Interview on 10/7/09 at 10:30am with E11 (PRSC) stated that the quarterly assessments are updated on the care plans. The annual assessments create a new care plan.

Medical record review revealed that prior to this serious incident on 6/7/09, R21 had again not been taking her prescribed meds. Even after the incident, there are medical notes that reveal R21 continued not to take her meds even up to survey dates such as 8/29, 8/26, 8/20, 8/18, 8/16, 8/8, 8/3, etc. R21 is taking Effexor, Valproic Acid, Risperdal for behavior.

Interview on 10/7/09 at 12:50pm with E1 (administrator) stated that while the facility knows its residents and deals with them effectively, there is not a formal documented process showing that the facility performs quarterly and annual re-assessments identifying strengths as they directly relate to residents' functional limitations.

(A)