STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E163	A. BUILDING _____ B. WING _____	C 11/01/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET PLACE	5009 NORTH SHERIDAN CHICAGO, IL 60640

(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) COMPLETION DATE
F 324	Continued From page 5 compliance. The Immediate Jeopardy was removed on 11/01/06 however the facility remains out of compliance at a severity level 2 to assure implementation of above plan.	F 324		
F9999	FINAL OBSERVATIONS IRI of 10/12/06/IL25418 Licensure Violations 300.690a) 300.690a)1) 300.690a)2) 300.690b) 300.690c) 300.1210a 300.1210b)4) 300.3100d)2) Section 300.690 Serious Incidents and Accidents a) The facility shall notify the Department of any incident or accident which has, or is likely to have, a significant effect on the health, safety, or welfare of a resident or residents. Incidents and accidents requiring the services of a physician, hospital, police or fire department, coroner, or other service provider on an emergency basis shall be reported to the Department. 1) Notification shall be made by a phone call to the Regional Office within 24 hours of each serious incident or accident. If the facility is unable to contact the Regional Office, notification shall be made by a phone call to the Department's toll-free complaint registry number. 2) A narrative summary of each accident or	F9999		

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F9999	Continued From page 6 incident occurrence shall be sent to the Department within seven days of the occurrence. b) A descriptive summary of each incident or accident shall be recorded in the progress notes or nurse's notes for each resident involved. c) The facility shall maintain a file of all written reports of serious incidents or accidents involving residents. 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 psychosocial 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)4) Personal care shall be provided on a 24-hour, seven-day-week basis. 300.3100 General Building Requirements d)2) All exterior doors shall be equipped with a signal that will alert the staff if a resident leaves the building. Any exterior door that is supervised during certain periods may have a disconnect device for part-time use. If there is constant 24-hour-a-day supervision of the door, a signal is not required. These requirements wer not met as evidenced by the following:	F9999		

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F9999	Continued From page 7 Based on record review, staff interviews and observations, the facility failed to ensure that 1 of 8 sampled residents (R8), who has been assessed to require supervision in the community, received adequate supervision to prevent elopement. R8 was subsequently found by police and taken to a local hospital and found to have fractures of the radius and ulna. The facility also failed to conduct an investigation as to how R8 was able to leave the facility unsupervised. The facility has 43 other residents who have been assessed to require supervision in the community and, are at risk for elopement because the facilty failed to investigate the elopement of 10/1/06 and failed to keep all doors alarmed for safety. Findings Include: R8's birth date is 01/11/1948 and diagnoses include schizophrenia. R8'sRecord indicates R8 has lived at facility since at least 1989. Nurses notes dated 10/11/06 at 2:00p.m. by E7, Staff Nurse, states call received from a local hospital emergency room stating R8 was now in emergency room after police found R8 laying on the street. Notes at 10:15p.m. state that R8 was admitted to the hospital with diagnosis of fracture of left radius and ulna. Physical examination completed at hospital on 10/11/06 states R8 had left upper extremity swelling and tender left wrist. X-ray on 10/11/06 of left wrist shows comminuted fracture involving distal radius with moderate impaction and anterior angulation at the fracture and fracture	F9999		

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F9999	Continued From page 8 involving ulnar styloid process which is fragmented. X-ray dated 10/13/06 of left wrist states radius fracture has been stabilized in normal anatomic alignment with a metal plate and screws. R8 had a Community Survival Skills Assessment completed 07/21/06. Results of assessments showed R8 unable to identify and/or defend himself against common dangers in the community. R8 also required prompting to cross the street correctly. Recommendations were R8 should remain a red dot restriction. Access to Community policy states a "red dot" indicates the resident may not leave the facility without staff or other responsible parties as identified by the Charge nurse or Psych Rehab Service Coordinator (PRSC). Facility sign out books were reviewed on 11/01/06 and 43 other residents had been identified as requiring supervision in the community. Minimum Data Set (MDS) assessment completed 08/04/06 indicates that R8 has severe cognitive impairments. Care plan dated 08/28/06 identifies that R8 is unable to navigate independently in the community due to episodes of confusion, delusions, lack of the ability to protect himself from unwanted advances in the community and inability to recognize and protect himself against common dangers out in the community. Surveyor was provided with two reports regarding this incident involving R8. Report dated 10/11/06 at 2:00p.m. states R8 was AWOL on 10/11/06, was located by Chicago Police and transported to hospital for an evaluation. Second report is dated	F9999		

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F9999	Continued From page 9 10/12/06 at 11:20a.m. and states received a call from hospital emergency room that R8 was transported by Chicago Police to the hospital for an evaluation. Upon examination R8 was noted with fracture of left radius and ulna. Neither of these reports contain any investigation of how R8 left the facility. During interview on 10/31/06 E2, Director of Nurses, confirmed that no investigation had been completed as to determine how R8 left the facility. E2 confirmed that on 10/11/06 facility was not aware that R8 had left the facility until E7 received the call from emergency room regarding R8 at 2:00p.m. During interview on 10/31/06 E7 did confirm that she last saw R8 having lunch on 10/11/06 at approximately 12:00p.m. On 11/01/06 at 12:15p.m. surveyor observed all exterior first floor doors with E9, Maintenance Supervisor. Two west exterior doors (both doors to the north of main entrance) were found not to have alarms activated. E9 stated alarms should be activated. E9 did state facility has been working on alarm systems but at time of observation, work was not being done and door alarms should be activated. E8, Front door security, was interviewed on 11/01/06 at approximately 12:45p.m. and stated he was not aware that any door alarms have been shut off. (A)	F9999		