STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145688	A. BUILDING _____ B. WING _____	05/18/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN PRINCETON REHAB & HCC	**255 WEST 69TH STREET CHICAGO, IL 60621**

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F 406	Continued From page 41 goal to complete one group weekly. R8 also has a goal, "will not exhibit signs of activity intolerance". There are no programs in place to address this R8' behaviors and psychosocial needs.	F 406		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS LICENSURE VIOLATIONS 300.1210a) 300.1210b)2) 300.1210b)3) 300.3220f) 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 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) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 2) All treatments and procedures shall be administered as ordered by the physician. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for	F9999		

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F9999	Continued From page 42 further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 300.3220 Medical and Personal Care Program f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's Director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. (Section 2-104(b) of the Act) These requirements are not met as evidenced by: Based on observation, record review and interviews the facility failed to ensure 1 of 3 residents (R19) with orders for dialysis, received dialysis as scheduled. In addition, the facility failed to report R19's missed scheduled dialysis to the physician and monitor R19 for negative effects from not receiving dialysis. The facility failed to have policies and procedures for assisting R19 to obtain routine dialysis services which led to R19 not being dialyzed for over 5 days. This put R19 at high risk for a potential life threatening condition. R19 was re-admitted to the facility on 5/06/2009 at 10:00pm with orders for dialysis three times weekly. R19 was unable to be dialyzed on 5/08/2009 and facility staff did not take aggressive actions to obtain dialysis treatment for R19. On 5/11/2009 R19 was transferred to the hospital and did not return to the facility as of 5/14/2009. R19 not receiving the dialysis put him at high risk for physical harm and/or death.	F9999		

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F9999	Continued From page 43 Findings include: R19 is a 77 year old with end stage renal failure. R19 was readmitted to the facility on 5/06/2009 with a physician's order for hemodialysis, Monday, Wednesday and Friday. R19's last minimum data set assessment dated 2/27/2009 indicated R19 was dependent on facility staff for all activities of daily living. On 5/11/2009 at 10:15am, R19 was positioned in a wheelchair near the nurse's station. After greeting R19, R19 told the surveyor he was waiting to be picked up for dialysis. At 11:00am, R19 was in the dining room attending an activity program. R19 told the surveyor he was still waiting to go to the dialysis center. On 5/12/2009 at 9:00am, the surveyor could not find R19 in the facility. R19 had been transferred to a hospital. R19's nurses' notes had the following information documented: -5/08/2009 at 3:00pm, Upon initial rounds, resident up in wheelchair alert and oriented. Resident verbally responsive, stated, I was sent home from dialysis center cause I've (I have been) gone for too long. Will f/u (follow-up) with staff 7-3 shift for more information. -5/11/2009 at 9:00am, Spoke with social worker from dialysis center. Was informed that resident could not receive dialysis today, because his admission process there was not yet completed. Due to the hospital not sending them adequate admission information. ADON (assistant director of nursing) spoke with social worker and was informed of the same information will notify MD	F9999		

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F9999	Continued From page 44 (medical doctor). -5/11/2009 at 11:35am, Spoke with MD at this time.. Informed him of resident not yet receiving dialysis. Order given to transfer resident to hospital for emergency dialysis treatment. -5/11/2009 at 11:30pm, Call made to hospital. Resident admitted for dialysis 5/12/2009..... R19's medical records had no special monitoring to alert staff of possible problems due to the lack of dialysis from 5/08 to 5/11/2009. On 5/13/2009 at 12:10pm, E2 (DON/director of nursing) informed the surveyor she was not aware of R19's missing dialysis. E2 was not available last week. 5/11/2009 she was informed by E7 (nurse) R19 did not go to dialysis. He (R19) was not registered at the dialysis center. Not sure if vitals were taken or if the physician was called prior to 5/11/2009. On 5/13/2009 at 12:30pm, E6 (nurse) informed the surveyor he was on duty 5/8/2009 and sent R19 for his dialysis treatment at 10:00am. E6 stated he was not on duty at the time R19 returned to the facility. On 5/13/2009 at 12:50pm, E7 (nurse) reported working on 5/09/2009 (Saturday). In the afternoon she was informed by E3 (Assistant Director Of Nursing) R19 did not get dialysis on Friday. She paged the physician sometime after 12:00pm, and he did not return the page by the end of the shift. E3 wrote the information on the 24 hour report and verbally reported to the next shirt nurse E11. E7 was off on Sunday. The surveyor asked who is responsible for confirming	F9999		

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F9999	Continued From page 45 a resident had a chair at the dialysis center. E7 stated the nurses. E7 stated, "On Monday when I was transferring R19 to dialysis, I talked with Z2. They discharged him. I paged the physician. I received an order to send R19 out to the hospital." The surveyor asked if R19's vital signs were taken during this period. E7 said she was involved with getting him out for dialysis, that it took up most of her time. E2 and E3 were made aware. The surveyor asked E7 if she was aware of the last day R19 received dialysis. E7 said it was on 5/06/2009. On 5/13/2009 at 1:10pm, E3 told surveyor that on 5/08/2009, E8 (social worker) initially reported to her that R19 could not be dialyzed. He was discharged from dialysis. She told me the dialysis center needed information to re-register him. I spoke with dialysis's social worker. She told me because the resident was not in the dialysis in the last 30 days, he was discharged. He would need a H & P (history and physical) but there was no doctor to do that. E8 told me she would get the information from the hospital record. Z2 told me if she could get the information the resident could be given dialysis on Saturday. I came in on Saturday (5/09/2009) to check to see if he got dialysis. E7 told me he did not go. I informed her to call the doctor for emergency dialysis. I came in on Monday and found the resident didn't go to dialysis. The surveyor asked why didn't the nurse on duty Friday call the doctor? E3 stated, I guess it was my fault. I dropped the ball. The surveyor asked E3 if she was working as a floor nurse on Friday, 5/08/2009. E3 indicated she was the assigned nurse on duty. The surveyor asked what is the facility's policy for communication with the dialysis center. E3 give no response.	F9999		

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F9999	Continued From page 46 According to E3, the hospital makes arrangement for dialysis for the resident and the facility sets up the transportation. Since R19 was getting dialysis at that center, we thought he would go back there. On 5/13/2009 at 2:07pm via phone, Z2 (dialysis social worker) reported no notification was given from the hospital or nursing home that R19 would be returning for dialysis. R19 showed up Friday (5/08/2009) at 10:00am. Because he was 30-days out of system, he could not be dialyzed. Talked with E8 on 5/08/2009 and told her and what was needed to get him back in the system; also that he did not have a chair and needed dialysis from emergency room. Z5 decided R19 could not be dialyzed at the center. On 5/11/2009 I talked to E7, and told her he (R19) should have been dialyzed over the weekend. On 5/13/2009 at 2:26pm, E8 (social worker) stated she received a call from the dialysis social worker (Z2) informing her R19 could not be dialyzed. On 5/8/2009 she informed E3 of the situation, while faxing Z2 needed information about R19. E8 did not report confirming if R19 had a chair for dialysis after faxing the information to Z2. On 5/18/2009 at 9:00am via phone Z5 (nephrologist) reported, R19 came to the dialysis center with papers but had no chair for dialysis. After 3 to 4 weeks of not receiving dialysis from the center, R19 had to be re-admitted. One of the requirements from CMS (Centers for Medicare/Medicaid Services) is that upon admission and re-admission a patient needs a hepatitis test. R19 did not have one. In addition, R19 had tube feeding, an indwelling catheter and	F9999		

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F9999	Continued From page 47 an infection. Z5 did not want to risk the chance of other patients getting an infection. It was a recommendation to the admission office that the facility should find dialysis at another facility. Z5 stated she is not aware of what specific impact it had for R19 not receiving dialysis. However, in general if any dialysis patient missed dialysis it could result in electrolyte imbalance, fluid overload and acidosis (build up of acid level in the blood). Basically dialysis replaces the function of the kidneys. On 5/13/2009 at 3:25pm, the facility's administrative staff members were present at the daily status. The surveyor reported the concern of the staff not confirming the availability of a dialysis chair for R19. According to E2 (DON), it was the responsibility of the hospital to schedule the dialysis and the facility sets up the transportation. At the time the surveyor requested the facility's policy and procedures for the dialysis resident. No policy was presented. The hospital records for R19 documented, R19 received dialysis on 5/13/2009. The last reported dialysis received by R19 prior to hospitalization was on 5/06/2009. R19's medical records had no special monitoring to alert staff of possible problems due to the lack of dialysis, during the 5/08 through 5/11/2009 period. (A)	F9999		