STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145963	A. BUILDING _____ B. WING _____	C 03/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN ORLAND PARK REHAB & HCC	**16450 SOUTH 97TH AVENUE ORLAND PARK, IL 60462**

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F 508	Continued From page 19 on the left side, R11 noted with good range of motion. The nurses notes at 8:40pm indicates that R11's physician was notified and orders were given to have an X-ray of R11's left hip done. According to the nurses notes dated 12/11/2011 at 4:00am there are no entries indicating if R11 was taken., 8.5 hours after R11's incident. Nurses notes on 12/11/2011 at 1:30pm indicates that that facility still pending the completion of the X-ray of R11's left hip. The nurse note at 12:30pm/1:00pm indicates that they are waiting for the radiologist to read the results, the note also indicates that the order was requested change to stat for quicker results, 15 hours after the initial test was ordered. On 2/9/2012 1:50pm E2 (Director of Nursing), said that she recalls R11 going out to the hospital after the fall incident on 12/10/2012, however R11 refused to answer why it took 15-plus hours for the outpatient radiology department to arrive to the facility and obtain an Xray of R11's hip. E2 said the facility has a contract with the outpatient radiology department. E2 again refused to answer when asked if 15-plus hours for an X-ray to be obtained is acceptable time frame. On 2/9/2012 at 4:20pm E1 (Administrator), said that we try to get radiology here as soon as possible. E1 said each situation is unique. E1 didn't answer when asked what the facilities expectation of a acceptable response time from the outpatient radiology department would be. E1 didn't provide surveyor with requisition requesting service. E1 also said that the facility didn't have a policy or contract that stipulated response time of service.	F 508		
F9999	FINAL OBSERVATIONS	F9999		

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F9999	Continued From page 20 LICENSURE VIOLATIONS 300.610a) 300.1010h) 300.1210c) 300.1210d)3) 300.1810b) 300.1810c)1)3) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident,	F9999		

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F9999	Continued From page 21 injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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: 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 further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. Section 300.1810 Resident Record Requirements b) The facility shall keep an active medical record for each resident. This resident record shall be kept current, complete, legible and available at all times to those personnel authorized by the facility's policies, and to the Department's representatives. c) Record entries shall meet the following requirements: 1) Record entries shall be made by the person providing or supervising the service or observing the occurrence that is being recorded. 3) Medical record entries shall include all notes, orders or observations made by direct resident care providers and any other individuals authorized to make such entries in the medical	F9999		

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F9999	Continued From page 22	F9999		

record, and written interpretive reports of diagnostic tests or specific treatments including, but not limited to, radiologic or laboratory reports and other similar reports.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These regulations are not met as evidenced by the following:

Based on interview and record review the facility failed to monitor and ensure adequate hydration was given to 1 of 3 residents (R7) who was identified to be at risk for dehydration. This failure resulted in R7 being admitted to the hospital and diagnosed with dehydration, severe free water deficit, and fecal impaction.

Findings include:

According to the clinical record, R7 was admitted to the facility on 11/5/11 status post hip replacement. According to the clinical record hydration assessment dated 11/5/11, R7 scored a (6). According to the hydration assessment key a score greater than 5 is considered at risk for dehydration. According to R7's interim plan of care R7 is identified with dehydration risk related to dry skin, unable to reach fluids independently and difficulties with chewing and swallowing. The interim plan of care also indicates that the facility will take the following approaches to monitor R7 for signs and symptoms of dehydration: monitor labs as ordered, offer fluids with every activity,

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and monitor skin turgor.

According to the nursing notes dated 11/6/2011 (all shifts included) through 11/13/2011 (2pm through 10pm), there were no entries noting R7's fluid intake. The same dates as noted above under the gastrointestinal area of the notes indicating if fluids were encouraged and documentation of appetite were found to be blank. In reviewing the notes there were also no entries indicating an assessment of R7's skin turgor.

According to the physician order sheet dated 11/9/11 there were lab orders written for R7 to have a complete blood count and basal metabolic panel to be drawn on Monday. The order was written by Z3 (Nurse Practitioner).

On 2/9/12 at 11:30am via telephone, Z3 (Nurse Practitioner) said that it is her routine to have labs collected at the beginning of the week and within the first week of a new resident's admission. Z3 said that she was aware that R7 was admitted on 11/5/11 and that on 11/9/11 she gave orders for labs to be collected on 11/14/11, nine days later. Z3 said that she sees a lot of residents and that it is easier for her review lab work if it is drawn at the beginning of the week. Z3 said that she ordered labs so she can get a baseline on R7's status based off of the results. Z3 was asked if it was usual to wait 9 days before drawing baseline labs on a new resident and Z3 said for her it is because she likes labs collected at the beginning of the week. Z3 denied that the facility staff alerted her that R7 was identified as being at risk for dehydration. Z3 said that the facility nursing staff should have documented R7's intake of food

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and fluids in the nursing notes and notified R7's attending physician of any abnormal or low intake of food/fluids. Z3 also indicated that free water deficit may be indicative to poor intake by mouth.

On 2/8/11 at 10:30am E19 (Assistant Director of Nursing) said that for residents identified to be at risk for dehydration, nursing staff monitors the residents intake by mouth and encourages fluids, however E19 was unable to verbalize how the facility actually measured and ensured fluid intake is measured for residents at risk for dehydration. E19 said that if the physician does not write an order for strict intake/output, the facility has no documentation to ensure residents are offered fluids other than the nursing notes. E19 agreed that nursing staff should document the amount of intake in the nursing notes and should notify the attending physician of poor appetite and poor fluid intake.

On 2/9/2012 via telephone at 1:00pm Z1 (physician) said that he only saw R7 once. Z1 said that he was not made aware of R7 being identified as being at risk for dehydration. Z1 also said that intake of fluids and food should be documented in the nursing notes. Z1 said if the facility nursing staff would have notified him that R7's oral intake was poor, he could have ordered strict monitoring of intake/output. Z1 said it is routine to collect labs within the first week of admission, not necessarily at the beginning of the week. Z1 said that he was not notified of R7's status until 11/13/11 when he wrote orders for stool softener and enema. Z1 also said that he reviewed R7's labs dated 11/14/11 yesterday (2/9/2012).

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F9999	Continued From page 25 According to the clinical record chemistry results dated 11/14/11 R7's blood urea nitrogen level was 91mg/dl (normal range - 6 -24 mg/dl), creatinine level 2.59 mg/dl (normal range - 0.6 - 1.4 mg/dl), and sodium level 153 meq/L (normal range 135 - 148 meq/L). According to R7's nursing notes there is no documentation or entries indicating that R7's physician was notified of the abnormal lab results. According to Z1 he reviewed the lab results for the first time yesterday (2/9/2012). According to the facility's hydration policy a plan of care will be developed utilizing identified risk factors based on resident's individualized needs. The policy also indicates that the effectiveness of the hydration plan of care will be monitored through clinical observations, and lab monitoring. According to the hospital records dated 11/15/11 at 2:52pm, R7's chemistries were noted creatinine level 5.1 mg/dl (normal range 0.6 - 1.0 mg/dl), blood urea nitrogen 143 mg /dl (normal range 7 - 18 mg/dl), and sodium level 156 meq/L (normal range - 136 -145 meq/L). According to the hospital record assessment and plan R7 presented to the hospital with multiple medical problems/issues to include: acute renal failure secondary to dehydration and severe free water deficit. According to the hospital record x-ray of the abdomen dated 11/15/11 impression indicates fecal retention and colonic ileus (disruption of normal propulsive ability). (A)	F9999		