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 _____	C 04/20/2012

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

(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 323	Continued From page 14 There were no injuries upon assessment. A sensor pad to chair was initiated and order for physical and occupational therapy evaluation. On 4/6/12 at approximately 10:50am, R6 was observed in the activity room in an unlocked wheelchair. R6 was transferred to a standing position with the assist of 2 staff. R6's chair alarm did not activate. Staff adjusted the cord that attaches the alarm to the chair. Again, the alarm did not activate when R6 was assisted to standing position.	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS: 300.610a) 300.1010h) 300.1210a) 300.1210b)5) 300.1210c) 300.1210d)3)5)6) 300.1220b)2)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	F9999		

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 _____	C 04/20/2012

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

(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
F9999	Continued From page 15	F9999		

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, injury or change in condition at the time of notification.
Section 300.1210 General Requirements for Nursing and Personal Care
a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)
b) The facility shall 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 resident care plan. Adequate and properly supervised nursing

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 _____	C 04/20/2012

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

(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
F9999	Continued From page 16 care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. 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. 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. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status,	F9999		

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 _____	C 04/20/2012

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

(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
F9999	Continued From page 17 sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months 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 requirements were not met as evidence by: Based on observations, record review and interview, the facility neglected to: a. Have identified fall prevention measures in place for 3 of 8 residents (R2, R5, R6,) reviewed for neglect in a sample of 8; b. Timely access emergency treatment for R5 following a fall; c. Stabilize R5 to protect from the potential of further injury after a fall;	F9999		

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 _____	C 04/20/2012

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

(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
F9999	Continued From page 18 d. Immediately report R5's fall to the physician and administrative personnel; e. Conduct a thorough, accurate investigation to rule out the root cause of fall for R5; R5 sustained an unwitnessed fall on 3/1/12 from which she complained of leg pain. Portable X-ray results were obtained 5 hours after the fall. R5 was transferred several times from chair to bed during the hours following the fall. R5 was evaluated in the emergency room 7 hours after fall occurrence. Hospital records shows a subcapital comminuted left femoral neck fracture with external rotation and superior displacement. Findings include: 1. R5 is a 100 year old resident admitted to the facility on 3/29/05. Diagnoses include Dementia, Osteoporosis, Osteoarthritis, Cerebro-vascular Disease with Hemiparesis of lower extremities. The Minimum Data Set (MDS) dated 12/9/11 states R5 has moderately impaired cognition with short and long term memory impairment and uses a wheel chair for mobility on the unit with limited, 1 person assist. Fall Risk Assessment dated 5/6/11, 8/6/11, 12/6/11 shows R5 at high risk for falls. Assessments dated 5/6/11 and 8/6/11 refers to history of fall in past 1-6 months, however, information regarding recent falls was not found in the clinical record. Hospital records dated 3/2/12 states an 'old fracture of the right inferior pubic ramos and right hip prosthesis was noted. Care Plan dated 5/26/11 shows the following fall	F9999		

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 _____	C 04/20/2012

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

(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
F9999	Continued From page 19	F9999		

prevention interventions: scheduled toileting, encourage to stay in high visibility areas, keep frequently used personal items within reach when in room. R5 has impaired physical mobility, impaired decision making.

Physician's monthly progress notes dated 10/30/11 through 1/31/12 describes R5 as confused. On 2/29/12 R5 was described as 'very confused'. There were no new interventions in place to address fall risk concerns with this change in condition.

E11's (Nurse) nursing notes dated 3/1/12, 3:25pm, states R5 was observed on the floor laying on her right side. R5 complained of pain to right side/leg area when the area was touched or moved. Approximately one-half hour later the physician was notified of the fall and complaint of pain and stat X-rays of left side and left hip were ordered (per previous notes, R5 was found laying on her right side and complained of pain in the right side). A portable X-ray provider was contacted and assistant director of nursing (no longer works at the facility) was notified.

Subsequent nurses notes written by E8 (Nurse-no longer employed at facility) at 4:00pm states R5 was given analgesic for pain in left leg and hip. At 7:30 pm E8 wrote that X-ray results were pending and R5 complained of pain to left hip with movement during X-ray procedure. At 9:05 pm E8 wrote that the physician was 'on page' related to X-ray result. At 9:40pm the physician called the facility and gave orders for R5 to be sent to the hospital. Patient transportation report shows R5 arrived at the hospital via ambulance at 10:51 pm.

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 _____	C 04/20/2012

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

(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
F9999	Continued From page 20	F9999		

R5 was moved from the floor to a chair being manually lifted off the floor by staff. There is no documentation regarding the time X-rays were done however the X-ray results were not received and relayed to the physician until 6 hours later (9:40pm) at which time the physician gave orders for R5 to be sent to the hospital. Patient transportation report shows R5 arrived at the hospital via ambulance at 10:51pm. Hospital records shows a subcapital comminuted left femoral neck fracture with external rotation and superior displacement.

E9 stated on 4/20/12 at 11:25 am that she was alerted to R5 being on the floor by another resident as they were both walking down the hallway. E9 stated she did not see the call light on nor heard an alarm activated.

E11 (Nurse) was at the nurses station at the time of the fall and was alerted to the occurrence by E9. E12 (Certified Nurses Aid-CNA) was also on the unit doing rounds and was not aware of the fall until informed by E11.

Fall investigation report dated 3/1/12 contains conflicting information. It states R5 fell while being transferred by 2 staff members. The report also states the bed alarm was sounding and R5's call light was on. The assistant director of nursing's (ADON) written statement states R5's fall occurred on 2/28/12, not 3/1/12. E1 (Administrator) stated that this erroneous date was brought to the ADON's attention and the ADON refused to change his statement.

E11 stated on 4/20/12 at 12:45pm that she

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 _____	C 04/20/2012

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

(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
F9999	Continued From page 21	F9999		

believe R5 was trying to go to the bathroom because she was found incontinent of bowel.

E12 stated the following during a telephone interview on 4/20/12 at 12:10pm that this was the first time working with R5 after 7 months and she was not familiar with R5's routine. E10 (CNA) removed R5's wheelchair from the bedside and put it in the bathroom. E12 stated being unfamiliar with R5's routine she did not know whether R5 would have need for the wheelchair. E12 went on to say that once R5 was put back in bed, she rolled her over to her left and right sides to provide incontinent care. One staff member held the affected limb as the other two conducted the roll. R5 was crying with pain during the rolling. A cushion was placed under R5's thighs when care was completed. R5 remained in bed for dinner where she was fed. She complained of pain when the head of her bed was raised and lowered. During X-ray procedure she was again complaining of pain. She had two more incontinent episodes during the shift and required to be changed with 2 persons assist.

E10 (CNA) stated during a telephone interview on 4/20/12 at 1:30 pm that she took care of R5 on a regular basis but was not the assigned care giver on the day of fall. R5 usually wants to go to the toilet shortly after her arrival on duty (3-11pm shift). She (R5) was in bed at the beginning of the shift so E10 wheeled the chair into the bathroom and closed the door as she did not want R5 to get to it. R5 has tried more than once to transfer herself to the wheelchair (this behavior is not addressed in the care plan). E10 decided it best to remove her wheelchair from the bedside to the bathroom and has been doing this since October

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 _____	C 04/20/2012

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

(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
F9999	Continued From page 22	F9999		

(past 6 months). E10 stated this was not standard practice for R5, but was her decision. E10 does not know what the other CNA's do to prevent her from transferring. E1 assisted with her transfer from the chair to the bed after her fall, stating a gait belt was used to stand R5 up, then lifted onto the bed. After the fall R5 was put back in the wheelchair and taken to the dining room. R5 seemed ok but was still complaining of pain.

A written statement from the then assistant director of nursing (no longer employed at the facility) shows R5 was back in her wheelchair at 4:30 pm, approximately one hour after the fall. R5 was taken to the dining room. On the following day E8 stated she forgot to report the fall to E2 (Director of Nursing). E2 was made aware of R5's fall and fracture on the day following the fall.

E8 was not available for interview.

E2 stated on 4/20/12 at approximately 4:50 pm that the facility took disciplinary actions against E8 and she was let go. E2 stated that R5's wheelchair was removed from the bedside because staff did not want her to transfer herself. E2 went on to say there was no need to have the wheelchair next to the bed because fall prevention measures were in place.

Z1 (Nurse Consultant) stated that there was no need for R5 to be sent out immediately to the hospital for X-Rays. Z1 further stated it is not a common practice to send a resident to the hospital immediately for a fall incident.

E1 (Administrator) stated on 4/20/12 at approximately 2:40 pm that it is still not known

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 _____	C 04/20/2012

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

(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
F9999	Continued From page 23 how R5 got onto the floor. E1 went on to say she is not convinced that R5 fell. Residents who are observed on the floor, unwitnessed, this occurrence is not classified as a fall unless the investigation proves that it is a fall. E1 went on to say she does not know what caused R5's fracture because she (E1) is not a doctor. R5 could have rolled out of bed. The facility could not determine why R5 was on the floor. E1 stated she would have to speak with E2 regarding the cause of the fall. (B) .	F9999		