		AND HUMAN SERVICES				FORM	07/11/2012 APPROVED 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		145688	B. WI	NG _		03/14/2012		
NAME OF P	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
ALDEN F	PRINCETON REHAB &	k HCC			255 WEST 69TH STREET CHICAGO, IL 60621			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 518	Continued From pa	ige 26	F	518				
F9999	lunch on the second who was in the dinii was asked what we residents safe if a fi residents were ther E7 was unable to si be to ensure the residents were to think of the to respond to the qu On 3/13/12 at 12:10 station, E8 (nurse/m some residents were were in the halls an fire were to breakoud do?" E8 stated " I w residents out of the staircase." R8 was residents in wheelc bedbound? R8 state person assist to can FINAL OBSERVATI LICENSURE VIOL 300.1210b)4) 300.1210d)2)4)A)5; 300.3240a) Section 300.1210 G Nursing and Persor b) The facility shall and services to attap practicable physica	Opm at the second floor nurses nds coordinator) was asked " if re in their rooms and some ad moving about the unit, and a ut on the unit, what would you would start moving the ir rooms, have them take the then asked what about the chairs and those who are ed " we would do a 2 or 3 rry them down the staircase". IONS ATIONS	F9	999				

		AND HUMAN SERVICES				FORM	: 07/11/2012 APPROVED 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		145688	B. WI	NG _		03/14	4/2012
NAME OF PROVIDER OR SUPPLIER ALDEN PRINCETON REHAB & HCC					REET ADDRESS, CITY, STATE, ZIP CODE 255 WEST 69TH STREET CHICAGO, IL 60621		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	 plan. Adequate and care and personal of resident to meet the care needs of the reshall include, at a mprocedures: 4) All nursing personencourage resident in activities of daily circumstances of the demonstrate that did This includes the rest dress, and groom; if eat; and use speec functional commun who is unable to care shall receive the se good nutrition, groot d) Pursuant to subscare shall include, at and shall be practice seven-day-a-week 2) All treatments ar administered as ord 4) Personal care s seven-day-a-week not be limited to, the function, including hygiene, in addition physician. 5) A regular program pressure sores, heat breakdown shall be seven-day-a-week 	Apprehensive resident care I properly supervised nursing care shall be provided to each the total nursing and personal esident. Restorative measures inimum, the following annel shall assist and as so that a resident's abilities living do not diminish unless the individual's clinical condition minution was unavoidable. esident's abilities to bathe, transfer and ambulate; toilet; h, language, or other ication systems. A resident rry out activities of daily living rvices necessary to maintain ming, and personal hygiene. section (a), general nursing at a minimum, the following ted on a 24-hour, basis: nd procedures shall be dered by the physician. hall be provided on a 24-hour, basis. This shall include, but	F9	999			

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		AND HUMAN SERVICES				FORM	: 07/11/2012 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		LE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		145688	B. WING	G		03/1	4/2012
NAME OF P	ROVIDER OR SUPPLIER		1		EET ADDRESS, CITY, STATE, ZIP CODE		
ALDEN F	PRINCETON REHAB &	& HCC		-	5 WEST 69TH STREET HICAGO, IL 60621		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	clinical condition de sores were unavoid pressure sores sha services to promote and prevent new pr Section 300.3240 A a) An owner, licens agent of a facility sh resident. (Section 2 These Regulations by: Based on observati review, the facility fa care and services to pre-existing pressu size for 2 residents ulcers. Findings include: 1) R3 is a 97 year of include Ulcer, press On 03/11/12 at 10:4 accompanied by E2 in bed laying on bac on was identified as was unable to answ The resident was in indwelling catheter R3 was identified as	ores unless the individual's emonstrates that the pressure dable. A resident having ull receive treatment and e healing, prevent infection, ressure sores from developing. Abuse and Neglect see, administrator, employee or hall not abuse or neglect a 2-107 of the Act) were not met as evidenced ion, interview and record ailed to provide the necessary o promote healing and prevent re ulcers from increasing in (R3 and R2) with pressure old with a diagnosis which sure, buttock-Stage 4.	F99	999			
	_	-					

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	: 07/11/2012 APPROVED 0938-0391	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		145688	B. WI	√G		03/14/2012		
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
ALDEN F	PRINCETON REHAB 8	k HCC			55 WEST 69TH STREET CHICAGO, IL 60621			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F9999	inspection of R3's b covers/linen were re- right side using the sheet covering the b have an extra large brown colored stood had a moderate am top portion of it. In F amount of semi-dry The large deep sac covering at all over At 10:55am, E4 (tre- in R3's room. E4 ac covering over the sa "There should be a wound." Then E21 was uncovered, but treatment to it (sacr don't know when th At 11:00am, the ass questioned related E14 stated, "There started at 7:00am. I care. I (E14) wash R3 could eat at 7:45 care yet, I (E14) wa (E14) didn't do it (re- over the stool soiled On 03/12/12 at 3:40 E20, R3's sacral pro E4. The measurem 2.3cm, width = 2.3cc The most recent we	body was done. When the top emoved and R3 turned to the chuck under R3, the bottom mattress was observed to e amount of semi-dry dark of with an odor on it. The chuck nount of the same stool on the R3's diaper was a large y sticky (inappearance) stool. cral pressure ulcer had no it. eatment nurse) joined the team isk whether R3 should have a facral wound. E4 stated, dry dressing covering the stated, "I (E21) didn't know it t I (E21) do know R3 has a ral pressure ulcer). I (E21) ne last time R3 was changed." signed aide E14 was to R3 being left in the stool. is enough help today. I (E14) Not yet I (E14) haven't did the ed R3's face and hands, so, 5am. I (E14) didn't do patient ant you (surveyor) to know I eferring to putting the chuck d sheet). Opm, accompanied by E4 and ressure sore was measured by nent's are as follows: length =	F99	999				

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	07/11/2012 APPROVED 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		145688	B. WI	NG_		03/14/2012		
NAME OF PROVI	IDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
ALDEN PRINCETON REHAB & HCC					255 WEST 69TH STREET CHICAGO, IL 60621			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
fac me = 2 The 03/ foll 2.4 The dep Per lon De And pre "ke and Bas Pre 01/ tak to e The Pre 13, E4 03/ ulc won turn Inc	easurement's as f 2.0, depth = 2.0. The Nutritional Assection (01/12 indicates the lows: length = 2.2 fcm. There was an increase pth of the wound. There was an increase pth of the wound. There was an increase pth of the wound. The wound of the wound. The would be wound of the wound. The would be would be would be would be would be would be wou	2012 depicts the sacral wound follows: length = 2.2cm, width essment/Reassessment dated he sacral pressure ulcer is as 2cm, width = 1.8cm, depth = ase in the length, width, and	F9	999				

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		AND HUMAN SERVICES				FORM	07/11/2012 APPROVED 0938-0391	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		145688	B. WI	NG		03/14/2012		
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
ALDEN PRINCETON REHAB & HCC					55 WEST 69TH STREET CHICAGO, IL 60621			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F9999	Per review of R3's of corresponding med dated (02/21/12 - 0) receiving multiple v daily for two weeks Beneprotein One S times a day. On 03/15/12 at 11:3 telephone to request dietary assessment was a nutritional as dated 03/01/12 and behavior dated 10/- results received as On 3/13/12 at 2:40p (Treatment Nurse) measurements of F of measurements v width 5.0cm x deptl 2) Weekly skin ass week of 3/6/12, per follows. Length 4.50 0.3cm. Results sho length and depth of week. E4 stated on 3/14/1	current physician orders and lication administration record 3/20/12), R3 has orders and is itamins including Zinc 220 mg. , and coop PO/by mouth TID, three 85am, E2 was contacted via at R3's lab results and recent t. Received via fax at 12:48pm sessment/reassessment l a care plan related to 15/11. There were no lab requested. om, in room 227-2, E4 was observed doing R2's sacral decubitus. Results were as follows, length 4.7cm x n 0.5cm. sessment form for R2 for the formed by E4, results were as cm x width 5.0cm x depth w a .2cm increase in the r R2's sacral decub within one	F9	9999				

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