STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012645	A. BUILDING: _____ B. WING _____	C 02/24/2023

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

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S 000	Initial Comments Facility Reported Incident of February 11, 2023 IL156658	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.3210 t) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures 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. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care 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 care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.	S9999	**Attachment A** Statement of Licensure Violations	

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Section 300.3210 General
t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property.

These requirements are not met as evidenced by:

Based on record review and interview, the facility failed to follow their abuse policy for two residents (R1,R2) out of four residents reviewed abuse. This failure resulted in a staff members not immediately intervening before R1 became physically aggressive towards R2. This failure resulted in R1 hitting R2 on the head, causing R2 a laceration requiring five staples.

The Findings Include:

R1's care plan, dated 11/2/19, denotes R1 is at risk for abuse related to: Not easily redirected with challenging behaviors. He has a history of being easily upset and quick tempered being verbally aggressive toward staff and peer.

On 1/24/2023 at 11:32, R2's Psychiatrist/Psychologist Note Text: Psychiatry Progress Note reads : "Present History: 75yr old male, was seen for follow-up, and is alert and oriented to self. Staff reported occasional aggressive behavior but can be redirected, no agitation or aggressive behavior was noted. Patient functioning at baseline."

R1's 2/11/2023 at 20:29 nurses note text reads : "Nurse was notified that resident hit another resident on the head with his walking stick.

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S9999	Continued From page 2 Resident voiced 'He was in my room so I told him to leave and he will not leave so I walked up to him and hit him on the head with my stick' . On getting to resident room nurse observed resident sitting in his bed complete body assessment done with no injury noted vitals taken at this time are as follow BP 132/68, P 78, T 98, R 18 spO2 98% RA (room air) resident remained in his room under security watched. Facility Administrator informed. NP (nurse practitioner) made aware order to petition resident out to (hospital) given. Order noted and carried out. Resident POA (Power of Attorney) made aware of resident situation and transferred." R2's 2/11/2023 at 23:33 nurses note text reads: "Nurse was called to room (residents room number) by a staff that resident was bleeding from the head . rResident voiced 'I got hit on the head'. On getting to room (residents room), nurse observed resident lying in bed. Complete body assessment and neuro check done with an open area to the top of the head observed and no confusion noted. The site was cleaned with NS (normal saline) and bandage applied vitals taken at this time are as follow (BP) 155/85, P 88, R 20 T 98 spO2 99% RA (room air) . Resident was taken to the nursing station for close monitoring . Facility Administrator made aware per facility protocol. NP (Nurse Practitioner) made aware order to send resident to (hospital) given order noted and carried out . Resident POA (Power of Attorney) was informed of resident condition and transferred Facility's abuse report, dated 2/11/23, denotes Administrator was made aware both residents (R1,R2) were in a physical altercation. Both residents were immediately separated. Full body assessment done. R2 sustained an injury and	S9999		

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S9999	Continued From page 3 was sent to the hospital per physician order. An investigation was immediately initiated. R2's hospital record, dated 2/11/22, denotes R2 was brought to emergency room for head injury, laceration. R2's hospital Computed Tomography Scan negative for any acute process . Laceration Wound closed with five staples. R2's 2/12/2023 at 05:23 Nurses Note Text reads : "Writer spoke to RN (Registered Nurse) who verbalized Resident being admitted to the Acute Care Area (room and bed number) for 1) Dizziness, Head injury with Scalp Laceration ,closed.2) Uncontrolled HTN (hypertension)" On 2/24/23 at 10:00 am, V20 (Doctor) stated R2 did sustain a cut to his head, which was superficial laceration. V20 stated, "Fortunately (R2) was not seriously harmed because his CT (Computed Tomography) showed that no subdural/epidural or acute bleed which could be considered potentially serious injuries". V20 stated R2 was treated the same day at the hospital and sent back to the facility in stable condition. On 2/22/23 at 10:00 am, V1 (Social Worker) statedshe has worked on the third floor for nine years, and R1 been a resident on the third floor for a few years. V1 stated R2 has been a resident on the third floor for a couple of years. V1 stated R1 is confused at times and gets agitated sometimes when asked to do something he does not like to do. V1 stated R2 is very confused and sometimes can be verbally aggressive with staff or his peers. On 2/22/23 at 10:30 am,V6 (Certified Nursing Assistant) stated she was in another room	S9999		

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serving dinner when she heard a loud commotion, then came out into the hallway, and saw R2 with blood with on his face. V6 stated she yelled for the nurse (V8) who came running towards R2. V6 stated sV6 aw the nurses assess R2, then took him to his room. V6 stated R2 has psych (psychiatric) issues, and his behavior changes from day to day. V6 stated whenever she has seen R2 getting into arguments with another resident, they have been able to redirect him. V6 stated R1 has a history of being aggressive when he has these mood swings. V6 stated she has never seen R1 hit another resident with his cane. V6 stated they have to redirect all the residents because it is a behavior unit with psych residents.

On 2/22/23 at 11:00am, V8 (Licensed Practical Nurse) stated he has worked at the facility for several years and took care of both R1 and R2. V8 stated R1 was alert and oriented times 2-3 with some confusion. V8 stated most of the time, R1 would stay in his room, but would walk out of his room using his cane if he needed something. V8 stated R1 has a history of aggression and needed to be redirected when he got upset. V8 stated R2 was alert times 1-2, and would roll around on the unit in his wheelchair. V8 stated R2 sometimes gets confused and wanders into the wrong room, but they usually see him and redirect him to his room. V8 stated on Saturday (2/11/23) around dinner time, V8 was at the nurses station when another staff member told him R2 was bleeding. V8 stated V8 noticed R2 had cut on the top of his head. V8 stated cleaned the wound with normal saline and applied a clean band aide. V8 stated asked R2 who hit him, and pointed to R1's room. V8 stated he went to R1's room to interview him to ask what happened. V8 stated during the interview, R1 told him R2 would not

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leave his room, so he hit him with his cane. V8 stated he called the doctor, Administrator and family members. V8 stated R1 and R2 were both sent to the hospital for evaluation. V8 stated this has never happened before while he was taking care of R1.

On 2/22/23 at 9:30 am, V2 (Administrator) stated all abuse reports should be sent to IDPH (Illinois Department of Public Health) within 24 hours according to the facility abuse protocol. V2 stated any allegation of abuse is filled out on the incident form, but the preliminary 24-hour abuse form then faxed to IDPH within 24 hours. V2 stated she got a call on Saturday R1 hit R2 on the head with his walking cane. V2 stated staff had separated both residents, doctor and family notified. V2 stated staff told her R2 sustained a cut to his head. V2 stated at this time ,she is not sure if R1 is coming back to the facility.

Facility's abuse policy denotes, "This facility prohibits mistreatment, neglect, or abuse of its residents and attempted to establish a resident sensitive and resident secure environment. This facility is committed to protecting our residents from abuse by anyone including, but not limited to, facility staff, other residents, consultants, volunteers and staff from other agencies providing services. Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means in a facility."

(B)