STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145688	A. BUILDING _____ B. WING _____	10/09/2020

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility has failed to determine the root cause for falls and failed to implement measures to reduce or minimize the risk for injury for 1 (R1) of 3 residents reviewed for falls in the sample of 3 residents. The findings include: R1 is disoriented, non-ambulatory, [AGE] year old male who was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. R1 also exhibits restlessness and agitation and has brief interview mental score of 3, which indicates not oriented to all spheres (person, place and time). R1 is oriented to self only, and requires extensive assist with his activities of daily living. R1 has had 2 injuries while in the facility and other injury outside the facility. Two of the falls (8/21/20, 9/10/20) required sutures for the laceration on the forehead. The injury on 8/20/20 was a bump/knot on the left forehead. R1 was sent to the hospital for the bump on the forehead, but while in hospital, he fell sustaining a laceration requiring stitches. The facility did an investigations into the falls and injuries but failed to determine root cause for the falls, and failed to implement measures to minimize the risk for injuries. V2 (Assistant Director of Nursing) and V10 (Director of Nursing) contributed the falls to gait imbalance, impaired memory, and poor safety awareness. On 10/6/20 at 12:30 PM, V2 stated that the injury of the bump on the forehead (8/20/20) was due to previous night of restlessness and that he may have bumped head on side rail. V2 stated that the staff are to wrap the side rails with cloth to cushion the side rails. On 10/6/20 at 1:45 PM, R1's room was seen to have non-cushioned Halo side rails at the head of the bed. On 10/7/20 at 3:46 PM, V10 stated the fall on 9/10/20 was due to restlessness while in bed. The plan is place R1 in wheelchair at the nurses' station when R1 exhibits restlessness. There was no documented intervention to minimize injury when falling from bed. The fall of 9/10/20, R1 was found at the foot of his bed. On 10/8/20 at 12:50 PM, V10 stated to understand the need to know the root cause of falls so the interventions can be made wisely and appropriately. The facility's policy labeled FALL MANAGEMENT PROGRAM documents the facility is committed to minimize resident falls and/or injuries so as to maximize each resident's physical, mental and psychosocial well-being. It is the facility's policy to act in a proactive manner to identify and assess those residents at risk for falls, plan for preventative strategies and facilitate a safe environment.
F 0758 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide documentation to support the use of the anti-psychotic medications in dementia resident, failed to provide documentation of an informed consent on anti-psychotic medication and failed to provide documentation of non-pharmacological interventions prior and during the use of the anti-psychotic medications for 1 (R1) of 3 residents reviewed for anti-psychotic medication in the sample of 3 residents. The findings include: R1 is disoriented, non-ambulatory, [AGE] year old male who was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. R1 also exhibits restlessness and agitation and has brief interview mental score is 3 which indicates not oriented to all spheres (person, place and time). R1 is oriented to self only, and requires extensive assist with his activities of daily living per the monthly nurses' note 9/5/20. The MDS documents R1 has been on anti-psychotics medications without a gradual dose reduction, and no detailed explanation on why the reduction is not applicable. Review of R1's current physician's orders [REDACTED]. Prior to 8/25/20, R1 was receiving [MEDICATION NAME] 2 mg at every night at bedtime since 4/17/20. R1 is also receiving [MEDICATION NAME] 0.5 mg orally every morning on Tuesday, Thursday, and Saturday prior to [MEDICAL TREATMENT] since 5/2/20. On 8/25/20, the [MEDICATION NAME] order was changed from routine to PRN (as needed) prior to [MEDICAL TREATMENT]. The new order is to give [MEDICATION NAME] 0.5 mg every 4 hours as needed. R1 receives the [MEDICATION NAME] every morning before [MEDICAL TREATMENT] regardless. There is another PRN order for [MEDICATION NAME] 5 mg intramuscularly every 6 hours as needed. R1 has received the PRN [MEDICATION NAME] and [MEDICATION NAME] for agitation and restlessness throughout the MARs, but no documentation was seen or presented on non-pharmacological interventions. In May 2020, R1 received [MEDICATION NAME] or [MEDICATION NAME] before [MEDICAL TREATMENT] with no reason why both medications are ordered for the same time period (5/2/20 to 8/24/20). On 10/7/20 at 3:46 PM, V10 (Director of Nursing) stated that R1 receives the [MEDICATION NAME] and [MEDICATION NAME] due to his restlessness and agitation. V10 stated that the [MEDICAL TREATMENT] center says R1 can get agitated so he gets medicated prior to [MEDICAL TREATMENT]. V10 stated that when R1 was admitted to the facility in 2016 he was already on anti-psychotic medication. V10 stated she would look for non-pharmacological interventions. On 10/7/20 at 3:25 PM, V5 (Registered Nurse) stated that the [MEDICATION NAME] is always given before [MEDICAL TREATMENT] due to R1's restlessness and agitation. V5 stated she documents the medication is unknown if effective because R1 leaves for [MEDICAL TREATMENT]. V5 stated that the staff have tried sitting with him, providing him snacks, anything to distract him. V5 stated that it works sometime but not all the time. V5 stated that the restlessness is R1 trying to get up and stand from wheelchair and he is a fall risk. V5 stated that she does not know why the [MEDICATION NAME] and [MEDICATION NAME] are given instead of another medication nor why R1 had both medications ordered for the morning before [MEDICAL TREATMENT]. V5 does not recall what medications R1 took prior to the anti-psychotics. Review of R1's falls document 2 falls in the facility and one fall in the hospital emergency room . Two of the falls required stitches. The falls were on 8/20/20, 8/21/20 and 9/10/20. R1 received a [MEDICATION NAME] PRN the early morning of 8/20/20 along with the [MEDICATION NAME] given in the morning for R1's [MEDICAL TREATMENT]. R1 received his bedtime [MEDICATION NAME] medication also. The facility staff failed to reassess and make changes to the medications. In fact, the [MEDICATION NAME] at night was increased by double and the standing [MEDICATION NAME] order was changed to PRN which does not matter because the morning [MEDICATION NAME] prior to [MEDICAL TREATMENT] is given every morning regardless. V7 (Physician) documents in her notes 3/13/20, 5/22/20, 8/20/20 and 9/15/20 that R1 is oriented times three, which is incorrect. V7 documents that R1 is calm and cooperative without agitation. A gradual drug reduction is contraindicated, but V7 fails to document what symptoms R1 would display for medication to be reduced or discontinued. On 10/8/20 at 11:26 AM, V7 stated she is the nurse practitioner for V13 (Psychiatrist) and she had inherited R1 on the [MEDICAL CONDITION] medications. V7 stated the [MEDICATION NAME] and [MEDICATION NAME] are for restlessness and agitation. V7 stated that the

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0758 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) word [MEDICAL CONDITION] is the wrong word used. V7 was asked about R1's orientation being documented by her as orient times three. V7 stated when she first met R1 he presented as orient because he knew his name, day, and location. V7 admitted she did not assess his cognition the last times she saw him, and understands R1 has had health decline. On 10/8/20 at 12:50 PM, V10 stated she was unable to locate any documentation on non-pharmacological interventions for R1. The facility failed to provide a signed informed consent for R1 on any of the [MEDICAL CONDITION] medications. The facility presented an informed consent with 2 unidentifiable signatures. V1 (administrator) identifies one signatures which was: R1's friend but no name given and other is staff but does not recognize the staff's signature. This consent is invalid. R1's care plan documents receiving [MEDICATION NAME] because of Dementia with behavioral disturbances, restlessness/agitation and signs and symptoms of [MEDICAL CONDITION]. There is no documentation to support [MEDICAL CONDITION]. The facility's policy labeled [MEDICAL CONDITION] MEDICATIONS - USE OF: To establish a standardized system to inform residents and/or their responsible parties about [MEDICAL CONDITION] medications and their side effects. Prior to administering of the anti-psychotic medications, the following must be documented: An appropriate supporting [DIAGNOSES REDACTED]. Targeted behavior symptoms to be treated. Targeted behaviors will be identified with supporting documentation in clinical record. Residents that display targeted behaviors or who take psychotherapeutic medications will have their behavior quantitatively and objectively documented on the behavior tracking form. Under the Consents section of policy: For each [MEDICAL CONDITION] medication ordered either verbal or a written consent from the resident or resident's responsible party will be obtained prior to initiation of the medication.