STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146179	A. BUILDING _____ B. WING _____	**08/03/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HEALTHBRIDGE OF ARLINGTON HTS	**1200 N ARLINGTON HEIGHTS RD ARLINGTON HEIGHTS, IL 60004**

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 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 identify and monitor specific behaviors, and implement non-pharmaceutical interventions for a resident (R2) receiving [MEDICAL CONDITION] medication. The findings include: R2's Physicians Orders dated July 13, 2020 at 7:50PM, shows, [MEDICATION NAME] 0.25mg give 2 tablet by mouth every eight hours as needed for anxiety related to anxiety disorder due to known physiological condition for 180 days. R2's MAR-Medication Administration Record [REDACTED]. Administered, July 16, 2020 at 11:57AM, July 17, 2020 at 1:13PM, and July 23, 2020 at 6:58PM. The MAR indicated [REDACTED]. The facility's [MEDICAL CONDITION] Medication Use policy date 11/28/2016 shows, [MEDICAL CONDITION] medications may be used to address behaviors only if non-drug approaches and interventions were attempted prior to their use. Facility staff should monitor the resident's behavior .

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.