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	09/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that residents in the facility were free from abuse. This failure affected one of three (R4) residents reviewed for abuse and resulting in R4 acquiring a laceration to the head requiring sutures.Findings include:R4's medical diagnoses include but are not limited to schizophrenia, bipolar disorder, essential hypertension and major depressive disorder.R4's Minimum Data Set (MDS) dated [DATE] has a Brief Interview for Mental Status (BIMS) score of 15, indicating R4's cognition is intact.R4's progress note dated 08/07/25 documents in part, Resident became agitated, pacing and engaged in a verbal altercation with peer that turned physical. Residents were separated and placed on 1:1. Hospitalization required.R4's progress note dated 08/08/25 documents in part, Resident has had an increase in anxiety and aggressive behavior.R4's progress note dated 08/16/25 documents in part, Writer made aware resident had and altercation as evidenced by pushing his co-peer.R4's care plan dated 09/18/25 documents in part, resident has the potential for/history of physical aggression towards others. History of physical aggression, poor impulse control.R5's medical diagnoses include but are not limited to schizoaffective disorder, violent behavior, bipolar disorder, chronic obstructive pulmonary disease.R5's MDS dated [DATE] has a BIMS score of 3, indicating R5's cognition is severely impaired.R5's progress note dated 08/16/25 documents in part, CNA (Certified Nursing Assistant) informed writer that resident had an altercation, and he was pushed to the floor, hitting the right side of his head. Some bleeding note by the right eyebrow and some swelling noted to the right side of his head.R5's care plan dated 07/01/25 documents in part, R5 is at risk for abuse related to: Has a dx (diagnosis) of severe mental illness and hx (history) of aggression.R5 will remain safe, calm and free from abuse.The Facility's Final Incident Investigation Report sent to the state agency on 08/21/25 documents in part, A follow up interview was conducted with R5 and he stated that while walking down the hallway R4 pushed him causing him to fall to the floor. R5 stated that he believes the incident was an accident. He doesn't feel it was intentional.The Facility's Final Incident Investigation Report sent to the state agency on 08/12/25 documents in part, CNA was interviewed and stated R4 was on his phone singing to himself and walking around the dining room. R7 returned to the dining room and approached R4. Both residents exchanged words. CNA called for help. When she returned to the dining room both residents were on the floor wrestling.On 09/27/25, surveyor attempted to interview R5 regarding the incident between R4 and R5. Surveyor was unsuccessful with interview due to R5's mumbled and distorted speech.On 09/27/25 at 1:00pm V18 (Licensed Practical Nurse/LPN) stated that she witnessed the altercation between R4 and R5 on 08/16/25. V18 stated that R4 and R5 were both walking in the hallway, going in opposite directions. V18 stated that when R4 and R5 were about to pass each other in the hallway, R4 pushed R5 to the floor. V18 stated that when R4 pushed R5 to the floor, R5 slid hit his head on the floor. V18 stated that she then ran to R5 because R5's head was bleeding. V18 stated that R5 was sent to the hospital for evaluation of R5's head wound and R5 received sutures to the head.On 09/27/25 at 1:52pm V16 (Certified Nursing Assistant/CNA) stated that R4 tries to intimidate other residents. V16 stated that R4 pushed R5 to the ground and R5 was sent to the hospital because R5's head was bleeding after being pushed to the ground. Facilities policy title abuse policy dated 07/2025 documents in part policy, This facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, corporal punishment and involuntary seclusion. This facility therefore prohibits mistreatment, neglect or abuse of its residents and has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of mistreatment, neglect or abuse of our residents. This will be done by:. 2. Orientating and training employees on how to deal with stress and difficult situations, and how to recognize and report occurrences of mistreatment, neglect and abuse;. 3. Establishing an environment that promotes resident sensitivity, resident security and prevention of mistreatment;.4. Identifying occurrences and patterns of potential mistreatment; 5. Immediately protecting residents involved in identifying reports of possible abuse;. 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 to the individual, family members or legal guardians, friends, or any other individuals. This facility will not knowingly employ individuals who have been convicted of abusing, neglecting or mistreating individuals.Definitions: Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by