STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0036244	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/28/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S0000	Initial Comments Complaint Investigation 2628837/2589346	S0000		09/29/2025
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) Section 300.3210t) 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. Section 300.3210 General	S9999		09/29/2025

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

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S9999	Continued from page 1 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 were not met as evidenced by: 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 09/18/25 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 a 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 07/01/25 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	S9999		

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S9999	Continued from page 2 bleeding noted by the right eyebrow and some swelling noted on 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 diagnosis (dx) of severe mental illness and a history (hx) 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. The surveyor was unsuccessful with the interview due to R5's mumbled and distorted speech. On 09/27/25 at 1:00 pm 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 and 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 forced 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,	S9999		

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S9999	Continued from page 3 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 accidental means in a facility… physical abuse includes hitting, slapping, pinching, kicking and controlling behavior through corporal punishment." (B)	S9999		