STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145730	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Continental Nursing & Rehab Center	5336 North Western Avenue Chicago, IL 60625

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 45110 Based on interview, and record review the facility failed make arrangements for one [R7] of eight residents reviewed to attend religious services of their choice. Findings Include, R7's clinical record indicates in part; R7's medical diagnosis includes but not limited to cerebral infarction with hemiplegia/hemiparesis affecting left dominant side, type II diabetes, atherosclerotic heart disease, dementia, systemic lupus, nephrotic syndrome, anemia, chronic kidney disease, essential hypertension, thyrotoxicosis, atrial fibrillation. Dysphagia, need assistance with personal care, weakness, anxiety disorder, and bipolar disorder. R7's minimum data set brief interview mental status dated 8/7/24 indicate R7 is cognitively intact. R7's 2/11/22 [Latest Quarterly Activity Evaluation Completed] documents in part. R7 is oriented x2-3 and is able to make needs and wants known although, speech is sometimes hard to understand. R7 is non-ambulatory and is assisted by a wheelchair. R7 enjoys talking to staff and peers, participating in arm and mind strengthening work outs, listening to calm instrumental music, having an opened discussion conversation about books, magazines, and short stories. R7 enjoys being read too and discussing what was just read, watching TV to see the news and maintain informed and last but not least, participating in religious services which she is highly interested in. Resident actually joins the ministries group that comes every Wednesday, and she joins and adds feedback to the group. So, her overall participation is stable, but we must try to maintain the resident active. Therefore, resident has met her goal this quarter, but we will be keeping the same goal to allow the resident to remain active and demonstrate enhanced involvement by engaging in arts & crafts, table games, exercise, Resident Council, and religious services at least 3 days a week until the next review date. R7's Progress note documented in part: V11 [Social Service Director] 9/25/2024 15:12 Social Service Note, Social services contacted R7's church to see if a representative is able to transport R7 to church services .i. e. church van. Church said they would follow up with facility. V9 [Social Service Assistant] (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9/25/2024 15:57 Social Service Note Note Text: RESIDENT REPORT: Social Service spoke with the church member/secretary from R7's church in regard to R7 having another church member come to the facility and sign her out on pass for service on Sundays. Church member/secretary took all the pertinent information to see if any of the church members will be willing to come sign R7 out. Church member/secretary did say that R7 does attend the afternoon service and usually arrives to church by about 11 AM. They will let us know if they find someone. Will continue to monitor. V9 [Social Service Assistant] note: 10/7/2024 17:19 Note Text: RESIDENT REPORT: Called R7's Church to follow up and see if any members were willing to assist with getting resident to Sunday service. They reported they have not found anyone as of yet. R7 also stated that she wanted her green pass back and was re-educated that her most recent doctors order states that she is only eligible for yellow pass. R7 was educated that any previously dated orders are void at this time. will continue to monitor. On 10/9/24 at 11:10 AM, R7 stated, I was going to my church that I attended every Sunday for over twenty years, and I am an active church member. Prior to September, I had a green pass [independent]. I would call the transportation service bus for people with disabilities, the fee is $3.75 for transportation. I would call a get transported from the facility to my church every Sunday. In September, I was out on my green pass [Independent Pass] crossing the street. Then I heard V3 [Director of Nursing] yelling my name, 'R7 get out of the street'. I was in my wheelchair crossing the street. I am in good mind; I know how to cross the street. After that the director of nursing [V3] and social service V9 [Social Service Coordinator] told me that I was on yellow community pass [Supervision] that I needed someone to out with me. I have not been to church for five weeks. V3 told me that I could not use the transportation bus without an escort, friend, or family member with me. I have the right to go to church. Now I cannot use my money to pay for my own way to church service. If I used the transportation bus and I can pay for it, the bus would pick me up here and drop me off at the church door, I would not be in the street. Last Friday, V9 [Social Service Assistant] took me to the court building for me to pick up papers using the facility's van. I don't understand why they cannot use the van to take me to church sometimes. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/9/24 at 2:00 PM, V11 [Social Service Director] stated, I was walking to the store with V3, and V12, when we saw R7 in the street, going down the street the against traffic like she was a car. All of us started yelling R7's name to get out of the street as we all ran to assist R7. She [R7] was not happy she started yelling at us, said she was an adult and in her right mind and knows what she is doing, and she doesn't have to stay on the sidewalk. The team had a meeting and decided R7's pass would be yellow, which means R7 needs someone to be with her outside. I explained to R7 the reason why her community pass was changed to yellow. R7 said she understood, but she was not happy. R7 is very persistent, I called her church to see if anyone would be able to pick R7 up for church on Sundays and no one gotten back in touch with the social service staff. Now that R7 is on the yellow pass which means, R7 needs an escort when she leaves the facility. R7 in the past paid for her bus transportation to and from church services, but I do not trust the transportation because the driver should come to the door and pick up R7 instead the drivers drop the resident's off at the corner. The bus service is for handicap individual in wheelchairs and suppose to pick them up and drop them off safely for a discounted price. I have not come up with a plan or made any arrangements for R7 to attend church. I need to revisit this situation. On 10/9/24 at 2:30 PM, V9 [Social Service Assistant] stated, I called R7's church to transportation assistance from the church. I have not made any arrangements or set up an escort for R7 to attend church services. The facility has escorts for resident medical appointment during the week, but not on the weekend. The transportation bus would come and take R7, but she needs supervision. R7 has missed about five Sundays. I make sure R7 gets to her court appointments, I took R7 downtown Chicago, to the court building to see someone and to pick up paperwork, using the facility's van. I don't believe the appropriate staff works on the weekend to drive the van to take R7 to church. On 10/10/24 at 11:45 AM, V3 [Director of Nursing] stated, On 9/22/24, R7 filed a concern regarding church services [signed by V3, and not resolved]. The social service department was waiting to hear back from the church to see if someone there would pick R7 up for services. No one has gotten back with the facility. I explained to R7 that she was on yellow pass and need supervision. R7 did get her pass taken away because she was in the street and following safety rules. The bus service is supposed to pick up R7 up at the door of the facility and drop her off at the location, but sometimes the driver drops the residents off at the corner. I have not come up with a plan or agreement to make any arrangements with R7 to attend her church. I will come up with a plan with the interdisciplinary team. The facility does have a van, but it does not work all the time. The van worked last Friday (10/4/24) and R7 was able to go to her court appointment, but sometimes the van does not work. The facility van can not be a resolution to R7 going to church, because the van does not always work. Policy documents in part: Illinois Ombudsman Program Resident Rights You have freedom of religion: At your request, the facility must make arrangements for you to attend religious services of your choice as long as you agree to pay any cost. The Facility may not force you to follow any religious beliefs or practices and cannot require you to attend any religious services.

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F 0600 Level of Harm - Minimal harm or potential for 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. 39779 Based on interview and record review the facility failed to protect the resident's right to be free from physical abuse (R2) by another resident that has documented aggressive behavior (R4) for two (R2,R4) of four residents reviewed for abuse. Findings Include: R2 has diagnosis not limited to Abnormalities of Gait and Mobility, Cognitive Communication Deficit, Essential (Primary) Hypertension, Benign Prostatic Hyperplasia with Lower Urinary Tract Symptoms, Schizoaffective Disorder, Bipolar Type, Obstructive and Reflux Uropathy, Type 2 Diabetes Mellitus, Suicidal Ideations, Delusional Disorders, Polyosteoarthritis, Atherosclerotic Heart Disease of Native Coronary Artery, Peptic Ulcer and Contact with and (Suspected) Exposure to other Viral Communicable Diseases. R2's MDS (Minimum Data Set) BIMS (Brief Interview for Mental Status) score is 15 indicating intact cognitive response. R2's Physical Aggression Received dated 09/29/24 document in part: This writer was sitting at the nurse's station when hollering could be heard coming from the dining room. When walking into the dining room the two residents' (R2, R4) were seen near each other and one said he (R2) was hit in the back of the head. Resident (R2) said he was sitting in the dining room when the other resident (R4) wheeled up behind him and hit him on the back of his head. The resident says his head did not hurt but it felt like a light bang. Immediate Action Taken: R2 directed to go into his room. PRN (as needed) pain medication offered but declined. Order for 72-hour neuro checks with monitoring and PRN pain medication if needed. R2/R4 Initial Reportable dated 09/29/24 document in part: Today R2 reports that R4 made contact while passing in the dining room. Staff were present and immediately separated them. R2/R4 Final Reportable dated 10/03/24 document in part: Conclusion: There have been no further incidents. Residents are being closely monitored. Residents have been redirected with appropriate responses. There is no substantiated evidence of abuse. R2's Care Plan document in part: Focus: Abuse, Neglect, Exploitation, Trauma My comprehensive assessment reveals a hx (history) of suspected abuse, neglect, exploitation, past trauma and/or other factors that may increase my susceptibility to abuse/neglect. The resident demonstrates: Diagnosis of Mental Illness, Inadequate coping skills, Difficulty in adjustment & generalized mood distress. Symptoms may be manifested by behavioral symptoms. Goals: The resident will be treated w (with)/ respect, dignity & reside in the facility free of mistreatment (i.e., abuse/neglect) (on-going). Interventions: Assure the resident that he/she is in a safe & secure environment with caring professionals. Progress note dated 09/29/24 14:58 document in part: Social Service Note Text: Resident Report: Resident (R2) reported to have been hit by a peer (R4) twice in the 3rd floor dining room. Resident (R2) and peer (R4) were separated and assessed for injuries. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Progress note dated 09/29/24 15:28 document in part: Nursing Progress Note Text: Resident (R2) had an altercation with another resident (R4) in the hallway. Both were arguing back and forth, and the two were separated for their safety. This resident (R2) was then hit on the back of his head after the other resident (R4) followed him (R2) into the dining room. The two were separated again and one was put in his room. NP (Nurse Practitioner) notified to continue to monitor and start neuro check for 72 hours. R4 has diagnosis not limited to Iron Deficiency Anemia, Gastro-Esophageal Reflux Disease, Polyneuropathy, Peripheral Vascular Disease, Type 2 Diabetes Mellitus, Mild Protein-Calorie Malnutrition, Enterocolitis due to Clostridium Difficile, Unilateral Primary Osteoarthritis, Left Knee, Acquired Absence of Right Leg Below Knee, Difficulty in Walking, Abnormalities of Gait and Mobility, Weakness, Need for Assistance with Personal Care, Cognitive Communication Deficit, Bipolar Disorder and Encounter for Orthopedic Aftercare Following Surgical Amputation. R4's MDS (Minimum Data Set) BIMS (Brief Interview for Mental Status) score is 13 indicating intact cognitive response. R4 Physical Aggression Received dated 09/29/24 document in part: Writer got a report that resident (R4) attacked another resident (R2) in the dining room area. Resident (R4) said the other resident (R2) triggered him (R4) to react the way he did. Notes: Resident keeps redirecting resident at intervals to deescalate situation. Predisposing Physiological Factors: Mental status change. R4 Physical Aggression Initiated dated 09/29/24 document in part: Writer got a report that resident (R4) attacked another resident (R2) in the dining room area. Resident (R4) said the other resident (R2) triggered him (R4) to react the way he did. R4's Care Plan document in part: Focus: Aggression, R4 has displayed aggressive, inappropriate, attention-seeking and/or maladaptive behavior. Reviewed: 09/16/2024 Resident continues verbal and physical aggression towards staff date initiate 09/10/24. Interventions: Intervene when any inappropriate behavior is observed. Communicate assertively that the resident must exercise control over impulses and behavior (Social Skills training) date initiated 09/10/24. Progress Notes dated 09/29/24 14:57 document in part: Social Service Note Text: Resident Report: Resident (R4) reported to have hit a peer twice in the 3rd floor dining room. Resident (R4) and peer (R2) were separated and assessed for injuries; resident (R4) began to be rude towards staff. Resident (R4) continued with heightened behaviors towards staff. Resident (R4) recommended to be petitioned out for psychiatric evaluation. Progress note dated 09/29/24 15:30 document in part: Social Service Note Text: Resident Report: Resident (R4) called his mother to complain about staff following recent incident. Progress note dated 09/29/24 16:02 document in part: Nurses Note Text: Resident (R4) was reported to have threatened and attacked another resident (R2) in the dining room area. Writer redirected resident to his room. Progress note dated 10/01/24 16:41 document in part: Social Service Note Text: PRSC (Psychiatric Rehabilitation Services Coordinator) met with resident (R4) for wellness check. Resident (R4) discussed disagreement with peer (R2) on 09/29/24, stating that he (R4) was provoked by peer (R2) in the hallway. Resident (R4) stated that peer (R2) was making racial slurs to resident and that I (R4) just had enough. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Progress note dated 10/04/24 13:22 document in part: Social Service Note Text: R4 has a dx of bipolar disorder. Resident (R4) is exhibiting agitation, verbal and physical aggression, as well as erratic, threatening, decompensating, unpredictable behaviors. Resident (R4) is verbalizing threats toward others. Progress note dated 10/04/24 18:36 document in part: Nurses Note Text: The resident (R4) was observed this morning having verbal, physical agitation and aggressive towards peers and staff. The writer called the resident (R4) doctor (psychiatrist) and Haloperidol PRN (as needed) Q6H (every 6 hours) was ordered. Two hours after administering the PRN the resident (R4) continued to be agitated and behavior worsening. The psychiatrist ordered the writer to send the resident (R4) to hospital for further evaluation. On 10/08/24 at 02:24 PM R2 stated R4 punched me in the back of the head a week ago on a Sunday. I was sitting in the lunchroom and R4 said I got another resident out of here. This was after they told him to go to his room and asked R4 to leave but R4 came back 3 times because they were ignoring him. The incident with R4 there were residents in the dining room. The certified nurse assistant saw R4 punch me in the back of the head and said I saw R4 hit you. On 10/09/24 at 10:14 AM V10 (Licensed Practical Nurse) stated On 09/29/24 it was my weekend to work. R2 had an altercation with R4. I don't know what was going on when R4 became aggressive, but R4 has a habit of it. I was made aware that R4 hit R2 when R4 and R2 were in the dining room. R2 said R4 hit him (R2) on the back of his head. It was an activity aide or certified nurse assistant that made me aware. That's when I went into the dining room, and they were separated. R4 has a habit of being aggressive with resident and staff. I am not sure what time, but it was in the afternoon between 1-3 pm. The doctor said to administer the prn (as needed) medication to R4, monitor both of the residents and start neuro checks on R2 since R2 was hit in the back of the head. I did documentation for R2 in the Risk Management Note. R2 said the hit felt like a light bang. On 10/09/24 at 02:31 PM V30 (Activity Aide) stated When I got off the elevator R4 was screaming at the certified nurse assistant and the nurse. The nurse was trying to redirect R4, but he was upset because R2 said something to him. On 10/09/24 at 03:17 PM V9 (Social Services Assistant) stated Recently R2 had a disagreement with R4. I did not witness it personally. During the disagreement R2 and R4 had to be separated and staff monitored. During the disagreement there was a lot of yelling and getting close to each other proximately wise. R4 was petitioned out because of his aggressive behavior. V34 (Activity Aide) was there during the initial intervention. On 10/09/24 at 03:39 PM V34 (Activity Aide) stated I witnessed an altercation between R2 and R4. We were doing activities, R4 was having one of those days and R2 was walking pass R4. R4 thought R2 was talking to him, and they started exchanging words. We separated them and I had to get them to calm down. V10 (Licensed Practical Nurse) and I got them to calm down. R4 grabbed R2's arm and as we separated them R4 left out. R2 was sitting in the dining room, R4 rolled up and hit R2 in the back of his (R2) head with his hand. R4 was yelling at me and V10. I do know what happened after that. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/10/24 10:20 AM V35 (Social Services Assistant) stated I was told that R2 and R4 had some type of disagreement. R2 and R4, I believe there was an unsubstantiated claim that R4 struck R2. Racial slurs and derogatory remarks were exchanged. R4 was petitioned out. My role if I am present is to intervene and separate the residents. I report to the clinical director and if she is not present the director of nursing or assistant director of nursing. On 10/10/24 at 10:30 AM V11 (Social Service Director) stated R2 and R4, I was not here that day. I believe that both of them were the aggressors, and both should have been separated prn medications should have been given and the physician/family should have been notified. If R4 struck R2 in the back of the head that is abuse. This has been an ongoing situation. On 10/10/24 at 11:52 AM V3 (Director of Nursing) stated R2 has a habit of calling people racial slurs and I think R4 hit him. The abuse was unsubstantiated. Physical contact it can be considered abuse. Policy: Titled Abuse Prevention Program revised 03/01/21 document I part: It is the policy of this facility to prohibit and prevent resident abuse, neglect, exploitation, mistreatment, and misappropriation of resident property and a crime against a resident in the facility. V. Identification of Allegations/Internal Reporting Requirements: Supervisors shall immediately inform the Administrator or in the absence of the Administrator, the DON (Director of Nursing) of all reports of incidents, allegations or suspicion of potential abuse, neglect, exploitation, mistreatment, and misappropriation of property or a crime against a resident. Upon learning of the report, the Administrator or in the absence of the Administrator, the DON shall initiate an incident investigation. If you suspect abuse: Separate the alleged perpetrator and assure all residents safety. Any incident or allegation involving abuse, neglect, exploitation, misappropriation of resident property or a crime against a resident will result in an abuse investigation. Once the Administrator or in the absence of the Administrator the DON determines that there is an allegation or a reasonable cause for suspecting abuse, neglect, exploitation, misappropriation of property, or a crime against a resident the Administrator or appointed investigator will investigate the allegation and obtain a copy of any documentation relative to the incident. The investigative team will follow the investigation procedure outlined in this policy. After a conclusion based on the facts of the investigation is determined, internal reports, interviews, and witness statements shall be released only with the permission of the administrator. The charge nurse must complete an incident report and obtain written, signed and dated statement from the person reporting the incident. The final report shall include facts determined during the process of the investigation, review of medical records, personnel files, and interview of witnesses. All residents that are near the alleged incident and in the facility will be interviewed for concerns related to abuse during the abuse investigation. The final investigation shall also include a conclusion of the investigation based on known facts. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Titled Abuse Prevention Program Abuse and Crime Reporting revised 01/19 document in part: This facility will not tolerate resident abuse or mistreatment or crimes against a resident by anyone, including staff members, other residents, consultant, volunteers, and staff of other agencies, family members, legal guardians, friends, or other individuals. 1. Abuse: The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm or pain or mental anguish. Willful, as use in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. 2. Verbal Abuse: Any use of oral, written, or gestured language includes disparaging and derogatory terms to residents or their families within hearing distance, to describe residents, regardless of their age, ability to comprehend or disability. 4. Physical Abuse: Hitting, slapping, pinching, kicking etc.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 39779 Based on record review and interview, the facility failed to thoroughly investigate an allegation of physical abuse for one (R2) of four residents who were reviewed for abuse. Findings Include: R2 has diagnosis not limited to Abnormalities of Gait and Mobility, Cognitive Communication Deficit, Essential (Primary) Hypertension, Benign Prostatic Hyperplasia with Lower Urinary Tract Symptoms, Schizoaffective Disorder, Bipolar Type, Obstructive and Reflux Uropathy, Type 2 Diabetes Mellitus, Suicidal Ideations, Delusional Disorders, Polyosteoarthritis, Atherosclerotic Heart Disease of Native Coronary Artery, Peptic Ulcer and Contact with and (Suspected) Exposure to other Viral Communicable Diseases. R2's MDS (Minimum Data Set) BIMS (Brief Interview for Mental Status) score is 15 indicating intact cognitive response. R2's Physical Aggression Received dated 09/29/24 document in part: This writer was sitting at the nurse's station when hollering could be heard coming from the dining room. When walking into the dining room the two residents' (R2, R4) were seen near each other and one said he (R2) was hit in the back of the head. Resident (R2) said he was sitting in the dining room when the other resident (R4) wheeled up behind him and hit him on the back of his head. The resident says his head did not hurt but it felt like a light bang. Immediate Action Taken: R2 directed to go into his room. PRN (as needed) pain medication offered but declined. Order for 72-hour neuro checks with monitoring and PRN pain medication if needed. R2/R4 Initial Reportable dated 09/29/24 document in part: Today R2 reports that R4 made contact while passing in the dining room. Staff were present and immediately separated them. R2/R4 Final Reportable dated 10/03/24 document in part: Conclusion: There have been no further incidents. Residents are being closely monitored. Residents have been redirected with appropriate responses. There is no substantiated evidence of abuse. R2's Care Plan document in part: Focus: Abuse, Neglect, Exploitation, Trauma My comprehensive assessment reveals a hx (history) of suspected abuse, neglect, exploitation, past trauma and/or other factors that may increase my susceptibility to abuse/neglect. The resident demonstrates: Diagnosis of Mental Illness, Inadequate coping skills, Difficulty in adjustment & generalized mood distress. Symptoms may be manifested by behavioral symptoms. Goals: The resident will be treated w (with)/ respect, dignity & reside in the facility free of mistreatment (i.e., abuse/neglect) (on-going). Interventions: Assure the resident that he/she is in a safe & secure environment with caring professionals. Progress note dated 09/29/24 14:58 document in part: Social Service Note Text: Resident Report: Resident (R2) reported to have been hit by a peer (R4) twice in the 3rd floor dining room. Resident (R2) and peer (R4) were separated and assessed for injuries. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Progress note dated 09/29/24 15:28 document in part: Nursing Progress Note Text: Resident (R2) had an altercation with another resident (R4) in the hallway. Both were arguing back and forth, and the two were separated for their safety. This resident (R2) was then hit on the back of his head after the other resident (R4) followed him (R2) into the dining room. The two were separated again and one was put in his room. NP (Nurse Practitioner) notified to continue to monitor and start neuro check for 72 hours. R4 has diagnosis not limited to Iron Deficiency Anemia, Gastro-Esophageal Reflux Disease, Polyneuropathy, Peripheral Vascular Disease, Type 2 Diabetes Mellitus, Mild Protein-Calorie Malnutrition, Enterocolitis due to Clostridium Difficile, Unilateral Primary Osteoarthritis, Left Knee, Acquired Absence of Right Leg Below Knee, Difficulty in Walking, Abnormalities of Gait and Mobility, Weakness, Need for Assistance with Personal Care, Cognitive Communication Deficit, Bipolar Disorder and Encounter for Orthopedic Aftercare Following Surgical Amputation. R4's MDS (Minimum Data Set) BIMS (Brief Interview for Mental Status) score is 13 indicating intact cognitive response. R4 Physical Aggression Received dated 09/29/24 document in part: Writer got a report that resident (R4) attacked another resident (R2) in the dining room area. Resident (R4) said the other resident (R2) triggered him (R4) to react the way he did. Notes: Resident keeps redirecting resident at intervals to deescalate situation. Predisposing Physiological Factors: Mental status change. R4 Physical Aggression Initiated dated 09/29/24 document in part: Writer got a report that resident (R4) attacked another resident (R2) in the dining room area. Resident (R4) said the other resident (R2) triggered him (R4) to react the way he did. R4's Care Plan document in part: Focus: Aggression, R4 has displayed aggressive, inappropriate, attention-seeking and/or maladaptive behavior. Reviewed: 09/16/2024 Resident continues verbal and physical aggression towards staff date initiate 09/10/24. Interventions: Intervene when any inappropriate behavior is observed. Communicate assertively that the resident must exercise control over impulses and behavior (Social Skills training) date initiated 09/10/24. Progress Notes dated 09/29/24 14:57 document in part: Social Service Note Text: Resident Report: Resident (R4) reported to have hit a peer twice in the 3rd floor dining room. Resident (R4) and peer (R2) were separated and assessed for injuries; resident (R4) began to be rude towards staff. Resident (R4) continued with heightened behaviors towards staff. Resident (R4) recommended to be petitioned out for psychiatric evaluation. Progress note dated 09/29/24 15:30 document in part: Social Service Note Text: Resident Report: Resident (R4) called his mother to complain about staff following recent incident. Progress note dated 09/29/24 16:02 document in part: Nurses Note Text: Resident (R4) was reported to have threatened and attacked another resident (R2) in the dining room area. Writer redirected resident to his room. Progress note dated 10/01/24 16:41 document in part: Social Service Note Text: PRSC (Psychiatric Rehabilitation Services Coordinator) met with resident (R4) for wellness check. Resident (R4) discussed disagreement with peer (R2) on 09/29/24, stating that he (R4) was provoked by peer (R2) in the hallway. Resident (R4) stated that peer (R2) was making racial slurs to resident and that I (R4) just had enough. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145730	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Continental Nursing & Rehab Center	5336 North Western Avenue Chicago, IL 60625

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Progress note dated 10/04/24 13:22 document in part: Social Service Note Text: R4 has a dx of bipolar disorder. Resident (R4) is exhibiting agitation, verbal and physical aggression, as well as erratic, threatening, decompensating, unpredictable behaviors. Resident (R4) is verbalizing threats toward others. Progress note dated 10/04/24 18:36 document in part: Nurses Note Text: The resident (R4) was observed this morning having verbal, physical agitation and aggressive towards peers and staff. The writer called the resident (R4) doctor (psychiatrist) and Haloperidol PRN (as needed) Q6H (every 6 hours) was ordered. Two hours after administering the PRN the resident (R4) continued to be agitated and behavior worsening. The psychiatrist ordered the writer to send the resident (R4) to hospital for further evaluation. On 10/08/24 at 02:24 PM R2 stated R4 punched me in the back of the head a week ago on a Sunday. I was sitting in the lunchroom and R4 said I got another resident out of here. This was after they told him to go to his room and asked R4 to leave but R4 came back 3 times because they were ignoring him. The incident with R4 there were residents in the dining room. The certified nurse assistant saw R4 punch me in the back of the head and said I saw R4 hit you. On 10/09/24 at 10:14 AM V10 (Licensed Practical Nurse) stated On 09/29/24 it was my weekend to work. R2 had an altercation with R4. I don't know what was going on when R4 became aggressive, but R4 has a habit of it. I was made aware that R4 hit R2 when R4 and R2 were in the dining room. R2 said R4 hit him (R2) on the back of his head. It was an activity aide or certified nurse assistant that made me aware. That's when I went into the dining room, and they were separated. R4 has a habit of being aggressive with resident and staff. I am not sure what time, but it was in the afternoon between 1-3 pm. The doctor said to administer the prn (as needed) medication to R4, monitor both of the residents and start neuro checks on R2 since R2 was hit in the back of the head. I did not get interviewed by the Director of Nursing or the Administrator. I did documentation for R2 in the Risk Management Note. R2 said the hit felt like a light bang. On 10/09/24 at 02:31 PM V30 (Activity Aide) stated When I got off the elevator R4 was screaming at the certified nurse assistant and the nurse. The nurse was trying to redirect R4, but he was upset because R2 said something to him. On 10/09/24 at 11:55 AM V31 (Registered Nurse) stated They never came to interview me for R2 or R4 and I never signed a statement. On 10/09/24 at 03:17 PM V9 (Social Services Assistant) stated Recently R2 had a disagreement with R4. I did not witness it personally. During the disagreement R2 and R4 had to be separated and staff monitored. During the disagreement there was a lot of yelling and getting close to each other proximately wise. R4 was petitioned out because of his aggressive behavior. V34 (Activity Aide) was there during the initial intervention. (continued on next page)

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	145730	A. Building B. Wing	10/11/2024

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/09/24 at 03:39 PM V34 (Activity Aide) stated I have witnessed an altercation between R2 and R4. We were doing activities, R4 was having one of those days and R2 was walking pass R4. R4 thought R2 was talking to him, and they started exchanging words. We separated them and I had to get them to calm down. V10 (Licensed Practical Nurse) and I got them to calm down. R4 grabbed R2's arm and as we separated them R4 left out. R2 was sitting in the dining room, R4 rolled up and hit R2 in the back of his (R2) head with his hand. R4 was yelling at me and V10. I do know what happened after that. I wrote a report on a piece of paper and gave it to V9 (Social Services Assistant). No one ever came to interview me. On 10/09/24 at 03:53 PM surveyor asked V2 (Regional Director of Operations) was there any additional documentation for R2 and R4 Reportable. V2 stated that's the only one. On 10/10/24 10:20 AM V35 (Social Services Assistant) stated I was told that R2 and R4 had some type of disagreement. R2 and R4, I believe there was an unsubstantiated claim that R4 struck R2. Racial slurs and derogatory remarks were exchanged. R4 was petitioned out. My role if I am present is to intervene and separate the residents. I report to the clinical director and if she is not present the director of nursing or assistant director of nursing. On 10/10/24 at 10:30 AM V11 (Social Service Director) stated R2 and R4, I was not here that day. I believe that both of them were the aggressors, and both should have been separated prn medications should have been given and the physician/family should have been notified. I am not aware of any physical contact between R2 and R4, none of the staff reported there was physical contact. I did not interview V34 (Activity Aide). If R4 struck R2 in the back of the head that is abuse. This has been an ongoing situation. On 10/10/24 at 11:52 AM V3 (Director of Nursing) stated We usually interview everyone on the floor and get statements and the staff sign the statements. R2 has a habit of calling people racial slurs and I think R4 hit him. The abuse was unsubstantiated. Physical contact it can be considered abuse. There was not a thorough investigation done for the allegation of abuse for R2 and R4. There was no certified nurse assistant or resident interview and V34 (Activity Aide) was not interviewed so it is not a thorough investigation. I have to agree we need the interviews. Policy: (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Titled Abuse Prevention Program revised 03/01/21 document I part: It is the policy of this facility to prohibit and prevent resident abuse, neglect, exploitation, mistreatment, and misappropriation of resident property and a crime against a resident in the facility. V. Identification of Allegations/Internal Reporting Requirements: Supervisors shall immediately inform the Administrator or in the absence of the Administrator, the DON (Director of Nursing) of all reports of incidents, allegations or suspicion of potential abuse, neglect, exploitation, mistreatment, and misappropriation of property or a crime against a resident. Upon learning of the report, the Administrator or in the absence of the Administrator, the DON shall initiate an incident investigation. If you suspect abuse: Separate the alleged perpetrator and assure all residents safety. Any incident or allegation involving abuse, neglect, exploitation, misappropriation of resident property or a crime against a resident will result in an abuse investigation. Once the Administrator or in the absence of the Administrator the DON determines that there is an allegation or a reasonable cause for suspecting abuse, neglect, exploitation, misappropriation of property, or a crime against a resident the Administrator or appointed investigator will investigate the allegation and obtain a copy of any documentation relative to the incident. The investigative team will follow the investigation procedure outlined in this policy. After a conclusion based on the facts of the investigation is determined, internal reports, interviews, and witness statements shall be released only with the permission of the administrator. The charge nurse must complete an incident report and obtain written, signed and dated statement from the person reporting the incident. The final report shall include facts determined during the process of the investigation, review of medical records, personnel files, and interview of witnesses. All residents that are near the alleged incident and in the facility will be interviewed for concerns related to abuse during the abuse investigation. The final investigation shall also include a conclusion of the investigation based on known facts. Titled Abuse Prevention Program Abuse and Crime Reporting revised 01/19 document in part: This facility will not tolerate resident abuse or mistreatment or crimes against a resident by anyone, including staff members, other residents, consultant, volunteers, and staff of other agencies, family members, legal guardians, friends, or other individuals.

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	145730	A. Building B. Wing	10/11/2024

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 39779 Based on observation, interview, and record review the facility failed to provide double portions as listed on the resident's meal ticket for 1 (R2) of 3 residents reviewed for nutrition. Findings Include: R2 has diagnosis not limited to Abnormalities of Gait and Mobility, Cognitive Communication Deficit, Essential (Primary) Hypertension, Benign Prostatic Hyperplasia with Lower Urinary Tract Symptoms, Schizoaffective Disorder, Bipolar Type, Obstructive and Reflux Uropathy, Type 2 Diabetes Mellitus, Suicidal Ideations, Delusional Disorders, Polyosteoarthritis, Atherosclerotic Heart Disease of Native Coronary Artery, Peptic Ulcer and Contact with and (Suspected) Exposure to other Viral Communicable Diseases. R2's MDS (Minimum Data Set) BIMS (Brief Interview for Mental Status) score is 15 indicating intact cognitive response. Wednesday 10/09/24 menu document in part: Lunch Breaded Pork Chop 3 ounces., Baked Sweet Potatoes with butter and brown sugar 1 potato, Mixed Vegetables 4 ounces, Peanut Butter Pie and 8-ounce beverage. R2's Lunch meal ticket that was observed on his meal tray on 10/09/24 document in part: Diet: CCHO (Controlled Carbohydrate) (LCS) (Low calorie sweetener) Texture: Regular, Liquid: Thin. Notes No fats, No sugar, No Muffin, No fish. Double Portion. R2's Order Summary: dated 06/17/24 document in part: Low Concentrated Sweets Diet Regular texture, Thin Liquids consistency. R2's Care plan document in part: Resident has the following medical &/or mental health conditions/behaviors which may compromise his/her nutritional status in the future: Diet Rx: (medical prescription) LCS, Regular Texture, Thin Liquids. On 10/09/24 at 10:54 AM R2 stated I might get a piece of chicken but that is not an adequate amount of food because I supposed to get double portions. On 10/09/24 at 12:52 PM the third-floor food carts arrived on the floor. Surveyor asked V28 (Certified Nurse Assistant) to locate R2's lunch tray on the food cart to check the contents. V28 located R2's lunch tray removed the cover then stated, there is one pork chop, corn and sweet potatoes on the tray. V28 put a cup of coffee and a cup of juice on the lunch tray, handed the lunch tray to V32 (Certified Nurse Assistant) then asked could she (V32) deliver the tray to R2. V32 proceeded to R2's room and placed the lunch tray on R2's overbed table. Surveyor asked R2 to remove the cover to observe the contents. R2 removed the cover then said see there is only on pork chop and there should be 2, some corn and sweet potatoes. That's not enough food. Surveyor asked could the meal ticket be taken from the tray and R2 responded, yes. (continued on next page)

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	145730	A. Building B. Wing	10/11/2024

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/09/24 at 01:13 PM V18 (Cook) stated the dietary aide read the meal ticket and whatever they tell me that is what I plate. Surveyor showed V18 R2's meal ticket then asked what was the meaning of double portion that was printed on the meal ticket. V18 responded that means 2 meats, 2 servings of potatoes and 2 servings of corn. We ran out of pork chops and that is why double portions was not given. On 10/09/24 at 01:21 PM V22 (Registered Dietitian) stated I work in this facility once a week. If there is double portion printed on the resident meal ticket, they get double of everything being served. R2 should have gotten 2 pork chops, 2 servings of the sweet potatoes and 2 servings of the corn. Usually, the double portion is the resident's preference. If they eat well that would be and extra and they are supposed to get a little more protein, carbohydrate and vegetable serving. R2 should have gotten the double portion. On 10/09/24 at 03:02 PM V16 (Interim Dietary Manager/Consultant) stated R2 is on a low sugar concentration diet with double portion. A resident receiving double portions would receive 2 meats, 2 servings of vegetables and 2 servings of carbohydrates depend on food preferences. There is a dietary aide reading the meal ticket and the cook plates the food. R2 should have received 2 pork chops, 2 servings of corn and 2 servings of sweet potatoes. The ticket should have been read off as double. The double portions should be ordered in Point Click Care and the dietitian will check the resident and make recommendation to the nurse. The nurse calls the doctor for the order. Based on seeing double portions on R2's meal ticket that is what he is supposed to be receiving. I will try to make it a point with all meals and make the nurse aware to put it in Point Click Care double portions with all meals. They will get an order from the physician for approval. On 10/10/24 at 11:52 AM V3 (Director of Nursing) stated If a resident has had double portion on the meal ticket, they should receive double portions. Policy: Titled Menu & Nutritional Adequacy Policy: Portion Control developed 09/26/23 document in part: Residents will receive the correct portions of food through adherence to planned menus and standardized recipes and utilization of proper serving utensils. Procedure: 1. Dietary staff will serve portions to residents based on planned menus that list the portion size for each food item. 4. In an individual requests small or double portions, the request should be communicated to the physician, documented in the medical record, sent to the Dietary Department as a diet order, and documented on the resident's tray card.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45110 Based on observation, interview and record review the facility failed to ensure the kitchen equipment and preparation area was clean, follow cleaning schedule for the kitchen and equipment and label/ date stored food, and discard expired food. These deficient practices have the potential to affect all 139 residents receiving food prepared in the facility's kitchen. Findings include: On [DATE] at 9:28 AM, V18 [Cook] stated, We do not have a dietary manager, I am a cook, but I am not in charge, please speak to V15 [Cook], I think he is in charge of the kitchen. On [DATE] at 9:30AM, V15 stated, I am not in charge of the kitchen, I am just a cook. The administrator is over the kitchen. I only been working her for seven months; I do not know who is in charge. The dietary manager left a couple months ago. Surveyor and V15 observed on the clean dish racks, a bag, coffee cup, paper cutter, resident's meal tickets, and 3-tier metal file organizer, on the rack above the clean plant lids and coffee cups. On the clean plate lids, and coffee cups, noted small paper pieces all over the clean dishes. V15 stated, I will have V17 [Dietary Aide] remove her purse. The office if full of stuff, and the paper cutter cannot fit on desk in the office. I will remove the office supplies off the clean dish rack. It could potentially cause an illness by cross contamination. On [DATE] at 9:31 AM, V17 stated, That is my purse on the rack. When I started working here, I was told it was okay to place my personal items on this rack. On [DATE] at 9:33 AM, V3 [Director of Nursing] and V16 [Interim Dietary Manager Consultant] walked into the kitchen. V16 told the surveyor she is the interim dietary manager along with the administrator. The administrator is out of town. V3 stated, The dietary manager left a couple weeks ago. V3, V16 and surveyor toured the kitchen and observed the following: Steam table metal pan#1 had dark black colored liquid substance with a dark thick line going around the circumference of the pan, metal pan #2 with light brown liquid with green spots on top, with brown, white noodles like substance at the bottom of the pan, metal pan #3 with yellow liquid with multi- colored substance in the pan and thick dark color going around the circumference of all the pans. V16 stated, The steam table metal are used to keep the food warm while preparing the food trays. The dietary staff recently completed serving breakfast, but I see noodles and other food partials in the pan that was not served for breakfast. The metal pans have not been cleaned. This could potentially cause a food born illness from food contamination. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	V3, V16 and surveyor observed the meat slicer on the counter with a red substance dried on the side of the blade with red and black substance in the blade. V16 stated, They cooked ham for breakfast, but I am not sure what the black thick substance is. The meat slice needs a deep cleaning. The meat slicer, all food preparations equipment must be sanitized and cleaned after every use, if not it could potentially cause cross food contamination and lead to a food born illness. V3, V16, and surveyor observed on all the counter tops in the kitchen large amounts of different colored crumbs, black, white, brown, red, and green, all on equipment and behind seasonings with the lids open, the stove was covered with half burnt corn, white, black crumbs, with thick black sticky substance all over the stove top, sides, back, down the front of the stove. The over door handles were covered with white power substance, black thick sticky substance. When surveyor opened oven door, there was thick black substance on the inside of the oven and puddles of black thick substance covering the bottom of the oven. Two garbage cans in the kitchen area were filled with garbage without a lid. Food crumbs and a couple of toasted slices of bread on the floor underneath the sink compartment. V16 stated, The stove and the oven need to be clean, and the black grease needs to be removed, the food crumbs and the black thick grease on the stove and oven could potentially cause a grease fire or food born illness. I will have V18 clean the stove and oven now. The floor needs sweeping, and mop as often as needed. The garbage cans should always be covered to prevent the potential spread of food born illness. There should be sanitation buckets placed throughout the kitchen to assist with cleaning and to prevent cross contamination. V16 and surveyor observed the walk-in cooler with two half-filled gallons of whole white milk with the expiration date of [DATE], a metal cart with raw thawed pork chops on metal trays with red substance on the tray uncovered with not date. V16 stated, The pork chop are thawed with a little blood on the tray, the pork chops should have been covered and dated, to prevent a potential food born illness. The expired milk should have been discarded on or before [DATE], the expired milk could potentially cause a food born illness. On [DATE] at 10:02AM, V18 [Cook] stated, I am the only cook with three dietary aides working. Either I can clean the kitchen or start cooking the resident's lunch, I cannot do both. The kitchen is not cleaned because we do not have a pan washer. The pan washer cleans up the counter tops, steam table pans, stove and the oven. I used the steam table pan this morning for breakfast to keep the breakfast food warm. I did not have time to wash the pans out. The clean food does directly sit in the warming pans. I am doing the best that I can do. There was not any sanitation bucket prepared today. On ,d+[DATE]/ 24 at 10:15 AM, V3 [Director of Nursing] stated, I know there was another cook, that was hired and should be starting soon. All staff have a locker they should use for their personal items, not to store in the kitchen or nursing areas. Policy documents in part: Food Safety and Sanitation dated ,d+[DATE]. Foods in the refrigerator will be covered, labeled, and dated. Foods will be used by its used by date or discarded. Cleaning Procedures (continued on next page)

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	145730	A. Building B. Wing	10/11/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Food service equipment shall be washed, rinsed, and sanitized to reduce the risk of foodborne illness. Sanitizing solution buckets will be made to reduce the risk of foodborne illness via cross-contamination. Oven The oven should be cleaned weekly. To remove the racks and scrub, scrape off burnt o food from inside and outside the unit. Steam Tables Remove the food containers from the steam table after each meal service, remove the metal container with water, brush all surfaces with a cleaning solution, remove all lime water and clean the area after each use. Food Slicer Remove meat carriage, remove blade wash thoroughly, rinse and sanitize. Air dry parts Garbage Cans Keep lids on the garbage cans when not in use. All sweepings solid or liquid waste will be removed in a manner to avoid creating a menace to health.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. 40061 Based on interviews and record reviews, the facility failed to follow physician's orders for therapy evaluation and treatment for one (R3) out of five residents reviewed for therapy services. Findings include: R3's Admission Record and Order Summary Report document in part diagnoses of spinal stenosis (narrowing of the spaces inside the bones which can put pressure on the spinal cord), radiculopathy (pinched nerve), morbid obesity, osteoarthritis (degenerative joint disease), and muscle wasting and atrophy. R3's care plan contains a focus for spinal stenosis. Intervention includes PT (Physical Therapy)/OT (Occupational Therapy) eval and treatment as indicated (date initiated 5/28/2024). R3's care plan documents in part that R3 requires extensive to total assistance with most activities of daily living affecting all extremities (last revised 6/07/2024). It also documents in part that R3 has a self-care deficit with impaired dressing and grooming abilities (last revised 6/07/2024). R3's Order Summary Report documents in part an active order for PT, OT, ST (Speech Therapy) screen on admit, readmit, and/or as needed. May evaluate and treat if appropriate (order date 5/24/2024). On 10/08/2024 at 11:48 AM, R3 was alert and oriented to person, place, and date. R3 stated facility was not currently providing physical therapy to R3. Facility informed R3 that insurance will not pay for additional services. R3 stated wanting more sessions. On 10/08/2024 at 2:25 PM, V8 (Therapy Manager/Occupation Therapist) stated R3 received therapy services in the past but was not under current treatment. V8 was not aware that R3 wanted more therapy services. V8 stated staff did not inform therapy department about any needs for a re-evaluation for R3. On 10/09/2024 at 11:30 AM, surveyor reviewed R3's Initial Visit History and Physical Note dated 9/25/2024 by V23 (Pain Clinic Physician). It documents in part that the plan was for physical therapy to evaluate and treat two times per week. On 10/09/2024 at 12:56 PM, V13 (Physical Therapist) stated being the regular Physical Therapist for the facility. V13 discharged R3 from physical therapy on 9/16/2024. V13 stated therapy did not re-evaluate R3 and was not on V13's caseload for treatment. Surveyor showed V13 R3's Initial Visit History and Physical Note dated 9/25/2024. V13 stated never receiving a copy of the paperwork. V13 stated therapy department has not seen R3 after 9/25/2024. V13 stated the pain clinic notes were orders and worth an evaluation right away or at least within a week the latest. V13 stated staff should have given the therapy department a copy of the document or the nurse should have informed the therapy department of the order. During a telephone interview on 10/09/2024 at 2:26 PM, V20 (Nurse that took care of R3 on 9/25/2024) stated R3 did not come back from the pain clinic appointment with any orders. V20 did not mention the physical therapy order. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145730	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Continental Nursing & Rehab Center	5336 North Western Avenue Chicago, IL 60625

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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 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/10/2024 at 11:44 AM, V3 (Director of Nursing) stated pain clinic plan were orders and staff should have followed through with getting physical therapy for R3. Facility's undated Physician Orders - (Following Physician Orders) policy documents in part: It is the policy of the facility to follow the orders of the physician. Facility's Therapy Evaluation/Treatment Procedures policy (dated 2/2013) documents in part: If the need for skilled PT/OT/ST services is identified, an evaluation order will be requested from the physician. Upon receipt of the order, the evaluation will be completed by the therapist with the report and recommendations placed in the medical chart and submitted to the physician.