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	11/08/2024

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

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** 41356 Based on review of records and interviews the facility failed to develop and implement a baseline care plan for falls upon admission and follow their incidents/accidents/falls policy to provide interventions for prevention of falls for 1 out of 3 residents (R6) with multiple falls. These failures affected 1 resident (R6) who had multiple falls in the facility without proper interventions and/or preventive measures. Findings include: R6 is [AGE] years old, initially admitted in the facility on 8/27/2024 with diagnosis that includes vascular dementia, cerebral infarction, and hemiplegia and hemiparesis. R6 cognition was moderately impaired with brief interview for mental status (BIMS) dated 10/4/2024 scored 8. R6's assessment on functional abilities dated 10/4/2024 documents that R6 has an impairment on both sides of his lower extremities. Progress notes of R6 related to fall: V19 (Registered Nurse) initial admission notes dated 8/28/2024, documents: Report from the hospital that R6 had history of multiple falls at home with multiple wounds related to the fall prior to being admitted and 1 episode of fall in the hospital. V20 (Registered Nurse) notes dated 8/30/2024 three (3) days after admission in the facility, documents: R6 was observed ambulating in the unit holding to wheelchair, redirected by staff with poor results. Wife visited the resident who told the staff that R6 told her he fell yesterday on the dining room. V21 (Licensed Practical Nurse) notes dated 8/31/2024, documents: R6 was noted on the floor, sitting position next to the bed. V19 notes dated 9/4/2024, documents: (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
	145730	A. Building B. Wing	11/08/2024

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

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	R6 was observed kneeling on the floor. Per R6's Fall Risk assessment, R6 was consistently assessed as high risk for falls. Fall Risk Review of R6 are as follows: 8/28/2024 (admission), 8/30/2024 (due to incident of fall), 8/31/2024 (due to incident of fall), 9/3/2024 (re-admission), 9/5/2024 (due to incident of fall). Review of R6 full care plan: Although R6 had multiple falls prior to and after admission in the facility. And R6 assessed as high risk for falls. R6's fall concerns were not address by the facility for lack of care plan from 8/27/2024 to 9/4/2024. By this time, R6 had three (3) incidents related to fall (8/30/2024, 8/31/2024, and 9/4/2024) per progress notes. R6's care plan documents, Focus: Falls: I am at risk for falls. Date initiated: 9/4/2024. On 11/06/2024 at 11:06 AM, V14 (Restorative Nurse / Licensed Practical Nurse) stated that R6 uses wheelchair for locomotion but non-ambulatory. Upon review of R6's full care plan, V14 stated, I only do care plan based on the assessment due date. V14 was asked, how about baseline care plan? When does it needs to be done? V14 stated I am not sure, but R6 had a lot of falls prior to admission at home and also in the hospital. And every time a resident falls, I need to do a care plan. I think baseline care need to be done during admission assessment by the nurse on the floor. V14 was asked would it help to prevent R6 from falling on 9/4/2024 if there were interventions on the falls prior to that date? V14 said, It may help. On 11/7/2024 at 10:40 AM, V22 (MDS Coordinator / Registered Nurse) stated the baseline care plan is done upon admission during the first 24 hours. And the purpose of baseline care plan is to create an interim plan of care on what they see at a glance upon admission. Fall care plan is to identify those that are at risk for fall. Even if they are high or low risk for fall, still need to do the care plan. We want to prevent falls no matter who it is. Care plan is needed for prevention of fall. It is important because it assist on how to prevent falls that could affect the resident. Under facility policy on IDT (Interdisciplinary Team) Care Planning Policy and Procedure (Person-Centered Plan of Care) dated 6/2020, reads: Each resident will have a comprehensive assessment completed that will assist in the development of an individualized (Person-Centered) plan of care that will include goals and interventions aimed to improve or maintain the residents' highest level of function, prevent decline, decrease risk of complications of medical conditions. New admission / readmission resident will have baseline care plan initiated by nursing with actual and potential problems identified and the comprehensive care plan will continue to be developed with the completion of the MDS (Minimum Data Set) Assessment process within the RAI (Resident Assessment Instrument) rules and regulations. Under CFR (Code of Federal Regulation) and RAI rules and regulation, baseline care plan must be developed within 48 hours of a resident's admission. Under facility policy on Incidents/Accidents/Falls policy not dated, reads: (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	11/08/2024

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

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	Under procedure, all falls will have a site investigation by appropriate staff in an effort to define the root cause of the fall. This will help provide information to enable staff to roll out interventions to prevent another similar occurrence. Note: Each fall needs a new intervention rolled out. Based on the results of the incident/accident/fall, the resident's care plan will be addressed to ensure that any needed points of focus have measurable goals with appropriate interventions in place.