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	12/13/2024

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 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. 49486 Based on interview and record review, the facility failed to prevent resident to resident abuse. This failure resulted in R3 and R4 engaging in a verbal altercation that led to R3 hitting R4 while in the hallway. Findings Include: On 12/10/24 at 11:36 AM, R3 stated that R4 was cursing R3 in the hallway few weeks ago, and R3 used R3's foot to hit R4's jaw while R4 was sitting in wheelchair. On 12/11/24 at 10:04 AM, R4 received alert in bed, appeared weak. R4 stated that R4 was up in wheelchair in the hallway arguing with R3, and R3 hit R4 on the cheek. R4 stated that R4 did not hit R3. On 12/11/24 at 11:30 AM, V18 (CNA) stated that V18 worked 3PM-11PM shift with R3 and R4 on the date of the incident (11/01/24). V18 stated that V18 heard R3 and R4 arguing around 4 PM, and the argument turned to R3 fighting with R4, and R3 hit R4. V18 stated that hitting is a form of physical abuse. On 12/11/24 at 12:34 AM, V19 (Director of Social Services) stated that V19 heard that R3 and R4 were pushing and hitting each other in the hallway and staff immediately separated R3 and R4. V19 stated that hitting is a form of physical abuse. On 12/11/24 at 2:32 PM, V2 (Assistant Director of Nursing/ADON) stated that it was reported to V2 that there was an altercation turned to physical between R3 and R4, and R3 was separated from R4. V2 stated that the physician was notified with order to send R3 and R4 out to the hospital, and the family were notified. On 12/11/24 at 2:56 AM, V22 (CNA) stated that V22 was working on the date of the incident between R3 and R4. V22 stated that R4 was up in wheelchair, very verbally aggressive with R3, and the verbal aggression turned to R3 and R4 physically boxing each other. V22 separated R3 and R4, and R4 stated that R3 hit R4's cheek. (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	12/13/2024

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/11/24 at 3:11 PM, V1 (Administrator) stated that there was physical contact between R3 and R4, and staff separated R3 and R4 immediately. V1 stated that the physician was notified, R3 and R4 were sent out to the hospital and readmitted back to the facility into a separate room to avoid proximity. Progress note dated 11/01/24 documents in part: Resident (R3) engaged in physical aggression with fell ow resident on the floor throwing punched at each other. A review of R3's care plan revision dated 12/09/24, R3 can be verbally aggressive and combative when redirected. Abuse Policy dated 01/2019 documents in part: It is the policy of this facility to prohibit and prevent resident abuse. Facility policy titled Your Rights and Protection as a Nursing Home Resident, documents in part: Be free from abuse and neglect. Witness statement dated 11/1/24 documents in part: There was argument between two clients (R3 and R4) around 4 pm and which escalated to fighting where both were exchanging of blows.

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	12/13/2024

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 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49486 Based on interview and record review, the facility failed to follow their abuse policy by involuntarily holding a resident in their room by blocking or holding the door closed with the use of a garbage bag. This failure affected 1 (R2) of 6 residents reviewed. Findings Include: R2 is a [AGE] year-old male. R2's Minimum Data Set (MDS) dated [DATE] shows R2 is severely cognitively impaired and has a diagnosis of Unspecified Dementia, with other behavioral disturbance, other disorders of brain, Alzheimer's disease, Cognitive communication deficit, Type 2 diabetes mellitus, Essential hypertension, other abnormalities of gait and mobility, and need for assistance with personal care. On 12/10/24 at 11:54 AM, R2 was observed pacing in R2's room. R2 appeared to be confused. Surveyor asked R2 if staff has blocked R2's door with a bag and if staff has been physically abusive to R2? R2 was unable to remember, R2's cognition is severely impaired. On 12/11/24 at V11 (CNA) stated that V11 was only in this facility for six months before V11 was fired by V1. V11 stated that V11 worked 11PM-7AM shift with R2 on the date of the incident (10/31/24), and V11 noticed R2 pacing around, then V11 assisted R2 back to R2's room and placed a bag around R2's door so R2 will not be pacing in the hallway. V11 stated that V11 did not place the bag by R2's door to restrain R2, and V11 did not handle R2 inappropriately. On 12/11/24 at 12:34 AM, V19 (Director of Social Services) stated that all staff should report both witnessed and unwitnessed abuse immediately to V1. V19 stated that placing a bag by the door of R2 is involuntary seclusion, and it is not allowed or tolerated. V19 stated that V19 heard of a staff blocking R2's door with a plastic bag so R2 cannot get out of R2's room. V19 stated that after a thorough investigation by V1, V11 was terminated for blocking R2's door with a plastic bag. On 12/11/24 at 1:12 PM, R7 stated that R7 was walking in the hallway at night on the day of the incident (10/31/24) when R7 noticed that R2's door was tied with a plastic garbage bag preventing R2 from coming out of R2's room throughout the night. R7 stated that R7 reported the incident and V1 fired V11 for doing such a terrible thing. On 12/11/24 at 2:32 PM, V2 (Assistant Director of Nursing/ADON) stated that staff reported that V11 blocked R2's door with a plastic bag preventing R2 from pacing at night shift. V2 stated that blocking R2's door is involuntary seclusion and V11 was fired after thorough investigation. On 12/11/24 at 3;11 PM, V1 (Administrator) stated that blocking R2's door by V11 is involuntary seclusion and V11 was fired for blocking R2's door. Reviewed R2's Face Sheet, POS, Care Plan, and Section C of MDS. There was no documentation or order to support the need to hold or separate R2 as a protective measure to others or as a means to prevent R2 from moving about the facility freely. (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	12/13/2024

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 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Progress note dated 10/31/24 documents in part: It was alleged that a facility staff (V11) was inappropriate with (R2) resident. A review of R2's care plan revision dated 10/4/24, Resident (R2) demonstrates pacing behavior, staff to make rounds/room checks to minimize chance of unauthorized leave. Abuse Policy dated 01/2019 documents in part: It is the policy of this facility to prohibit and prevent resident abuse. Facility policy titled Your Rights and Protection as a Nursing Home Resident, documents in part: Be free from abuse and neglect. Be treated with dignity and respect. Witness statement dated 11/5/24 documents in part: Sometimes early in the morning when I (R7) was walking around, I (R7) saw resident (R2) door tied.