

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145730	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/20/2025
NAME OF PROVIDER OR SUPPLIER Continental Nursing & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45000</p> <p>Based on interview and record review, the facility failed to prevent and protect one resident (R8) from resident-to-resident physical abuse by (R9) for two of three residents reviewed for physical abuse. This failure resulted in R8 being beaten with a walking cane while in the facility and sustaining a left hip fracture.</p> <p>Findings include:</p> <p>On 01/19/2025, at 1:40 PM, V12 (Licensed Practical Nurse/LPN) states he was the nurse assigned to care for R8 when R8 was sent out to the hospital. V12 states on 01/16/2025, R8 was involved in a verbal and physical altercation with his roommate (identified as R9). V12 states he was at the nurses' station someone informed him that R8 and R9 were in an altercation. V12 states he did not witness the altercation but was informed that the aggressor was R9. V12 states R8 told him that R9 used R9s' walking cane to strike R8, which is why R8 was sent out to the hospital. V12 states R8s' other roommate (identified as R3) witnessed the altercation between R8 and R9 and brought it to V12s' attention. V12 states he documented the altercation in the electronic health records and informed V1 (Administrator) of what happened. V12 states he also notified R8 and R9s' doctors and received orders to send both residents out to the hospital. V12 states R8 complained of pain to his left hip, and he administered pain medications to R8 while R8 waited for the ambulance to arrive.</p> <p>Nursing progress note dated 01/16/2025, written by V12 documents in part 6:40 PM, there was an alleged altercation between R8 and R9. Investigation initiated. R8 stated that he had complained to his roommate that the room was cool. R8 wanted to have R9 close the window but R9 refused and chose to come on his side to turn off the heater. That is when R8 and R9 got into a verbal altercation. R9 used his cane on R8s' left leg. A head to toe assessment was completed. R8 complained of pain on the left hip to lower extremity. Pain medication was given to R8. R8's skin intact, vitals were stable, the ADON (Assistant Director of Nursing) was notified and the administrator was made aware. Physician order for R8 to be sent to hospital for medical evaluation and no family member listed as a contact.</p> <p>Nursing progress note dated 01/16/2025, documents in part 6:40 PM there was an alleged altercation between R9 and R8. R9 stated R8 wanted the window closed and feels comfortable stating the room is cold. R9 then switched off the heater that was close to R8 which led to shouting and screaming against each other and knocking down R8's food. Staff did a head to toe assessment. R8 had no skin openings or cuts. Staff notified the physician. The psychiatrist ordered R9 to the hospital. The ADON and the administrator were made aware.</p> <p>(continued on next page)</p>

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
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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 01/19/2025, at 2:11 PM, V13 (LPN) states he did not witness the altercation that occurred between R8 and R9. V13 states R8 and R9s' altercation took place on the previous shift prior to his scheduled shift. V13 states he was the oncoming nurse on 01/16/2025, and was informed by V12 during shift change about R8 and R9s' altercation. V13 states he was given report by V12 that R8 was complaining of leg pain and awaiting the arrival of the ambulance. V13 states he was also informed by V12 that R9 struck R8 with a walking cane. V13 states later in his shift, he followed up and called the hospital to check the status of both R8 and R9. V13 states a hospital nurse informed him that R8 was admitted to the hospital with a femoral fracture.</p> <p>Nursing progress note dated 01/17/2025, written by V13 documents Followed up on R8 status at the hospital. Per floor nurse RN, R8 is admitted to the hospital with a diagnosis of Left Femoral Fracture. Unable to reach Primary care at this time. Will follow up to notify. ADON made aware. R8 is self-responsible.</p> <p>Nursing progress note dated 01/17/2025, written by V13 documents Writer called hospital to follow up on R9. R9 is admitted . admitting diagnosis is bipolar disorder and insomnia.</p> <p>On 01/19/2025, at 2:20 PM, V1 (Administrator) states she has been working at the facility since April 2024 and she is the abuse coordinator. V1 states she is currently working on and investigating the facility reported incident involving R8 and R9. V1 states R8 and R9 were roommates and allegedly something happened. R8 was sent to the hospital for medical evaluation and R9 was sent to the hospital for agitation. V1 states she submitted an initial report to the state agency on 01/16/2025, and is still in the process of investigating the incident. V1 states she has not spoken to any of the other residents residing in the room with R8 and R9. V1 states she has not received a definitive report of R8s's hip being fractured. V1 states R8 and R9 are still hospitalized and has not returned to the facility. V1 states she plans to contact the hospital liaison for more information regarding R8.</p> <p>On 01/19/2025, at 3:55 PM, R3 states he witnessed the altercation between R8 and R9. R3 states he resides in the same room as R8 and R9 and walked in on the altercation. R3 states R8 wanted the window closed in their room. R9 opened the window instead and then R8 began yelling at R9 to close the window. R3 states R8 uses a wheelchair to ambulate. R3 states when he walked in his room, he observed R9 beating R8 with R9s' walking cane. R3 states R8 was lying on the floor bleeding from the head while R9 beat R8 with a cane. R3 states he broke the fight up and informed the nurse (identified as V12) of the altercation between R8 and R9. R3 then goes to R9s' bed and points to a cane hanging on R9s' bed. R3 states to surveyor that the cane is the same cane that R9 used to beat R8 with. Surveyor observes a cane with a grey, rubber, hook handle with a single metal pole frame. R3 states no one has inquired about the altercation between R8 and R9 other than surveyor. R3 states this is not the first time that R8 and R9 have gotten into a physical altercation. R3 states approximately one month ago, R8 and R9 were involved in another physical altercation and R3 reported this to a CNA/Certified Nursing Assistant staff member. R3 states the altercations between R8 and R9 have been getting worse.</p> <p>Upon reviewing medical records for R8, R8 reported to hospital staff that he was in a physical altercation with another resident and was hit in the left thigh with a cane. R8 also reported to hospital staff that he fell and hit his head with no loss of consciousness.</p> <p>R3s' MDS/Minimum Data Set, dated dated [DATE] documents that R3 has a BIMS of 15/15, indicating that R3 is cognitively intact.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>R8s' Facesheet documents that R8 has diagnoses not limited to: Osteoarthritis of hip, epilepsy, abnormalities of gait and mobility, unsteadiness on feet, vitamin D deficiency, weakness, and myocardial infarction.</p> <p>R8's MDS/Minimum Data Set, dated dated dated [DATE] documents that R8 has a BIMS of 12/15, indicating that R8 is cognitively intact. R8 requires partial/moderate assistance with ADL/Activities of Daily Living care and ambulates via wheelchair.</p> <p>R8s' Trauma Screening dated 01/17/25 documents that R8 had an alleged disagreement with his peer.</p> <p>R9s' Facesheet documents that R9 has diagnoses not limited to: Cardiomyopathy, major depressive disorder, insomnia, essential hypertension, weakness, abnormalities of gait and mobility.</p> <p>R9's MDS/Minimum Data Set, dated dated dated [DATE] documents that R9 has a BIMS of 13/15, indicating that R9 is cognitively intact. R9 requires supervision with ADL/Activities of Daily Living care.</p> <p>R9s' Trauma Screening dated 01/17/2025 documents that R9 had an alleged occurrence with his peer.</p> <p>Facility initial reported incident dated 01/16/2025 documents that R8 and R9 had a disagreement and were separated.</p> <p>Ombudsman Residents' Rights for People in Long-Term Care Facilities dated 11/2028 documents in part, You must not be abused, neglected, or exploited by anyone - financially, physically, verbally, mentally, or sexually.</p> <p>Facility policy dated 03/01/2021 titled Abuse Prevention Program documents in 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.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>45000</p> <p>Based on observation, interview, and record review, the facility failed to provide supervision and monitoring of residents to prevent residents from smoking in the facility and ensure residents practice safe smoking in the designated area for two (R2 and R4) residents and has the potential to affect (R5, R6, and R7) residents reviewed for smoking safety on the sample list of nine.</p> <p>Findings include:</p> <p>On 01/18/2025, at 1:23 PM, R1 states R2 has been smoking in the facility unauthorized. R1 states he has never seen R2 smoking cigarettes in the facility, but he can smell cigarette smoke coming from R2s' room. R1 states a CNA/Certified Nursing Assistant staff member (identified as V14) also smelled smoke in the third-floor shower room while R2 was the only person inside the shower room. R1 states he reports his suspicion of R2 smoking in the facility to all the staff members, but they tell R1 they don't see it happening. R1 states there are several residents who are prescribed oxygen in the facility and the smoking affects them.</p> <p>On 01/18/2025, at 1:54 PM, surveyor enters R2s' room to conduct an interview, R2 observed exiting his bathroom located inside of his room with room/air freshener in his left hand. R2 observed with right sided weakness and impaired speech and is not interviewable. Surveyor then enter R2s' bathroom and smell a strong smell of tobacco/cigarette smoke.</p> <p>On 01/18/2025, at 2:00 PM, R3 (R2s' roommate) states he sees R2 smoking in the bathroom and also smells smoke in their shared bathroom. R3 states the reason R2 had the air freshener in his hand was because R2 wanted to cover up the smell of smoke. R3 states he informed a staff member of R2 smoking inside of the bathroom about 2 hours ago.</p> <p>On 01/18/2025, at separate times, surveyor takes V2 (Social Worker), V3 (Activity Aide), V4 (Director of Housekeeping), V5 (CNA), V6 (RN), and V7 (RN) inside of R2s' bathroom. All staff members verbalize to surveyor that they also smell the scent of cigarettes/smoke inside of R2s' bathroom.</p> <p>On 01/18/2025, at 2:58 PM, V2 (Social Worker) states to surveyor that R1 did make her aware of allegations of a resident inside of R2s' room who was smoking. V2 states she informed R1 that she would check on that later due to her being busy with helping another resident to be transferred out of the facility.</p> <p>On 01/18/2025, at 4:02 PM, V2 and surveyor located inside of R2s' room. Upon asking R2 to search his person, R2 shakes his head no and does not comply. V2 searches R2s' nightstand and finds cigarette ashes inside of R2s' second drawer. V2 then educates R2 that he is not supposed to smoke in the facility especially around residents with oxygen because of safety reasons.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 01/18/2025, at 3:28 PM, during tour of the smoking patio, surveyor observes two activity aides (V8 and V9) standing next to the patio door by the smoking cart. V8 observed talking on her cell phone at that time. There were no staff members outside on the patio monitoring residents while they smoked. R4 observed lighting his own cigarettes with a lighter and discarding his cigarette butts on the floor. V8 states it is too cold to go outside with the residents, so they monitor the residents from inside of the glass patio door.</p> <p>On 01/18/2025, at 3:30 PM, V9 (Activity Aide) states none of the residents are allowed to light their own cigarettes with a lighter. Surveyor makes V9 aware that surveyor observed R4 on the smoking patio lighting his own cigarette. V9 states some of the residents hide their lighters and staff are not aware that residents have lighters in their possession. V9 states cigarette butts should be discarded in a designated bin, but residents are not compliant with this and throw the cigarette butts on the ground. V9 states there is potential for a fire to start, and residents can burn themselves if residents light their own cigarettes and are not properly monitored while smoking.</p> <p>On 01/19/2025, at 10:43 AM, V11 (Social Services Director) states if staff smells smoke in the facility, the protocol is as follows: inform direct supervisors and the administrator, conduct a search of the residents' room, ask the resident to search his person, notify the doctor, and await any further orders/instructions from the doctor. V11 states the facility cannot force a resident to be compliant with searching their person. V11 states sometimes the doctor may send the resident to the hospital. V11 states smoking in the facility is prohibited and can cause safety issues especially with residents who are prescribed oxygen. V11 states the facility follows its' smoking policy and procedures to ensure everyones' safety in the facility. V11 states residents' safety can be compromised if a resident is caught smoking in the facility. V11 states a fire or explosion can happen if residents smoke near residents with oxygen.</p> <p>On 01/19/2025, at 3:42 PM, V14 (CNA) states about one week ago, he entered the third-floor shower room and smelled cigarette smoke while R2 was located inside the shower room. V14 states he re-enforced education to R2 that R2 was not allowed to smoke in the facility. V14 states he did not witness R2 smoking but still educated him on the importance of not smoking while in the facility. V14 states he informed the nurse on duty that day but cannot remember who the nurse was.</p> <p>Facility document lists a total of 22 residents are prescribed oxygen in the facility. According to the list of residents who are prescribed oxygen, there is a total of 4 residents (R4, R5, R6, and R7) who reside on the same floor as R2, who are prescribed oxygen.</p> <p>Facility document titled Smokers List lists R2 as a resident who smokes in the facility.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Facility policy dated 05/28/2024 titled Guidelines for smoking documents in part, Policy: There will be no smoking permitted inside the facility. Smoking will be allowed for residents, staff, and visitors in designated areas only. All residents' smoking material will be kept by the facility in a secure location. 4. All smoking remnants will be discarded into appropriate/approved receptacles by staff or under staff supervision. 5. Upon admission, the resident/representative will be educated on the provision of smoking materials to be managed only by facility staff. The resident will be educated as to safe smoking practices. 8. Residents/Representatives will be required to sign a smoking Behavior Contract. 9. All residents will be under supervision while smoking. Smoking monitors will hold lighters for ignition of cigarettes. Monitors will supervise or perform the extinguishing of cigarettes (based on resident ability) into a proper approved container. 10. Smoking materials will be kept in a safe/secure location within the facility under staff control. 11. Residents will have no smoking materials in their possession.</p>