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	01/02/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of records and interviews the facility failed to follow reporting procedures of injury of unknown origin or source for 1 out of 3 residents (R8) total sample of 3 residents reviewed for right of every resident to be free from all forms of abuse. These failures are not in accordance with facility's abuse policy applicable to 1 resident (R8) who sustained injuries of unknown origin or source. Finding includes: R8 is [AGE] years old, initially admitted in the facility on 04/10/2018 medical diagnosis dated 07/13/2025, includes metabolic encephalopathy, displaced fracture of anterior wall of right acetabulum, wedge compression fracture of first lumbar vertebra. R8 has impaired cognition unable to perform brief interview of mental status assessment (BIMS) dated 07/28/2025. V28 (Registered Nurse) nursing notes dated 07/08/2025, documents that R8 was transferred to hospital due to weak, pale, difficult to arouse and minimal respond to call. Facility submitted initial transmittal report to State Agency dated 07/15/2025. On that report it documents that R8 returned from the hospital to facility on 07/13/2025. The hospital records include an imaging (CT scan) fracture of the right acetabulum (near hip/pelvis) and compression fracture to vertebral bodies (support of the spine). Facility submitted final report of investigation dated 07/21/2025, without definite conclusion as to how R8 sustained those fractures. Per Minimum Data Set (MDS) assessment dated [DATE], R8 does not walk, uses wheelchair for locomotion and dependent for functional abilities including bed mobility. R8 was care planned as substantial assist on bed mobility, dependent on transfers that needs mechanical (Hoyer) lift, non-weight bearing on right lower extremity and non-ambulatory. On 12/31/2025, at 10:23 AM, V6 (Assistant Director of Nursing) stated R8 went to the hospital because he was difficult to arouse. At that time there was no concern with fall or trauma. R8 went back to the facility on [DATE], that was when facility knew about the fracture based on hospital records. V6 stated that R8's fracture was reported on 07/15/2025, per facility's procedure on timely reporting of resident's injury is within 24-hours when facility knew about the fracture. V6 stated that it should have been reported on 07/14/2025. After checking the calendar, 07/14/2025 falls on Monday. V6 stated there was no determination on how exactly R8 sustained fracture. Abuse Prevention Policy dated 01/2019: Injuries of unknown origin procedure on reporting requires facility as follows: Report shall be made immediately, but no later than two hours after allegation is made. If the event that cause the allegation involve abuse or resulted to serious injury, or not less than 24-hours if the event that cause the allegation do not involve abuse and did not result in serious bodily injury.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of records and interviews the facility failed to timely and accurately assess 1 out of 3 residents (R8) on identifying pressure injuries and update R8's care plan after the identification. These failures are not in accordance with facility's pressure injury prevention policy guidelines that affected 1 resident (R8) who sustained bilateral heel deep pressure injuries (deep tissue injuries). Finding includes: R8 is [AGE] years old, initially admitted in the facility on 04/10/2018. Medical diagnoses dated 07/13/2025 includes metabolic encephalopathy, displaced fracture of anterior wall of right acetabulum, wedge compression fracture of first lumbar vertebra. R8 has impaired cognition unable to perform brief interview of mental status assessment (BIMS) dated 07/28/2025. On 12/30/2025, at 12:08 PM, V18 (Wound Coordinator / Registered Nurse) stated that R8 was admitted in the facility from the hospital on [DATE], with right and left heel deep tissue injury which is considered as pressure injuries. R8's right and left heels pressure injuries were treated with skin prep and foam dressing to help with the friction. R8 was to use heel protector but was not placed as a physician order and was not placed as an intervention on the care plan. Per V28 (Registered Nurse) dated 07/08/2025, nursing notes documents that R8 was transferred to hospital due to weak, pale, difficult to arouse and minimal respond to call. Hospital records dated 07/08/2025 the same day R8 was transferred from facility to the hospital, R8 was assessed with bilateral heel pressure injury (deep tissue injuries) when admitted to the hospital. R8 returned in the facility per census history on 07/13/2025. On 12/31/2025, at 10:23 AM, V6 (Assistant Director of Nursing) stated that residents need intervention to prevent pressure ulcer. V6 stated that it includes turn every two (2) hours or as needed, barrier cream for skin protection, heel protection, cushion while on the wheelchair, vitamins or supplements, and low air loss mattress. Multiple assessments were reviewed with V6. V6 reviewed R8's BRADEN assessment dated [DATE] (BRADEN assessment is use as a tool to identify risk on predicting pressure injury) it documents that R8 walks occasionally and with slightly limited on bed mobility. V6 said, I know R8, and he is dependent, he does not walk at all. BRADEN assessment is inconsistent with MDS assessment dated [DATE] and care plan of R8. Per Minimum Data Set (MDS) assessment R8 does not walk, uses wheelchair for locomotion and dependent for functional abilities including bed mobility. Per care plan R8 needs substantial assist on bed mobility, dependent on transfers that needs mechanical (Hoyer) lift, non-weight bearing on right lower extremity and non-ambulatory. R8's care plan failed to address right and left pressure injuries (deep tissue injuries). V6 stated that facility does weekly skin assessments as part of preventive measure for all residents to prevent from pressure injuries. V6 said, the purpose of that if the resident has any problem with skin integrity so that we can catch it on time. V6 stated that weekly skin assessment is done for all residents, while weekly wound assessments are done to residents that have wounds. Weekly skin assessment is part of preventive measure for pressure ulcer while we are doing it, we can see if resident has skin problem that we can prevent. V6 reviewed R8's weekly skin assessment of R8 that documents as follows: R8's weekly skin assessments dated 06/06/2025, 06/13/2025, 06/2025, 06/20/2025, 07/02/2025, 07/09/2025, 07/15/2025, 07/23/2025 documents no loss of skin integrity existing or new for all assessment. R8 was assessed by V18 (Wound Coordinator/Registered Nurse) on 07/09/2025 although R8 was not in the facility (on that date). At that time R8 right and left pressure injuries were already identified by hospital on [DATE], which was the date of transfer. After R8 was re-admitted in the facility from the hospital on [DATE]. R8's weekly skin assessments dated 07/15/2025 and 07/23/2025 documents no concern with skin integrity although hospital and facility records document that R8 have left and right pressure injuries. V6 stated, I do not know how they assess R8 on 07/09/2025 when resident was not here, they do not do assessment when resident is not here. That may be an error. As to assessments dated 07/15/2025 and 07/23/2025 I have to ask V18 (Wound Coordinator) about this. Per facility's guidelines for prevention / treatment of pressure injuries dated 10/09/2023: If upon assessment an actual pressure injury is found appropriate treatment and intervention will be added on residents' care plan. Skin assessments will identify other risk factors including existing pressure injuries. Assessments will repeat at least weekly. The Braden Scale will be performed in addition to weekly skin assessments being completed as per policy and regulation. Ensure all assessments are timely and accurate.

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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. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and records review, the facility failed to provide a safe mechanical lift transfer for one dependent resident (R9), of 5 residents reviewed for transfers out of a total sample of 10 residents. Findings Include:R9's Face Sheet documents resident is a [AGE] year-old with diagnoses including but not limited to: Cerebral palsy, chronic obstructive pulmonary disease, obesity, muscle wasting and atrophy, hypertensive heart disease without heart failure. Minimum Data Set Section (MDS) section C (dated [DATE]) documents that R9 has an Interview for Mental Status (BIMS) score of 10, indicating that R9 has moderate cognitive impairment. Minimum Data Set Section (MDS) section GG (dated [DATE]) documents that R9 is dependent on staff for transfers. Care plan (dated 12/23/2025) documents that R9 is dependent on staff for transfers and requires a mechanical lift. On 12/30/2025 at 10:21AM, surveyor conducted an interview with R9, a bed-bound dependent resident, pertaining to a fall incident that R9 had on 10/04/2025. R9 stated, On 10/04/2025, V19 (certified nursing assistant) and V26 (licensed practical nurse) were attempting to transfer me from the wheelchair to my bed. The mechanical lift was in front of me, while I was sitting in the wheelchair. All of a sudden, the mechanical lift machine tipped over and fell on my wheelchair, causing my wheelchair to completely tip over and I fell to the ground together with the wheelchair. They did not spread the legs of the mechanical lift appropriately and that's why the fall happened. I did not have any injuries. They sent me to the hospital for evaluation, and everything was fine, no injuries. I don't have any pain. On 12/30/2025 at 10:17AM, V3 (restorative nurse) stated, R9 transfers with a mechanical lift. At least 2 staff members have to be present during the transfer for R9. R9 had a fall 10/04/2025. While staff were transferring the resident from the wheelchair to the bed with a mechanical lift, the mechanical lift tilted while the resident was in the wheelchair and the wheelchair tipped over and fell to the floor. R9 was sitting in the chair when the chair tilted and fell to the floor. R9 did not obtain any injuries. R9 was sent to the hospital for evaluation via 911. R9 had a CT scan in the hospital, and it was negative. When the mechanical lift is being used, the legs must be opened wide, if it is not opened wide and properly, the mechanical lift can tilt. The nurse and the certified nursing assistant were performing the transfer. After the fall, I did an educational training with the nurses and the certified nursing assistants for proper techniques of mechanical lift transfers. I performed a complete fall risk assessment, call light within reach, free of clutter, clean environment. The machine tilting is the reason why R9 had a fall. R9 is dependent on staff for all ADLs. The mechanical lift was inspected after the fall occurred and there was nothing wrong with the machine. On 12/30/2025 at 1:56PM, V19 (certified nursing assistant) stated, On 10/04/2025, V26 (licensed practical nurse) and I were transferring R9 from her wheelchair back to bed with a mechanical lift. I was assisting the nurse. The mechanical lift was being used. The resident was sitting in the wheelchair, and I was holding the mechanical lift, and the nurse was fixing the ears of the sling. I am not sure what happened or what caused the mechanical lift to tilt. During the preparation before the transfer, the wheelchair flipped, and the resident fell together with the wheelchair to the floor. R9 was still sitting inside the wheelchair when the wheelchair flipped. I did not notice any injury on R9. R9's Progress Note (dated 10/04/2025) documents, While staff were transferring the resident from the wheelchair to her bed VIA Hoyer Lift, the Hoyer lift tripped/tilted the wheelchair and the resident's wheelchair fell while the resident was on the wheelchair. Head to toe assessment was completed. The resident is A/O x3, and able to express her needs. Vitals as follows: BP-128/84, P- 84, Temp- 97.5F, Resp 18, oximetry 98% VIA R/A, and no visible bruises or injury noted from the fall. A 72-hours neurological assessment initiated, ROM within the resident's baseline, PERRLA was noted, no C/O pain. Physician group was called and an order to transfer the resident to the nearest hospital VIA 911 for CT-Scan was obtained and carried out. The writer spoke with the nurse practitioner and the director of nursing was made aware of the incident. R9's Progress Note (dated 10/05/2025) documents, The resident was brought back into the facility by 2 paramedics on a stretcher, the resident was transferred to bed and was made comfortable. A/Ox3, vital signs were BP-124/84, P-80, R-16,02-95%RA. No complaints of pain or discomfort. Director of nursing and State Guardian office made aware. Guidelines for Mechanical Lift Transfer/Usage Policy (dated 07/08/2024) states in part: Many residents who require a two-person transfer- will need to be transferred using a mechanical lift. The type of transfer must be the safest method based on the resident's assessed ability to safely assist in their own transfer. Two staff members are required when a mechanical lift is used. Position the lift around the resident's bed/chair/surface. Base legs are usually more stable in full open

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. Based on observation, interview, and record review, the facility failed to record the daily refrigerator temperature log on a personal refrigerator for one (R1) in a total sample of 3 residents reviewed. Findings include: On 12/30/2025 at 11:14 AM, Surveyor observed R1 laying down in his bed while watching television, there were no signs of discomfort or pain. R1 is alert and oriented to person, place and time. Surveyor observed R1's personal refrigerator temperature set to 40 degrees Fahrenheit. Surveyor observed the daily refrigerator temperature log was did not have a temperature or initial documented for several dates on the month of December. Surveyor observed the refrigerator was attached to the wall outlet. Surveyor observed the refrigerator was clean, organized, and there were no odors at this time. On 12/30/2025 at 11:15 AM, R1 stated in the past a complaint was filed about the refrigerator not being attached to the wall outlet, causing the food to get spoiled. R1 stated the staff always says the temperature is at 39 degrees Fahrenheit, but it is never recorded. R1 stated housekeeping should come every day to check the temperature in the refrigerator to prevent the food getting spoiled. On 12/30/2025 at 11:41 AM, V10 (Registered Nurse) stated housekeeping is responsible for ensuring that the refrigerator temperature is approximately 39-40 degrees Fahrenheit. V10 stated there is a log attached to the refrigerator, and it is expected to be recorded every day. Surveyor asked V10 what can potentially happen to the food inside the refrigerator if the temperature log is not being recorded per facility policy. V10 stated the temperature should be checked and documented daily. On 12/30/2025 at 2:05 PM, V21 (Housekeeping Director) stated housekeeping staff is responsible for making sure the refrigerator is clean, sanitized, organized, and temperature is documented every day. V21 stated the refrigerator should be at approximately 35-40 degrees Fahrenheit. Surveyor asked V21 what can potentially happen to the food inside the refrigerator if the temperature log is not being recorded per facility policy. V21 stated the food can get contaminated if the temperature is not at the expected temperature range. V21 stated the temperature should be recorded daily to avoid exposure to residents getting sick for eating potential spoiled food. On 12/31/2025 at 10:15 AM, surveyor observed R1's refrigerator temperature thermostat, it was at 39 degrees Fahrenheit. Survey observed inside R1's refrigerator, it was clean and organized and there were no odors noted. There was no refrigerator temperature recorded on the daily refrigerator temperature log. On 12/31/2025 at 10:19 AM, V25 (Housekeeping) stated she is responsible for making sure residents' personal refrigerator is kept clean. V25 stated she makes sure to monitor the temperature, and document it on the refrigerator temperature logs every day. V25 stated the temperature should be set to approximately 39- 40 degrees Fahrenheit. Surveyor asked V25 what can potentially happen to the food if the temperature is not being recorded daily. V25 stated the food will get contaminated causing the resident to get sick. Policy titled Unit (Resident Room) Refrigerators with no review date documents in part It is the policy of the facility to assure that perishable food requiring refrigeration is stored at the proper temperature. Each refrigerator will be provided with a thermometer to ensure that the refrigerator is maintained between 35 degrees and 40 degrees Fahrenheit. Refrigerator temps will be checked and documented daily. Policy titled Food Brought into the Facility by Friends/Family/Others (Outside Sources)For Residents Policy with review date 11/28/2016 documents in part Facility staff will monitor resident rooms, resident personal refrigerators, unit pantries as well as facility refrigerators and freezers for food and beverage disposal needs for safety.