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	06/05/2026

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 - 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one resident (R3) was free from abuse from another resident (R8). This failure resulted R3 being evaluated at the hospital and diagnosed with a closed head injury, sprain of right wrist and sprain of left shoulder. Findings include:According to R3's face sheet, R3 is a [AGE] year-old resident with diagnoses that include but are not limited to polyneuropathy; type 2 diabetes mellitus; heart failure; pulmonary hypertension.According to R3's Minimum Data Set (MDS), 3/20/26, R3 has a BIMS (Brief Interview for Mental Status) score of 15 indicating intact cognition. R3 is dependent and requires assistance for mobility performance.According to R8's face sheet, R8 is a [AGE] year-old resident with diagnoses that include but are not limited to major depressive disorder; sequelae of unspecified cerebrovascular disease.According to R8's MDS, 2/27/26, R8 has a BIMS score of 12 indicating moderate cognitive impairment.R8's care plan, initiated 12/2/25, reading in part: R8 displays behavioral symptoms related to a history of non-compliance with recommendations from health care professionals, history of or current symptoms for substance abuse, poor and/or ineffective coping skills. Disagreement and conflict with roommate.R8's Screening Assessment for Indicators of Aggressive and/or Harmful Behavior, 12/11/25, reads in part: Potentially able to integrate with structure, direction, and supportive counseling.On 6/2/26 at 11:46 AM, R3 stated, their roommate (R8) assaulted them. R8 slammed R3 on the head with a glass jar of instant coffee. I had a knot on my head. I was sent to the hospital. I got x-rays and an MRI (Magnetic Resonance Imaging). There was no concussion and my skull was intact. I had a major headache. My right wrist is injured. I was trying to block the shots to defend myself. R8 was cussing at my roommate, trash talking to them, I don't remember anything R8 said. I told R8 to leave them the f*** alone. On 6/3/26 at 11:44 AM, R8 said they and R3 just exchanged some words. There was no physical hitting. I did not hit R3 with a jar. If I had hit R3 with a jar they would have been knocked out. I don't know what we were exchanging words about, just mouthing off. Nobody else was in the room. They immediately took me to another room. R3 did not hit me. I don't remember what was said. I went to the hospital, and they sent me back. On 6/3/26 at 12:59 PM, V13 (Registered Nurse) stated I am familiar with R3 and R8. I was their nurse the evening of the incident. I was in the nursing station. I think it was V16 (Certified Nursing Assistant) who told me that R3 and R8 were having an argument. I went to their room to check what's going on. I saw R8 standing arguing with R3. I only saw a verbal argument. I couldn't tell what it was about. I saw it was escalating so I took R8 out of the room. I would interpret a closed head injury as an internal injury resulting from possible trauma to the head. Sprain can also be a result of possible trauma to the joint and cause inflammation but not total dislocation.On 6/3/26 at 3:49 PM, V14 (Physician) stated I am familiar with R3. From the hospital discharge papers that reflect closed head injury, sprain to wrist and shoulder, I think R3 had an altercation, and someone hit their head. It sounds like someone hit R3 and it resulted in a head injury and sprains. It could be physical abuse. A closed head injury and sprains are indicative of physical abuse.On 6/4/26 at 2:48 PM, V1 (Administrator) stated I was called and told R3 was claiming physical abuse by R8. I came to the facility and went to talk to R3. R8 had (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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	already been moved to another room. R3 told me that they told R8 to shut up because R8 talks too much. R3 said R8 hit them with a coffee cup.R3's progress note 5/8/26, 4:25 PM, documents in part: Writer called into resident room on seeing the ongoing verbal disagreement. Writer went ahead to separate them. Resident (R3) stated they got into a verbal disagreement with their roommate (R8).R3's progress note 5/8/26 4:45 PM, stricken from record, documents in part: Writer notified of an altercation with their roommate (R8). On assessment, resident noted to have a bump on the back of their head and redness on their wrist. No change to shoulders noted. Resident stated they have pains to their head and shoulders. Ice placed to the back of the head. Orders placed for x-ray of head and shoulders to rule out injury. R3's hospital discharge instructions, 5/8/26, documents in part: Diagnosis: closed head injury, initial encounter; sprain of right wrist, unspecified location, initial encounter; sprain of left shoulder, unspecified shoulder sprain type, initial encounter.R8's progress note 5/8/26 4:28 PM, documents in part: Writer called into resident room on seeing the ongoing verbal disagreement. Writer went ahead to separate them. Resident (R8) stated they got into a verbal disagreement with their roommate (R3). Resident remained anxious and agitated. Resident placed on 1:1 supervision. Medical Doctor notified, orders to send to hospital for psych evaluation.R8's progress note 5/8/26 4:30 PM, stricken from record, documents in part: Writer notified of an altercation with roommate (R3). On assessment, no physical bruising or injury noted. Resident overly agitated and verbally aggressive. Writer tried redirection but no change. Medical Doctor notified, orders to send to hospital.Incident report, 5/8/26, reads in part: Nurse on duty reported that R1 (R3) alleged that they had physical contact from roommate R2 (R8)Facility Abuse Prevention Program, 1/2019, 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.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure proper discharge planning by not verifying placement and not arranging services for one resident (R4) in a total of 14 residents. Findings include:MDS (minimum data set) with review date of May 4, 2026, BIMS (brief interview of mental status) indicates R4's cognition is intact.Care plan dated 02/18/2026, documents in part, at risk for self-care deficit and required/ potentially requires assistance with ADLs (activity of daily living) to maintain the highest possible level of functioning; use walker for mobility, occupational therapy to screen/ evaluate and treat per order. Physical therapy to screen/ evaluate and treat as indicated per orders. Provide assistance with all ADL's as required per my dependence needs: eating, transferring, bed mobility, bathing dressing, personal hygiene, ambulation and personal hygiene. Eating set up or clean up assistance, oral hygiene partial/ moderate assistance, toileting hygiene partial/ moderate assistance. Shower/ bathe self-partial/ moderate assistance.On 06/02/2026 at 10:39 AM, this surveyor had a phone interview with R4. R4 stated he is currently in Texas since he was discharged from the facility on 04/30/2026. R4 stated V9 (Social Services Director) has been terminated, from his position and no longer works for the facility. R4 stated before V9 left the facility he was supposed to send out all of the required documents to the new facility. R4 stated the facility has not received any medical records. R4 stated he has asked to speak to staff regarding this issue, but no one is available to speak with him. R4 stated he has copies of the XRAY of his knee and arm, but the new facility in Texas is requesting images from former facility in Chicago.On 06/03/2026 at 11:51 AM, V2 (Director of Nursing) stated R4 had an order from the provider to discharge back to the community. V2 stated he spoke with R4's brother who lives in Texas, in which he provided an address, telephone number, and a train station ticket for R4. V2 stated R4 was given all his discharged documents as well as his belongings. V2 stated R4 signed the checklist and did not voice any concerns at the time of discharge. V2 stated R4 has not called this facility requesting any additional documents. V2 stated the facility provided transportation to the train station.On 06/04/2026 at 9:54 AM, surveyor asked V2 if he or anyone had verified the address provided. V2 stated he did not call the phone number that was provided to verify placement. V2 stated R4's brother and R4 both confirmed the address, and they stated it was their home. V2 stated he was not aware that R4 wanted to transfer to another facility. V2 stated there is a process that needs to occur before a resident is discharged . V2 stated a referral must be sent out to the new facility, and then after the acceptance letter received then the interdisciplinary team will meet and discuss any additional services are needed, making sure all goals have been met, referrals are given if needed [NAME] physical therapy, occupational therapy or speech, etc. V2 stated R4 with a referral for the orthopedic for a right wrist fracture, which was included with his discharge documents.On 06/04/2026 at 12:01 PM, V1 (Administrator) stated when a resident is requesting a discharge the interdisciplinary team will have a care plan meeting to discuss the discharge process with resident or responsible party. V1 stated if it is an immediate discharge then the doctor will be called for discharge orders and recommendations. V1 stated if there is enough notice for a discharge, then the interdisciplinary team can determine the residents' needs. V1 stated when a resident is to be discharged to the community, the facility must contact the family member and verify the placement, V1 stated once the placement has been confirmed, the facility will ensure that the residents' needs are met, and that transportation is set up. V1 stated if the resident is interested in a facility-to-facility discharge, the facility must contact the providers for discharge order. V1 stated a referral is sent to the facility, and an acceptance letter is required to move forward with discharge. V1 stated if a resident is discharged with an orthopedic referral, the facility must ensure that the order is sent to the facility, make sure that the insurance will cover the services.On 06/04/2026 at 2:20 PM, V1 (Administrator) stated from his understanding V9 and V2 coordinated the (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	discharge, however he is not sure if V9 verified the address that was provided or arranged any services for the orthopedic consult for R4. V1 states they spoke to the brother because he was the one coordinating the discharge. V1 stated R4's brother provided the address and phone number, R4 was discharged . V1 stated the facility provided R4 with transportation to the train station. V1 stated the facility gave him a rollator to take with him. V1 stated R4 had not called him or left any messages for him.Reviewed physician order sheet, documents in part, outpatient referral to occupational therapy for consultation. Policy titled, Guidelines for discharge/ transfer with review date of 02/202/2025, documents in part, A resident will be discharged / transferred (home or another facility) by order of their attending physician in accordance with the specific state/ federal standard and practice guidelines. All discharge plans will be planned. lower level of care (planned) 1). Discharge instructions are completed when the resident is discharged to home or to another facility. Send face sheet, send advanced directives, send MAR/ TAR, other pertinent information or required information as per state regulation.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and review of records facility failed to provide residents with proper equipment (wheelchair) per therapy recommendation for 1 out of 3 residents (R2) for a total of 3 residents reviewed for activities of daily living. Findings include: R2 is [AGE] years old, initially admitted in the facility on 01/22/2026 medical diagnosis includes stage 5 chronic kidney disease, diabetes mellitus, bipolar disorder among others. R2 cognition is intact with BIMS score of 14. On 06/02/2026 at 01:22 PM, R2 was seen in his room alert and able to express his thoughts clearly and within topic. R2 stated that he has been without a wheelchair since he was initially admitted . R2 stated that he was using specialized chair for all his needs. The chair was seen on the bedside of R2 Per R2's referral dated 01/01/2026 documents that R2 is continually interested in obtaining electric wheelchairs. admission functional assessment and goals dated 01/22/2026 reads: R2 was assessed dependent on staff help on transfers, mobility and needs of wheelchair. On 06/02/2026 at 01:42 PM, V3 (Director of Rehab / Occupational Therapist) stated that R2 is not currently on therapy and does not ambulate. R2 was in therapy from April 22, 2026, and was discharged on May 20, 2026, because he reached his full potential. V3 stated, I think he has manual wheelchair from restorative. V3 stated that R2 was doing very well after being discharged for therapy. On 06/02/2026 at 02:22 PM, V11 (Director of Restorative) stated that R2 is non-ambulatory and uses a specialized wheelchair when getting out of the bed, for dialysis and for locomotion. V11 stated that R2 did not request wheelchair and is not appropriate to use a wheelchair, due to poor trunk control. He cannot sit up straight. V11 stated that he cannot say if an adjustable wheelchair or a wheelchair that can recline it will be appropriate for R2 because he did not test R2 with that equipment. V11 stated, The specialized chair has a cushion that a wheelchair does not have. V11 was asked if R2 can use wheelchair. V11 replied I did not try that if he (R2) can wheel himself. V11 stated that R2 was not assessed for wheelchairs but for the specialized chair. He (R2) never did have manual wheelchair. On 06/03/2026 at 10:19 AM, V3 stated that he needs to clarify about wheelchair of R2. V3 stated that he requested R2 to have a lightweight wheelchair presenting an email communication and correspondence dated 05/20/2026 to 05/26/2026 requesting lightweight manual wheelchair. V3 stated that the specialized chair does not help R2 at all because he does not perform anything when in the specialized chair. Unlike the wheelchair that helps with upper body strength. On 06/03/2026 at 12:08 PM, V2 (Director of Nursing) stated that restorative does functional assessment upon admission. V2 stated that residents that are assessed need DME (Durable Medical Equipment) such as walkers, canes, crutches, wheelchairs facility will order and provide. Upon reviewing R2's functional assessment dated [DATE] date when R2 was admitted . R2 was assessed to use wheelchair. V2 called V11 (Director of Restorative), upon arrival V11 verified R2's functional assessment. V2 stated that the special chairs cannot be used as a means of locomotion while wheelchairs can be used, which is less restrictive. As to R2, he may not be able to use manual wheelchair properly because he needs motorized wheelchair. V2 was made aware that V3 (Director of Rehabilitation) through email requested for a lightweight wheelchair. V2 called V3 who stated upon arrival that R2 will benefit using ultra lightweight wheelchair that is why it was ordered. On 06/04/2026 at 10:15 AM, V2 was asked what the prospective plan for R2's equipment for locomotion. V2 replied that wheelchairs will help R2 to assist him with locomotion. If R2 continues to use the specialized chair it will not help him and may decline. The goal is to help him progress by using wheelchair. He was placed in therapy to help him with his lower and upper extremities. The facility needs to provide equipment if it benefits the residents and needs to be implemented. If he refuses, we will give education because wheelchairs will benefit him compared to using the specialized chair. Per R2's record, he was seen by physical and occupational therapists from 04/22/2026 to 05/20/2026. Per physical therapy documentation reason for discharge on [DATE] of (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2 was maximized functional potential. PT reports further read, R2 made consistent progress throughout physical and occupational therapy and has reached maximum potential with skilled services. R2's prognosis current level of function (CLOF) excellent with consistent staff support. Discharge recommendation functional maintenance program (FMP) and restorative nursing program (RNP). R2's community mobility documents wheelchair use, and management. Restorative nursing program to facilitate R2 in maintaining current level of performance to prevent decline. R2's care plan on activity of daily living (ADL) dated 01/23/2026 identified R2 as self-care deficit requiring assistance with ADLs to maintain the highest possible level of functioning. Intervention in the same plan of care is provided R2 assistance with all ADLs due to being dependent including transferring, mobility, ambulation, etc. To provide education on the risk factors associated with refusing to comply with ADL care and/or restorative program. Per Guidelines for Activities of Daily Living (ADL) policy of the facility with no date, it reads:Residents are given routine daily care and health services care by nursing staff. ADL care is provided throughout the day, evening and night as care planned and/or as needed. ADL care is coordinated between the residents and the care givers with emphasis on resident preference as much as possible. ADL includes assisting with movement and ambulation and range of motion (ROM) as indicated and care planned.