(X6) DATE

Illinois Department of Public Health

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		IL6002075	B. WING		10/2	24/2024
NAME OF PROVIDER OR SUPPLIER CONTINENTAL NURSING & REHAB CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 5336 NORTH WESTERN AVENUE CHICAGO, IL 60625						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
S 000	Initial Comments		S 000			
	Complaint Investiga 2488528/IL179564 2488130/IL178985	ations:				
S9999	Final Observations Statement of Licens 300.610a) 300.1210b) 300.3240a)	sure Violations:	S9999			
	Section 300.610 R	esident Care Policies				
	procedures governifacility. The written be formulated by a Committee consisting administrator, the amedical advisory confiners of nursing and othe policies shall complete the facility and shall shall according to the written policies.	dvisory physician or the ommittee, and representative r services in the facility. The ly with the Act and this Part. shall be followed in operating the reviewed at least annual documented by written, signed.	he all			
	Section 300.1210 (Nursing and Persor	General Requirements for nal Care				
	care and services to practicable physical well-being of the re- each resident's com- plan. Adequate and	shall provide the necessary of attain or maintain the higher of attain or maintain the higher of the	3			

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 11/14/24

TITLE

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING.	A. BUILDING:		
		IL6002075	B. WING			4/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
CONTIN	ENTAL NURSING & R	EHAB CENTER	RTH WESTEI D, IL 60625	RN AVENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
S9999	Continued From pa	age 1	S9999			
	resident to meet the care needs of the r	e total nursing and personal esident.				
	Section 300.3240	Abuse and Neglect				
	employee or agent	icensee, administrator, of a facility shall not abuse or (Section 2-107 of the Act)				
	These requirement by:	s were not met as evidenced				
	failed to ensure tha from staff to reside affected one reside	and record review the facility at one resident (R2) was free nt mental abuse. This failure ent (R2) in a total sample of abuse. This failure resulted in mental anguish.				
	Findings include:					
	V12 (Psych tech) c threatened to have	28am R2 stated on 10/11/24 ame to her room and R2's green pass privileges mily member continued to call aplaints.				
	threatening to take threatened and abu was advocate for the mental abuse here	30am R2 stated, "The facility my pass away made me feel used. All me and my family didnem not picking me up. The is terrible. I don't feel safe me now but he doesn't say				
	informed R2 that V	15pm V12 stated that he only 13 (social service vanted to speak with R2				

Illinois Department of Public Health

STATE FORM 6899 WO9U11 If continuation sheet 2 of 5

Illinois Department of Public Health

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			71. BOILDING.			
		IL6002075	B. WING		1	4/2024
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CONTIN	ENTAL NURSING & R	EHAR CENTER	RTH WESTER), IL 60625	RN AVENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
\$9999	regarding pass priv On 10/23/24 at 11:0 witness statement, to me that by the accalling the facility of there's no transpor could get her pass On 10/22/24 at 12:0 never requested R2 V13's witness state came to front office pass issues. Residshe (R2) felt he (') letting her know I (') her about her pass R1's witness stater heard V12 say to R jeopardy." On 10/23/24 at 1:40 Nursing/ADON) state to his office and tole threatened to have removed by V12 ar informed him that sand V13. V2 stated down and have a she spoke to R2's ro make the statemer stated that R2's ro told R2 that her gre	dileges. Disam V12 read aloud V12's "Early a message was relayed ctions of her (R2's) sister alling on her behalf saying tation for her, by the actions took." 40pm V13 stated that she to come to speak with her. ament documents in part, "R2 to discuss possible green ent was agitated with the news V12) disrespected her (R2) by V13) would have to speak with " Inent documents in part, "I (R1) to green pass is in Dispm V2 (Assistant Director of the that on 10/11/24 R2 came do him that she (R2) was her green pass privileges and V13. V2 stated that R2 the did not feel safe with V12 do that he asked R2 to calm the toommate who witnessed V12 are garding the pass. V2 to make R1 stated that V12 teen pass was in jeopardy. V2 take something away from	S9999			
	"Threatening to ren	8pm V1(Administrator) stated, nove someone's privileges abuse but in this situation, I				

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5336 NORTH WESTERN AVENUE CHICAGO, IL 66625	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			(X3) DATE SURVEY COMPLETED	
CONTINENTAL NURSING & REHAB CENTER (X4) D			IL6002075	B. WING			
PRÉFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) S9999 Continued From page 3 don't believe that it was. Out of all the residents that reside here, I've completed the most abuse allegations for R2." R2's care plan dated 10/16/24 titled "Abuse, Neglect, Trauma Factors" documents in part, "The resident will be treated with respect, dignity and reside in the facility free of mistreatment." R2's medical diagnoses include chronic obstructive pulmonary disease, unspecified sequela of cerebral infarction, anxiety disorder, grastro-esophageal reflux disease without esophagitis, major depressive disorder, post-traumatic stress disorder, post-traumatic stress disorder. R2's Minimum Data Set (MDS) dated 10/16/24 has a brief interview for mental status (BIMS) score of 14 which indicates R2's cognition is intact. R2's active physician order dated 8/12/24 documents, "Resident may go out on green pass." Facility's job description titled "Psychiatric Technician" documents in part, "Essential Position FunctionsIntervenes with clients in a manner that offers dignity and support." Facility's policy revised 3/1/21 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			FHAB CENTER 5336 NO	ORTH WESTER			
don't believe that it was. Out of all the residents that reside here, I've completed the most abuse allegations for R2." R2's care plan dated 10/16/24 titled "Abuse, Neglect, Trauma Factors" documents in part, "The resident will be treated with respect, dignity and reside in the facility free of mistreatment." R2's medical diagnoses include chronic obstructive pulmonary disease, unspecified sequela of cerebral infarction, anxiety disorder, grastro-esophagies, major depressive disorder, post-traumatic stress disorder. R2's Minimum Data Set (MDS) dated 10/16/24 has a brief interview for mental status (BIMS) score of 14 which indicates R2's cognition is intact. R2's active physician order dated 8/12/24 documents, "Resident may go out on green pass." Facility's job description titled "Psychiatric Technician" documents in part, "Essential Position FunctionsIntervenes with clients in a manner that offers dignity and support." Facility's policy revised 3/1/21 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	PRÉFIX	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACT) CROSS-REFERENCED TO T	ON SHOULD BE HE APPROPRIATE	COMPLETE
Facility's undated policy titled "Your Rights and Protection as a Nursing Home Resident"	S9999	don't believe that it that reside here, I'v allegations for R2." R2's care plan date Neglect, Trauma Fa "The resident will be and reside in the fa R2's medical diagnobstructive pulmons sequela of cerebral grastro-esophageal esophagitis, major post-traumatic stress R2's Minimum Data has a brief interview score of 14 which in intact. R2's active physicial documents, "Resident actions and property in Facility's policy reviprevention Functions manner that offers are Facility's policy reviprevention Program policy of this facility resident abuse, negmistreatment, and in property and a criminacility."	was. Out of all the residents e completed the most abuse ad 10/16/24 titled "Abuse, actors" documents in part, e treated with respect, dignity cility free of mistreatment." oses include chronic ary disease, unspecified infarction, anxiety disorder, I reflux disease without depressive disorder, as disorder. a Set (MDS) dated 10/16/24 or for mental status (BIMS) indicates R2's cognition is an order dated 8/12/24 ent may go out on green option titled "Psychiatric ents in part, "EssentialIntervenes with clients in a dignity and support." sed 3/1/21 titled "Abuse in documents in part, "It is the form to prohibit and prevent glect, exploitation, misappropriation of resident are against a resident in the olicy titled "Your Rights and				

Illinois Department of Public Health

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Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED				
IL6002075 B. WING			C 10/24/2024					
NAME OF I	DPOVIDED OD SLIDDLIED		<u>I</u>		10/2	4/2024		
	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5336 NORTH WESTERN AVENUE							
CONTINI	ENTAL NURSING & R	CHICAGO	, IL 60625					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFICIENCY)	D BE	(X5) COMPLETE DATE		
S9999	Continued From pa	ge 4	S9999					
	from abuse and neg	"You have the right to be free glect: You have the right to be exual, physical, and mental						

Illinois Department of Public Health

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