STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002075	A. BUILDING: _____ B. WING _____	C 01/20/2025

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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S 000	Initial Comments Complaint Investigations: 2580453/IL184742	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) 300.3210t) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each	S9999		

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S9999	Continued From page 1	S9999		

resident to meet the total nursing and personal care needs of the resident.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.3210 General

t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property.

These requirements were not met as evidenced by:

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.

Findings include:

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

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S9999	Continued From page 2	S9999		

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.

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."

Nursing progress note dated 01/16/2025,

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S9999	Continued From page 3	S9999		

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."

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.

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."

Nursing progress note dated 01/17/2025, written by V13 documents "Writer called hospital to follow up on R9. R9 is admitted. admitting

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S9999	Continued From page 4 diagnosis is bipolar disorder and insomnia." 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. 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,	S9999		

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S9999	Continued From page 5	S9999		

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.

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.

R3s' MDS/Minimum Data Set dated 10/30/2024 documents that R3 has a BIMS of 15/15, indicating that R3 is cognitively intact.

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.

R8's MDS/Minimum Data Set dated 10/03/2024 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.

R8s' Trauma Screening dated 01/17/25 documents that R8 had an alleged disagreement with his peer.

R9s' Facesheet documents that R9 has diagnoses not limited to: Cardiomyopathy, major

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S9999	Continued From page 6	S9999		

depressive disorder, insomnia, essential hypertension, weakness, abnormalities of gait and mobility.

R9's MDS/Minimum Data Set dated 11/25/2024 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.

R9s' Trauma Screening dated 01/17/2025 documents that R9 had an alleged occurrence with his peer.

Facility initial reported incident dated 01/16/2025 documents that R8 and R9 had a disagreement and were separated.

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."

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."

(A)