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 02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL NURSING & REHAB CENTER	5336 NORTH WESTERN AVENUE CHICAGO, IL 60625

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Investigation of Facility Reported Incident of (1/13/25) IL185313	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 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 resident to meet the total nursing and personal care needs of the resident.	S9999		

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S9999	Continued From page 1 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 observations, interviews, and records review the facility failed to protect the rights of a resident to be free of resident to resident abuse for one (R5) out of three residents reviewed for abuse. These failures were not in accordance with abuse policy of facility and resulted to one resident (R5) with cognitive impairment sustaining injuries in two separate incidents with (R6 and R9). R5 sustained scratches and abrasion on the neck on 01/13/2025 and right eye swelling and redness on 11/18/2024 which resulted in R5 being sent to the hospital. Findings include: On 02/11/2025 at 11:10 AM, R5 was initially seen in his room sleeping. R5 was unable to respond by calling his name multiple times. On 02/14/2025 at 09:44 AM, R5 was with V19 (Certified Nursing Assistant) was seen doing bedside care. R5 was on his bed awake but does not respond when his first name was called. R5 stares to the wall without reaction to any conversation. V19 stated that R5 does not talk and only respond to his name. V19 stated that R5 can walk if he wants to, and that R5 declines because he is now on hospice. V19 said, "He does not understand and only respond to his name."	S9999		

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R5 is 67 years old, initially admitted in facility on 12/28/2020. R5 medical diagnosis includes dementia / Alzheimer's disease, cognition deficit, brain disorder, behavioral disturbance. R5 has severe impairment on his cognition. Per brief interview of mental status (BIMS) dated 02/07/2025, R5 never or rarely understood.

On 02/11/2025 at 11:16 AM, R6 was seen at dining room sitting on his wheelchair near the window with view overlooking the street. R6 is alert and able to express his thoughts within topic during conversation. R6 stated that he knows R5 and remember very well the incident or conflict that happened between him (R6) and R5. R6 stated that R5 was blocking the way so he punched R5 on his face. R6 said, "I punch him in his face. I just hit him twice both in his face." R6 stated that he told R5 four (4) times to move but R5 did not move. R6 stated that R5 did not hit him back because R5 cannot fight. R6 said, "R5 is an old timer, you know what I mean, he (R5) lost his memories." R6 was asked instead of hitting R5, why not inform the staff to move R5 if he was blocking the way? R6 replied, "But I did, they were busy talking. I asked the nurse, but he won't stop it. I have to do what I have to do." On 02/14/2025 at 09:50 AM, R6 was seen at dining room same place near the window. R6 was able to make conversation with staff. R6 then wheeled himself moving his wheelchair to the hallway. On 02/18/2025 at 11:21 AM, R6 was seen at dining room same location. R6 stated that incident between him and R5 happened in the dining room. R6 said, "I asked him many times, three (3) times to move. But he refused to move. So, I punched him on the face."

R6 is 63 years old, initially admitted in facility on 03/23/2021. R6 medical diagnosis includes

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hypertension. R6 has intact cognition, per brief interview of mental status (BIMS) dated 01/13/2025, R6 scored 14.

Documentation between R6 and R5 incident dated 01/13/2025 are as follows:

V4 (Registered Nurse) clinical notes dated 01/13/2025 documents: It was reported by the Certified Nursing Assistant on duty that during her rounds, R5 and R6 had interaction. R5 sustained scratches on left side of the neck and face. Upon assessment of R5 abrasion noted on left side of the neck and face.

V8 (Certified Nursing Assistant) written confidential witness statement dated 01/15/2025 reads: I saw them arguing and I separated them.

On 02/18/2025 at 10:02 AM, V8 stated that while she was passing trays for dinner. She (V8) heard something on the dining room. V8 said, "Shout, shout, shout." V8 stated that when she went to dining room, she saw R5 and R6 fighting. "R6 was waving his hands on the air." R6 was on his wheelchair and R5 standing because he walks everywhere in the hallway and room to room. V8 stated that R5 needs to be monitored because R5 walks around. V8 stated that there was no staff in the dining room because they were passing trays, and she (V8) was on the hallway passing trays when she heard commotion in the dining room. It happened between 05:45 PM to 6:00 PM during dinner time. V8 stated that after separating R5 and R6, R5 has scratches and abrasions. V8 stated that she was going to tell the nurse (V4) but was not able to see or find him. V8 stated that she looked for V4 but nowhere to be found. V8 said, "Maybe he (V4) was on a break." When V9 (Registered Nurse) came in for the next shift

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(from 7:00 PM to 7:00 AM), and during endorsement with V4, V8 stated that V9 inquired about R5's scratches during endorsement with V4, and that was the time she (V8) informed V4 and V9 what happened in the dining room. Per V8 during incident V4 was her nurse working from 7:00 AM to 7:00 PM, then V9 came in to work from 7:00 PM to 7:00 AM.

V9 (Registered Nurse) written confidential witness statement dated 1/15/2025 reads: I saw R5 had a superficial scratch. I assessed him and started to evaluate what happened. I didn't see what happened, but I treated the scratch, and everything was fine. Signed by V1 (Administrator) only, signature of witness left blank.

On 02/18/2025 at 10:33 AM, V9 stated that she came to work for 7:00 PM to 7:00 AM shift. Upon making her rounds at the beginning of her shift, R5 was seen with scratch and bruise on his neck. V9 said, "I know it was fresh because it was a bit bleeding." V9 stated that because R5 was confused and cannot tell what happened, she (V9) asked around all CNA (Certified Nursing Assistant). Called V4 (Registered Nurse) and asked him about R5's neck abrasion. V4 came, stated he does not see anything. V8 (Certified Nursing Assistant) informed them about the incident that happened in the dining room between R5 and R6. V4 then made a report about the incident.

Clinical Notes by V4 dated 01/13/2025 (late entry) documents: V8 reported to him (V4) that R5 and R6 had interaction, and that V8 noticed scratches on R5's left side of neck and face. Injury site was cleaned with normal saline and dried.

On 02/18/2025 at 10:48 AM, V4 stated that he

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was on break at the time of the incident. When I came back from break, I was informed by V8 and V9 about the incident contact between R5 and R6. On 02/19/2025 at 10:44 AM, V4 clarified that it was V9 who informed him that something happened with R5 and R6. When he (V4) came to the floor, V8 told him that something happened to R5 and R6. That R6 made physical contact to R5. R6 touched R5 but V8 was not sure if it was done on purpose.

Another incident that happened on 11/18/2024. In this incident, R5 was also the victim and sustained swelling and redness into his right eye when another resident R9 hit R5's face.

V10 (Registered Nurse) clinical notes dated 11/18/2024, documents that on the hallway R5 bumps into R9. R9 then proceeded to tap R5's face. R5 was observed with slight swelling, redness in right eye area. Ice pack was applied, and neuro check was initiated to R5. R5 was transferred to the hospital for medical intervention including CT scan. Per hospital records, R5 was considered a victim of assault.

V10 (Registered Nurse) written confidential witness statement dated 11/18/2024 reads: I observed from the nurse station the resident (R5) moved towards another resident (R9) and got tapped in the face. Resident was separated and moved away. Signed by V1 (Administrator) only, signature of witness left blank.

On 02/14/2025 at 11:41 AM, V10 stated that R9 was sitting on wheelchair near the nurse station. Because R5 likes to wander, he accidentally bump to R9. R9 tapped face of R5 that resulted to slight redness. Then she (V10) applied ice pack to R5's right eye area. V10 was asked to

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elaborate more on R5's right eye after R9's tapped. V10 stated there were redness, erythema and swelling with skin irritation. V10 stated a soft tap will not result to redness or swelling. Yes, it needs to be force enough. V10 stated that R5 is not very much alert and wanders a lot. R5 is not able to make conversation, uses jumbles speech or incoherent speech. V10 stated that if what happened to R5, happened to any of his family or friends she will really feel bad. And would not want that to happened to any of her family members. V10 stated that she does not want resident that does not work well with other residents on the same floor. V10 stated that R5 likes to get up at times. And the incident happened around breakfast time. Nursing staff were busy, and she was busy with her computer. R5 may have been getting out for breakfast.

Clinical notes of V11 (Registered Nurse) dated 11/18/2024, documents that she asked R9 why did he did that? R9 replied, "Shut up you b***h! I wanna spill this coffee on your face."

On 02/18/2025 at 02:50 PM, R9 was seen in front of nurse station sitting on his wheelchair. R9 was alert and able to express his thoughts within topic during conversation. R9 agreed to go to his room for an interview. When asked about R5, R9 a bit evasive with the question. R9 replied, "R5 cannot talk to me, he is mad. He is here for murder." R9 was asked if he can elaborate more about his statement. R9 a bit uncomfortable, stated he cannot elaborate or cannot remember about the incident.

R9 is 78 years old, initially admitted in the facility on 03/21/2011 with medical diagnosis that includes dementia, schizoaffective disorder, cognitive communication deficit. R9 assessment

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dated 01/02/2025, documents that R9 has intact cognition to slight impairment with BIMS (Brief Interview of Mental Status) score of 13. And that R9 is non-ambulatory and uses motorize wheelchair per functional abilities assessment with the same date.

On 02/19/2025 at 09:21 AM, V1 (Administrator) stated that on the incident dated 11/18/2025, R5 has dementia that likes to wander around. R9 tapped R5's face and staff immediately remove R5 and R9. V1 was asked how R9 able to tap R5's face? V1 stated that R9 cannot walk but can stand. R5 on the other hand cannot understand. V1 said, "What happened was not intentional. It happened to two dementia residents."
V1 was asked about the incident dated 01/13/2025. V1 stated that there was a concern between two individuals (R5 and R6). V1 stated that after investigation there was no proof that superficial scratch was done by R6. V1 said, "I think R5 done it to himself." V1 was asked what did R6 said about the incident? V1 took written statement of R6 and read: "He said R5 was in his way, and he asked him to move." V1 was asked how did she first learn about the incident? Who was the facility staff who contacted her? V1 replied that the person contacted her was V9 (Registered Nurse). V1 was made aware that V9 was not in the facility during the incident because she started working 7:00 PM. V1 then stated that V8 (Certified Nursing Assistant) was the only staff that saw what happened. And V8 did not see that scratches was done by R6. V1 was made aware that R6 stated that he punched R5 on the face because he told R5 to move multiple times but R5 did not move.

Abuse policy dated 03/01/2021 reads:

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Policy
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.
This facility will not tolerate resident abuse or mistreatment or crimes against a resident by anyone, including staff members, other residents, consultants, volunteers, and staff of other agencies, family members, legal guardians, friends, or other individuals.
For the purposes of this policy, and to assist staff members in recognizing abuse, the following definitions shall pertain:
Abuse: The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm or pain or mental anguish or deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental psychosocial well-being. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.

Identification of Allegations/ Internal Reporting Requirements

The nursing staff is additionally responsible for reporting on a facility Incident Report the appearance of bruises, lacerations, or other abnormalities as they occur. Upon report of such occurrences, the Nursing Supervisor is responsible for assessing the resident, reviewing the documentation, and reporting to the Administrator or in the absence of the Administrator, the Director of Nursing.

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