Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0049932	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL NURSING & REHAB CENTER	5336 NORTH WESTERN AVENUE , CHICAGO, Illinois, 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) COMPLETION DATE
S0000	Initial Comments Complaint Investigation: 2586047/IL195678	S0000		
S9999	Final Observations Statement of Licensure Violation 300.610a) 300.1210b) 300.3210t) 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. 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		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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S9999	Continued from page 1 300.3210. 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 observation, interview and record review the facility failed to ensure the resident the right to free of abuse for one (R2) of three residents included in a sample of 8 who was physically assaulted by R1, resulting in R2 sustaining a laceration to the top of head requiring 8 staples. Findings include: R1 is a 58 year old male with a diagnosis including Pulmonary Disease , Diabetes 2 , Heart Failure and Low Back Pain. R1 was first admitted to the facility on 2/11/25 and was discharged from the facility on 7/1/25. R1 has a BIMS (Brief Interview Of Mental Status) Score of 15/15 . R1 is care planned for including abuse potential resulting from 6/30/25 incident where R1 and R2 got into an argument with no physical contact, and on 7/1/25 where there was an altercation between R1 and R2 with physical injury to R2 . R1 was first admitted to the facility on 2/11/25. R2 is a 58 year old male with a diagnosis including Parkinsons Disease , Dementia , Bi Polar Disorder and Repeated Falls . R2 was first admitted to the facility on 6/28/25 R2's BIMS (Brief Interview Of Mental Status) score of 15/15. R2 is care planned for abuse potential based on 6/30/25 and 7/1/25 incident. On 7/3/25 at 9AM R2's head was observed with V2 (DON). A 3.2 CM (centimeter) laceration with 8 staples was observed on top of head. On 7/2/25 at 10:45AM R2 stated, I was out smoking and R1 came up and sprayed me. I fell down and hit my head on the metal side of bench. I couldn't see. There was	S9999		

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S9999	Continued from page 2 15-people out there when this happened. I got 8 staples at the hospital. I don't know where he got the mace from. We also had an altercation in the dining room that happened the night before on 6/30/25. The nurse stopped the altercation right away in the dining room the day before the smoking patio incident. R1 accused me of wearing his shoes. I never touched his shoes. I found them under his bed. I am ok and feel safe now since the incident. I don't see R1 here and heard he isn't coming back. On 7/2/25 at 10:54AM V1 (Administrator) stated, I am the abuse prevention coordinator. R1 and R2 got in altercation in the dining room on 6/30/25. They had an argument and were separated. V5 (Nurse) was there. On 6/30/25, R2 was moved to another room upon agreement of R2. We increased monitoring of both residents. Yesterday (7/1/25) there was a code gray called. I went out to smoking patio. I saw R2 was by edge of patio. R1 was on the bench 5 feet away. R2 had blood on head. R1 had no injury and was sitting on bench. I called the nurse to take care of R2. Nurses applied first aid while I stayed there with R1. R1 said he was having trouble breathing because he has COPD. Am ambulance was called for both of them per doctors order. R1 was presented with an IVD (Involuntary Transfer or Discharge) for emergency discharge. I went to the hospital to have R1 sign Notice of Involuntary Transfer or Discharge and Opportunity for Hearing. He requested his belongings. I went back to facility and got those belongings. I brought the belongings the same day. R2 was just readmitted to facility. R2 has stitches on his head. R1 sprayed mace and pushed R2. R1 went out on pass on 7/1/25 and I think that is how he got the mace. On 7/2/25 at 1:10PM V8 (RN) stated, I was on floor Code gray (Fight) was called on patio. Everybody rushed out. R2 was bleeding on head we assisted him. First aid was given, 911 called. Both were alert and oriented. R1 stated he couldn't breath, we gave oxygen. 911 arrived. On 7/2/25 at 1:13PM V9 (LPN) stated, I went to patio after a code gray was called out on patio. I cleaned out the cut approximately 1.5 inches. We put a steri strip on it and covered with clean gauze. I am not aware that he was sprayed with mace. I didn't treat his eyes. I helped the other nurse tend to the cut on top of R2's head. On 7/2/25 at 1:30PM V10 (Physician) stated, yes I was	S9999		

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S9999	Continued from page 3 the doctor that the facility contacted on the R1, R2 incident. R2's injury to the top of the head is consistent with hitting the head on a metal part of the bench after being pushed. I am not aware of the mace being sprayed into R2's eyes by R1. I saw R2 yesterday after he came back from the hospital and he didn't complain of any eye discomfort. His eyes were clear and had no visible sign of injury. R2 hospital record dated 7/1/25 shows diagnosis of laceration of scalp , initial encounter. Facility policy titled Abuse Prevention Program Revised 3/1/21 shows 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. B	S9999		