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 07/12/2022

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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 Complaint: 2284708/IL148039	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c)3) 300.1210d)6) 300.1220b)2) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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. Restorative measures shall include, at a minimum, the following procedures: c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 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 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 2) Overseeing the comprehensive assessment of the residents' needs, which	S9999		

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S9999	Continued From page 2 include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These Regulations were not met as evidenced by: Based on interview and record review, the facility failed to 1) have a system in place to prevent one resident (R1) with a history of confusion, behaviors, and known to tamper with dialysis catheter from removing the dialysis catheter cap. 2) the facility failed to identify, assess, and provide emergency care for one resident (R1) reviewed for supervision/monitoring & bleeding from dialysis access catheter. These failures resulted in R1 removing the dialysis catheter access cap, with a loss of a large amount of blood from R1's right subclavian dialysis catheter and delayed cardiopulmonary resuscitation (CPR). R1 was emergently transferred to ER admitted with diagnosis of cardiac arrest and hypovolemia. Findings include: R1's Hospital discharge summary record dated 5/17/2022 at 3:22pm by discharging hospital	S9999		

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S9999	Continued From page 3 Present Illness states, in part, 61-year-old female who was admitted to local hospital for COPD (Chronic Obstructive Pulmonary Disease) exacerbation. Developed R-facial droop and weakness. Imaging revealed SAH (Subarachnoid Hemorrhage) and transferred to name (Another Local Hospital) for neurosurgical intervention. CTA (Computed Tomography Angiography: a type of medical test that combines a CT scan with an injection of a special dye to produce pictures of blood vessels and tissues in a part of your body) head showed RICA/PCOM (Right Internal Carotid Artery/Posterior Communicating Artery Aneurysm) artery aneurysm measuring 4.5 x 2 mm in size. Underwent coiling and EVD (External Ventricular Drain) placement. EVD eventually removed but patient remained confused and agitated. Assessment/Plan: needing restraints and will try to discontinue. Preadmission Screening and Resident Review dated 5/23/2022 documents, in part, Patient (R1) intermittently confused. R1's Hospital discharge summary record dated 5/26/22 at 7:55 progress notes: documents in part, "Patient's restraints were discontinued around 20:30. Instructed patient not to remove the Dialysis Catheter if she will, we will put the soft restraints back." R1's hospital discharge 6/2/2022 documents in part, Critical Care Initial Evaluation Note ER (Emergency Room) staff called nursing home and RN notes that R1 is known to play with her dialysis catheter and for it to become uncapped. R1's was admitted to facility on 6/1/2022 around 6:30pm according to V18 (RN) admission record dated June 1, 2022, documents diagnoses of: Chronic Obstructive Pulmonary Disease,	S9999		

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S9999	Continued From page 4 Hypertension, Chronic Kidney Disease, Dialysis, Hyperlipidemia, Gastro- Esophageal reflux Disease, Restlessness and Agitation. R1's Hospital discharge summary lab results dated 6/1/22 at 5:01 am indicates R1's Hemoglobin is 9.6. The normal range for hemoglobin is: For women, 12.0 to 15.5 grams per deciliter. R1's Admission/Readmission screener dated 6/01/2022 documents under section E. Neurological R1 is orientated to person under section K. Teaching/Education Skilled Care Daily Progress Note resident is extensive for ADL's (Activities of Daily Living), Uses bed side commode, Right side facial and eye dropping. Resident on pureed low sodium diet. R1's Daily Skilled Nursing Note dated 6/1/2022 documents under mental status documents R1 is alert, disoriented, forgetful and confused. Nursing Progress Note 6/1/2022 at 19:01(7:01pm) documents in part, Note Text: Received this 61 years old black African American female from Local Hospital with admitting diagnosis of subarachnoid with history of COPD (chronic obstructive pulmonary disease), hypertension, stage renal disease, bipolar disorder, right artery aneurysm and right external ventricular drain. Resident arrived to the unit on a stretcher accompanied by two paramedics staff. Resident noted in stable condition. AOx2-3. Vital signs taken BP 107/61, Pulse 66, temp 97, RR 18, O2sat 99%RA(room air-amount of oxygen in blood). Head to Assessment completed. Resident is ambulatory with an assistance. Resident is a dialysis patient. All medications verified by NP (V16) and reconciled with and an order. 72 Hours new	S9999		

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S9999	Continued From page 5 admission monitoring initiated per facility protocols. DON made aware. Author of note V18 Late Entry Nursing Progress Note 6/1/2022 at 19:05 (7:05pm) documents in part, Note Text: Alert and oriented x 2, Resident mood is pleasant, no behavior noted, not in any type of distress, able to makes needs known, resident denied any pain at this time. Upon assessment vital sign within normal range B/P - 105/56, P-70, R-18, Temp-97.6, Spo2-99% room air, Blood glucose level-90. All due medication administered and well tolerated. Author of note V12 Progress noted dated 6/02/2022 at 2:30AM states V13 (CNA) alerted nurses on duty that R1 observed on the floor immediately rushed to the room noted resident bleeding from her dialysis catheter port. 911 called, oxygen placed via non-rebreather (type of oxygen mask) mask, pressure applied to the site firmly with a clean bandage. Assessment revealed that resident had opened the dialysis catheter port and the cap was found on the dining room table. Cap replaced to the opened catheter. 911 transferred resident to the nearest hospital. NP (Nurse Practioner) (V16) made aware. R1 transferred to local hospital on 6/2/2022 at 2:40am by EMS (Emergency Medical Service) in cardiac arrest. R1's Local fire department run sheet, dated 6/2/22 at approximately 2:17am documents in part, "Called for a bleeding victim in NH (Nursing Home) found pt (R1) on the floor of dining room on several bloody sheets and towels. There's much blood on the floor. She's (R1) agonal (gasping) breathing and crew couldn't detect a pulse. CPR (Cardiopulmonary Resuscitation)	S9999		

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S9999	Continued From page 6	S9999		

initiated and ventilation by BVM (Bag Value Mask), RN said he found pt(patient) (R1) alone on the floor bleeding from the dialysis chest access. He capped it off and called 911. It's unknown how long she's (R1) been down. Removed pt (R1) to the ambulance with ongoing CPR and ventilated by BVM, O2 (oxygen) 15L(liters). Initial rhythm was PEA (Pulseless Electrical Activity) After 3rd epi(epinephrine) pt (R1) was in vfib (ventricular fibrillation, an irregular heart rhythm). Crew defibrillated pt (R1) at 200j (Joules). She (R1) went back to PEA. Crew continued CPR. OLMC (Online Medical Command) ordered transport to ED (Emergency Department) with continuing efforts. Release pt (R1) to ED staff without change or incident. All treatment times were estimated."

On 7/11/2022 at 4:10pm surveyor asked V19 (Paramedic) to describe what V19 saw upon arrive to the dining room where R1 was located. V19 stated, when we (referring to paramedics and firefighters) got there a male nurse (V14 RN) was just leaving the room (referring to dining room) and stated he (V14) had capped the port. V19 was asked if anyone else was in the dining room and if CPR or any type of care was being done for R1. V19 stated, "No there was no one in the room with R1. She (R1) was laying on the floor alone in the dining room. No staff were there, no one was doing CPR, no crash cart was present, I (V19) cannot remember if R1 had any oxygen on. We (referring to paramedics) went over to R1, and she was having agonal (gasping) respirations and no pulse was felt so CPR was immediately started, and we put pads on the patient (R1)". V19's narrative stated his patient care report narrative was accurate. V19 also stated, "The facility did not call the right information in regarding the patient so all of the

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S9999	Continued From page 7	S9999		

right equipment was not brought up immediately, this should have been an ACLS (Advanced Cardiac Life Support) call, and it was not, but we had equipment to take care of the patient." V19 stated, I am not sure what happened to the patient (R1) but I believe she was given blood when we got her to the hospital.

R1's Risk Management report dated 6/2/22 at 3:33 AM document in part, Type/Nature of Incident: Fall, Nursing Description: "NOD (Nurse on Duty, V12) was made aware by CNA (V13) that while walking on the hallway, he (V13) saw resident on the floor in the dining room." Description of Action Taken: Nurse went to the dining room, observed resident on the floor bleeding from her dialysis access site, pressure dressing applied, 911 called. Resident transferred to the nearest hospital. MD (Medical Doctor) and family notified.

R1's Risk Management dated 6/2/2022 no time documented Note Text shows: NOD (Nurse on Duty) was made aware by CNA (V13) that while walking on the hallway he saw resident on the floor in the dining room. Nurse went to the dining room, observed resident on the floor bleeding from her dialysis access site, pressure dressing applied, 911 called, VS 132/76-98-20-97.4. Resident transferred to the nearest hospital. MD and family notified, DON also notified. Facility unable to identify who documented note.

R1's Emergency Room Provider Notes Chief Complaint: Patient presents with Cardiac Arrest. HPI (history of present illness) in part shows R1 presented to ED via EMS in cardiac arrest. R1 apparently found down in pool of blood with source seemingly port site in R chest wall. En (sic) route, R1 received in total x5 epi

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S9999	Continued From page 8 (Epinephrine). Presenting rhythm PEA (Pulseless Electrical Activity (no heart beat), in total R1 received x3 Epi, x1 bicarbx1, Ca, 10u insulin with ROSC. R1 initial rhythm s/p ROSC sinus tach degenerated to slow Afib (irregular heart rhythm). No evidence of trauma on primary survey pt subsequently intubated sedated and levophed gtt (IV drip, which helps elevate blood pressure) started via R fem (femoral) central line. R1's Emergency Room Records dated 6/2/22 at 3:58 am, documents in part, page 17 of hospital records indicates hemoglobin 7.4, RBC 2.28 Pulmonary/Critical Care ICU consultation Physician note document 6/2/2022 at 0542(5:42am) in part shows R1 presents s/p (status post) cardiac arrest from nursing home. R1 unfortunately had a prolonged period of pulselessness. She had apparently suffered blood loss from her HD (hemodialysis) catheter, so hypovolemia (low blood volume) is the suspected cause. Critical Care Initial Evaluation Note date of admission 6/2/2022 at 0542(5:42am) Physician Note, Chief Complaint: Presented cardiac arrest, HPI/ED Course in part shows R1 with PMH (past medical history) of hypertension and ESRD (end stage renal disease) who was found on floor of her dining room at the nursing home copious (large amount) blood with multiple bloody sheets. EMS called and noted a significant amount of blood and no pulse felt and ACLS initiated. Per RN at nursing home, he noted that he found patient with dialysis catheter uncapped and laying on the floor and that's when he called EMS. Unknown downtime. ACLS (advanced cardiac life support) was continued with 3 more rounds of epinephrine given, V. Fib and defibrillated	S9999		

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S9999	Continued From page 9 (electric shock with goal to restore a heart rhythm) at 200J. En Route had received a total of 5 rounds of epinephrine. R1 presented to ER in PEA and received another 3 rounds of epinephrine, bicarbonate and calcium with 10 units of insulin and ROCA (resumption of care achieved) achieved. Post arrest rhythm ST which degen (degenerated) to slow afib. Intubated without issues and right femoral central line in place. Head CT (computerized tomography scan) without any acute bleeding and chest CT without any focal changes. ER staff called nursing home and RN notes that R1 is known to play with her dialysis catheter and for it to become uncapped. Assessment/Recommendations: R1's hospital Emergency Room record dated 6/2/22 at 05:42am (5:42am) documents in part, Cardiovascular: Cardiac arrest at nursing home with unknown downtime. Received a total of 8 rounds of epinephrine and had one shock delivered for V fib (Ventricular Fibrillation). ROSC (Return of Spontaneous Circulation) obtained and post arrest EKG (Electrocardiogram) with sinus rhythm. Cause of cardiac arrest unclear at this moment but suspect from significant blood volume loss. Nephrology Physician Note dated 6/2/2022 at 0959 (9:59am) documents in part, R1 found in cardiac arrest at the nursing home. Per nursing home documentation patient was playing with her dialysis catheter and she uncapped it. R1 likely profusely exsanguinated (large blood loss). R1 had unknown down time. ACLS was performed after Total of 5 round of epinephrine ROSC was achieved. R1 is given blood transfusion. Impression & Plan: 2. Hypotension-on pressors postcardiac arrest 3. Hypervolemia - UF as tolerated 4. Acute blood loss anemia on top of	S9999		

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S9999	Continued From page 10 anemia of chronic disease-status post 2 units blood transfusion. General Surgery Consult Physician note dated 6/14/22 at 1222pm documents in part, HPI: currently hospitalized for cardiac arrest. R1 was found down in nursing home, with dialysis catheter uncapped and bleeding from this. R1 was pulseless at time of discovery, achieved ROSC in ER. R1 remains intubated, CT demonstrating anoxic (oxygen deprivation) brain injury. At bedside, R1 is not responsive to verbal or physical stimuli. On 6/28/22 at 10:07am V2 DON (Director of Nursing) stated that V12 LPN (Licensed Practical Nurse) called and stated that R1 was in the dining room and wanted to watch TV. V2 stated, "I (V2) told V12 to let R1 stay in the dining room because R1 was in there by R1's self". V2 (DON) stated, "V13 (CNA) was making rounds and saw R1 in the dining room on the floor". V2 stated, "V13 told me that V13 saw blood". V2 stated, "V12 (LPN) told me that the blood was coming out of the R1's dialysis catheter site and V12 saw the cap off the dialysis catheter and the cap was on the dining room table". V2 stated, "The nurse did not describe if blood was on the floor". V2 stated, "There was no CPR initiated at the facility, R1 did not need CPR because R1 was breathing and talking". V2 stated, "If something is not documented, I (V2) will not say it's not done". V2 stated, "The nurse's chart by exception and that the nurse did not do vital signs because she was holding pressure to R1's dialysis catheter and holding pressure on a dialysis catheter is more important because R1 was bleeding out". On 6/28/22 at 12:14 PM surveyor asked V12	S9999		

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S9999	Continued From page 11	S9999		

(LPN) to tell surveyor what happened to R1 on 6/1/2022 to 6/2/2022. V12 stated that she (V12) was R1's nurse and at midnight V12 could not find R1 when V12 was doing rounds. V12 stated that I (V12) went to R1's room and R1 was not there so I (V12) went to R1's bathroom and R1 was not there. V12 stated that I (V12) went to the dining room and saw R1 in the dining room. V12 stated that I (V12) told R1 to stay in her (R1's) room. R1 stated that I (R1) want to stay in the dining room. V12 stated that I (V12) called V2 (DON), and V2 said R1 can stay in the dining room since no one is in there. V12 stated that I (V12) continued to make rounds. V12 stated about ten minutes later I (V12) saw R1 again in the dining room watching TV. V12 stated that V12 asked R1 was she ready go to R1's room. R1 said let me stay here please. V12 stated that I (V12) said I (V12) will be back. V12 stated that I (V12) asked V13 (Certified Nursing Assistant, CNA) to watch R1 because R1 was in the dining room. V13 was in the hallway when I (V12) talked to V13. Surveyor asked V12 what time this occurred. V12 stated, "I do not know".

On 6/28/2022 at 12:17pm V12 stated that V13 called me (V12) and said blood was coming from R1's chest in the dining room. V12 stated she (V12) went there (referring to dining room) and saw R1 bleeding from chest and called out to V14 RN (Registered Nurse) to call 911. Surveyor asked V12 what time this occurred. V12 stated, "I (V12) do not know". V14 (Registered Nurse, RN) called 911. V12 stated that R1 was in the dining room alone. V12 stated, "R1 was sitting in the chair, and I (V12) lowered R1 to the floor because I (V12) did not want R1 to fall out of chair". V12 stated that I (V12) put sheets under R1 while lying on floor so R1 was not lying on a dirty floor. V12 stated that I (V12) put a pressure dressing to the

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S9999	Continued From page 12	S9999		

catheter site and then I (V12) saw the caps were off R1's dialysis catheter. V12 stated, "The caps were on the dining room table". V12 stated, I (V12) put the cap back on. V12 stated, "I (V12) asked R1 why you (R1) pull your (R1) caps off your (R1's) dialysis catheter". V12 stated, "R1 looked like R1 didn't know R1 had done something wrong and R1 stated, I (R1) did not know why". V12 stated that I (V12) took Vital Signs at the beginning of my (V12's) shift. V12 stated that V12s' shift is 7:00pm to 7:00am. V12 stated, "I (V12) did not take R1's vital signs when I (V12) responded to R1 in the dining room bleeding because I already took them".

On 6/28/22 at 12:55 PM V13 (CNA) stated that R1 was walking around in the hallway when V13 came in at 11:00 pm. V13 stated, I (V13) tried to redirect R1 at that time but R1 kept on walking. V13 stated that V12 asked me (V13) to keep an eye on R1. R1 was in the dining room. V13 stated, "I (V13) do not know what time it was that I (V13) observed R1 in the dining room". V13 stated, "it was less than every two hours". V13 stated, "I couldn't watch R1 continuously, because I (V13) have other residents". V13 stated, "When making rounds I (V13) noticed R1's shirt with blood on it and both nurses came and assisted R1". V13 stated, "There was no blood on the floor just on R1's shirt". V13 stated, "R1 was sitting in a chair and R1 did not say anything. The nurses then took her (R1) off the chair and sat her down on the floor then one of nurses call 911. V13 was not able to state which nurse called 911. V13 stated that the paramedics came around five or ten minutes later and took R1 away and no CPR (Cardiopulmonary Resuscitation) was started on R1 at that time.

On 6/28/22 at 3:13 PM V12 stated, "911 was

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 07/12/2022

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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S9999	Continued From page 13 called because every time there is a bleed you don't know what is going to happen". V12 stated that R1's skin was warm to touch and R1's skin color was within normal limits. V12 stated that the paramedics saw the blood and V12 told them V12 had just closed the cap on the dialysis catheter. V12 stated, "R1's gown was changed before R1 left the facility with the paramedics". Surveyor asked V12, with a change of condition with R1 bleeding from the dialysis catheter, should R1's vital signs been taken? V12 said, "Yes the vitals should have been taken, I do know that." V12 stated, "There was no indication of R1's condition declining. R1's breathing was normal. R1's mental status was not changing". V12 stated that R1 didn't know R1 had done something wrong when R1 took the cap off. On 6/28/2022 at 3:19pm surveyor asked V12 regarding the progress note dated 6/02/2022 at 2:30am by V12 that documents that V13 alerted Nurses on duty that resident observed on the floor, immediately rushed to the room noted resident bleeding from her dialysis catheter port, 911 called, oxygen placed via nonrebreather mask, pressure applied to the site firmly with a clean bandage. Assessment revealed that R1 had opened the dialysis catheter port and the cap was found on the dining room table. cap replaced to the opened catheter. V12 stated, "She (R1) was not on the floor I (V12) lowered R1 onto the floor; I put a sheet on the floor and lowered her (R1) to the floor". Again, V12 stated, "She (V12) put R1 on floor. V12 stated, "I (V12) documented wrong, and it was not that much blood". V12 stated, "Blood was dripping from catheter on her (R1) clothes, but there was no blood on floor". On 6/28/22 at 4:40 PM surveyor asked V14 (Registered Nurse, RN) what happened to R1 on	S9999		

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 07/12/2022

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
S9999	Continued From page 14 6/2/2022. V14 stated, "V12 yelled out and said R1 had removed R1's cap from the dialysis catheter. V14 stated that V12 called out orders to call 911". V14 stated, "It was a minimal amount of blood on R1's dress". V14 stated, "The dialysis cath was open and the cap was put back on the dialysis catheter. I (V14) did not notice or see any more blood after the cap was put back on the dialysis catheter. R1 was no longer bleeding from the dialysis catheter". V14 stated that after I (V14) called 911, I (V14) went back into the dining room to assist V12. V14 stated, "I (V14) cannot not remember if vital signs were done". V14 stated that V12 was in the room also. V14 stated, "R1 was verbally responsive even when R1 was leaving for the hospital". V14 stated, "When the paramedics came, I (V14) don't remember what the paramedics did". V14 stated that when there is a change in condition, standard nursing is to assess the resident, call the doctor, get recommendation from the doctor, and get labs. V14 further stated that getting vital signs is included in the assessment. Surveyor asked V14, what is the professional standard for charting? V14 stated that professional standard for charting is objective information, document what happened, orientation of resident, what care was provided to the resident and every interaction with the resident. V14 stated, "If not charted it's not done". On 6/29/2022 at 1:28pm V2 stated, "V13 was monitoring R1, he (V13) is making sure that another resident does not come into the dining room and that R1 does not leave the dining room". V2 stated, "V13 would be in the hallway and can observe the resident through the windows of the dining room. R1 did not display any behaviors according to the head-to-toe assessment after we (Staff) spoke to the	S9999		

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 07/12/2022

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
S9999	Continued From page 15	S9999		

resident". V2 stated, "V12 will keep an eye on R1 and if anything is noticed then V12 would notify me (V2), and it would be recommended for her to be monitored more closely and possibly moved. If she (R1) was in her room then R1 would have been monitored every two hours, but since she was in the dining room, she was being monitored from the hallway to prevent the spread of Covid-19". Surveyor asked V2 if V13 could monitor R1 closely and care for other residents. V2 stated, "No, he (V13) would not be able to look after other residents because she (V2) told the CNA to monitor R1 closely to prevent her from wandering out of the room or someone from wandering into the room. Monitoring means the resident should be in his line of sight, at all times, so that he (V13) could redirect her (R1) if she tries to leave the dining room".

On 6/30/2022 at 1:54pm V14 (RN) stated, "I saw R1 in the hallway interacting with V12 and I supposed V12 was telling R1 to go back to the blue zone". V14 said, "I don't remember what time, but it was late at night, and it was before the incident occurred and the incident occurred around 2:30am." The nurse (V12) had a call, and she (V12) came to answer the call and then she (V12) went back to talk to R1.
Surveyor inquired about who made the 911 call. V14 replied, "I think I did; the call was made within minutes of the other nurse (V12) asking me (V14) to call 911." Surveyor inquired about what was told to the 911 responder. V14 stated, "I don't recall, but no vitals were given." V14 stated, after making the call I (V14) printed the transfer papers and then went into the dining room and we (V12, V13 and V14) were helping the patient (R1). We (V12, V13, V14) stayed with the patient (R1); we changed the gown because there was blood from the dialysis cath. It didn't take 911

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 07/12/2022

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
S9999	Continued From page 16	S9999		

long to arrive it took about 3-5 minutes. Surveyor asked if there was blood on the floor. V14 stated, "No, there was no blood on the floor. There was a sheet on the floor that the nurse (V12) had put on the floor and the resident (R1) was sitting on the flat sheet. I (V14) don't recall if there were any towels, but she (R1) was not on the bare floor. I (V13) don't know if it was a white sheet or blanket. I (V14) didn't take vitals and I (V14) don't know if V12 had taken vitals. V13 was in the dining room with us (V12 and V14) while we (V12 and V14) were taking care of the resident (R1). V13 was the one who brought the gown and was there interacting with the resident (R1) during this time".

On 6/30/2022 at 2:44pm V18 (RN) stated, "Yes, I (V18) completed the admission for R1 and received report from the hospital prior to receiving the resident (R1). I (V18) can't remember much about this resident (R1). Surveyor asked if the sending hospital nurse told you (V18) that R1 had any behaviors or tampered with her dialysis catheter. V18 stated, "No, they didn't tell me (V18) about any behaviors while R1 was in the hospital and R1 was not having any behaviors when I (V18) received her (R1). V18 stated, "The hospital nurse giving me (V18) report on R1 didn't tell me anything about restraints and I (V18) don't think I saw anything in the discharge papers about restraints. V18 stated that R1's orientation status was alert & oriented x 2-3 because she (R1) was able to tell me her name and where she was. Again, V18 stated, "No, I (V18) didn't get anything about the hospital staff having to use restraints on R1 verbally or in the written documentation and no, I (V18) am not sure about anyone telling me or reading about the resident (R1) tampering with her (R1) catheter." V18 stated, we don't do training about managing a

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 07/12/2022

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
S9999	Continued From page 17	S9999		

cognitively impaired resident with a dialysis catheter and it depends on the mental status of the resident. We have to educate the resident about safety concerning the catheter. Most of the time we would have a one to one for 24 hours with a cognitively impaired resident. We always educate them about not touching or tampering with the catheter or any part of that area. Surveyor inquired regarding orders to manage the dialysis catheter. V18 replied, "I don't really have a specific answer, but we always educate the resident, and we sometimes involved the dialysis department of the condition of the resident."

On 7/6/2022 at approximately 8:04am surveyor asked V18 were you made aware in report (verbal or written) that R1 had behaviors. V18 stated, "I didn't see any behaviors in the report that stated the resident had any behaviors. No, I did not review that the hospital had to use soft restraints on R1". Surveyor asked V18 was she aware that the soft restraints had been discontinued on the 26th or 27th of May. V18 said, "Yes, that they had discontinued the use soft restraints". Surveyor asked V18 if she informed the V16 (NP) about the discontinued use of the soft restraints. V18 said, "No, I did not tell him (V16) about the restraints". I (V18) told him (V16) about the medications and that R1 had a dialysis catheter and V16 told me to continue the orders." V18 stated that the NP visits with the resident the next day and will review the medications again. Surveyor asked V18 again about informing the doctor about the discontinued use of the restraints. V18 said, "No, I didn't inform the NP about the restraints.

On 7/6/2022 at 8:45am asked V2, what are the steps for completing a new admission for a

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 07/12/2022

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
S9999	Continued From page 18 resident. V2 stated, nurse will have to do head to toe assessment (LOC(level of consciousness) and alertness and for behaviors). If any notice of any behaviors, then the nurse will notify me and then we will talk about it. If there are behaviors, then we will put interventions in place to deal with the issues. Nurses are to verify medications and other orders such as behaviors with the doctor, than they would have to put the medications in the system so that pharmacy can bring to them facility. Document in PCC your admission notes, the assessments, any abnormalities noted and any interventions that was recommended. Notify the family, and DON. Surveyor asked V2 what would be done for a resident with a dialysis catheter. V2 stated, "Normal admission is done, but they would have to assess to see if the resident is ok. They are looking for any behaviors such as tampering or playing with the dialysis catheter". On 7/6/2022 at 9:27am Surveyor asked V12 what steps were taken when you admitted R1. V12 stated, when you receive the resident, you go with the paramedics as they transfer the resident into her (R1) bed so you can do a quick assessment as far as how's she breathing and looking before you sign the release paperwork. After that you would complete your head-to-toe assessment. After head-to-toe assessment then you would notify the doctor of any wounds, bed sores and or if the resident has a dialysis catheter and any abnormalities of your head-to-toe assessment. V18 stated that you would also verify the meds with the doctor, receive new orders from the doctor in regard to meds and labs. The next step should be is that you to instruct the CNA to inventory the residents' belongings, provide water, and determine if the resident has eaten. Overall goal is to make sure the resident is	S9999		

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 07/12/2022

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
S9999	Continued From page 19	S9999		

comfortable. The next thing is you have to start your admission which is to do your assessments and write your notes, then you have to monitor every two hours until the next shift comes in and takes over. V12 clarified that she would let the doctor know that the resident is in the building and if there are any abnormalities with the head-to-toe assessment such as wounds, bed sores and dialysis catheter. Then you would verify the medications and receive new orders for medications and labs. Surveyor asked, V12 how do you provide care for residents with dialysis catheter? V12 stated, "You educate them on the dialysis catheter and safety, meaning not to bother with the dialysis catheter". Surveyor asked, who gave you report the night R1 was admitted? I received report from V17 (RN). V17 told me (V12) I would have a new admission and that R1 has a dialysis catheter. I started the admission on R1. No one told me, anything other than R1 has a dialysis port. I don't remember if the resident was in the building when my shift began or came after". V12 stated, "No, I didn't receive the report from the hospital nurse. I received report from V17 that I was going to have an admission and he didn't provide any additional information". Yes, I reviewed the hospital discharge papers that came with the resident and don't recall any orders for the dialysis catheter. Surveyor asked if she received in report information regarding R1 playing with her dialysis catheter. V12 said, "No, she was so nice and did not have any behaviors. No, I didn't see her playing with or tampering with the dialysis catheter". V12 stated that if I would have saw this behavior I would have contacted the DON immediately and monitored R1 more frequently. V12 stated that more frequently would mean more than every two hours.

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 07/12/2022

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
S9999	Continued From page 20 Surveyor asked, how do you provide care for a resident that has a dialysis catheter. V12 stated, "We always monitor them to make sure they don't mess with the catheter. We monitor the resident with a dialysis catheter for safety and we monitor them every two hours unless. We monitor them not to touch it and we monitor the site to make sure it is not bleeding. The site is always covered but you can see if it is bleeding or not. We don't touch it and we monitor if it is bleeding. Dialysis staff will change the dressing unless it is bleeding than we would apply pressure and send the resident to the hospital". Surveyor asked did you perform a head-to-toe assessment on R1. V12 stated, "Yes, I did, and her mental status was alert & oriented times two". V12 stated that she called the DON between midnight and one o'clock to inform her about the resident not wanting to leave the dining room. V12 stated, she V12 can't force her to leave the dining room. Because she was responding to her questions normally and did not show any behaviors to make me think it would be unsafe to leave her in the dining room, I did not think R1's behaviors were abnormal. V12 stated, I did not call the receiving hospital and the receiving hospital will not call. V12 further stated, I can't recall if I called the hospital to get an update. On 7/6/2022 at 9:53am asked V2, if there are notes in the discharge paperwork regarding restraint usage what is the expectation of your nurses. V2 stated, "I mean, first of all, they send the packet and we review it and if it states that the restraint usage we won't take the patient and we tell them that the resident has to be off of the restraints for a least 5 days before we take the resident". V2 further stated, "Soft restraints, yes that is what was in use, and we denied the patient	S9999		

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 07/12/2022

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
S9999	Continued From page 21 because we don't use restraints in the facility. Days later they called back and stated that she wasn't agitated anymore, and she wasn't using the restraints for a few days. I requested the paperwork that stated she was off the restraints". V2 stated that we have an admission person here in the facility who communicates with the social worker at the hospital. The soft restraints were discontinued on the 26th of May. V2 stated, "I was aware that R1 had behaviors while in the hospital regarding her dialysis catheter and I was aware that soft restraints had been used on the resident while in the hospital". Surveyor inquired, did V12 call you to tell you that R1 wanted to stay in the dining room. V2 stated, "It was in the middle of the night, and I was sleep and it was late night and was woken up from sleep. She (V12) told me that R1 is in the blue zone, and she went to the dining room and she's refusing to get out. I said OK and asked if she (V12) tried to convince her (R1) and she said yes. She (V12) said she could not force her, and I asked her to monitor her and make sure no one else goes into the dining room". Surveyor asked what does monitoring mean. V2 stated, "Monitoring means that it is not like a one on one and if she displayed any kind of behaviors than it would be a one on one and they would be at arm's length. In this situation it was not a one on one and she could be observed through the window. V12 did not inform her V2 that R1 was having any type of behaviors that would lead her to an assessment of close or one to one monitoring. V2 told her that she tried to convince her and that R1 told her in a nice way to leave her alone and just let her watch TV. V12 asked if she had a TV in her room and she said yes, but she just wanted to watch TV in the dining room".	S9999		

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 07/12/2022

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
S9999	Continued From page 22 Surveyor inquired, what assessment did you use to determine if R1 was safe being in the dining room? V2 stated, "I saw her (R1) myself and the nurse called me (V2) about R1 having staples. V2 stated, there were no orders for these staples. V2 stated that she (V2) and the NP (V16) went to look at the resident and tried to find out more information about the surgical wound and the resident stated that she didn't remember. V2 stated, V16 said that the staples were mature, and we can't just leave them there. He (V16) requested a staple remover, but I (V2) couldn't find one, so he said to make sure the wound care nurse removed the staples the next day and the wound care nurse had left for the day. V2 stated that it was between 6:30p and 7:00 pm when we saw the resident. V2 stated that R1 came late, and I (V2) don't really remember the exact time, but it was after 5:30pm. Surveyor asked, did you ask V12 whether R1 had any behaviors and what her diagnoses were. They (nurses) will tell you if there are behaviors and they would let us know because we have those two rooms on the 4th floor, so I (V2) didn't ask her (V12). Criteria for the resident are for people that have a urinary catheter, and they are tugging or pulling it or if they are a fall risk. V2 stated that a resident who is trying to pull, tamper or play with the catheter would be a candidate for those rooms. Those monitoring rooms are on the fourth floor and those rooms are for those residents who are a safety hazard to themselves or others. V2 stated that R1 was not a candidate to be moved to that floor based the behaviors she had displayed. Surveyor asked V2 if in verbal report or if the paperwork states the resident had previous behaviors what is done. V2 stated, "It depends on the verbal report coming from the hospital and what the paperwork states. If they	S9999		

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 07/12/2022

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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S9999	Continued From page 23 are telling us that she was not displaying any behaviors and our assessment confirms that she has no behaviors than there is no reason to have placed that resident in the monitoring rooms. The monitoring rooms are 408 and 418 and a psych tech would sit there 24/7. If someone gets better and have no behaviors than they would be moved to the regular room. Surveyor asked V2, if R1 had behaviors with tampering with her dialysis catheter is this someone you would leave alone in the dining room. V2 stated, "No, if she showed any behaviors of tampering with the dialysis catheter, she (R1) would have been moved to the 4th floor and provided with frequent monitoring which means a one to one is at arm's length, at all times with Psych tech". V2 stated, there was nothing in report or discharge orders about the staples in her right or left hip and that is why the nurse called me (V2) to inform me of these staples. V2 stated she was still at the facility. V2 stated that she waited for the NP (V16) so she could see the wound herself. At that time V2 did not see any behaviors from R1. On 6/29/2022 at 12:30pm V16 (Nurse Practitioner, NP) stated, "The nurse (V12) called and said that R1 was full of blood and believed the dialysis catheter was pulled out". V16 stated, the nurse (referring to V12) just said that R1 was full of blood. V16 stated, "I (V16) asked V12 how R1 was doing and V12 said R1 was alert". V16 stated that I (V16) told V12 to send R1 out to the hospital. Surveyor asked V16, V16's professional opinion regarding a bleeding dialysis catheter. V16 stated, "A pressure dressing is definitely needed to the area and vital signs are needed when there is a change of condition". Surveyor asked V16 the importance of obtaining vital signs	S9999		

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S9999	Continued From page 24 when a resident is bleeding out from a dialysis catheter. V16 replied, "Absolutely, vital signs are very important." Surveyor inquired about the volume of blood coming from a dialysis catheter. V16 stated, "A dialysis catheter is a high-pressure catheter, and it would take 5-10 minutes for a resident to be full of blood with a high-volume catheter and it would depend on when they found R1. It definitely will not be drops or a trinkle of blood, because of the type of dialysis catheter it is". V16 stated, "With a high-volume catheter, in 10-15 minutes R1 could be gone (deceased). It is not a good sight, and it is not an ambulance call it is a 911 call". On 7/6/2022 at 4:37pm surveyor asked V16 (NP) if it is okay to leave a new resident (R1) that had behaviors of tampering with their dialysis catheter in the dining room alone. V16 stated, "No, I would not leave that type of patient (R1) in the dining room alone. V16 further stated, V18 did not tell me R1 had a history of tampering with her dialysis catheter when V18 called to verify orders. To be honest, the nurses do not sit down to read the resident's chart. It is hard for the nurse to know what happened to R1 from the hospital. They (referring to the nurses) do not read the papers. Sometimes the facility (hospital) will tell them that but sometimes the facility (hospital) will hide that information. To come to a nursing home the resident has to be 3 days with no restraints. In the nursing home they have LPN's. This resident (R1) did not come till about 6pm so one nurse had the resident then another nurse came and had the resident for only 7 hours. They do not know the resident (R1) that would come with time. The mindset of a LPN in the nursing home is totally different than a practitioner or nurse in the hospital. The nurses don't read the papers,	S9999		

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S9999	Continued From page 25	S9999		

they just don't. Surveyor stated R1's diagnosis included restlessness and agitation, is that someone you would leave alone in the dining room. V16 stated, "Again like I said, no this resident (R1) should not have been left alone in the dining room. This resident (R1) should have had someone always able to see her. I did not think residents were left alone in the dining room. A new patient coming to the facility can develop sundowning and psychosis generally on admission and is at risk for almost anything for the first 72 hours. You don't know them; you have to be close to them. They should not be left in the dining room. When the nurse called me, she did not tell me the resident (R1) had any behaviors and we did not discuss the dialysis catheter and there were no orders regarding the dialysis catheter given. Surveyor asked what is the harm that can occur to someone who has known behaviors of tampering (i.e., removing the cap) with their dialysis catheter. V16 stated, "What is the harm?, dangerous they can bleed to death in the blink of an eye. The resident (R1) had a high shunt catheter and fortunately she is still alive. By the time they (EMS) took her she was still alive. This is a teachable moment. The curriculum of the nurse in the nursing home has not changed, the need to upgrade their level of care to take care of these residents. It is difficult for these nurses to care for a central or dialysis catheter, most of these nurses do not know what your are talking about. We have to figure out how to help these nurses. Someone needs to take report and help the nurse know what to do. The care and acuity of this patient is far from the care in the hospital.

On 7/07/2022 at 1:41pm Surveyor asked V18 what does head to toe assessment mean. V18 stated, "That you have to assess every part of the

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S9999	Continued From page 26 patient. You would state the system you would state what you saw on the head-to-toe assessment. I was not informed that the resident was any restraint order for resident. Neuro assessment for R1 was able to move her hands; can't really remember too much about this patient (R1). She (R1) was walking. She (R1) was not confused. On 7/11/2022 at approximately 2:57pm surveyor asked V2 if a resident is found bleeding with agonal (irregular gasping) respirations and no pulse, what is the expectation of staff. V2 (DON) stated, "The nurse will do CPR (cardiopulmonary resuscitation) and call a code so lots of people can come to help with crash cart, but in this particular case, the resident (R1) was breathing with a pulse and alert. On 7/11/2022 at approximately 3:04pm Surveyor asked V2 if a resident is in the dining room alone, how will the resident call for help. V2 stated, "The dining room is close to the nurses station. We usually do not put resident there because they cannot call for help, but R1 walked to the dining room. We would not put residents that can't call for help in the dining room. Surveyor asked V2 again, even if a resident can walk into the dining room but then needed help and were not able to walk to get help, how would the resident call for help. V2 stated, we had the CNA (V13) monitor her (R1) to make sure one will go in room and R1 will not go out. The residents on this floor are independent and the dining room is close to the nursing station so someone could help them. During the day, there is always someone in the dining room. We will not leave people unattended in the dining room and will not let them sit in the dining room without any supervision. We do not let residents go into the dining room at night we	S9999		

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S9999	Continued From page 27 try to redirect the resident, but V12 tried to redirect R1. V12 called me and I directed them to stand there and monitor her. V2 stated the dining room has glass windows so V13 was able to watch the resident. V2 stated R1 was not being watched constantly. V13 walked back and forth V13 had to stay right there where he could see her (R1). V13 was not sitting in front outside the room. R1 was sitting in a chair. V13 was just monitoring her. Surveyor asked V2 if V13 was monitoring R1, would V13 be able to see R1 trying to remove the cap from the catheter. V2 stated monitoring is not 1:1, R1 had supervision there is not a timeframe just have to be where resident is visible. 1:1 is always constant observation. This is not necessary for monitoring. V13 was outside the room watching R1. V13 was not continuously watching R1 like a 1:1. Any resident we do not know we just monitor. R1 did not display any behaviors. I was aware R1 was in restraints, we don't restrain in our facility, R1 had restraints off for 5 days. R1 was stable, no restraints needed and 1:1 not needed. During this survey, V2 (DON) did not provide any policy regarding resident supervision or resident safety, baseline care plan, and 72-hour admission documentation as requested by the surveyors. Undated Facility Registered Nurse Job Description states, in part, Position Summary: The Registered Nurse provides direct nursing care to the residents. The person holding this position is delegated the administrative authority, responsibility, and accountability for carrying out the assigned duties and responsibilities in accordance with current existing federal and state regulations and established company policies and procedures to ensure that the highest degree of quality care is maintained at all times. E. Role	S9999		

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S9999	Continued From page 28 Responsibilities- Nursing Care: 8. Implement and maintains establish nursing objectives and standards. Undated Facility Certified Nursing Assistant Job Description states, in part, the primary purpose of your job position is to provide each of your assigned residents with routine daily nursing care and services in accordance with the resident's assessment and care plan, and as may be directed by your supervisors and ensure that residents who are unable to call for help are checked frequently. Undated Facility Licensed Practical Nurse Job Description documents in part, Position Summary: The Licensed Practical Nurse provides direct nursing care to the residents. The person holding this position is delegated the administrative authority, responsibility, and accountability for carrying out the assigned duties and responsibilities in accordance with current existing federal and state regulations and established company policies and procedures to ensure that the highest degree of quality care is maintained at all times and monitors seriously ill residents as necessary. Undated Facility Assessment Tool states, in part, Management of Medical Conditions: Assessment, early identification of problems/deterioration, management of medical and psychiatric symptoms and conditions. Facility's Policy dated 6/26/11 and titled, "Change in Resident's Condition or Status," documents, in part, 3. A significant change of condition is a decline or improvement in the resident's status that: will not normally resolve itself without intervention by staff or by implementing standard	S9999		

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S9999	Continued From page 29 disease related clinical interventions. 4. During medical emergencies such as unstable vital signs, respiratory distress, uncontrolled bleeding and unresponsiveness 911 will be notified for transport to the hospital. Facility's Policy revised dated 4/15/22 and titled, "Accident Incident Reporting Policy," documents, in part, Procedure: 1. If a resident is involved in an accident/incident an immediate assessment of the resident will be completed. First aid will be provided as necessary. Facility Assessment tool dated 2/9/22, document, in part, Part 3: Facility Resources Needed to Provide Competent Support and Care for our Resident Population Every Day and During Emergencies. Staff type: Nursing Services (DON, RN, LPN, or CNA) (A)	S9999		