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 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 Investigation: 23810687/IL168106	S 000		
S9999	Final Observations Statement of Licensure Findings: 300.610a) 300.1210b) 300.1210d)3) 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	S9999		

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S9999	Continued From page 1	S9999		

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:

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.

These requirements were not met as evidenced by:

Based on interview and record review the facility failed to follow their change of condition policy and assess one resident [R2] with an acute change in condition and failed to call 911 when the resident's condition worsened. This failure resulted in R2 experiencing an acute change in condition, a delay in receiving a higher level of care.

Findings include,

R2's clinical record indicates but not limited to; R2 was a 71-year-old with medical diagnosis of asthma, cerebral infarction, type 2 diabetes, dysphagia, oropharyngeal phase, dementia, unsteadiness on feet, dependence on renal dialysis, essential (primary) hypertension, bipolar disorder, anemia, insomnia, acute myocardial infarction, and weakness.

R2's Emergency Department History and Physical Note dated 12/24/23 at 2:14AM,

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 01/31/2024

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S9999	Continued From page 2	S9999		

documents in part: R2 presents to the emergency room from nursing home for three days of hiccoughs as well as appearing lethargic and having oxygen desaturations. Final Disposition: R2 full admission to ACU [Acute Care Unit. Diagnosis: Acute respiratory failure with hypoxemia [low blood oxygen levels], AMS [Altered Mental Status], Hiccups [involuntary spasms of the diaphragm], SIRS [Systemic inflammatory response syndrome- life threatening medical emergency], Elevated lactic acid [decrease oxygen delivery].

R2's EMS (emergency medical systems) report documents in part: Narrative: RN (registered nurse) reported patient having prolonged hiccups, lethargic, hypotension (not baseline) and oxygen saturation being low ....Vitals in transit, patient oxygen levels rapidly declining.

R2's progress notes document in part: Nursing Progress Note, Effective Date: 12/23/2023 21:30:00, Department: Nursing, Created By: V7 [Registered Nurse], Created Date: 12/24/2023 00:36:49 12/23/2023 21:30-Nursing Progress Note:
Note Text: NOD [nurse on duty V7] observed that the patient is lethargic but arousable @ times, continuous hiccup. Assessed right away, Vital signs taken & recorded, T [temperature]98.4 , P [pulse] 100, R [respirations] 18 , B/P [blood pressure] 102/84 , O2 sat.[oxygen saturation] ranging from 82 % to 90 % , Oxygen @ 4 L [liters] / nasal cannula administered ,increased to 96 % with O2 [oxygen] , on close monitoring , color is not good , skin slightly moist Referred to V22 [R2's Physician] with tel. (telephone) order to send the patient out to hospital for ER evaluation ,order carried out right away . All paper works were made, DON [V2] notified, message left to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 3	S9999		

R2's family member [V11], facility's contracted ambulance company called with an ETA [estimate time of arrival] of 2-3 hours, report given to ER [emergency room] nurse.

Nursing Progress Note, Effective Date: 12/23/2023 21:45:00, Department: Nursing, Position: Registered Nurse, Created By: V7 [Registered Nurse], Created Date: 12/27/2023 17:58:29
Late Entry: Note Text, Note Text: @ 2145 hrs. [hours], writer [V7] checked on patient [R2}, A/O x 2-3, verbally responsive, on continuous pulse oximeter @ bedside saturating @ 96-98 percent with oxygen. Denies any chest pain nor chest discomfort. & 2200 hrs. vital signs as follows T 98.0 tympanic P 83, R20, B/P 113/69 Right arm lying, O2 saturation of 97 percent. Offered a carton of Nepro & he took 90 percent. @ this time patient is stable & able to sleep fairly. @ 2300 hrs. patient O2 Saturation remains 97 percent, PR 80, RR 20 B/P 110/71. (RA) lying, @ 2430 hrs. patient is awake & able to move his upper & lower extremities within normal limits. [R2's change of condition was on 12/23/23. R2 expired on 12/26/23. V7's progress note was entered 4-days later (12/27/23)]

12/24/2023 06:37 V7's Nursing Progress Note: Note Text: NOD [V7] called Hospital & the patient [R2] is being admitted with an admitting diagnosis of acute respiratory failure with hypoxemia [low oxygen] and elevated troponin per nurse.

R2's SBAR [Situation, background, assessment and recommendation] dated 12/23/23, documented by V7 [Registered Nurse] documents in part:
-Change of condition symptoms: lethargy, continuous hiccup and desaturation, since this

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 4	S9999		

started it has stayed the same.
-Mental status: Altered level of consciousness
-Code Status: Full Code

On 1/2/24 at 9:59 AM, V11 [R2's Family Member] stated, "On 12/25/23 at 6:30 PM, I received a call from the hospital acute care unit nurse. She said R2 arrived on 12/24/23 around 1:30 AM, in respiratory failure, and low blood pressure. I was informed R2 arrived at the emergency department very sick. I stayed at the hospital with him, and on 12/26/23, R2 passed away. I left the hospital and went to the nursing facility for answers. I spoke with V1 [Administrator] and V2 [Director of Nursing], they told me on 12/23/23 around 9:30 PM, the nurse noted R2 with low oxygen levels, started on oxygen, R2 was stable and sent to the hospital emergency department. V1 and V2 said V22 [R2's Physician] gave an order to send R2 to that specific hospital emergency room and the nurse[V7] and ambulance service company followed the physician order. I expressed to V1 and V2, they made no common sense to me. If R2 was stable, then why did the physician give the order to send a stable resident to the hospital emergency department. From the nursing home facility which is located on the north side of Chicago and transported R2 to a south side of Chicago hospital which was 19 miles away from each other, bypassing several closer hospitals that was terrible. R2 arrived at the hospital over 4 hours later in respiratory failure. V1 and V2 seems not to understand, a delay in transport means a delay in R2 receiving medical treatment, just maybe R2 would still be alive, all V7 had to do, was call 911."

On 1/3/24 at 12:36 PM, V7 [Registered Nurse] stated, "I have been a registered nurse for twelve years. I am familiar with R2. Some of R2's

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 01/31/2024

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 5	S9999		

medical diagnosis was asthma, high blood pressure and on renal dialysis due to kidney failure. I was R2's nurse on 12/23/23. Around 8:30 PM, I noted R2 was lethargic but arousable sometimes, like he was sleeping and hard to wake him up, and R2 would not stay woke for long. R2 had continuous hiccups sound like making gasping air sounds. R2's oxygen level was around 80 to 83% on room air, I started oxygen at 4 liters per nasal cannula and R2's oxygen level increased to 96%. However, R2's skin was gray in color, wet and sweaty. At 9:15PM, I called V22 [R2's Facility Physician] and received an order to send R2 to the hospital for an emergency room evaluation. I completed all R2's needed paperwork and then I phoned V2 [Director of Nursing], V11 [R2's Family Member] there was no answer, so I left a voice mail. Next, I phoned the facility's contracted ambulance company around 9:20 PM, for R2's transport to the emergency room. The ambulance company told me there would be a two-to-three-hour estimate time of arrival. I phoned the hospital emergency department and gave report to the registered nurse. I did not call V22 or V2 to notify them that transport was not available for at least two-to three hours. I monitored R2 closely to make sure he was okay." [Surveyor asked V7 why she [V7] noted R2's vital signs and monitoring noted in the chart four days later (dated 12/27/23 at 17:58), and how did she remember the exact times and vital signs readings that was documented in R2's chart] V7 stated, "I did not place the note in on 12/27/23, I completed the note on 12/23/23."
Surveyor explained the late entry was shown effective date was 12/23/23 at 21:45 [9:45 PM], but the note create date was 12/27/23 at 17:58 [5:58PM]. V7 stated, "Oh Wow, I did not know you could see the note was typed on 12/27/23,

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 01/31/2024

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 6	S9999		

this is too much. I don't know why I placed the note in four days later, you need to ask V2 [Director of Nursing] why I placed in the note four days later and where I got the vital signs from, I have nothing else to say."

On 1/23/24 at 11:06 AM, V7 [Register Nurse] stated, "I observed R2 with a change in condition around 8:30PM. R2 was making continuous hiccups sounds, skin was looking greyish and moist, heart rate was elevated, oxygen saturation levels were between 82-90%. R2 was not stable, he was in respiratory distress, that's why I administered [R2] 3 liters of oxygen per nasal canal and completed a change in condition assessment. R2's oxygen level went up to 96% while on 3 Liters of oxygen, he looked better, but his hiccup sounds continued. I received the physician order to send R2 out the hospital emergency department around 9:15 PM and called the ambulance company right away for transport. I don't why the ambulance report sheet documents I called at 10:26 PM, I'm pretty sure I called right away, I don't remember the time I called. The ambulance company told me it would be a 2-to-3-hours estimate time of arrival. I did not notify the physician [V22] or director of nursing [V2] of the estimated time of arrival from the ambulance, because I felt that R2 was okay to wait 2 to 3 hours to be transported. I monitored R2 closely, about every hour. My late entry progress effective date of 12/23/2023 at 21:45:00 [9:45 PM], was placed in R2 clinical record on 12/27/2023 17:58:29, the oxygen saturation levels were charted, I forgot to put the amount of oxygen R2 was receiving. R2 was receiving 3 Liters of oxygen. When any resident has a change of condition it is up to the individual nurse how often the resident is monitored. I had to check on my other residents as well and I was

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	IL6002075	A. BUILDING: _____ B. WING _____	C 01/31/2024

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 7	S9999		

busy providing care to other residents."

On 1/23/24 at 1:27 PM V24 [Basic Emergency Medical Technician (BEMT)] stated, "Upon arrival to facility V7 gave me report on R2 and said R2's oxygen had dropped down to 92% and administered oxygen per nasal cannula, and R2 had excessive hiccups for a few days. Upon my assessment R2 was in bed sitting up, R2 was lethargic, incoherent, unable to speak clearly, increase in heart rate and wheezing in bilateral lungs. V7 told me that was R2's base line orientation and vital signs, but the oxygen was new. V7 did not tell me in report that R2's oxygen earlier had dropped to 82%. If I would have received that information in report, I would have called our advance life support, if they were too far out the I would have called 911 and stayed with R2 until 911 arrived. V23 [Basic Emergency Medical Technician (BEMT)] and I are not trained to provide advanced life support. R2 needed to be placed on a cardiac monitor, and intravenous line accessed. Once a person oxygen drops down that low, they are in respiratory distress even if the oxygen came back up with supplemental oxygen."

On 1/23/24 at 1:01 PM, V23 [Basic Emergency Medical Technician (BEMT)] stated, "V24 [Basic Emergency Medical Technician] and I arrived at the facility. R2 was alert and oriented x1-2, V7 said R2's normal orientation was x2-3, he had a decrease in alertness. R2 was trying to communicate but was not coherent. R2 was receiving 2-3 liters of oxygen per nasal cannula upon our arrival. R2's blood pressure was reading low, and V7 said R2 usually have a low blood pressure and that was his baseline. Due to V7 telling V24 and I that R2 was at his baseline, we felt comfortable transporting R2. V24 and I are

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	IL6002075	A. BUILDING: _____ B. WING _____	C 01/31/2024

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 8	S9999		

BEMT, meaning we provide basic support, such as oxygen, and to monitor the residents' basic vital signs."

On 1/3/24 at 11:32 AM, V12 [Contracted Ambulance Company-Assistant General Manager] stated, "According to R2's "Patient Care Report" dated 12/23/23. The facility staff nurse phone dispatch on 12/23/23 at 22:26 [10:26 PM] and requested ambulance service to a specific emergency room department per physician order. Facility nurse was made aware there would be a two-to-three hour wait for transport. The ambulance arrived at the facility on 12/24/23 at 00:25 [12:25 AM]. The ambulance crew was in direct contact with the resident at 00:30 [12:30 AM. The ambulance left the facility at 01:02 AM. R2 arrived at the hospital emergency room at 1:38 AM.
[V22 gave physician order to send R2 to the hospital at 9:15 PM, V7 phoned the Contract ambulance company at 10:26 PM, noted a one-hour delay to call for ambulance transport. At 1:38 AM, R2 arrived at the hospital 4-hours later diagnosed with acute respiratory failure.]

On 1/4/24 at 12:22 PM V26 [Register Nurse (In house Contracted Dialysis Unit)] stated, "I am very familiar with R2. He [R2] receive dialysis five times per week, Monday thru Friday. On 12/23/23 was on a Saturday, R2 did not receive dialysis on that day. R2 last day he received dialysis was on 12/22/23, and he tolerated dialysis well, and all vital signs were stable before and after dialysis. According to R2 clinical dialysis record, there is no documentation that R2 has ever needed oxygen during dialysis treatments. Vital signs such as blood pressure, heart rate, respirations, oxygen saturations, and temperature are monitored before, during treatment every fifteen

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	IL6002075	A. BUILDING: _____ B. WING _____	C 01/31/2024

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 9	S9999		

minutes and after dialysis treatment. All of R2's vital signs were stable on the last day he received dialysis 12/22/23."

On 1/4/24 at 1:43 PM, V2 [Director of Nursing] stated, "On 12/26/23 R2's family member V11 came into the facility yelling, crying, and very upset that R2 had expired. I calmed her and we sat down in the conference room to talk. V11 was upset that R2 was transported so far away from the facility bypassing several other near hospitals. I explained nurses follow the physician orders and send the resident where the physician request the resident to be sent unless it is a 911 situation. When any resident is at their "baseline" that means they are at their normal status, they are stable. R2 was not on oxygen according to his chart. On 12/23/23 R2 was given 4Liters of oxygen because he was noted with a low oxygen level. Once R2 received oxygen, is became stable. No, it was not R2's baseline to receive oxygen, but I asked V7 twice, was R2 stable and she told me yes. I have not spoken to V22, I do not know why he did not order the mobile services, since R2 was stable. If R2 had a change in condition, then V7 knew to call 911. I am not sure why V7 said to ask me why she [V7] placed in a progress note on 12/27/23, with times and vital signs for 12/23/23. I did not tell V7 to place in a progress note four days later after the event, nurses have 72-hours to place in a late entry. V7 should have documented at the times she [V7] assessed and monitored R2 with the times and vital signs readings. V7 did not notify me that there was a three hour wait before the ambulance could transport R2."

On 1/23/24 at 2:52 PM, [Telephone Interview] V2 stated, "On 12/23/23, V7 called me after all measures was in place. V7 told me R2's

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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 10	S9999		

assessment, and after applying the oxygen R2 was stable, so I did not recommend V7 to call 911. During an acute change of condition, R2's vital signs should've been taken a few times within each hour, even if he [R2] became stable, to ensure R2 remained stable. R2'S vital signs should have been documented soon as possible in the resident's progress notes."
[Surveyor read the policy to V2-The change of condition policy reads in part; a significant change in condition is a decline, that will not normally resolve itself without interventions by staff or clinical interventions and during medical emergencies such as unstable vital signs, or respiratory distress 911 will be notified for transport.] V2 stated, " I understand the policy, however, once R2 was receiving 4 liters of oxygen he became stable, and V7 should not have phoned 911. The change of condition policy was not followed in terms of calling 911, that was because R2 became stable, there was no reason to call 911. The ambulance company said it was going to be a 2 to 3hour wait, but V7 knew to call 911 if R2 was not stable."

On 1/5/24 at 12:23 PM, V22 [R2's Facility Physician] stated, "Baseline means any resident is at their highest level of functioning, residents are stable at their baseline. On 12/23/23, V7 phoned me and said R2's oxygen level dropped a little like 91 to 92%, V7 administered oxygen, and R2 was now stable. I gave an order to send R2 to a specific hospital emergency room because that is the hospital where R2's primary care physician is on staff, and I told V7, if R2's condition changes to call 911. I did not order the facility's mobile services, because due to R2's medical history with asthma, I felt he needed to assess by a physician sooner than later. Some residents with low oxygen levels may require intubation."

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 01/31/2024

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 11	S9999		

[Surveyor read V7's progress note dated 12/23/23 at 21:30 to V22.] V22 stated, "Oh my goodness, V7 absolutely did not tell me that R2 was lethargic, continues hiccups, elevated heart rate, oxygen saturation in the 80's, skin color was not good, and skin was moist. I would have called 911 myself. I would have told V7 to call 911 for immediate care, treatment, and transport. V7 did not notify me that the ambulance service was going to be two-to-three hours getting to the facility. V7 should have called 911 for R2, he was not stable. I am so sorry that R2 expired. V7 did not tell me all the information stated in her [V7] progress note (12/23/23 at 21:30), V7 should have called 911."

On 1/3/24 at 11:18 AM, V1 [Administrator] stated, "On 12/26/23 V11[R2's Family Member] came into the facility very upset. Requesting information regarding the ambulance run sheet. I called V12 [Contracted Ambulance Company-Assistant General Manager] and went over the details. V12 emailed me a copy of the report. Corporate told me I could not give V11 a copy, she had to obtain her own copy from the ambulance company. I don't understand what the problem is, the ambulance sheet stated, that R2 was stable on the first sentence, that says it all."

Facility Policy: Change in Resident's Condition or Status [No Date]. Document in part:
-A significant change in condition is a decline that will not normally resolve itself without intervention by staff or clinical interventions
-The Nurse will notify the resident's attending physician when there is a significant change in the resident's physical, mental or psychological status.
Except: In medical emergencies, notifications will be made within 24-hours of a change occurring in

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 01/31/2024

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 12 the resident's condition or status. During medical emergencies such as unstable vital signs, respiratory distress, uncontrolled bleeding, and unresponsiveness 911 will be notified for transport to the hospital. Facility Registered Nurse Job Description: documents in part: -The registered nurse provides direct nursing care to the residents, carrying out the assigned duties and responsibilities in accordance with current existing federal and state regulations -Chart nurse notes in an informative and descriptive manner that reflects the care provided to the resident -Notifies the resident attending physician when there is a change in the resident's condition -Must be able to relate information concerning resident's condition (A)	S9999		