STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145730	A. BUILDING _____ B. WING _____	**03/05/2020**

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0677 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** Based on interview and record review the facility failed to follow their policy to provide weekly showers for one resident (R6) of three residents (R5 and R7) reviewed for activities of daily living. Findings include: 3/3/2020 at 12:55 PM, R6 said, I don't get a shower every week. I sometimes get bed baths instead of a shower if there is not a second person to help with the (mechanical) lift. The Skin Check/Shower Worksheets for 1/12/2020 and 1/19/2020 for R6 are not marked that a shower was given. 3/5/2020 at 12:10 PM V3 (Assistant Director of Nursing) said, the CNAs (Certified Nursing Assistants) should check the sheet when the shower is given. Residents should get a shower once a week. There should be enough staff to help the assigned CNA with the lift. There are two nurses on the floor or a second CNA to help with the lift. R6 should be getting showered every week. The Minimum Data Set for R6 is coded 3/3 for bathing which means that she needs extensive physical assistance. The Care Plan reads bathing total two person. Policy, Shower and Baths (dated 2018) includes: 1) Showers will be given per resident preference at minimum of 1 per week and they are on the schedule for 2 days per week and as often as they desire.

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.