STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145778	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midway Neurological / Rehab Center	8540 South Harlem Bridgeview, IL 60455

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40066 Based on interviews and records reviewed the facility failed to notify 1 resident (R11) of 3 in writing prior to performing a room change. The findings include: R11 diagnosis include, but not limited to Chronic Pain Syndrome, Bipolar Disorder, Psychotic Disorder, Depression, and Suicidal Ideations. R11's cognitive patterns assessment dated [DATE] states score of 15, cognitively intact. On 4/11/24 at 9:40AM V28 (Social Services) said on 12/4/23 we were doing a room change for R11. V28 said I think R11 may have had a behavior and so he was being moved. On 4/12/24 at 12:24PM V14 (Social Services Director) said we do not give the residents a copy of the written room change notice. On 4/12/24 at 1:53PM R11 said they didn't give me any notice or paper that I was moving. They just said you're moving. R11 said I never said I wanted to move. R11's Progress notes dated 12/4/2023 states resident continued to disrupt the common area of the unit. Resident was then transferred to second unit to reside. R11's Notification of room change form effective date 12/5/2023 date of change 12/4/2023 from room X to room X, on different units. This form is completed the day after the room change. The facility undated policy Resident Right -Choose/Be Notified of Roommate Change States the resident has the right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility changes.

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.

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40066 Based on interview and record review the facility failed to prevent incidents of staff to resident verbal/mental abuse. This affected four of four (R10, R21, R22, R23) residents reviewed for abuse. The findings include: 1.On 4/10/24 at 10:59AM R10 said the staff say I don't need help with anything, but they can be nice to me. R10 said they talk about me, saying I'm not blind. I'm blind I need help. R10 said V20 tells them (other staff) that I don't need help, that I can do things myself. R10 said V20 makes everything harder for me. R10's diagnosis include, but are not limited to Schizoaffective Disorder, Schizophrenia, Chronic Obstructive Pulmonary Disease, Type 2 Diabetes Mellitus, Tourette's Disorder, Generalized Anxiety Disorder, Blindness, One Eye, Psychosis, Conduct Disorder, and Depressive Disorder. R10's cognitive patterns assessment dated [DATE] indicates a score of 15, cognitively intact. 2.On 4/12/24 at 9:34AM R21 said V20 (Registered Nurse/RN) laughs at other patients. R21 said V20 is my nurse but is not here today. R21 said V20 says we are stupid, crazy, or she won't help us. R21 said V20 has a bad attitude. R21 said we talked about it at a meeting. R21's diagnosis include but are not limited to Major Depressive Disorder, Weakness, Anxiety Disorder, and Unspecified Psychosis. R21's cognitive patterns assessment dated [DATE] indicates a score of 15, cognitively intact. 3.On 4/12/24 at 9:45AM R22 said V20 has been her nurse. She is not nice, arrogant, she has a problem with everyone. R22 said we told them at the (resident) council meeting. R22's diagnosis include but are not limited to Epileptic Seizures, Schizoaffective Disorder, Bipolar Type, Weakness, Major Depressive Disorder, Generalized Anxiety Disorder, and Suicidal Ideations. R22's cognitive patterns assessment dated [DATE] indicates a score of 14, cognitively intact. 4.On 4/12/24 at 9:50AM R23 said V20 talks down to us, like she is authoritative over us. She argues with us, that triggers a lot of us, we have Mental illness, or some are just crazy. She used to be my nurse, but not anymore. We told them at the (resident) council meeting that she is mean to us. R23's diagnosis include but are not limited to Bipolar Disorder, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Type 2 Diabetes Mellitus with Diabetic Neuropathy, Atrial Fibrillation, and schizoaffective disorder. R23's cognitive patterns assessment dated [DATE], indicates a score of 15, cognitively intact. The February 26, 2024 resident council meeting includes residents in attendance R21, R22, and R23 resident council president. Section titled new issues/concerns/ complaints nursing V20 (by name) is mean. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/12/24 at 10:35AM V36 (Activity Director) said normally, following Resident Council, any nursing concerns are taken to the Director of Nursing (DON). V36 said the supervisor of the department is expected to handle the concerns. On 4/12/24 at 11:15AM V13 (DON), said I met with R24 following the February Resident Council, because she is the one that started saying that V20 is mean. V13 said R24 said nurse V20 was mean. V13 said V20 is not mean she is just firm with the residents and R24 was upset she was asked to stop pushing the wheelchairs with other residents in them. V20 said R24 was just being mad. V20 said none of this was documented. V13 said if an investigation was needed after a concern from resident council, then I would have investigated. V13 said I spoke with R24 and V20 about it. V13 said V20 has been investigated before. The surveyor noted that R24's name does not appear on the February 2024 Resident Council meeting notes. On 4/12/24 at 1:14PM V5 (Administrator) said I am the abuse coordinator. V5 said verbal abuse would be saying something derogatory towards the patient, calling them a name, or anything considered disrespectful. V5 said mental abuse is the same way, emotional saying things that are derogatory, mocking them, making fun of them, or insulting them. V5 said it is my job to determine if there is abuse and I work with department managers to gather all information. V5 said for allegations I would interview staff and resident witnesses. V5 said staff being mean could be an allegation or concern. V5 said I would meet with the employee, and I would ask the residents for more details. V5 said since being notified, I reported what R24 said about V20, based on interview with the surveyor. V5 said I met with V20 in February, and she was counseled, it was more of a concern in February. During the survey there was no concern form presented from R24 alleging V20 is mean dated February 2024. The facility Abuse Prevention Program Policy and Procedure dated 11/21/20 defines abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm or pain or mental anguish or deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintained physical, mental psychosocial well-being. Verbal abuse any use of oral, written or gestured language that includes disparaging and derogatory terms to residents or their families, or within their hearing distance, to describe residents, regardless of their age, ability to comprehend or disability. Mental abuse including, but not limited to humiliation harassment, threats of punishment, or withholding of treatment or services.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40066 Based on interview and record review the facility to prevent the loss of a resident's funds during a room change. This affected one of three residents (R11) reviewed for misappropriations of funds. The findings include: R11 diagnosis include, but not limited to Chronic Pain Syndrome, Bipolar Disorder, Psychotic Disorder, Depression, and Suicidal Ideations. R11's cognitive patterns assessment dated [DATE] states score of 15, cognitively intact. On 4/10/24 at 10:35AM R11 said I gave V6 (Social Services) my locker key. I had $1332.00 in the envelope and when V6 brought it to me, there was only $532.00 there. R11 said I told V6 to bring the envelope in the pocket of my coat in my locker. R11 said I asked V6 about the money and he said you aint getting that back. V6 said the facility said they investigated. They blamed it on me. V6 said I had the money from a $1900.00 check I had received. V6 said I can't spend it. R11 said V22 cashed the check for me. R11 said it started because V32 (Prior Administrator) instructed them to do a room search. R11 said then they said they were moving me. On 4/12/24 at 1:53PM R11 said the envelope was a regular white envelope, no window on it, and it was not sealed, it was never sealed. R11 said I left it open to add and remove money. R11 said during the room change he was made to stay in the dining room. R11 said I never denied the money or that it was taken, they just said you're not getting any money. On 4/10/24 at 1:45PM V22 (Business Office Manager) said R11 received a check, and we cashed it for him. V22 said R11 does his own funds. V22 said if the resident has any issue with their money, they are redirected to the social service person. V22 said we never give more than $100 in cash at a time to the resident. On 4/11/24 at 9:40AM V28 (Social Services) said we were doing a room change for R11 not a room search. V28 said V6 (Social Services) and I were told to do the room change. V28 said later the police came, for some money missing. V28 said after we moved him, I went back upstairs, and then I was called because R11 alleged money was missing. V28 said my boss called me to speak with V6 and R11. V28 said R11 was in his room while we did the room change and then he came down to the new floor and watched us put his belongings in his new room. V28 said R11 was agitated at the time of the room change. V28 said V6 was helping me with the room changing. V28 said I only saw R11 clothes and personal hygiene bags. V28 said I didn't have an envelope. V28 said I don't remember anything about the envelope being given to R11. On 4/11/24 at 10:04AM the surveyor read the facility investigation related to R11 to V4 (Security Staff). V4 said I never witnessed that. V4 said I have never heard R11 accuse anyone of stealing. V4 said I never spoke to the police about R11. V4 said I never saw a white envelope. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/12/24 at 11:15AM V14 (Social Service Director) said on 12/4/23 when I came in they were already in the process of moving R11. V14 said V28 and V6 were helping to move R11. V14 said the police came to meet R11, because R11 called them, and he alleged he was missing money. V14 said I walked the officer up to R11, he was in the dining room, sitting in a chair and security was present. V14 said this was the first I heard about the missing money. V14 said R11 alleged V28 and V6 took the money, because they were the ones that helped move him. V14 said there were no findings to the investigation, there was no proof of that amount of money that R11 had. V14 said R11 is only allowed $100.00 at a time, and he spends his money. V14 said R11 spends his money ordering food and buying cigarettes. V14 said I saw a white envelope in R11's hand, it was not torn and open. V14 said R11 didn't count the money in front of me. On 4/11/24 at 2:30PM V13 (Director of Nursing) said R11 gave V6 the key and then V6 went up to get the money, and returned and gave R11 a sealed envelope. V13 said V6 gave R11 the envelope, but R11 did not open it. V13 said R11 was accusing V6 of taking the money. V13 said I did not see the envelope. V13 said R11 was saying something about the weight in the envelope. V13 said they asked R11 for proof of the money, but R11 wasn't able to provide proof. V13 said we have vending machines, R11 may have used the money for something. V13 said R11 never accused anyone of taking his money prior and not since. On 4/11/24 at 2:59PM V6 (Social Worker) said R11 told me to get his envelope from his left coat pocket in his closet. V6 said R11 was in the dining room, and he requested I retrieve the envelope for him. V6 said I was given the directive from V32 (Prior Administrator) to move R11. V6 said at the time R11 gave me the key is when he said about the jacket pocket. V6 said R11 said it was an envelope with money. V6 said V28 never touched the envelope. V6 said all I got was the money during the move. V6 said the closet was locked when I got there. V6 said the envelope was a standard white mailing one, no clear window, nothing written on it. V6 said R11 acted like he was weighing the envelope when he gave it to him. V6 said I said to R11 the envelope was sealed, licked shut. V6 said R11 didn't open and count the money. V6 said someone called 911 and I spoke with the officer. V6 said I did not see R11 have any behaviors that morning and I was not aware of any words exchanged and or behaviors that day. No witness or documentation of R11 counting the money at the time of the allegation was documented or found. Census review for R11 shows a room change on 12/4/24. R11's financial fund management record reviewed with V22. R11 had 2 deposits in the amount of $1400.00 and $1951.19 in 2023. From June 2023 to December 2023 R11 had withdrawn $2052.00. (It is possible R11 had unspent money in his possession.) R11 ' s abuse investigation initiated on 12/4/23 includes record that V4 directed R11 out of the area and notified the nurse and the administrator to report the allegation. (V4 's Interview is different than report.) Report alleges V28 witnessed V6 with the envelope and delivered it to R11 with V6. (V28's interview is not the same as the statement. V28 told surveyor I don't remember anything about the envelope being given to R11.) Abuse investigation alleges R11 recanted his allegation. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	V32 completed the report and is no longer employed at the facility. Police report dated 12/4/23 at 10:15AM was obtained and reviewed. Police report indicates crime incidents, theft over $500. Police report notes R11 presents alert and coherent. R11 reported that $800.00 were missing from the envelope. Report states R11 stated he saves his $100.00 stimulus payment every month and had $1300.00 in the envelope prior to turning his key over to V6. The officer asked V14 about R11's spending habits at the facility, R11 replied I only buy cigarettes and you know that. The officer asked who handled the black leather jacket and V6 raised his hand and said he did. The facility provided a documented signed by V5 (Administrator), R11, and V24 Social Services) dated 4/23/24. The document states, in part, in an effort to resolve a matter pertaining to my missing money dating back to 12/4/23 I have agreed to the following terms suggested as a final resolution to this matter: $400 to be paid out equally $100 over four months in retail purchases of my choice. The facility Abuse Prevention Program Policy and Procedure dated 11/21/20 includes misappropriation of resident property is the deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a resident's belongings or money without the resident's consent.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40066 Based on interviews and records reviewed the facility failed to report an allegation of abuse to state surveying agency. This failure affected 4 of 4 (R21-R24) residents reviewed for abuse reporting. The findings include: 1.On 4/12/24 at 9:34AM R21 said V20 (Registered Nurse) laughs at other patients. R21 said V20 is my nurse, but not here today. R21 said V20 says we are stupid, crazy, or she won't help us. R21 said V20 has a bad attitude. R21 said we talked about it at a meeting. R21's diagnosis include but are not limited to Major Depressive Disorder, Weakness, Anxiety Disorder, and Unspecified Psychosis. R21's cognitive patterns assessment dated [DATE] indicates a score of 15, cognitively intact. 2.On 4/12/24 at 9:45AM R22 said V20 has been her nurse. She is not nice, arrogant, she has a problem with everyone. R22 said we told them at the (resident) council meeting. R22's diagnosis include but are not limited to Epileptic Seizures, Schizoaffective Disorder, Bipolar Type, Weakness, Major Depressive Disorder, Generalized Anxiety Disorder, and Suicidal Ideations. R22's cognitive patterns assessment dated [DATE] indicates a score of 14, cognitively intact. 3.On 4/12/24 at 9:50AM R23 said V20 talks down to us, like she is authoritative over us. She argues with us, that triggers a lot of us, we have Mental illness, or some are just crazy. She used to be my nurse, but not anymore. We told them at (resident) council that she is mean to us. R23's diagnosis include but are not limited to Bipolar Disorder, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Type 2 Diabetes Mellitus with Diabetic Neuropathy, Atrial Fibrillation, and schizoaffective disorder. R23's cognitive patterns assessment dated [DATE], indicates a score of 15, cognitively intact. The February 26, 2024 resident council meeting includes residents in attendance R21, R22, and R23 resident council president. Section titled new issues/concerns/complaints nursing V20 (by name) is mean. On 4/12/24 at 11:15AM V13 (Director of Nursing) said I met with R24 following the February Resident Council, because she is the one that started saying that V20 is mean. V13 said R24 said nurse V20 was mean. V13 said V20 is not mean she is just firm with the residents and R24 was upset she was asked to stop pushing the wheelchairs with other residents in them. V20 said R24 was just being mad. V20 said none of this was documented. V13 said if an investigation was needed after a concern from resident council, then I would have investigated. V13 said I spoke with R24 and V20 about it. V13 said V20 has been investigated before. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The surveyor noted that R24's name does not appear on the February 2024 Resident Council meeting notes. On 4/12/24 at 1:14PM V5 (Administrator) said I am the abuse coordinator. V5 said verbal abuse would be saying something derogatory towards the patient, calling them a name, or anything considered disrespectful. V5 said mental abuse is the same way, emotional saying things that are derogatory, mocking them, making fun of them, or insulting them. V5 said it is my job to determine if there is abuse and I work with department managers to gather all information. V5 said for allegations I would interview staff and resident witnesses. V5 said staff being mean could be an allegation or concern. V5 said I would meet with the employee, and I would ask the residents for more details. V5 said since being notified, I reported what R24 said about V20, based on interview with the surveyor. Review of the facility Abuse Investigations did not include an allegation from R24 towards V20 in February 2024. The facility Abuse Prevention Program Policy and Procedure dated 11/21/20 states all incidents, allegations, or suspicion of abuse, neglect, exploitation, or misappropriation of property will be documented. Any incident or allegation involving abuse, neglect, exploitation, or misappropriation of resident property will result in an abuse investigation. Employees are required to immediately report any incident, allegation or suspicion of potential abuse, neglect, exploitation, misappropriation of resident property, or mistreatment they observe or hereabout or suspect to the administrator. Supervisor shall immediately inform the administrator or the DON of all reports of incidents allegations or suspicion of potential abuse. Upon learning of the report, the administrator or the DON shall initiate an incident investigation. A completed copy of the incident report and written statements from the witness, if any, will be provided to the administrator within 24 hours of the occurrence of such incident.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38796 Based on interview and record review the facility failed to develop an individualized plan of care for a resident identified to be at risk for aspirations and assessed to have impairments while eating. The facility also discharged resident from speech therapy before reaching the short-term goals identified in evaluation. This affected one of one resident (R13) reviewed for safe oral intake. This failure resulted in R13 becoming unconscious, CPR (cardiopulmonary resuscitation) being initiated, excessive amount of food found in R13's airway, and resident being admitted to hospital. Findings include: R13's face sheet shows diagnosis of alcohol dependence with alcohol induced persisting dementia, induced by alcohol dependence, heart failure, atherosclerotic heart disease of native coronary artery. R13's MDS (Minimum Data Set) dated [DATE] section C for cognition denotes a score of 9 (cognitive impairments). Section G for functional status denote in part eating, self-performance is extensive assist (resident involved staff provide weight bearing support), support denotes 2 (one-person physical assist). Police report dated [DATE] denotes in-part ambulance call, to nursing home name listed, victim is R13, date of birth noted, other individual denotes V40 name and date of birth, call in at 12:34pm, In brief on [DATE] at 12:34 pm, r/o (responding officer) was dispatched to (facility address noted) 4th floor (facility name noted) in regard to an ambulance call. Upon arrival r/o spoke with V40 Nurse (name is noted in police report) advise that patient identified as R13 was observed on the ground in the hallway in the middle of the hallway unresponsive and not breathing. Staff immediately began CPR (cardiopulmonary resuscitation) on R13 and called paramedics. R13 was seen eating lunch prior to this incident and believed that may have been choking. FD (fire department) arrived on scene and began working on patient. Patient was transported to (hospital name) for further treatment. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	R13's emergency room records denote in-part, prior to seeing patient review of triage note, vitals. This is a [AGE] year-old male presenting as a cardiac arrest, patient was at the nursing home today was eating lunch walked out of the dining room, had jerky movements was lowered to the to the ground, turned blue, arrested. Patient often walked around all day long, staff did CPR for 10 minutes. EMS (emergency medical services) arrived and did additional 20 minutes of CPR. Patient initially pulseless, had 2 defibrillations for ventricle tachycardia. He receives epinephrine 4 times prior to arrival and his second shock was just prior to arrival. On arrival his first pulse check he had a pulse. Patient had a LMA (laryngeal mask airway) placed. They noted in route that there was some foreign material in his airway, but they were able to bag with that with slight difficulty. Resuscitation cardiac arrest. I spoke with patient's sister and nursing home. Per the family patient was at the nursing home, he has dementia in the setting of alcohol abuse. He was eating in the dining hall, got up and walked out to the hallway. Began to have choking, staff came to assist, they lowered him to the ground where he continued to choke and went unresponsive and turned blue. He started CPR. Suspected hypoxic arrest. Here with occlusion of airway, able to bag with removal of significant foreign body. Impression and plan; cardiac arrest. Chief complaint; cardiac arrest. R13 is a [AGE] year-old at (nursing home name) presenting for cardiac arrest. History per EMS (emergency medical services), NH (nursing home) staff, chart review based on clinical condition. Per EMS, they were called for cardiac arrest to NH. Witnessed, bystanders EMS chest compressions. There were concerns about a choking episode. EMS removed a significant amount of food from his airway upon arrival. They placed a supraglottic device. They were able to use BVM (bag valve mask) without resistance. Downtime prior to EMS arrival at the nursing home was 12 minutes. EMS remained on scene for 19 minutes. They administered a total of 3 rounds of epinephrine. Initially patient was PEA, asystole. V-fib, PEA, V-fib, PEA. A total of 3 rounds of epinephrine. Two defibrillations. Antiarrhythmics not given. Normal accu-check. Patient arrives to us with I-gel in place. Repeated accu-check in the 200s. Definitive airway established, see MDM. Additional history obtained from nursing home staff. Patient has resided at nursing home x 4 years. He is admitted for severe alcohol induced dementia. The patient was in the dining room, ate lunch. Walked out of the dining room into the hallway and started making chocking noises. They immediately went to attend to him and then the patient collapsed, was cyanotic. CPR was initiated. Full code. ED course, based on history and airway findings, concerns for aspiration event, hypoxia, cardiac arrest. ED diagnosis; cardiac arrest. R13 fire department report dated [DATE] denotes in part in summary: was dispatched to the nursing home to assist fire department for [AGE] year-old male for the reported cardiac arrest, U/A (upon arrival) to the scene pt (patient) was found lying supine on the ground unresponsive, pulseless, and apneic with (fire department) crew actively performing CPR with BVM (bag valve mask) ventilation. Healthcare staff on scene stated the patient was eating when he walked into the hallway gasping for air and was witnessed collapsing to the ground inro cardiac arrest. Nursing home staff originally began CPR and applied AED, patient had been down approximately ten minutes when crew arrived. When visualized the vocal cords via laryngoscope crew noted an excessive amount of food in the patient's airway. Crew began to remove the debris, via forceps from patient airway intermittently between ventilations. Number 4 I-gel inserted after vocal cords were still unable to be visualized due to aspiration, confirmed by other crew members. Continues CPR began. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145778	A. Building B. Wing	05/03/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 10:56am V40 (Licensed Practical Nurse/LPN) said she was in the dining room when she observed R13 with jerky movements. V40 said she went over to R13 and R13 became unconscious. V40 said a code blue was called and R13 was lowered to the floor. V40 said R13 did not have a pulse nor did R13 have any respirations. V40 said she don't know why she was in the dining room; she just knows she was there. V40 said she don't know how long she was in the dining room. V40 said she did not see R13 eat his lunch. V40 said R13 was finished with lunch when she observed him. V40 said she don't remember if R13 needed assist with meals. V40 said she don't know who she told to call a code blue; she doesn't know who she told to call 911. V40 said she don't know if R13 had issues with chewing or swallowing, she doesn't know if R13 had all his teeth. V40 said she started chest compression on R13 when R13 was observed unconscious. V40 said she may have talked to the paramedics when they arrived on the scene. V40 said she did not tell the medics that R13 was found in the hallway unconscious. R13 Fire department report reviewed with V40. V40 said she don't know why the paramedics stated that in their report. V40 denied telling the paramedics that R13 was in the hallway collapsed. V40 said sometimes the hospital do call the facility when they want more information on the resident. V40 said she don't remember if she talked to the emergency room regarding R13. V40 denied knowing if R13 was at risk for choking, V40 denied that R13 was at risk for aspiration. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 1:38pm V43 (Certified Nursing Assistant/CNA) said she was R13's aide on [DATE]. V43 said R13 spoke Spanish but was able to understand English when she communicated with him. V43 said she passed R13 his tray lunch tray on [DATE], but she did not assist R13 with his meal. V43 said she only cut R13's food up. V43 said she was in the dining room doing a one-to-one observation with a resident that was experiencing a behavior episode. V43 said lunch was over, trays had been picked up. V43 said she looked over and saw R13 shrugging his shoulders. V43 said she did not hear R13 making any coughing sounds. V43 said she thought R13 was exercising. V43 said V40 was in the dining room, and she got V40 attention and told her to check on R13. V43 said V40 was in the dining room covering for another aide that was completing patient care at that time. V43 said V40 went to R13 and placed him on the floor from the chair. V43 said V40 told her to call code blue. V43 said she don't know who called 911. V43 said all the staff came to assist V40. V43 said she don't know who came, she doesn't recall. V43 said she don't know what happened after that because she was removing the resident from the dining room. V43 said she often worked with R13 and R13 did not need any assistance with meals. V43 said she has never assisted R13 with any meals. V43 said she only cut up R13's food (set up tray). V43 said she cut the food up because that's what they do for all the residents on the 4th floor because they have dementia. V43 said R13 does have dementia. V43 said some residents on the 4th floor be gobbling their food down, V43 said the residents eat fast. V43 omitted reporting her observations of residents gobbling there food down to the nurse or the Director of Nursing. V43 denied knowing if the resident that was gobbling their food down were at risk for aspiration. V43 said she only observed R43 being assisted with meals once. V43 said the residents were served pork on [DATE]. V43 denied that R13 was at risk for choking/ aspiration. During a follow up interview on [DATE] at 3:56pm V43 said she documented 3, 2 for eating for R13 on [DATE] for breakfast and lunch. Review of the documentation denotes 3 is for extensive assist, and 2 is for one-person physical assist. V43 said she thought she was documenting for set up only. V43 said she received training on documentation in the system. V43 said she knows the difference in extensive assist and set up because she helps R3 get dressed and R13 needs extensive assist with dressing. Review of V43 documentation for R13, denotes V43 documented 3, 2 for eating for R13 on multiple days that week for multiple meals. V43 then said R13 does need a lot of cueing when eating, V43 said R13 was constantly reminded to eat his food. V43 said she puts R13's hand on the spoon and guide R13 to put the food in his mouth also when she had to cue him. V43 described R13 would stop eating and began to stare, that's why he needs constant reminders to eat. V43 said she cuts R13's food up because he has dementia. V43 said V40 was responsible for monitoring the dining room on [DATE] and V40 was responsible to monitor the residents for safety. V43 said V40 was to monitor to make sure the residents were eating, monitor the residents for choking, and assist and cue the residents as needed. V43 said usually there are 3 to 4 staff (activity aides and social worker) monitoring the big dining room, and all CNAs would monitor the small dining room during meals times. V43 restated that she did not assist R13 with lunch on [DATE]. V43 denied that she spoke to the paramedics when the arrived at the facility on [DATE]. Review of the facility 4th floor dining room time for [DATE] denotes V40 name listed for the 12:30pm time. There is no name or time listed for the 12:00pm time. V43 name is listed for the 11:30am time. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 2:28pm V51 (Rehab Director) said R13 was referred to speech therapy on [DATE] for a swallow assessment due to weight loss and increased need for assistance/ cues required to complete meals for adequate and safe oral intake. V51 said she did not conduct the evaluation, V51 said she was not sure of some of the language in the evaluation and discharge summary. V51 agreeable to have a speech pathologist assist with review of R13's speech evaluation and discharge summary. On [DATE] V51 said R13 did not have dysphagia, and the diagnosis dysphagia is a treatment diagnosis to allow for the speech evaluation. V51 said R13's last speech treatment date was [DATE], and that [DATE] was not correct. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 12:25pm am V56 (Speech Pathologist) said she did not complete the assessment for R13 in [DATE] however was agreeable to review the evaluation and discharge summary. V51 was present. V56 said R13 was referred per MD orders and facility dietary tech for evaluation for swallow assessment due to recent decline in weight and increase need for assistance/ cues required to complete meals for adequate and safe oral intake. V56 said R13's evaluation denotes labial closure for solids, mild (difficulties). V56 described R13 had difficulties with bring the lips to a closure, R13 ate with his mouth open. V56 said R13 noted with rapid mastication (R13 ate fast). Bolus formation - moderate (difficulty). V56 said R13's evaluation denotes R13 was found to have swallow disorder involving the oral phase. Patient presents with mild oral dysfunction, evidenced by difficulty initiating oral stage, anterior spillage of solids, incomplete bolus formation, inadequate mastication/ rotary chew pattern, effortful mastication, oral residue, and poor attention to task. V56 said R13 had behaviors, the therapist documented R13 would get up walk away, R13 would eat fast. V56 explained that difficulty initiating oral phase could be getting R13 started with the meal, anterior spillage is food falling out the mouth, R13 had difficulty chewing the food and forming a bolus of the food (that's when chew the food and mixing it with saliva making it a bolus, inadequate mastication is inadequate chewing of the food, oral residue is when some food remains in the mouth after swallowing, and poor attention to task.) V56 said the recommendations was for dysphagia treatment. Supervision was distant supervision. Strategies to facilitate safety and efficiency, it is recommended the patient use the following strategies and or maneuvers during oral intake, general swallow techniques/precautions, alterations of liquids/solids and bolus size modifications, upright posture during meals and upright posture for greater than 30 minutes after meals, environmental modifications via reduction of distraction, setup and food cutting up assistance, supervision. V56 said general swallow techniques and precautions as listed. V56 described alternating between solids and liquids would be taking a sip of water/liquids after swallow food. V56 described cutting the food into small sizes would be bolus size modifications, sitting upright during meals and sitting up after meals for greater than 30 minutes would aide in digestion of food. During the evaluation short term goals are developed based on the identified issues. Review of R13's goals, patient will improve oral clearance during meals in response to cues/strategies provided by ST (speech therapist) and trained caregivers at 80% of opportunities. Patient will improve bolus control and labial seal to reduce bolus loss in response to cues/strategies provided by ST and trained caregivers at 80% of opportunities. Patient will improve attention to meals in response to cues/strategies and environmental modification provided by ST and trained caregivers. V56 said R13's discharge recommendations were that prognosis was good with consistent staff follow through. R13's recommended diet was regular texture, thin liquids, swallow strategies/position: to facilitate a safety and efficiency, it is recommended patient use the following strategies and maneuvers during oral intake; general swallow techniques/ precautions, alterations of liquids/solids, rate modification and bolus size modifications, upright posture during meals and upright posture for greater than 30 minutes after meals, meal intake in dining room. Supervision for oral intake; distance supervision. V56 said she don't know how the facility planned to ensure swallow techniques/precautions, alternating between liquids and solids, rate modifications and bolus size if the recommendation is distance supervision. V56 said the discharge report denotes R13 was discharged prior to meeting his goal for oral clearance at 80% of opportunities. V56 said R13 was discharged meeting goal at ,d+[DATE]% of opportunities. R13 did not meet his goal for improving bolus control and labial seal to reduce oral bolus loss in response to cues/strategies, and R13 continued to need for redirection and attention to meal. V56 said R13 was at risk for aspiration due to the swallowing difficulties identified, eating with mouth open, incomplete bolus formation, inadequate bolus control, inattention, fast eating, and difficulty with oral clearing. V56 said upon review of the evaluation and discharge, she would have questions as to why was R13 discharged before meeting his short-term goal. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On [DATE], V13 (Director of Nursing) said he was not at the facility during the code blue for R13. V13 said the nurse documented what happened. V13 was asked if R13 choked on food. V13 said the nurse documented what happened. V13 said the facility did not complete an incident report for R13. V13 said he is aware that R13 was admitted to the hospital for aspiration. V13 said he is aware that R13 expired. On [DATE] at 2:00pm V50 (Restorative Nurse) said she was the restorative nurse, she was not employed in 2023, review of R13's care with V50, V50 said R13 required extensive assist of one-person physical assist with meals. Review of R13's annual restorative review with V50, V50 said R13 required extensive assist with eating, support of one-person physical assist with eating. [DATE] at 1:57pm V10 (Prior Restorative Nurse) said she is familiar with R13. V10 said she was the restorative Nurse in 2023. V10 said R13 required extensive assist of one-person physical assist with meals. V10 said the staff should be assisting with feeding by sitting with R13, cutting up R13's food, cueing R13 as needed, assisting R13 with eating. V10 said the aides are aware of the level of care the resident need because it's listed on the (electronic) charting. V10 said the aides also document the level of assist that's provided during ADLs and eating in the (electronic) charting. On [DATE] at 2:20pm V52 (Assistant Administrator) said she completed R13's restorative assessment on [DATE] for R13. V52 said R13 needed extensive assist of one-person physical assist with eating. V13 explained that she was helping the Director of Nursing when she completed R13's assessment. V52 said she completed a physical assessment and she also review the 7-day look back for R13 and it was documented that R13 needed extensive assist of one-person physical assist greater than 3 times. V52 said the staff did not inform her of any issues, concerns with R13's eating abilities. R13's progress note dated [DATE] completed by V40 at 1:05pm denotes in-part resident was noted at approximately 12:30pm in the dining room and had finished eating (per staff), he started to have some jerky movements and was lowered by staff to the floor. Resident loss consciousness and code blue was called. CPR was initiated and 911 was called. Resident was taken to hospital via stretcher, resident sister was notified, MD (Medical doctor) was also called, and supervisor made aware. At 1:55pm hospital called back, and stated resident was admitted to hospital with diagnosis of aspiration. All parties made aware and resident belongings remain in his room, at this time meds placed in proper storage. R13's physician order sheet dated [DATE] denotes in-part ST (speech therapy) to evaluate and treat 5 times a week for 4 weeks for dysphagia management s/p (status post) weight loss and increased need for assistance at meals. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	R13's care plan dated [DATE] denotes in-part R13 requires assist with ADL's (activities of daily living) to maintain highest possible level of functioning as evidence by the following limitations and potential contributing diagnosis, schizophrenia, heart failure, dementia, weakness, abnormalities of gait and mobility, hyperlipidemia, chronic kidney disease, anemia, anxiety disorder, unsteadiness on feet abnormal posture. Bed mobility up to EXT-X1 (extensive assist x1), transfer up to EXT-X1 (extensive assist x1), toileting up to EXT-X1 (extensive assist x1), eating up to EXT-X1 (extensive assist x1), transfer. R13 will maintain present level of function without decline by next review. Assist with meals as needed, bathing dressing transfers as needed, explain all tasks prior to starting, ensure proper positioning while in bed/chair, encourage resident to participate in all areas of care we are involved in exercise program as tolerated, rest periods as needed, involve social services as needed, turn and reposition every 2 hours, all meal trays to be set up with milk and other container open. R13's care plan for alteration in nutrition denotes in part receives therapeutic diets or mechanically altered diet, receives double portion with all meals, staff supervision with all meals. R13's care plan dated [DATE] denotes in part R13 has some or all-natural tooth loss, R13 will tolerate diet as ordered through next review. Monitor for chewing difficulty, monitor for mouth, or tooth pain, refer to dentist as needed encourage good oral care and/or assist with oral care as needed, encourage resident to wear dentures and/or bridges if applicable and that food serves as appropriate. R13's death certificate denotes date of death [DATE], cause of death complications of choking, how injury occurred choked on food bolus. Facility policy titled Care Plan Policy and Procedures, no effective or review date noted, denotes in-part each resident will have a comprehensive assessment completed that will assist in the development of an individualized plan of care that will include goals and interventions and to improve or maintain the residents highest level of function prevent decrease the complications of medical conditions medications and diagnosis decrease risk of injury or to promote comfort at end of life. Each resident will have a comprehensive assessment completed by the interdisciplinary team upon admission quarterly and with significant changes and an individualized care plan will be developed and updated as needed with readmissions and changes in condition. Weather care plans will be reviewed and updated as needed with readmissions quickly and with any significant changes in condition. The MDS nurse will be the primary lead of the care conference but in the absence of MDS the nurse, Social Services or other designee may conduct the meeting. The care plan will also be updated with any additional identified problems or approaches. Review of R13 care plan there is not documentation denoting the identified issues observed during the speech evaluation had resolved, there is no documentation of reevaluation of identified issues for safe oral intake for R13. Upon exit of this survey the facility failed to present the plan to ensure safe oral intake for R13, and or plan to reduce risk for aspiration for R13. Facility failed to present documentation denoting R13 was discharged from speech therapy before he met his short-term goals. Facility failed to present documentation for plan for aspiration for R13.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 38796 Based on interview and record review the facility failed to have an effective smoking policy and contraband policy to prevent unauthorized items/smoking material. This affected on two of three (R3, R7) residents reviewed for safety and supervision. This failure resulted in R3, a resident with visual impairment and assessed to require supervision while smoking, to bring unauthorized smoking material from a home visit and drop a lit cigarette into a garbage can causing a fire. This has the potential to affect 84 residents on the fifth floor. Findings include: R3 face sheet shows diagnosis of legal blindness, auditory hallucinations, schizoaffective disorder, post-traumatic stress disorder, bipolar disorder, and anxiety. Facility incident report dated 2/5/2024 denotes in-part writer was at the nurses' station and smelled smoke, writer observed smoke coming from resident bathroom, garbage can. Resident stated she was smoking in the bathroom. Writer evacuated resident from room, fire extinguisher was used to put out the fire. Full body assessment was performed, resident has no injuries, no s/s (signs and symptoms) smoke inhalation, v/s (vital signs) WNL (within normal limit). Fire department notified and responded to the unit. MD (medical doctor) and mother was made aware. On 4/4/24 at 10:06am R3 observed sitting at the bedside, R3 agreeable to speak to surveyor, R3 said she got the cigarette and lighter from her brother when he visited her. R3 said she put the cigarette in the garbage can, R3 said she did not know that the cigarette was lit or not when she put it in the garbage can. R3 said she was smoking in the bathroom in her room. R3 said she should not be smoking in the bathroom, and she should not have cigarettes or lighters in her possession. R3 denied having smoke material in her possession during this interview. R3's progress note dated 2/5/24 denotes in-part resident was in room when writer started smelling smoke. Writer entered room and observed smoke coming from bathroom. Writer evacuated resident from room, fire extinguisher was used to put out the fire. Full body assessment was performed, resident has no injuries, v/s (vital signs) WNL (within normal limits). Resident has no complaints of pain, With no s/s (signs/ symptoms) of smoke inhalation. MD (medical doctor) and Mother was made aware. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R3's social service progress notes dated 2/6/24 denotes smoke was observed coming from resident's room, staff immediately reported to the room. Fire appeared to be coming from the resident's bathroom garbage can. Fire department was called immediately to the facility. Maintenance staff was able to successfully use the fire extinguish to put out the fire. The room was properly evacuated. After questioning, Resident admitted to smoking in her bathroom. Staff was able to recover the cigarette butt and lighter from the bathroom garbage can. Writer reeducated Resident on the importance of following the facility's Safe-Smoking Policies and procedures by only smoking in facility's designated smoking areas, such as the patio at all times and refraining from involving herself in hazardous behavior. Resident was receptive to counseling at this time. Resident's mother was informed about the incident at the facility and was educated on the facility's smoking policy which prohibits Residents independently having smoking materials. Nurse made aware. Care plan will be updated. Writer encourages resident to attend smoking cessation. Social Services will continue to monitor, support, and encourage resident towards the goal of her treatment plan. R3's smoke evaluation dated 01/04/2024 denotes in-part yes for use of smoke/tobacco product, cigarette, no is checked ability to dispose of ashes in the ashtray and extinguish cigarette. Behavior/attitude; needs redirection. Eyesight- impairment is checked. Awareness of smoking safety procedure. Resident is legally blind and has difficulty hearing. Requires someone to light/extinguish cigarette, someone to retrieve if dropped, one on one assistance. Resident uses a walking stick for mobility. Resident is escorted by staff during all supervised smoking times to and from patio at all times. Resident does not have desire to stop smoking. Additional comments: resident is a supervised smoker. Resident is not capable of handling her own smoking material at this time. Resident uses a walker stick for mobility. Resident is escorted by staff during all supervised smoking time to and from the patio at all times. On 4/4/24 at 10:35am V20 (Registered Nurse/RN) said she was R3's nurse on date of incident. V20 said V19 (Licensed Practical Nurse/LPN) got her attention because she smelled smoke, and she went to see where it was coming from. V20 said she ran and got the fire extinguisher. V20 said R3 and roommate (R7) was removed from the room to the other side of the building. V20 said V21 (maintenance staff) extinguished the smoke. V20 said she called 911 and announced code red. V20 said everyone responded. On 4/4/24 at 10:35am V19 (LPN) said she was on duty when the incident occurred. V19 said she heard some noise (fire alarm), then she smelled smoke. V19 said she went to investigate where it was coming from and it was R3 bathroom. V19 said R3, and her roommate was removed from the room. V19 said when she looked in the bathroom, she observed smoke coming from the garbage can. V19 said maintenance put the smoke out. V19 said R3 was okay she did not go to the hospital, nor did she have complaints of anything. V19 said all the residents was escorted to the game room/ dining room. On 4/4/24 at 2:53pmV14 (Social Services) said R3 went out on a visit and brought smoking material back to the facility. V14 said the smoking policy and contraband policy was reviewed with the family upon admission. V14 said R3 goes out with family often. V14 said R3 informed her that she brought the cigarette and lighter back to the facility after her visit with family during the Christmas holiday. V14 presented R3's pass denoting R3 was out on pass with family from 12/24/23 through 12/26/23. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/4/24 at 2:45pm V13 (Director of Nursing) said R3 went out with family and brought smoking material back into the facility. V13 said the smoking and contraband policy was reviewed with the family upon admission. V13 said R3's brother signed the admission packet. Surveyor inquired about R3's level of safety awareness, since she was in the room, potentially smelled the smoke and did not yell out for anyone or staff. V13 said he understands what surveyor is asking. On 4/5/24 at 11:06am V21 (Maintenance tech) said on the date of the incident, he was on the fifth floor working, he heard the fire alarm sound and announcement of code red. V21 said he went to the area of R3's room, he retrieved the fire extinguisher from V20 (RN), he extinguished the smoke, V21 said he observed thick smoke, and whatever that was in the garbage can smoldering. V21 said the garbage can was hot. V21 said the fire department arrived. V21 said he cleaned the bathroom, primed, and painted the bathroom walls to remove the smoke smell, V21 said he replace several floor tiles because they had bubbled up (destroyed) from the heat, V21 said the garbage can slightly melted from the heat. V21 said everyone responded quickly. R3's care plan with initial date of 3/24/23 denotes in-part, I am a smoker and desire to smoke. I recognize that I will be assessed and monitored to fully manage my compliance with facility rules. I have been educated on the health risks/dangers/hazards of smoking and have been offered assistance with smoking cessation. I recognize that I may not be allowed to carry any smoke materials and I agree not to engage in any of the following behaviors: smoking inside the facility in any area smoking at non designated times. Begging borrowing stealing selling and or trading for smoke material. Burning clothes lips and or fingers with lit cigarettes and or matches. Littering by carelessly dropping cigarette butts and ashes. Lighting a cigarette of other residents. Violating state city municipal smoking ordinance. Attempt to pick up cigarette from ashtray. No smoking in room. Resident was educated on contraband. Residents is able to express her wants and needs. Goals I (R3) recognize that smoking is a privilege, and I will comply with all rules and policies regulating smoking including signing a smoking safety contract. I will be supervised within the structured smoking program and will not carry or control any smoking materials through the next review. Approaches: Provide me with a copy of the facility safety safe smoking policy and explain the policy to me so that I am fully aware of all obligations and conduct a smoking safety assessment as necessary. Explain to me the consequences outlined in the policy for smoking policy noncompliance and disregard for the health safety of others this includes the removal of all smoking material and only being allowed to smoke when supervised. Review important elements of smoking policy with me this includes educating me where smoking may occur times of smoking sessions using ashtrays properly not discarding ashes or butts on the floor not lighting pier cigarettes not giving or trading cigarettes to peers and the health and safety related risk associated with smoking offer me smoking cessation information. Remind me that staff will be observing and supervising my smoking related behavior non-compliance will be documented in the medical record. If I am continually observed to be non-compliant then staff will remove all smoking materials and place me on a supervised smoking program pursuant to facility policy. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145778	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midway Neurological / Rehab Center	8540 South Harlem Bridgeview, IL 60455

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Facility policy and procedure smoking program no date noted, denotes in-part midway neurological and rehabilitation center strives to maintain the dignity and respect of residents at all times and encourages resident to take responsibility for making positive choices in their lives. In this effort all residents who are safe to do so will be allowed to hold their own cigarettes can smoke during established smoking times. The residents who assessed to practice unsafe smoking habits will also be allowed to smoke but under supervised condition to maintain safety. The only authorized smoking area in the facility is the outside patio, during open hours residents who have a pass may also smoke outside the facility away from the building. General smoking rules no lighters or matches are allowed in the building. Unsafe smokers may not hold a cigarette or others. Staff will hold cigarettes for unsafe smokers and distribute them on the patio during smoking hours. Staff may search on safe smokers as well as their room to ensure that there are no cigarettes in their possession room searches of unsafe smokers will take place at least weekly to help ensure safety but may also take place at other times. Staff may also act on so smokers to the parts for the purposes of maintaining safety. Facility policy dated 3/19/2009 titled Policy on room searches contraband items and removal of contraband this organization reserves the right to conduct inspections if there is a reason to suspect or believe that a resident has contraband items or materials in his or her possession. These items include but are not limited to alcohol illicit drugs weapons and smoking material individual has proven to be dangerous or irresponsible with smoking related materials. These items must be turned over to facility personnel immediately upon arrival the organization will try to balance individual rights against the safety needs of peers' visitors and staff members in decision making about further investigation of contraband. Again, safety and security are the utmost concern. The following items are not allowed in the resident's possession if he or she has been assessed as an unsafe smoker (because of smoking in the residence rooms other areas causing burns or otherwise exposing self or peers to a dangerous situation by dropping lit matches cigarettes): cigarettes, cigars, pipes, tobacco including rolling tobacco.

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F 0692 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide enough food/fluids to maintain a resident's health. 38796 Based on observation, interview, and record review the facility failed to develop, implement, evaluate, and reevaluate a plan to prevent a continued insidious unplanned weight loss for one of three residents (R14) reviewed for unplanned weight loss. This failure resulted in R14 having a continued weight loss resulting in a significant weight loss of 18.55% in 90 days. Findings include: On 4/11/25 at 4:30pm V25 (R14's family) said R14 has lost a lot of weight. V25 said R14 lost about 30 pounds. V25 said she knows this because R14 would visit her home from time to time and she could recognize the difference in R14's weight. V25 said R14 has told her that the facility doesn't feed him. On 4/9/24 at 12:08pm R14 observed awake, alert, unable to be interviewed. R14 observed with non-sensical speech, very low tone. R14 cannot be interviewed. R14's physician order sheet dated 11/07/23 denotes orders for no added salt and concentrated sweets diet, regular texture, thin liquids consistency, add double portions at breakfast and sandwich at HS (nighttime). R14 weight record dated 4/8/24 denotes R14 weighed 179.2 pounds. R14 weighed 220 pounds on 1/5/2024. On 4/23/24 at 2:12pm with assist from V42 (Restorative Aide) and V50 (Restorative Nurse), R14 observed to weigh 175.3 pounds. On 4/9/24 at 12:58pm V26 (Dietary Assistant) said the resident's meal is served based on the information on the meal ticket. V26 said the dietary staff do not inform nursing staff if a resident does not come down for meals. Request was made to review R14's meal ticket. On 4/9/24 at 2:24pm V26 (Dietary Assistant) presents R14's diet slip. V26 reviewed the diet slip and stated she do not see any orders for double portion for breakfast and sandwich at night-time. R14's diet slip presented by V26 does not denote double portions and sandwich at HS as noted in the physician order sheet. On 4/11/24 at 8:46am V47 (Certified Nursing Assistant) said he was R14's CNA. V47 said he works with R14 often. V47 said he is familiar with R14. V47 said R14 was finished with breakfast, request was made to observed R14 breakfast tray. V47went to the food cart, retrieved R14's tray, R14's meal ticket observed on tray. R14's meal ticket did not denote double portions for breakfast and sandwich at HS. V14 said R14 ate 50% of meal. There was a half of a biscuit and sausage gravy observed on R14 tray. V47 said R14 did not have double portions for breakfast. V47 was asked if R14 should have double portions for breakfast. V47 said he does not know. V47 said he do not know if R14 had a significant weight loss. V47 said he is not aware of R14 having a weight loss. V47 said he does not know if R14 is currently on a calorie count. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 4/9/2024 at 3:12pm V49 (Psych Physician) said he did not have much time to speak with surveyor as he had to pick his children up from day care. V49 said he does not deal with weight loss. V49 said psych medications do not cause weight loss but in-fact will result in weight gain. V49 was made aware that one of R14's recommendations for weight loss was to consult the psych provider. V49 said he will assess R14 in front of surveyor, surveyor made V49 aware that, that was not necessary. V49 said he will speak to the Director of Nursing regarding the recommendations for him to see R14 due to weight loss. On 4/24/2024 V48 (Dietitian) said R14 is reviewed during the NARS (Nutrition at Risk) meeting in February 2024, V48 said R14 is reviewed for unplanned weight loss. V48 said R14 has had a significant weight loss in 6 months. V48 said initially in 2023, R14 had a desirable weight loss. V48 said the plan was to implement double portions at breakfast and a sandwich at HS, consult with the psych physician, and weekly weights. V48 did not respond when asked when did the planned weight loss become unplanned weight loss. V48 said usually the facility serve the resident meal based on the information on the diet slip. R14's diet slip from 4/11/24 (retrieved from meal tray) and 4/9/24 (presented by dietary assistant) reviewed with V48. V48 confirmed that there is not documentation denoting that R14 should have double portions for breakfast and a sandwich at HS. V48 said she believes she knows why but she does not want to discuss that with the surveyor. V48 made aware that surveyor retrieved the tickets on different days and surveyor cannot conclude that the physician orders and dietitian recommendations was followed for R14 for weight loss interventions. V48 was made aware that the psych physician said he does not see residents for weight loss, and that psych medications do not cause weight loss but in fact will result in weight gain. V48 said the double portion and sandwich is to increase calorie intake to stop weight loss. R14's dietary progress note dated 4/8/2024 denotes in-part weight warning, 7.5%, 10%, diet NCS/NAS (no concentrated sweets, no added salt) regular thin liquids, double at B (breakfast), sandwich at HS, plan recommendations continue current nutritional management. R14's care plan for weight loss denotes in part, resident has experienced weight loss, resident will not have any sig (significant) wt. (weight) until next review. Intervention refers to MD/RD if there is a 5% wt. loss x 1 mo. (month) or 10%, wt. loss over 6 months. Weight resident monthly per facility protocol, weekly weights/ NARs review. Provide diet as ordered. Notify MD of weight change greater than 5% x 1 month. Double portions at breakfast, sandwich at HS, refer to SS(social services)/psych, weight monitoring/NARS review refer to RD (Registered Dietitian). Facility policy titled care plan and procedures, no effective, review or revised date noted denotes in-part each resident will have a comprehensive assessment completed and will assist in the development of an individualized plan of care that will include goals and interventions aimed to improve or maintain the resident highest level of function prevent decline decrease risk of complications of medical conditions medications and diagnosis, decrease risk of injury or to promote comfort and end of life. Each resident will have a comprehensive assessment completed by the interdisciplinary team upon a mission quarterly and with significant changes and in individualized care plan will be developed and updated as needed with quarterly assessment, readmissions, and changes in condition. Resident care plans will be reviewed and updated as needed with readmissions quarterly reassessment annually and with significant changes in condition.