| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145778 | A. Building<br>B. Wing | 06/27/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Midway Neurological / Rehab Center | 8540 South Harlem<br>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.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0622<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44570<br><br>Based on interview and record review, the facility failed to follow their resident discharge policy by failing to document a discharge summary and plan of care for a resident who was hospitalized for destructive behaviors and did not return to the facility. This failure applied to one (R5) of one resident reviewed for discharge procedures.<br><br>Findings include:<br><br>R5 was originally admitted to the facility 11/29/19 with diagnoses that included Schizoaffective disorder, Dementia, Attention-Deficit Hyperactivity Disorder, and bipolar disorder.<br><br>According to Minimum Data Set, dated dated dated [DATE], R5 was assessed with moderate cognitive impairment and required staff assistance with activities of daily living.<br><br>During this investigation, progress notes, assessments, physician orders and care plans were reviewed for R5. R5 was admitted to the hospital for acute behaviors on 4/17/24 and returned to the facility 4/23/24. The facility sent R5 out again on 4/25/24 and discharged R5 on 5/16/24. The facility failed to provide any documentation related to a planned discharge, nor did the facility provide any documentation to establish a continuation of care to another long-term care facility on behalf of R5. Bed hold was not documented. A discharge summary was not available to view or provided during this survey.<br><br>On 6/24/24 at 3:20PM V2 (Director of Nursing) said, R5 was tearing down the room with bare hands. R5 was sent to the hospital and the guardian refused medication management for R5's psychiatric issues but said that they liked this facility for R5. We (administration) had a meeting with the guardian and said if they were willing to give medications for the behaviors, we could work with R5. These behaviors had been present; however, it has been some time since R5 has been destructive. When R5 returned from the hospital, R5 was furthermore destructive, and we had to send R5 back out to the hospital. After that, R5 was discharged . It was a collective decision, but ultimately V1 (Administrator) made the decision. The hospital found R5 another facility to go to because we were delaying deciding whether to take them back.<br><br>(continued on next page) |

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 0622<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 6/26/24 10:28AM V1 (Administrator) said we had every intention of bringing R5 back. We told the hospital to do the best they could to stabilize, and we would take R5 back. We let the social worker at the hospital know that if no other facility would take R5 he could return to us. V1 said at the end of the day, we know we can't dump the patient and we were willing to take them back if nothing else worked.<br><br>According to progress note dated 4/17/24 at 5:12PM: Writer received a report that resident defaced facility property by removing ceiling tiles and also removing his bathroom sink and light fixtures. Shortly after at 5:38PM, a continuation of the incident was documented and included, The resident has a [history]of being destructive. Social service attempted to counsel resident on the need to refrain from engaging in these practices, but resident was not receptive. The note following written on 4/18/24 at 1:10AM included that R5 was picked up to be transported to the hospital but does not indicate a reason for the hospitalization .<br><br>As read in progress note 4/23/24 at 3:24PM, R5 returned to the facility presenting calm and stable, readjusting to the facility and did not express any concerns.<br><br>Physician's Order Sheet 4/24/24 at 4:37PM stated Resident may be transferred to hospital for destroying property. On 4/25/25 at 12:55AM, a note was written: Two Emergency Medical Technicians arrived at the building and left with [R5] enroute to hospital. The following and final note written 5/16/24 at 8:26PM simply said discharged .<br><br>Policy and Procedure Resident Discharge (no revision date) states in part; When resident is transferred to another nursing facility or lesser care facility a transfer form will be completed with pertinent medial information for the receiving facility. The Physician Order sheet is copied with all medications and treatments relayed to the receiving facility. Communication will be completed with the receiving facility to maintain continuity of care. |

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| F 0690<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40920<br><br>Based on observation, interview, and record review, the facility failed to ensure that staff provide timely assessment and adequate intervention for a resident who was experiencing complications with an indwelling urinary catheter. This failure affected one (R2) of two residents reviewed for urinary catheter care. This failure resulted in R2 experiencing a delay in assessment and treatment while experiencing a leaking urinary catheter, abdominal fullness, and pain before being transferred to hospital and being treated for urinary retention secondary to malfunctioning urinary catheter and (UTI) urinary tract infection.<br><br>Findings include:<br><br>R2 is a [AGE] year-old male admitted to the facility on [DATE], medical diagnosis includes, but not limited to Multiple Sclerosis, quadriplegia, cardiomyopathy, bipolar disorder, other specified myopathies, abnormal posture, vitamin D deficiency, major depressive disorder, essential primary hypertension, acute cholecystitis, epilepsy, hyperlipidemia etc.<br><br>Minimum Data Set (MDS) assessment dated [DATE] section C (cognitive) documented that resident is cognitively intact with a BIMs score of 15; Section H (bowel and bladder) stated that resident is always incontinent of bowel; Section GG (functional status) documented that R2 requires substantial/maximal assistance to total dependence on staff for all activities of daily living (ADL) care.<br><br>Care plan initiated 2/9/2024 stated that R2 is at risk for complications related to catheter use, interventions include monitor indwelling catheter and change urinary bag as needed, observe intake and output, monitor urine for increase sediment, cloudy urine, odor, etc.<br><br>6/24/2024 at 11:45AM, R2 was observed in his room, awake and alert sitting in his motorized wheelchair. R2 stated that he has been at the facility since February 2024. The day he went to the hospital, his urinary bag was leaking, bladder was very full, urine was backing up to his bladder and causing him a lot of pain. R2 went to the nurse at the nursing station and told the nurse that he would like his bag to be changed and she told him to go back to his room. R2 said he went to the nurse again because he was in a lot of pain and asked the nurse to call 911 and she told him to call 911 himself after all he has a phone. R2 called 911 and was taken to a local hospital where they drained a large amount of urine from him and he felt better immediately, the hospital told him that he had a bladder infection, and he was started on antibiotics.<br><br>Hospital record dated 6/23/2024 to 6/24/2024 states in part: patient's presentation seems most consistent with acute urinary tract infection and urinary retention secondary to malfunctioning urinary catheter, urinalysis seems consistent with infection. Patient's urinary catheter was replaced, and he had decompression of his bladder with resolution of his lower abdominal discomfort. Patient received an IV dose of ceftriaxone in the emergency room and to be discharged with 10-day course of Keflex. emergency room physical assessment of the abdomen documents the following: there is tenderness, palpable suprapubic fullness, tenderness to palpation. Bladder scan on 5/23/2024 at 23:44 showed 1358 ml of urine.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Medication administration record (MAR) documented that R2 was receiving Keflex 500mg, 1 tablet by mouth three times a day for UTI starting 5/24/2024 and completed on June 2, 2024.<br><br>On 6/24/2024 at 10:16AM, V5 (Registered Nurse/RN) said that she was the nurse that took care of the resident at the hospital, resident was crying and stated that he asked numerous nurses at the nursing home to change his urinary catheter, he was in so much pain and felt like his bladder is full. V5 said that it took them 5 minutes to change the resident's urinary catheter and he felt immediate release. V5 added that R2 was also treated with oral antibiotics for urinary tract infection, she stated that all these could have been avoided if the facility just changed the resident's urinary catheter.<br><br>6/24/24 at 3:50PM, V2 (Director of Nurses/DON) said that the day R2 went to the hospital, he called 911 because he said that his urinary catheter was leaking and needed to be changed, the nurse told him to wait until after medication pass because it is not an emergency. V2 stated that resident's urinary catheter was changed in the emergency room , and he was treated for urinary tract infection (UTI). V2 added that UTI can be caused by lack of proper urinary catheter care, not being changed on time or urine output not being emptied, poor hygiene etc.<br><br>6/24/2024 at 12:45P, V3 (RN) said that she was off for two days, came back to work the day R2 went to the hospital and worked double shift that day. Resident came to her and stated that he has been asking nurses to change his urinary catheter for the past three days, his catheter was leaking. V3 checked the catheter, and it was not leaking, resident still wanted his catheter changed and V3 told the resident to wait until after medication pass. V3 stated that this happened around 4 to 5PM, resident never told her to call 911, the next thing she saw was the paramedics that came to take resident to the hospital around 10:00pm.<br><br>6/25/2024 at 1:50PM, V7 (Certified Nursing Assistant/CNA), said that she was assigned to R2 the day he had an issue with his urinary catheter. R2 stated that his urinary catheter was pulling and leaking, that was before lunch and the nurse was aware. V7 added that she did not empty any urine from resident's bag on her shift (7am to 3pm) because his bag was leaking and all the urine was in the incontinence brief, resident was also complaining of pain. V7 added that the CNAs are supposed to tell the nurse how much urine they emptied from the urinary catheter bag, the nurses document them in medical record.<br><br>6/26/2024 at 11:46AM, V6 (Attending Physician) said that that nurses are supposed to change resident's catheter every month and as needed and this should be documented. V6 added that some factors that could contribute to the development of UTI in residents with urinary catheter include lack of routine care with aseptic technique, making sure the catheter is in place, monitoring intake and output, etc.<br><br>Physician order dated 2/9/2024 reads as follows: Change urinary catheter bag monthly and as needed every night shift starting on the 10th and ending on the 10th every month for infection control. Urinary catheters care every shift and as needed for soilage, Monitor and record amount/character of urine every shift for urinary catheter, Monitor and Record Color of urine.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | A document presented by V2 (DON) (undated), titled, Urinary Catheter Care states in its purpose: a resident with an indwelling catheter is susceptible to urinary tract infection. Under standards, the document states in part: catheter care should be provided every shift and any time incontinent episode occurs .urinary bags will be changed monthly and PRN (as needed). Intake and output will be monitored via physician orders. |