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	04/03/2025

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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40102 Based on interview and record review, the facility failed to follow their change in condition policy and did not notify a family member of a resident's (R2) change in condition and need to be sent out to the hospital for one (R2) out of four residents reviewed for change in condition in a total sample of seven. Findings Include: R2 is a [AGE] year old with the following diagnosis: psychosis, mood disorder, suicidal ideation, and anxiety disorder. A Social Service note dated 3/27/25 documents R2 became verbally and physically aggressive with staff. R2 attempted to go to the patio but the patio was currently closed. Staff redirected R2 back to R2's assigned unit, but R2 refused. R2 became increasingly agitated R2 then attacked staff by slapping them and kicking them in the stomach. A behavioral code was called, and CPI (Crisis Prevention and Intervention) methods were applied to stop R2 from attacking staff. R2 was escorted back to R2's unit once calm. Social services attempted to educate R2 on house rules and behavior expectations but R2 continued to display inappropriate verbal behavior. R2 was placed on 1:1 monitoring. A Nursing note dated 3/28/25 documents the nurse received in report that R2 was being sent to the hospital for a psych evaluation due to aggressive behavior and suicidal ideation. Transportation was called and R2 left the facility around 4:10PM. There is no documentation that family was notified of R2's behavior or that R2 left the facility that was documented before R2 left the facility. A Late Entry Nursing note dated 3/28/25 documents R1 remained on 1:1 monitoring for verbal threats to staff. The physician was notified and ordered to petition R2 to the hospital for a psych evaluation. All responsible parties were notified including family members. This note was entered into the charting system on 4/2/25 at 10:47PM. A Nursing note dated 3/29/25 documents R2 remained at the hospital for a psych evaluation. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/1/25 at 12:47PM, V1 (R2 Family Member) stated R2 called V1 on the evening on 3/28/25 to tell V1 that R2 was in the hospital. V1 reported R2 did not remember how or why R2 was sent to the hospital. V1 stated V1 tried calling the facility to confirm what R2 said but calls to the facility went unanswered. V1 reported V1 tried to call the facility eight to nine times but no call was answered. V1 stated V1 came to visit R2 at the facility on 3/29/25. V1 reported V1 was given badges to go up to the floor to visit R1 but R1 was not in the facility. V1 stated because it was a weekend no management was in the building to explain what happened to R2. V1 reported the nurse manager told V1 someone from the facility would call V1 on 3/31/25 with answers on what happened to R2 but V1 denied receiving a call yet. On 4/1/25 at 1:29PM, V4 (Nurse) stated the previous nurse (V9) coordinated the entire transfer for R2 except calling for transportation. V4 denied calling R2's family to notify them R2 was leaving the facility. V4 reported V4 thought V9 called the family. V4 stated family must always be called before a resident is sent out because the family needs to be made aware of what is going on. On 4/2/25 at 1:54PM, V9 (Nurse) stated R2 was aggressive and talked about self harming so R1 was sent out to the hospital for a psych evaluation. V9 reported V9 delegated to the next shift to arrange transportation for R2 that everything else was completed. V9 stated the DON (Director of Nursing), physician, and V1 were called to notify them of the situation. V9 reported V9 had a family emergency and needed to leave right when to the shift ended so V9 did not document that V9 spoke with V1. V9 reported family should be notified of a change in condition and transfer due to facility protocol and the family needing to be aware where a resident is located. V9 stated if there is no documentation then it means it wasn't done. V9 reported V9 was going to chart the conversation the next time V9 worked but V9 never got the chance to complete the note. On 4/3/25 at 10:15AM, V10 (DON) stated R2 began being aggressive and was put on 1:1 monitoring on 3/28/25. V10 reported the following day R2 was still aggressive and then began making comments about self harming. V10 stated R2 was sent to the hospital via petition for a psych evaluation. V10 stated the nurse's responsibility is to call the physician, call the family, and get the paperwork ready for transfer. V10 reported the conversation with the family needs to be documented. V10 stated V9 could not document the conversation with family due to V9 needing to leave early cause of a family emergency. V10 denied witnessing V9 speak to R2's family member. V10 reported telling V9 to enter in a late note about speaking to R2's family since V9 didn't get a chance to when R2 was sent out. The Petition for Involuntary Admission that is not dated documents R2 needed an emergency inpatient admission for being physically aggressive with staff and having suicidal ideation with a plan. The box for the guardians/family representative is blank indicating no family was notified of R2's transfer. There is no documentation that a Transfer form or Change in Condition form was completed for this transfer to the hospital. This again shows there is no documentation a family member was notified of R2 being sent to the hospital. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The policy titled, Change in Condition Process, that is not dated documents, Intent: The purpose of this policy is to ensure the facility promptly informs resident, consults the resident's physician; and notify, consistent with his or her authority, resident's representative when there is a change requiring notification. Procedure: The facility must inform the resident, consult with the resident's physician and/or notify the resident's family member or legal representative when there is a change requiring such notification. Situation requiring notification include: .2. A significant change in the resident's physical, mental, or psychosocial status that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications .4. A decision to transfer or discharge the resident from the facility .Situation to Consider: Competent individuals: The facility must still contact the resident's physician and notify the resident and/or resident's representative, if known and approved by the resident.