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	01/23/2026

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 0695 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide safe and appropriate respiratory care for a resident when needed. Based on interview and record review, the facility failed to maintain oxygen levels above ninety-three percent (93%) for a resident who was diagnosed with Chronic Obstructive Pulmonary disease (COPD) and required at continuous oxygen of four to six (4-6L) liters per nasal cannula. This affected one of three residents (R1) reviewed for oxygen and oxygen use. This failure resulted in R1 being found with labored breathing, low oxygen saturation of eighty percent (80%) per nasal cannula and being hospitalized with the diagnosis of COPD exacerbation. Findings Include:R1's discharge hospital paperwork dated 1/6/26 documents: Principal problem. Acute on chronic respiratory failure with hypoxia and hypercapnia COPD with acute exacerbation. Increase oxygen demand from four to six liters (4-6L) at home to 15L nasal cannula in emergency department. Patient (R1) eventually weaned down to baseline supplemental oxygen needs. R1 refused the BIPAP. R1's discharge medication list did not document the amount of oxygen to be administered upon discharge. R1's physician order sheet dated 1/10/26 documents check oxygen saturation every shift and keep it above ninety-three percent (93%). Oxygen at three-four (3-4) liters per nasal continuously.On 1/22/26 at 1:09pm, V14 (complainant) said, when R1 was assessed, R1 was slow to respond, pale with difficulty breathing. V14 said, an unnamed nurse confirmed that R1 was on three (3) liters of oxygen. V14 said, R1 was placed on six liters of oxygen and improved immediately.On 1/22/26 at 2:34pm, V32 (nurse) said, she was the nurse that discharged R1 to the hospital because V33 (R1's family) was not happy with R1's placement. V32 said, R1 had oxygen via the nasal cannula but she does not recall at what liter. V32 said, she took R1's vitals and they were within normal limits. V32 said, she does not recall what R1's vitals were. V32 said R1 was not in any distress. V32 said, V33 reported, he knows how to get R1 discharged out of the facility. V32 said V33 reported R1 was having chest pains.V32's progress note dated 1/10/26 (12:50pm) documents: V33 visited the facility and requested for R1 to be sent out because R1 wasn't supposed to transfer to the facility in the first place. R1 refused assessment and didn't want to be bothered.On 1/23/26 at 1:09pm V32 said, R1's oxygenation was at ninety-eight percent (98%). V32 said R1's vitals were okay, not bad but could not recall R1's vitals. V32 said R1 was not in any distress. V32 said she did not stay in the room with R1 after V33 reported R1 having chest pain because R1 was not in any distress. V32 said, she left R1's room and continued her medication pass/rounds.R1's electronic record did not document any vitals on V32's shift.On 1/23/26 at 1:46pm, V2 (Director of Nursing) said, R1's oxygen order was not sent with her discharge paperwork but was given in nurse-to-nurse report. V2 said R1 was stable on baseline oxygen which was three to four liters (3-4L) via nasal canula with a goal to maintain oxygen level above ninety-three percent (93%). V2 said R1's oxygen orders were verified with the medical doctor and input in the computer. V2 said, R1 was placed on four liters of oxygen (4L) and her oxygen level was maintained above 93% while in the facility. V2 said V32 did not assess R1 because R1 refused. V2 said, if a resident complained of chest pain, he wound expect the nurse to stay with that resident.V9 (Nurse) nursing note dated 1/10/26 (6:12am) documents: R1 was alert and orient(ed) times (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145778	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2026
NAME OF PROVIDER OR SUPPLIER Midway Neurological / Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0695 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	three, breath sounds non labor(ed), oxygen at four liters per minute via nasal cannula, head of bed elevated. Skin upper extremities with noted with discoloration. Denies any discomfort at this time. Vital signs peripheral oxygen saturation (SPO2) 97% will continue to monitor.Runsheet dated 1/10/26 documents: Advance life support service was dispatched to nursing home for patient (R1) with breathing problems. Arrived at Patient Time 12:10 pm. At 12:13pm, SPO2 80% (Nasal Cannula), Respiratory rate 26, Labored. Upon arrival at the scene, the crew made contact with the R1's registered nurse (RN). The RN reported R1 is on three (3) liters (L)/minute of supplemental oxygen (O2) but she was not aware of R1's baseline oxygen status or if 3L/min is R1 baseline amount of O2. The RN reported R1's family wants R1 to go to the hospital for evaluation for the shortness of breath (SOB). The crew found R1 responsiveness was slower than baseline according to V33 (R1's family) at the bedside. R1 was pale, had labored tachypneic breathing (rapid, shallow breathing typically exceeding twenty (20) breaths per minute in adults), and appeared in respiratory distress. R1 was on three liters per minute (3 L/min) of supplemental O2 via nasal cannula. V33 indicated, R1 is usually on six liters per minute (6 L/min) via nasal cannula and ten liters per min (10 L/min of BiPAP). The crew assessed R1's vital signs. R1 she was hypoxic (very low level of oxygen) at eighty (80% SpO2/peripheral oxygen saturation). The crew increased R1's O2 level to six liters per minute (6 L/min). After a few minutes of R1 being on her appropriate O2 level, her breathing rate and effort became more normal. R1's skin returned to normal color parameters and her SpO2 increased to 93% which was a good number with R1 having a history of COPD and Emphysema. R1's responsiveness increased, and she became more relaxed. R1's lung sounds revealed bilateral wheezing and stridor which tracks with R1's extensive respiratory history. V33 indicated to the crew R1 was supposed to be discharged to a different facility yesterday. When R1 arrived here yesterday, the facility did not have R1's meds, BiPAP, or correct oxygen orders.Oxygen administration policy documents: It Is the policy of the facility to provide oxygen to maintain levels of saturation to residents as needed and as ordered by the attending physician.