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	05/22/2026

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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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** Based on observation, interview, and record review, the facility failed to protect R2's right to remain free from physical abuse from another Resident (R3). This affects 2 of 3 residents (R2, R3) reviewed for abuse in the sample of 3. This failure resulted in R3 striking R2 with a wheelchair leg rest, causing multiple injuries including two fractures to the left hand, lacerations to the left arm, a mild brain bleed, a collection of blood in the lung, rib fractures, and a facial fracture.Findings Include:R3 is no longer lives in the facility.R2 is a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including encephalopathy, cerebral infarction, epilepsy, heart failure, osteoarthritis, dementia, anxiety, hypertension, major depressive disorder, and hemiplegia. R2's Brief Interview for Mental Status (BIMS) score was 6 (dated 3/9/2026).On 5/19/2026 at 11:32 AM, during the initial day of the investigation, observations and interviews were conducted on the facility's fourth-floor dementia unit. At the time of observation, activity and restorative programs were taking place in two separate rooms. Two Certified Nursing Assistants (CNAs) were observed positioned at opposite ends of the hallways monitoring resident activity. V5, (Certified Nursing Assistant/CNA), stated that the hallways require close monitoring to ensure resident safety because some residents frequently wander throughout the unit and in the residents' room.On 5/19/2026 at 11:40 AM, R2 was observed lying in bed with the left arm wrapped in an elastic bandage. Multiple facial lacerations and facial bruising were noted. The surveyor attempted to interview R2; however, R2 refused to engage.On 5/19/2026 at 11:46 AM, V18, Registered Nurse (RN), stated that residents on the fourth floor include individuals with dementia and psychiatric conditions. V18 stated that staff must closely monitor residents to ensure safety and prevent injuries, adding, we don't want any resident to be hurt. V18 added that the facility conducts two activities during the day on the fourth floor to help keep residents engaged and supervised because residents on that floor require close monitoring. V18 described R2 as quiet and not known to initiate physical altercations or fights.On 5/19/2026 at 12:00 PM, V19 (Licensed Practical Nurse/LPN), R2's nurse, stated that R3 was new to the floor and had been moved to the fourth floor due to multiple attempts to elope. V19 further stated that R3's room was located three rooms away from R2's room and would always be observed wandering around.On 5/20/2026 at 10:15 AM, V2 (Director of Nursing/DON) said that R3 was often confused, wandered throughout the facility, and frequently attempted to open doors. R3 experienced multiple room changes during his stay. V2 explained that the 4th floor was considered more secure because elevator access could be better monitored, allowing staff to observe R3 more closely. V2 described R3's behavior as delusional but non-violent. V2 stated that when staff responded to the incident, they found both residents, R2 and R3, together in R2's room and immediately separated them. R3 was placed on one-to-one observation immediately following the incident because it occurred during the night, and the facility's goal was to petition him out appropriately and prevent his return to the facility. R3 was petitioned the following morning and transferred to the hospital where he was admitted to the psychiatric unit.On 5/20/2026 at 11:48 AM V9 (Certified nursing assistant/CNA supervisor) stated that the night shift from 11:00 PM to 7:00 AM typically has three CNAs assigned, although occasionally there may be four. According to (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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	her, night shift CNAs are expected to complete rounds every two hours and as needed. The purpose of the rounds is to ensure and maintain that residents are safe, prevent falls, and check whether residents need assistance.On 5/20/2026 at 12:41 PM, V12 (Social Service Director) said that R3 was observed repeatedly attempting to open and exit through doors, appearing to move in a looping pattern. R3 was noted trying to look out of doors on the parking lot side and attempting to access the main entrance. V12 said that there was one time when he tried to hit a staff member while attempting to leave. V12 also added that it was the reason why R3 was placed on a locked dementia unit (4th floor) requiring a code for entry and exit. The night shift staff who were working at the time of the incident were contacted by telephone for interview. On 5/20/2026 at approximately 2:38 PM, V13 (CNA) stated that she was not assigned to the resident involved. V13 stated that a staff member informed her that there was something going on in R2's room. Upon responding, V13 observed R2 bleeding from the face. V13 stated that nurses called 911 and security, and R2 was transported to the hospital. V13 described R2 as quiet and stated that he always sleeps at night. Regarding R3, V13 stated that R3 was new to the floor and that she did not know much about R3. V13 further explained that staff conduct rounds and provide routine resident care to monitor residents and ensure their safety and well-being.On 5/20/2026 at 3:00 PM, V14 (LPN) who was the nurse on duty when the incident happened said that she checked on R3 around 1:00 AM and he was seen sleeping. Then later, V14 observed R3 walking in the hallway and was redirected back to his room. At approximately 2:15 AM, she heard noise coming from R2's room and heard R3 screaming inside the room. Upon entering, V14 observed R3 holding R2's hand while R2 was bleeding from his head and arm. V14 pulled R3 out of the room. She stated that there was blood on R2's bed and on the wheelchair leg rest on the floor. When V14 was asked why the incident occurred, V14 stated that she had no idea. V14 said that staff are responsible for ensuring residents are kept safe and free from harm. V14 explained that R3 had wandered into R2's room.On 5/20/2026 at approximately 3:02 PM, V20, (CNA), stated that at the beginning of her shift, around 11:00 PM, she observed R3 standing near his doorway while she was conducting rounds. V20 stated that she instructed R3 to return to bed because it was late. Then at approximately 1:00 AM, she observed R2 asleep in bed. According to V20, R2 typically goes to bed early as part of his normal routine and usually sleeps throughout the night. Then at approximately 2:15 AM, she heard the nurse calling for help. Upon arriving at R2's room, V20 observed R3 standing near the doorway and saw R2 covered in blood.On 5/21/2026 at 10:21 AM, V21 (CNA), stated that she regularly cares for R2. She described R2 as a resident who just smiles, is very quiet, sweet, and does not bother anyone. V21 stated that R3 was new to the unit and that she was not familiar with him. However, she reported observing R3 walking around the unit appearing confused and cursing. V21 stated that one of the responsibilities of nurse aides is to monitor residents and keep them safe. V21 further stated, No one deserved to be hurt. R2 was asleep in his bed and R3 should also be in his bed at that time. I felt bad and sorry for R2. V21 added that having security personnel assigned to the floor could help prevent incidents like this from occurring.On 5/21/2026 at 10:12 AM, interviews were attempted with R7 and R8, who were R2's roommates, regarding the incident; however, neither resident was able to provide details about the event. R7 stated, the guy next to me is now sick.According to the police report, R3 stated that R3 attacked R2 because he had gone to his room asking for a woman. None of the staff witnessed how the assault began. The nurse on duty learned of the assault because of R2's roommates approached her and told her that someone was fighting with his roommate (R2) in the room. Blood covered wheelchair leg was observed at the scene.Record reviews conducted on 5/22/2026 revealed the following:There were multiple Social Service notes indicate that R3 was observed wandering within the facility and had attempted to elope on multiple occasions, and they are as follows:4/28/2026 it was reported that R3 presented with verbal inappropriate language and attempted to hit at the staff while attempting to leave out the unit door.5/5/2026, R3 was observed by staff attempting to elope through the 2nd floor west exit. R3 presented with delusions that his family was waiting for him. Despite redirection, R3 remained (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	non-receptive and continued to exhibit delusional behavior.5/7/2028, R3 attempted to elope through the back door. R3 was noted to be delusional, refused redirection, used profanity, and continued to display inappropriate behavior.5/8/2026 indicates that R3 attempted to elope again. Due to the resident's repeated elopement attempts, R3 was placed on a secured unit on the 4th floor.R3 was petitioned for involuntary discharge on [DATE]. According to the petition, R3 has a violent temper and was involved in a physical altercation with another male resident. R3 is uncontrollable, placed on 1:1 with staff and resident needs immediate hospitalization because is a danger to self and others.The primary care provider's note, dated 5/5/2026, states that R3 has diagnosis of delirium, alteration in mental status, and confusion.On 5/20/26 V12 (Social Service Director) acknowledged that although efforts were made to monitor and redirect R3, he could not definitively state that R2 was fully protected from R3 at all times. V12 further stated that R2 should not have experienced harm and acknowledged that additional measures potentially could have been implemented to better ensure R2's safety. V12 emphasized that residents have the right to feel safe and stated that no one should experience such an incident.Record Review of R2 and R3's care plan show they do not have an abuse care plan on their comprehensive care plans and no abuse assessments were completed.On 5/21/2026 at 2:02 P.M., V12 (Social Service Director) stated an abuse care plan should be included in a resident's comprehensive care plan. V12 stated an abuse care plan should be added for new residents, a significant change in status, revised and updated as necessary. V12 stated R2 and R3 did not have an abuse care plan implemented in their comprehensive care plan. V12 states it is expected that the residents have an abuse care plan. V12 states R2s care plan should have been in place after R2 sustained multiple injuries from R3.On 5/21/26 at 10:21 AM, V21 has agreed that a resident wandering can present a risk to other residents and entering other residents' rooms can cause fear or altercations, or physical aggression. All staff interviewed in relation to this investigation expressed that R2 should not have experienced the physical assault.The facility's abuse prevention program, (latest revision dated 1/2019), states that: As part of the social history evaluation and MDS assessments, staff will identify residents with increased vulnerability for abuse, neglect exploitation, mistreatment, or who have needs and behaviors that might lead to conflict. Through the care planning process, staff will identify any problems, goals and approaches which would reduce the chances of mistreatment to these residents.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interviews and record review, the facility failed to follow their Abuse Prevention Program by not implementing the care planning process, not identifying any problems, goals, and approaches which would reduce the chances of mistreatment for 4 residents (R1, R2, R3, R4) out of 4 residents reviewed for abuse.On 5/21/2026 at 2:02 P.M., V12 (Social Service Director) stated an abuse care plan should be included in a resident's comprehensive care plan. V12 stated an abuse care plan should be added for new residents, a significant change in status, revised and updated as necessary. V12 stated R1, R2, R3, and R4 did not have an abuse care plan implemented in their comprehensive care plan. V12 states it is expected that the residents have an abuse care plan. V12 states R2s care plan should have been in place after R2 sustained multiple injuries from R3.Record Review of Police Report documents on 5/12/2026 local police officer dispatched to facility regarding a battery that occurred between R3 to R2. R3 used a wheelchair leg to strike R2.Record Review of R3's social service notes 4/28/2026 at 3:51 P.M., reads it was reported that R3 presented with verbal inappropriate language and attempted to hit at the staff while attempting to leave out the unit door.Record Review of R1, R2, R3, and R4's care plans show no abuse care plan on their comprehensive care plans and no abuse assessments.Abuse Policy and Procedure Abuse Prevention Program:As part of the social history evaluation and MDS assessments, staff will identify residents with increased vulnerability for abuse, neglect, exploitation, mistreatment, or who have needs behaviors that might lead to conflict. Through the care planning process, staff will identify any problems, goals, and approaches which would reduce the chances of mistreatment for these residents. Staff will continue to monitor the goals and approaches on a regular basis.