STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003826	A. BUILDING: _____ B. WING _____	C 12/10/2021

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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S 000	Initial Comments 2198235/IL139991 2198565/IL140398 2198672/IL140533 2198638/IL140496 2198810/IL140721 2198813/IL140724 2198983/IL140932	S 000		
S9999	Final Observations Statement of Licensure Violations (1 of 2): 300.610a) 300.1210b) 300.1220b)3) 300.3240f) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. Section 300.3240 Abuse and Neglect f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. (Section	S9999		

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S9999	Continued From page 2 3-612 of the Act) These requirements were not met as evidenced by: Based on interviews and records reviewed the facility failed to prevent intimidation and resident to resident physical assault. This failure resulted in R7 being intimated and physically assaulted by R8. R7 now verbalizes fear towards R8. This effects 1 of 3 residents reviewed for abuse. Findings include: R7 is a 37-year-old male. R7's Cognitive Assessment indicates he is cognitively intact. R7's diagnosis include Schizoaffective Disorder, Depressive Disorder, Auditory and Visual Hallucinations, and Suicidal Ideations. R8 is a 34-year-old male. R8's care plan dated 11/10/21, states he is alert and oriented. R8's care plan diagnosis include Schizophrenia, Bipolar Disorder, Type 2 Diabetes, Abnormal Posture Unspecified Psychosis, Depressive Disorder, Anxiety Disorder, Other Manic Episodes, and Auditory Hallucinations. On 11/30/21 at 12:20PM R7 said around 10/1/21 he was in his room in bed on the 2nd floor after breakfast was served. R7 said a large man came into his room and hit him on the outer leg. R7 said he did not know the man at the time. R7 said he found out later the man who hit him was R8. R7 said there was no witness to this. R7 said after that happened "I feared for my life". R7 said he requested to be moved to another floor away from R8. During an interview on 12/1/21 at	S9999		

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S9999	Continued From page 3 12:55PM, R7 said he reported the incident to V27, Nurse. On 11/30/21 at 1:57PM V6, Psychiatric Rehabilitation Services Coordinator, said R7 accused another resident of bullying him and then we moved him to the 5th floor. V6 stated that R7 said that a resident came in and bullied him. V6 stated R7 said it was R8 who bullied him. V6 said as a result, R8 was placed on monitoring. On 12/1/21 at 10:00AM V3, Director of Nursing, said there were no reports or investigations related to R8 prior to 11/30/21. On 12/1/21 at 1:06PM V27, Nurse, said when R7 told him R8 was intimidating him he took R7 to a social worker. V27 was unable to name the social worker. V27 said the purpose of taking R7 to the social worker was to have them take care of the issue. On 12/1/21 at 11:25AM V23, Psychiatric Rehabilitation Services Coordinator (PRSC) said R7 is alert and oriented, can be impulsive at times, is rational, and is easily redirected. V23 said he has not known R7 to be delusional or hallucinate. On 12/1/21 at 12:07PM, R8 who was alert and oriented x3 said he attends groups at least weekly including anger management. R8 said there was a resident he approached in the hallway to introduce himself and the resident blew him off. R8 said he got mad and punched the other resident in the leg. R8 stated, it happened about a month ago and he cannot remember residents name, but the resident moved to the 5th floor.	S9999		

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S9999	Continued From page 4 On 12/1/21 at 1:40PM V1, Administrator, said allegations of abuse should be reported immediately. V1 said intimation from resident to resident is abuse and would be investigated. Surveyor read portions of R8's progress notes dated 10/10/21, which state R8 was verbally inappropriate by "bullying" another resident. V1 stated, I should have been made aware, should have reported, and it should have been investigated. Abuse training occurs with staff and orientation at least annually and with any new incident. Review of R7's Progress Notes does not include any documentation from 9/30/21 thru 11/1/21 of a resident hitting him or bullying him. Review of R8's Progress Notes dated 10/10/21, states R8 was verbally inappropriate by bullying another resident. The facility policy and procedure "Abuse Prevention Program" revised 11/21/20, states: This facility will not tolerate resident abuse or mistreatment by anyone. All personnel, residents, visitors, etc. are encouraged to report incidents of resident abuse, mistreatment or neglect or suspected abuse, mistreatment or neglect; any alleged violations involving mistreatment, abuse, neglect, exploitation, misappropriation of resident property and any injuries of an unknown origin MUST be reported to the Administrator or Director of Nursing. The Administrator is the Abuse Coordinator of the facility. The charge nurse must complete an incident report and endeavor to obtain a written, signed and dated statement from the person reporting the incident. "B"	S9999		

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S9999	Continued From page 5 Statement of Licensure Violations (2 of 2): 300.1210b) 300.1210a) 300.1210d)2) Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following	S9999		

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S9999	Continued From page 6 and shall be practiced on a 24-hour, seven-day-a-week basis: 2) All treatments and procedures shall be administered as ordered by the physician. These requirements were not met as evidenced by: Based on interviews and records review the facility failed administer Norco tablet 5-325 MG (hydrocodone-Acetaminophen) by for complaints of pain scores of 7 out of 10 for 1 of 4 residents reviewed for pain management. This failure resulted in a delay in pain medication administration for approximately 5 days post hospitalization. Findings include: Record review of R4's face sheet documents R4 as a 44-year-old female with diagnosis of Malignant neoplasm of unspecified site of right female breast (onset 8/27/2021). Progress note dated 11/21/2021, documents R4 sent to the hospital for pus draining from right breast surgical incision cite. Progress note dated 11/25/2021, documents R4 returned from hospital. Discharge instructions dated 11/25/21, document Norco PRN (as needed) is continued. Physician order sheet documents the following order: 11/25/2021 Norco tablet 5-325 MG (hydrocodone-Acetaminophen) give 1 tablet by mouth every 6 hours as needed for pain related to Malignant Neoplasm of Unspecified Site of	S9999		

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S9999	Continued From page 7 Right Female Breast. On 11/30/2021 at 1:40 PM, R4 states she is not getting her Norco pain medication that she was prescribed after getting out of the hospital. R4 states she has been asking for the Norco medication since she got out of the hospital. R4 states she has pain in her right breast is 7/10. R4 states, "the charge nurse [V40], I think she likes to see me in pain." On 11/30/2021 at 1:49 PM, V10 (RN) states R4 requested Norco and V10 told R4 that she couldn't take Norco with Naproxen this morning. V10 states she told R4 that V10 would give Norco to her around 4 hours from now. V10 states she told R4 that around 9:00 or 9:30 AM. V10 states R4 can have the Norco now. V10 states, she has given R4 Norco once when I she had her before. V10 states R4 can have Norco every 6 hours. On 11/30/2021 at 3:26 PM, R4 states she still has not gotten any Norco and her pain is 7/10. 11/30/2021 at 3:29 PM at the nurse's station, V10 (RN) states she had not given R4 Norco yet, "it just got here, I told her (pointing to V17 RN) and she will give it to her." V10 states R4 doesn't have any other Norco cards and she didn't know R4 didn't have any Norco earlier when R4 asked for it this morning. On 11/30/2021 at 3:34 PM V41 (RN) states, "the pharmacy just delivered the medication today, just now." On 11/30/2021 at 3:36 PM observed V17 (RN) take Norco for R4 out of white bag. V17 (RN) states R4 has been asking for the Norco. V17 states R4 "asked about it before today. I don't	S9999		

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S9999	Continued From page 8 remember what day. I told her I would order it." V17 states they order Norco in the computer. Review of facility's Controlled Drug record documents the following: Form 1) Norco received 10/26/2021 and completed on 11/20/2021. Form 2) Norco received on 11/30/2021 On 11/30/2021 at 11:47 PM V24 (Pharmacy Tech) states Norco was filled on 11/30/2021 and delivered to the facility at 3:32 PM the same day. On 12/2/21 at 11:25 PM R4 states, "it made me mad that they didn't give me my medication because I was in pain. I told them the doctor ordered it. They told me there was no prescription in there. I felt like they were playing favoritism. [V40] is mean, she told me 'you ain't hurting girl.' V40 said they just gave it to me after the procedure. I told [V40] that's not what the doctor said. It made me sad. It made me feel like I wasn't anything." On 12/2/2021 at 12:28 PM V40 states she is R4's regular nurse and R4 was looking for Norco prescription on 11/29/2021. V40 states she did not look to see if R4 had Norco already ordered. She did not know that R4 already had an order for Norco. R4 states she ordered the Norco on 11/29/2021 from the pharmacy. Review of R4's pain review dated 11/25/2021 documents: Lists Hydrocodone-acetaminophen 5-325mg as a prn medication. "B"	S9999		