Illinois Department of Public Health

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 05/04/2021

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 Complaint Investigation: 2192423/ IL132604 2192622/ IL132904 2192499/ IL132722	S 000		
S9999	Final Observations Statement of Licensure Violations: I of III. 300.1210 a) 300.1210 b)4)5) 300.1210 c) 300.1210 d)6) 300.3240 a) Section 300.1210 General Requirements for Nursing and Personal Care 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. b) The facility shall provide the necessary care and services to attain or maintain the highest	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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. 4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene. 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee	S9999		

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or agent of a facility shall not abuse or neglect a resident

This REQUIREMENT is not met as evidenced by:

Based on interview and record review, the facility failed to develop an effective plan to provide safety interventions to prevent or reduce the risk of falling and failed to ensure the safety intervention of wearing a helmet were implemented to reduce the risk of serious injury during a fall incident for 1 of 3 residents (R1) reviewed for fall risk and prevention. This failure resulted in R1 having multiple falls, sustaining closed head injury, and right humeral head and neck fracture.

Findings include:

1. R1 was admitted to facility in 5/14/2015 with diagnosis of epilepsy, schizophrenia, abnormal posture, unsteadiness on feet, extrapyramidal and movement disorder.

R1's progress note dated 1/16/21 states "Writer responded to a sound heard from resident's room. Upon entering the room, resident was observed on the floor but quickly got himself up before writer could get to him. A head to toe body assessment was conducted on resident. A mild swelling to the right shoulder and a skin tear to left upper eyelid area were noted, first aid treatment was immediately provided. Resident was observed bear footed, resident had removed his shoes before attempting to walk."

R1's fall care plan under problem dated 1/6/21 documents R1 is at risk for falls related to history of falls, visual acuity impairment, seizure disorder, decreased strength and endurance. Interventions

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include the following: ensure call light is within reach and encourage to use it for assistance; gather information on past falls and attempt to determine cause of falls. Anticipate and intervene to prevent future occurrence.

R1's minimum data set dated 1/14/21 documents under toilet use extensive assistance and two-person assist. Under locomotion on unit (how resident moves between locations in his/her room and adjacent corridor on same floor) documents extensive assistance and two-person assist. Under balance during transitions and walking documents not steady, only able to stabilize with staff assistance.

R1's fall risk assessment dated 1/5/21 and 4/2/21 document a score of 5. A score of 10 or above represents high risk.

On 4/30/21 at 11:44 am, V4 (ADON) said R1 wanders and is impulsive. R1 has had these behaviors upon admission. R1 is at high risk for falls and unsure why fall risk assessments do not reflect that. R1 needs monitoring at least every 2 hours.

On 4/27/21 at 3:15 pm, V7 (nurse) said R1 is a fall risk because he has unsteady gait and wanders. V7 said on 1/16/21 she heard a noise in the R1's bathroom. V7 entered bathroom and observed R1 getting up from the floor. There was no staff present with R1 in the room. Upon assessment V7 observed changes in R1 Range of motion to right arm and orders for x-ray received. R1 did not have socks or shoes at time of fall.

R1's x-ray report dated 1/17/21 document acute humeral head and neck fracture.

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Facility reportable dated 1/18/21 documents under conclusion that R1 sustained right humeral head and neck fracture as result of a fall. R1 was attempting to use the bathroom unassisted and failed to put on appropriate footwear.

2. During the survey on 4/22/21 at 12:30 pm and 4/28/21 at 11:35 am, R1 was observed in his bed without helmet.

R1's care plan dated 1/6/21 documents R1 is high risk for falls/safety issues and wears a safety helmet. Intervention listed include: Educate resident and staff on use of helmet; monitor intervals for proper placement any discomfort; keep environment free of clutter; provide glare-free lighting; remove helmet if complaints of pain, signs of redness or improper fitting; anticipate and intervene to prevent recurrences. Educate on safety reminders.

R1's progress note dated 4/27/21 documents: Staff member heard resident yell help from room and noted him lying on floor. Writer was called immediately, and observed resident lying on floor near left of second bed. When asked resident stated he was trying to get in bed. Writer had just left resident room about 35-40 minutes ago giving his medication and was in his own bed. Range of motion done. No skin break noted. Resident has raised area over right eyelid.

R1's incident report dated 4/27/21 documents resident is known to be impulsive and restless. Under notes documents swelling to forehead.

On 4/28/21 at 11:52 am, V12 (nurse) said R1 was observed on the floor near window. R1 had discoloration to right upper eye lid. V12 said R1

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did not have helmet on at time of fall.

On 5/4/21 at 10:33 am, V21 (NP) said he was unclear when R1 received helmet, but he should be wearing it to prevent head injuries due to falls and seizures.

R1's hospital record dated 4/27/21 documents under diagnosis: Fall, closed head injury and traumatic hematoma of forehead.

Facility policy titled fall prevention and management program version 080317 documents the program will identify risk for falls, decrease incidence of falls, and decrease the incidence of falls with injuries. The facility will provide fall prevention assessment, implement interventions to prevent falls as much as possible and manage post fall treatment by: individualized fall risk assessment; interventions that are implemented based upon the identified risk factors, reassessment of risk after fall with modification and additional interventions as appropriate.
(A)

II of III. Licensure Violations:
300.610 a)
300.1210 c)
300.1210 d)6)
300.3240 f)

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

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S9999	Continued From page 6 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 and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. 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. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to follow their abuse policy by not protecting a resident from resident to resident assaults in 1	S9999		

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of 4 residents (R1) reviewed for physical abuse. This failure resulted in R1 being punched in the head by a peer resident and attacked by another peer resident. This attack resulted in R1 sustaining a subdural hematoma, skull fracture and right orbital fracture.

Findings include:

1. R6 admitted to the facility on 8/9/2019 with a diagnosis of asthma, lack of coordination, depressive disorder, auditory hallucinations, insomnia, paranoid personality disorder, restlessness and agitation.

R6's baseline care plan dated 8/13/19 documents under behavioral concerns: Resident stated when he gets frustrated, he will get violent towards other.

R6's Preadmission screening dated 8/12/19 documents under poor judgement placing self or others at risk documents high level and under description documents history of noncompliance with treatment. Patient endorsed auditory hallucinations and multiple hospitalizations.

R6's screening for indicators of aggressive and/or harmful behaviors documents a score of 5. A score of 5-10 documents potentially able to integrate with structure, direction, and supportive counseling. Additional SMI interventions may include limited/supervised community access, group intervention and one to one intervention. Under comments documents, R6 appears to be at minimal risk for aggressive/harmful behavior at this time. Staff to continue to monitor resident as needed.

R6's incident report dated 12/25/20 documents

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S9999	Continued From page 8 R6 was involved in physical altercation with co-peer. Under resident description documents R6 pulled R1 by his leg from bed. Facility abuse report dated 12/25/20 documents under brief description: R6 returned to his room to find R1 asleep in his bed. R6 grabbed R1's feet and pulled him from the bed causing R1 to fall to the floor. Under conclusion documents the facility conducted a comprehensive investigation and the evidence does not indicate that there was any intent by either resident to engage in a physical altercation. Therefore, the situation cannot be classified as abuse. R6's interview statement documents he pulled R1 out of his bed because he did not want to get COVID. R12's (R6 roommate) interview statement documents R6 pulled R1 by his legs out of bed and R1 fell to the ground. On 4/30/21 at 11:00 am, R12 (R6 roommate) who was alert and oriented at time of interview said he heard R6 tell R1 to get out of their room and heard R6 punch R1 and then kick him in the head. Staff came in but unable to recall what staff. R6's progress notes dated 12/25/20 document: Nurse was summoned to resident room. Staff observed resident being agitated. Staff stated he was immediately redirected. Resident was seen pulling peer out of his bed. Resident became slightly agitated when he was approached by staff. Resident stated you don't know if he has COVID. Why is he on my bed? Staff immediately placed resident on 1:1 monitoring, PRN was administered as directed by the psychiatrics. Resident was later calm and was educated to report such incident to a staff instead of intervening. Will continue to monitor.	S9999		

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S9999	Continued From page 9 R6's progress notes dated 12/25/20 document: Resident returned to his room and found a Peer asleep in his bed. Resident grabbed Peer's feet and pulled him from the bed causing the Peer to fall to the floor. Upon conversation, resident who appeared calm stated to staff "he might have COVID". Staff immediately redirected resident by assuring resident that all residents are frequently tested and that any resident diagnosed with the COVID virus are separated from residents who do not test positive for the virus. Resident became slightly agitated and stated "y'all don't know who's got it." Resident was exhibiting paranoia and continued to voice non-factual beliefs about COVID-19. Resident is not receptive to redirection and reality orientation at this time. Resident is currently on monitoring till he can present as stable. Staff will continue to monitor and educate Resident as needed. On 4/30/21 at 10:50 am, R6 who was alert and oriented at time of interview said he came back from getting a pop and saw R1 in his bed. R6 told him to get out of his bed and R1 didn't listen so he grabbed his arms and pulled him out of bed. R6 does not recall anything else about incident. R6's care plan dated 11/18/20 documents R6 has a diagnosis and history of severe mental illness. Interventions include utilize assessment data to help determine the residents present needs, deficits, abilities, strengths. Explain facility rules, resident behavioral expectations and resident rights. Provide psychiatric management to monitor psycho-active medications, provide support and enhance structure. Staff will encourage resident to be in compliance with mental health treatment as well as attend therapeutic groups and activities of interest.	S9999		

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Under concern dated 11/18/20 documents R6 requires psychotropic medication to help manage and alleviate psychosis, agitation, depression, insomnia, paranoid personality. The interventions documented include assure residents diagnosis corresponds with medication prescribed; carry out medication management regimen as prescribed; assess the side effects; offer behavioral counseling and interventions to help resident cope with mood/behavioral distress. Teach resident coping strategies to enable him/her to compensate for delusions; if behaviors symptoms are observed record, document untoward effects and abnormalities to MD; psyche evaluation s needed, social service visits to increase socialization, give positive reinforcements.

R6's progress notes dated 10/21/20 document R6 "attacked security then jumped the fence."
On 5/4/21 at 11:17 am, V5 (Psychiatric Rehab Services Director/PRSD) said he did not observe any documentation after incident 10/21/20 until 11/18/20 which was a quarterly review of R6 behaviors. R6 would have been provided one to one counseling since groups were suspended due to COVID. One to one may be documented in progress notes or behavior tracking.

Review of R6's behavior monitoring tool dated 10/22/20 through 1/4/21 documents under behavior observed R6 appears calm. No other documentation of counseling provided.

R1 was admitted to facility in 5/14/2015 with diagnosis of epilepsy, schizophrenia, abnormal posture, unsteadiness on feet, extrapyramidal and movement disorder.

R1's progress note document on 12/25/20 that he wandered into peer's room.

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R1's incident report dated 12/25/20 documents R1 was observed on the floor in co-peers' room. Under immediate action documents discoloration noted to right side of face and abrasions to right elbow, right eye above eyebrow and bilateral legs. New orders to schedule CT scan at local hospital.
R1's progress note dated 12/27/20 R1 had appointment for CT scan at hospital.
R1's hospital record dated 12/28/20 documents R1 was allegedly in an altercation with another peer over the weekend. R1 CT scan documents acute subdural hematomas measuring up to 4mm on left and 5mm on right, right parietal scalp hematoma, acute nondisplaced fracture of the right side of skull and acute fracture of right orbital wall.
R1's progress note dated 12/29/20 document R1 admitted to local hospital with subdural hematoma.
On 5/4/21 at 12:21 pm, V1 (Administrator) said physical abuse would include hitting or striking another resident causing harm. The incident with R1 and R6 was not substantiated because they did not intend to fight or cause harm to each other. The Surveyor asked V1 if pulling someone from the bed would cause harm and he responded not all the time. V1 was asked if R1 sustained harm from this incident and responded yes.

Abuse prevention program revised 6/21/20 documents it is the policy of this facility to prevent resident abuse, neglect, exploitation, mistreatment and misappropriation of resident property. Abuse is the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting harm or pain or mental anguish or deprivation by an individual, including caretaker of goods or services that are necessary to attain or maintain physical, mental

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psychosocial well-being. Physical abuse is hitting, slapping, pinching kicking etc. It also included controlling behavior through corporal punishment.

2. R13 was admitted to facility on 3/20/20 with diagnosis of contractures of lower legs, anxiety, depressive disorder, hypertension and anemia.

R13 minimum data set dated 4/1/21 document brief interview for mental status score 15/15 which means cognitively intact.

On 4/22/21 at 4:05 pm, R13 who was alert and oriented at time of interview said he hit R1 in the head. R13 said R1 fell on his bed on 4/21/21. R13 was upset because R1 incontinence product was dirty, and he was unable to get off R13' bed. R13 said he hit R1 in back of the head and R1 fell off bed near window. R13 said V9 (Certified Nurse Assistant/CNA) came and assisted R1 back to bed.

On 4/22/21 at 4:08 pm, R1 who is alert and oriented x1 said R13 hit him in the back of head but no other details provided.

R14 was admitting to facility in 6/5/2018 with diagnosis of malnutrition, weakness, difficulty walking, bipolar and anxiety.

R14 minimum data set dated 1/19/21 document brief interview for mental status score 15/15 which means cognitively intact.

On 4/22/21 5:02 pm, R14 who was alert and oriented at time of interview said yesterday (4/21/21) he observed R1 fall onto R13's bed. He saw R13 hit R1 in the head and then R1 fell off the bed. Staff came in and helped R1 back to bed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 13	S9999		

Abuse prevention program revised 6/21/20 documents it is the policy of this facility to prevent resident abuse, neglect, exploitation, mistreatment and misappropriation of resident property. Abuse is the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting harm or pain or mental anguish or deprivation by an individual, including caretaker of goods or services that are necessary to attain or maintain physical, mental psychosocial well-being. Physical abuse is hitting, slapping, pinching kicking etc. It also included controlling behavior through corporal punishment.
(A)

III of III. Licensure Violations:
300.3250 h) 1)2)3)4)

SECTION 300.3250 COMMUNICATION AND VISITATION
h) Any employee or agent of a public agency, any representative of a community legal services program or any member of a community organization shall be permitted access at reasonable hours to any individual resident of any facility, if the purpose of such agency, program or organization includes rendering assistance to residents without charge, but only if there is neither a commercial purpose nor affect to such access and if the purpose is to do any other the following:

1) Visit, talk with and make personal, social, and legal services available to all residents;

2) Inform residents of their rights and entitlements and their corresponding obligations, under federal and State laws, by means of educational materials and discussions in groups and with individual residents;

3) Assist residents in asserting their legal

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 05/04/2021

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S9999	Continued From page 14 rights regarding claims for public assistance, medical assistance and social security benefits, as well as in all other matters in which residents are aggrieved. Assistance may include counseling and litigation; or 4) Engage in other methods of asserting, advising and representing residents so as to extend to them full enjoyment of their rights. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to provide assistance to the outpatient program to conduct a comprehensive assessment and medical record request for protected class member residents. This failure affected 4 of 4 residents (R7, R8, R10 and R11) reviewed for social service assistance. Findings include: Email communication dated 3/11/21 documents V15 (outpatient program manager) requesting medical records and assessment requests for R7, R8, R10 and R11. On 4/29/21 at 9:49 am, V15 (outpatient program manager) said the program procedure consists of performing an initial outreach interview which is then followed with a request for medical records and an interview to complete a comprehensive assessment. The results of the assessment will determine if the resident will be recommended to the next phase of the program which includes possible placement or discharge into the community. If there is a delaying scheduling interviews for assessment completion and review of the records delays the entire process and the possibility of the resident moving to the next phase of possible discharge.	S9999		

Illinois Department of Public Health

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S9999	Continued From page 15 On 5/4/21 at 11:10 am, V15 said they have not completed comprehensive assessments for R7, R8, R10 and R11 and received medical records on 4/29/21. V15 said they would like the documents within 7 days of Outreach and then the assessor has 7 to 14 days to complete the assessment and interview. On 4/30/21 at 3:54pm, V5 (Psychiatric Rehab Services Director/PRSD) said she did receive email sent on 3/11/21 requesting records and assessment requests for R7, R8, R10 and R11. V5 said it was an oversight on the facility's part on why the requests were not fulfilled. V5 said the medical records for R7, R8, R10 and R11 were picked up on 4/29/21 and unable to provide any documentation of comprehensive assessment being attempted prior to 4/29/21. (C)	S9999		