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 06/24/2021

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MIDWAY NEUROLOGICAL / REHAB CENTER	8540 SOUTH HARLEM BRIDGEVIEW, IL 60455

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S 000	Initial Comments Complaint Investigation: 2193814/IL134513	S 000		
S9999	Final Observations I. Licensure Violations: 300.610 a) 300.690 b) 300.690 c) 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 and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.690 Incidents and Accidents b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the facility failed to notify State Agency (SA) within 24 hours for an accident when a significant injury had occurred. This deficient practice affects one (R2) of three residents reviewed for reportable incident and accident to State Agency. Findings Include: Record reviewed. R2 had a fall incident in the facility on 5/10/21. R2 complained of hip pain and V20 (Nurse) noted a bump on R2's forehead. V20 received an order to send R2 to local hospital for further evaluation. R2 returned to the facility on 5/17/21. Hospital record reviewed and reads in part: 5/10/21 Hospital Chief of Complaint was fall. Right hip with questionable femoral neck fracture that will be followed-up with MRI, ortho is on consult and following. No hip fracture on dedicated x-ray of hips. Neurosurgery on consult after findings of subdural hematoma on initial CT (Computed Tomography). Repeat CT of head prior to MICU (Medical Intensive Care Unit) admission demonstrates stable appearance of	S9999		

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S9999	Continued From page 2 acute subdural and subarachnoid hemorrhage overlying left frontal convexity. CT head without contrast signed on 5/10/21 at 12:03 pm final result shows stable appearance of acute subdural and subarachnoid hemorrhage overlying left frontal convexity. No New areas of hemorrhage are identified. X-ray of hips and femur bilateral views signed on 5/10//21 at 10:59 am final result reads in part: Soft tissue swelling and increased density in mid right thigh correlating with hematoma demonstrated on preceding CT scan. CT of pelvis without contract signed on 5/10/21 at 6:44 am final result reads in part: This report contains findings that may be critical to patient care. The findings were verbally communicated via telephone conference. Intramuscular hematomas expands the left adductor muscles without definite evidence accompanying avulsion fracture. Facility's reportable file reviewed. R2 fall incident with major injury on 5/10/21 was reported to SA on 5/19/21 (Initial Report) reads in part: Per hospital report, resident sustained a minimally displaced femoral neck fracture, subdural hematoma and subarachnoid hemorrhage. Final report sent on 5/24/21. Interviewed V21 (Nurse) on 6/23/21 at 3:45pm, stated "I called to follow up for admitting diagnosis and also to ask for CT scan result. Hospital was unable to give me the result and they said because of HIPAA (Health Insurance Portability and Accountability Act). I let my DON know that I did not get further information in regard to results of any testing done after a fall. I	S9999		

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S9999	Continued From page 3 probably reported this to my DON immediately after I called the hospital. I reported to the DON that I did not get any report in regards CT scan result". Interviewed V2 (DON) on 6/23/21 at 10:00am, "The hospital did not reported an injury after R2 fall, only the other diagnosis mentioned in the chart, so I assumed there is no injury because the hospital would have informed us when we called them. R2 came late on the 17th of May, it was a huge file of medical record. I reviewed it the next day (May 18) but I did see the injury documentation not until the next day (the 19th of May). I reported the incident with major injury to IDPH (Illinois Department of Public Health) on May 19, the day I encountered the documentation stating that there are injuries." Accident Incident Reporting Policy with a revised date of 4/15/21 reads in part: Notification to IDPH will be made within 24 hours for any incident or accident when a significant injury has occurred. The facility shall notify the Department of any serious incident or accident. For the purpose of this section, "Serious" means any incident or accident that causes physical harm or injury to the resident. "C" II. Licensure Violations: 300.610 a) 300.1210 a) 300.1210 b)4) 300.1210 b)5) 3001210 b)6) Section 300.610 Resident Care Policies	S9999		

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S9999	Continued From page 4 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 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 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 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	S9999		

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resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:

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.

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

This REQUIREMENT is not met as evidenced by:

Based on interviews and record reviews, the facility failed to follow their Fall Prevention and Management Program Policy by not identifying risk for falls with effective intervention for assistance to the bathroom to decrease the risk of falling for one of three residents reviewed for fall incident. This failure resulted in R2's having a fall incident while attempting to go to the bathroom unassisted and was found on the floor. R2 was transferred to local hospital. R2 was

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S9999	Continued From page 6 assessed and treated for subdural hematoma and subarachnoid hemorrhage and minimally displaced right femoral neck fracture. Findings Include: R2's facility record reviewed. R2 with initial admission on 2/22/2013. R2 had two fall incidents during R2 stay in the facility. First incident dated on 4/12/2020 when R2 observed sitting on her bathroom floor attempting to use the restroom. Resident description: R2 states "I slipped and fell on my butt" while attempting to use the restroom. Second fall incident documented on 5/10/21 when nurse observed R2 on the floor. Nurse noted bump on forehead and received an order to send R2 to local hospital for evaluation. R2 returned on 5/17/21. Hospital record reviewed and reads in part: 5/10/21 Hospital Chief of Complaint was fall. Right hip with questionable femoral neck fracture that will be followed-up with MRI, ortho is on consult and following. No hip fracture on dedicated x-ray of hips. Neurosurgery on consult after findings of subdural hematoma on initial CT (Computed Tomography). Repeat CT of head prior to MICU (Medical Intensive Care Unit) admission demonstrates stable appearance of acute subdural and subarachnoid hemorrhage overlying left frontal convexity. R2 care plan reviewed dated 4/10/21, documented that R2 is at risk for falls related to: Requires ADLs assistance for transfers and mobility. Impaired range of motion and/or loss of functional movement of joints. Incontinence. Decrease strength and endurance. Use of Antipsychotic medications. Heart failure, COPD (Chronic Obstructive Pulmonary Disease) and Dementia. On 5/10/21 facility added intervention status post fall, 5/10 21 interventions read in part:	S9999		

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S9999	Continued From page 7 Voiding Diary, Call light at easy reach, neurological check, Physical Therapy to screen upon return, send resident out for evaluation. Fall Risk Review (prior to fall incident on 5/10/21) dated 4/3/21 conclusion shows a total score of 10. A score of 10 or above represents HIGH RISK. Interviewed V2 (DON) on 6/23/21 at 10 am, stated ""We added voiding diary, frequent voiding activity encouragement. Because there was a history of fall about a year ago that R2 tried to use the washroom. R2 needs assistance for safe transfer. R2 still can move in bed, wiggle herself out of bed if she wanted to move. R2 because of sepsis diagnosis in the hospital, she was confused prior to the fall, IDT (Interdisciplinary Team) believed that the root cause was probably R2 woke up in the middle of the night wanting to use the toilet and thought she was able to use the toilet independently and tried to get up and fell. Floor mat is not appropriate for R2 because it could trip R2 and fall. Side rails is a restraint, but I am considering it when R2 returns. I will talk to the family about side rails". Interviewed V17 (ADON) on 6/23/21 at 10:30 am, stated "I am the one that investigate the fall incidents in the facility. R2 is confused and has dementia. R2 reside on the 4th floor. R2 not able to give any description of what R2 was attempting to do. IDT members discuss fall incidents in the facility to know what intervention to put in place. For R2, we made sure that PT saw her upon return. We placed voiding diary. The team feels like the fall was because she was trying to attempt to use the washroom. R2 is not bed ridden, R2 still able to move in bed but not safe to physically get up on her own. Prior to the fall, R2	S9999		

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S9999	Continued From page 8	S9999		

functional ability was still able to assist in turning herself to bed. I observed R2 moving in bed by herself at times. There is no other intervention we can put to prevent a fall, because if we put a preventative such floor mat it could be a trigger for her to fall. R2 has a history of getting up off her bed, but R2 is not able to stand on her own, and because R2 has not fallen in a long time, there were no added intervention. The mat might trip R2 if we put it in place. If the bedridden resident is fall risk the mat would work and be effective because it would not trip them and cause them to fall. But during R2 fall incident, the nurse reported that the bed was in lowest position and call light within reach. We cannot put side rail because this could be a form of restraint for this resident".

Interviewed V18 (Restorative Nurse) on 6/23/21 at 10:45 am, stated "I am familiar with this resident. R2 was declining with walking ability, wheelchair was provided but R2 refused to use the wheelchair and still wants to use her walker, however the wheelchair is still available in her room when needed. I assessed R2 and R2 needs to use wheelchair and not walker because R2 has an unsteady gait, in which R2 is not safe to be walking with a walker".
Interviewed V19 (Certified Nurse Assistant/CNA) on 6/23/21 at 11:50 am, stated "I have been R2's CNA lately. R2 started declining and started using a wheelchair and place in dining room for monitoring. R2 stays in bed and able to move her body, but not off the bed".

Facility's Fall Prevention and Management Policy reviewed and reads in part: The Fall Prevention and Management Program uses clinically accepted guidelines to guide the prevention and management of falls. The Program will: Identify

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S9999	Continued From page 9 risk for falls, decrease the incidence of falls, and decrease the incidence of fall with injuries. Fall related injuries decrease the resident's quality of life and ability to function. Resident who fall without injury may develop a fear of falling that leads to self-imposed limitation of activity. Falls can lead to fractures, traumatic brain injury, decreased mobility, fear of falling, and increase isolation. This facility uses "SAFETY FIRST" approach for falling prevention. "A"	S9999		