Illinois Department of Public	Health			FORM	APPROVE
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6003826			CONSTRUCTION		E SURVEY PLETED
		A. BUILDING:		С	
	1			06/.	27/2024
NAME OF PROVIDER OR SUPPLIER		DDRESS, CITY, S			
MIDWAY NEUROLOGICAL / R	REHAB CENTER	VIEW, IL 6045			
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETI DATE
S 000 Initial Comments		S 000			
Complaint Investig 2494092/IL173567 2494234/IL173749	,				
S9999 Final Observations	3	S9999			
Statement of Licen 300.610a) 300.1210b) 300.1210d)2)3)	sure Violations:				
a) The facility shall procedures govern facility. The written be formulated by a Committee consist administrator, the a medical advisory c of nursing and othe policies shall comp The written policies the facility and shall	advisory physician or the ommittee, and representatives er services in the facility. The oly with the Act and this Part. s shall be followed in operating Il be reviewed at least annually documented by written, signed	· · · · · · · · · · · · · · · · · · ·			
Nursing and Perso b) The facility shall and services to atta practicable physica well-being of the re each resident's con plan. Adequate and care and personal	I provide the necessary care ain or maintain the highest al, mental, and psychological esident, in accordance with mprehensive resident care d properly supervised nursing care shall be provided to each the total nursing and personal				
	DER/SUPPLIER REPRESENTATIVE'S SI	GNATURE	TITLE		(X6) DATE
Electronically Signed					07/10/24
ATE FORM		6899 X	97N11	If continu	ation sheet 1

Illinois D	epartment of Public	Health			FORM APPROVED	
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
IL6003826		B. WING		C 06/27/2024		
	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
		8540 SO	UTH HARLEN			
MIDWAY	NEUROLOGICAL / R	FHAB CENTER	/IEW, IL 604			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETE	
S9999	Continued From pa	ige 1	S9999			
	care shall include, a and shall be practic seven-day-a-week 2) All treatmen administered as or 3) Objective of resident's condition emotional changes determining care re further medical eva	basis: nts and procedures shall be dered by the physician. bservations of changes in a , including mental and , as a means for analyzing and equired and the need for luation and treatment shall be aff and recorded in the				
	This REQUIREME	NT is not met as evidenced by:				
	review, the facility f provide timely asse intervention for a re- complications with This failure affected reviewed for urinary resulted in R2 expe- assessment and tre leaking urinary cath pain before being to being treated for ur	ion, interview, and record ailed to ensure that staff essment and adequate esident who was experiencing an indwelling urinary catheter. d one (R2) of two residents y catheter care. This failure eriencing a delay in eatment while experiencing a neter, abdominal fullness, and ransferred to hospital and inary retention secondary to ary catheter and (UTI) urinary				
	on 2/9/2024, medic limited to Multiple S cardiomyopathy, bi	male admitted to the facility al diagnosis includes, but not Sclerosis, quadriplegia, polar disorder, other specified				
nois Depai IATE FORI	rtment_of Public Health M		6899	X97N11	If continuation sheet 2 o	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6003826			(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		E SURVEY PLETED	
		B. WING			C 06/27/2024	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, SI	TATE, ZIP CODE		
MIDWAY	NEUROLOGICAL / R	FHAB CENTER	UTH HARLEM VIEW, IL 6045	5		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
S9999	Continued From pa	age 2	S9999			
	myopathies, abnormal posture, vitamin D deficiency, major depressive disorder, essential primary hypertension, acute cholecystitis, epilepsy, hyperlipidemia etc.					
	5/16/2024 section ( resident is cognitive 15; Section H (bow resident is always i GG (functional stat requires substantia	(MDS) assessment dated C (cognitive) documented that ely intact with a BIMs score of el and bladder) stated that ncontinent of bowel; Section us) documented that R2 I/maximal assistance to total ff for all activities of daily living				
	risk for complication interventions includ and change urinary	2/9/2024 stated that R2 is at ns related to catheter use, le monitor indwelling catheter bag as needed, observe monitor urine for increase rine, odor, etc.				
	room, awake and a wheelchair. R2 stat facility since Februa the hospital, his uri was very full, urine and causing him a nurse at the nursing that he would like h told him to go back to the nurse again l and asked the nurs to call 911 himself a	AM, R2 was observed in his lert sitting in his motorized ted that he has been at the ary 2024. The day he went to nary bag was leaking, bladder was backing up to his bladder lot of pain. R2 went to the g station and told the nurse his bag to be changed and she to his room. R2 said he went because he was in a lot of pair te to call 911 and she told him after all he has a phone. R2				
	where they drained him and he felt bett	a large amount of urine from ter immediately, the hospital d a bladder infection, and he				

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STATEMENT OF DEFICIENCIES(X1) PROVIDER/SUPPLIER/CLIAAND PLAN OF CORRECTIONIDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
IL6003826			A. BUILDING:	A. BUILDING:		С
		B. WING			27/2024	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
IDWAY	NEUROLOGICAL / R	FHAB CENTER	UTH HARLEM			
		BRIDGE	VIEW, IL 6045			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
S9999	Continued From pa	ge 3	S9999			
	states in part: patie consistent with acu urinary retention se urinary catheter, uri infection. Patient's and he had decomp resolution of his low Patient received an emergency room at 10-day course of K physical assessme the following: there suprapubic fullness	ed 6/23/2024 to 6/24/2024 nt's presentation seems most te urinary tract infection and condary to malfunctioning inalysis seems consistent with urinary catheter was replaced, pression of his bladder with ver abdominal discomfort. IV dose of ceftriaxone in the nd to be discharged with eflex. Emergency room nt of the abdomen documents is tenderness, palpable to, tenderness to palpation. 23/2024 at 23:44 showed 1358				
	documented that R 1 tablet by mouth the	tration record (MAR) 2 was receiving Keflex 500mg nree times a day for UTI and completed on June 2,	,			
	Nurse/RN) said that care of the resident crying and stated that the nursing home catheter, he was in bladder is full. V5 s to change the resid felt immediate release also treated with or infection, she states	:16AM, V5 (Registered t she was the nurse that took at the hospital, resident was nat he asked numerous nurses to change his urinary so much pain and felt like his aid that it took them 5 minutes ent's urinary catheter and he ase. V5 added that R2 was al antibiotics for urinary tract d that all these could have facility just changed the atheter.				
		V2 (Director of Nurses/DON) 2 went to the hospital, he				

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		IL6003826	B. WING		06/	27/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	ATE, ZIP CODE		
MIDWAY	NEUROLOGICAL / RI	FHAB CENTER	UTH HARLEM /IEW, IL 6045	5		
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\$9999	catheter was leakin the nurse told him to pass because it is r that resident's urina the emergency roor urinary tract infectio can be caused by la care, not being emptied, p 6/24/2024 at 12:45F off for two days, car went to the hospital day. Resident came been asking nurses catheter for the pass leaking, resident sti and V3 told the resi medication pass. V3 around 4 to 5PM, re 911, the next thing s that came to take re 10:00pm. 6/25/2024 at 1:50PI Assistant/CNA), sai the day he had an is R2 stated that his u and leaking, that wa was aware. V7 add urine from resident' 3pm) because his b urine was in the inc also complaining of are supposed to tell	he said that his urinary g and needed to be changed, o wait until after medication not an emergency. V2 stated ry catheter was changed in m, and he was treated for on (UTI). V2 added that UTI ack of proper urinary catheter nged on time or urine output poor hygiene etc. P, V3 (RN) said that she was me back to work the day R2 and worked double shift that to her and stated that he has to change his urinary t three days, his catheter was d the catheter, and it was not II wanted his catheter changed dent to wait until after 3 stated that this happened esident never told her to call she saw was the paramedics esident to the hospital around M, V7 (Certified Nursing d that she was assigned to R2 sue with his urinary catheter. rinary catheter was pulling as before lunch and the nurse ed that she did not empty any s bag on her shift (7am to bag was leaking and all the ontinence brief, resident was pain. V7 added that the CNAs I the nurse how much urine he urinary catheter bag, the				

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	IL6003826		B. WING		06/2	27/2024
AME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	ATE, ZIP CODE		
IDWAY	NEUROLOGICAL / R	EHAB CENTER	UTH HARLEM VIEW, IL 6045	5		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
S9999	Continued From pa	ige 5	S9999			
	said that that nurse resident's catheter and this should be some factors that c development of UT catheter include lac technique, making monitoring intake a Physician order dat Change urinary cat needed every night ending on the 10th control. Urinary cat needed for soilage, amount/character of catheter, Monitor an A document presen titled, Urinary Cathe a resident with an in susceptible to urina standards, the docu care should be provincontinent episode changed monthly a	AM, V6 (Attending Physician) is are supposed to change every month and as needed documented. V6 added that could contribute to the 1 in residents with urinary of routine care with aseptic sure the catheter is in place, nd output, etc. and every month for infection heters care every shift and as Monitor and record of urine every shift for urinary and Record Color of urine. and by V2 (DON) (undated), eter Care states in its purposes indwelling catheter is ary tract infection. Under ument states in part: catheter vided every shift and any time a occursurinary bags will be and PRN (as needed). Intake nonitored via physician orders.				

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