Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C B. WING IL6000822 12/07/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 11401 SOUTH OAKLEY AVENUE **BELHAVEN NURSING & REHAB CENTER** CHICAGO, IL 60643 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) S 000 **Initial Comments** S 000 Complaint Investigation 2389321/IL166463 S9999 Final Observations S9999 Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210b 300.1210d)3) 300.3240a) Section 300.610 Resident Care Policies 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 300.1010 Medical Care Policies The facility shall notify the resident's physician of any accident, injury, or significant Attachment A Statement of Licensure Violations change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

manifest decubitus ulcers or a weight loss or gain

TITLE

(X6) DATE

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AND PLAN OF CORRECTION IDENTIFICA		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: B. WING	CONSTRUCTION	СОМ	(X3) DATE SURVEY COMPLETED C 12/07/2023	
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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	documented weekl (Electronic Medical that shower/skin chimpairments, failed impairments upon accurate skin integ were on the care pipeling were on the care pipeling were on the care pipeling to ensure treated to ensure treated to ensure treated to ensure treated and pain for several member requested (Emergency Room subsequently diagrams.)	ailed to ensure that Nurses y skin checks in the EMR I Records), failed to ensure necks included skin integrity to document skin integrity re-admission, failed to ensure rity impairment/ interventions lan, failed to timely notify the nt change in condition, and atment orders were obtained idents (R2) reviewed for n. These failures resulted in rextremity redness, edema, at days. On (11/3/23) a family R2 be sent to the ER of tissue emia, and pneumonia.	S9999				
	Health) received all were not properly to infected; and that R2 was diagnosed pneumonia. R2's diagnoses inclocal infection of the R2's progress note bedside requesting (Emergency Room) notified with orders Admit from hospital hypoglycemia, soft lower lobe pneumonistic services and services are services and services	Illinois Department of Public legations that R2's leg wounds reated at the facility and are t2 sits in soiled diapers all day. with low glucose and lude dementia, and (11/10/23) e skin/subcutaneous tissue. Is state (11/3/23) Daughter at resident be sent to ER of for evaluation. Doctor to send to ER. (11/10/23) i. Admitting diagnoses: tissue infection, and right inia. Skin intact. Doctor sion; orders verified.					

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assessment and appropriate follow-up to include

physician notification as indicated.

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