STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000822	A. BUILDING: _____ B. WING _____	C 03/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELHAVEN NURSING & REHAB CENTER	11401 SOUTH OAKLEY AVENUE CHICAGO, IL 60643

(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
S 000	Initial Comments Complaint Investigation 2282323/IL145001	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210b) 300.1210d)3) 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 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant 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 manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days.	S9999	**Attachment A** **Statement of Licensure Violations**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000822	A. BUILDING: _____ B. WING _____	C 03/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELHAVEN NURSING & REHAB CENTER	11401 SOUTH OAKLEY AVENUE CHICAGO, IL 60643

(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 1 The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. (B) 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. 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. These requirements are not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure psychotropic medications were administered per physician orders for one (R1) of 3 residents reviewed for psychotropic medications. This failure resulted to R1 exhibiting withdrawal symptoms such as	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000822	A. BUILDING: _____ B. WING _____	C 03/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELHAVEN NURSING & REHAB CENTER	11401 SOUTH OAKLEY AVENUE CHICAGO, IL 60643

(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 2 agitation and crying. Findings include: On 03/24/22 at 10:00 AM, V25 (R1's Power of Attorney) who is also her (R1) sister, stated that R1 was prescribed Clonazepam from 2019 onwards and then discontinued on 3/3/2022. The facility psychiatrist then ordered Buspirone as an alternative. V25 stated that she (V25) didn't give consent for Buspirone and wanted to talk to the physician, but no physician called her back. V25 stated, R1 did not receive any Buspirone or Clonazepam for 2 weeks. V25 stated that R1 received her next Clonazepam on 3/19/2022. V25 also stated that she (V25) visited R1 on 3/16/2022 and she saw R1 had thrown up on her clothes and was crying. R1 stated that the CNA told her that R1 has been crying for past three days and she (R1) started throwing up. That very day, she scheduled an appointment with her psychiatrist at an outside clinic. R1 left for the appointment with V19, Certified Nursing Assistant/CNA. On 03/24/2022 V2 (Director of Nursing) stated she (V2) is unsure why R1's Klonopin was discontinued without anything to replace it. V2 stated the nurse who signed off on the doctor's discontinue order did not follow and make sure another medication other than Buspirone was ordered. That nurse does not work at the facility anymore. V2 stated that it was not right R1 was off of her Klonopin for two weeks without any alternative therapy because she could have withdrawal symptoms. On 03/24/2022 at 03:15 PM, V20 (Psychiatrist) stated Klonopin is a benzodiazepine. Depending on the dose if you stop benzodiazepine abruptly	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000822	A. BUILDING: _____ B. WING _____	C 03/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELHAVEN NURSING & REHAB CENTER	11401 SOUTH OAKLEY AVENUE CHICAGO, IL 60643

(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 3	S9999		

you could have withdrawal symptoms. V20 also stated no one from the facility failed to mention to her (V20) that V25 refused the Buspirone for R1.

When V19 (Certified Nursing Assistant) took R1 to her (R1) appointment on 3/16/22, V19 stated that R1 was tearful and agitated in the ambulance.

On 03/24/2022 at 2:00 PM, V21 (Primary Care Physician) stated that being off of her (R1) Klonopin for two weeks can probably lead to withdrawal symptoms such as agitation and crying depending on the dose.

R1's physician orders documents in part: KlonoPIN Tablet 0.5 MG (clonazePAM) Give 0.5 mg by mouth two times a day for agitation; start date 12/29/2019, discontinue date 3/3/2022. KlonoPIN Tablet 0.5 MG (clonazePAM) Give 0.5 mg by mouth two times a day for agitation; start date 3/19/2022 17:00; revision date 3/19/2022. BusPIRone HCl Tablet 5 MG Give 1 tablet by mouth two times a day for anxiety; start date 3/7/2022 17:00; Discontinue 3/7/2022.

Reviewed R1's Medication Administration Record. No Clonazepam and Buspirone nor any other medication for agitation/anxiety was administered from 3/3/22 to 3/19/22.

R1's medical diagnosis list documents in part: Schizophrenia, unspecified.

Facility's Psychotropic Drug Usage Policy documents in part: Dosage reduction of antipsychotics, anxiolytics, and hypnotics are attempted per CMS guidelines unless clinically contraindicated. The Physician weights the risk versus the benefits and documents it in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000822	A. BUILDING: _____ B. WING _____	C 03/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELHAVEN NURSING & REHAB CENTER	11401 SOUTH OAKLEY AVENUE CHICAGO, IL 60643

(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 4 medical record. If the gradual dose reduction is causing an adverse effect on the resident or is deemed a failure, the gradual dose reduction is discontinued. Documentation of this decision and the reason for it are included in the clinical record. Dosage reduction is contraindicated for residents with severe mental illness such as but not limited to bipolar disorder, schizophrenia, and mental illness with psychotic features. Dosage reductions are not attempted for residents that have a history of recurrence of psychotic features which have been stabilized with a maintenance dose of a psychotropic medication without incurring a significant side effect. Facility's Behavioral Management Program documents in part: Acceptable diagnosis: 1. Schizophrenia. The committee will continue to routinely review the resident as long as the resident continues to receive antipsychotic medications. The committee will recommend that initiation when applicable or a gradual dose reduction unless clinically contraindicated in an effort to maintain the resident at the lowest possible dose or to discontinue the medication. Clinically contraindicated means that the resident need not undergo a GDR if: the resident has a specific condition (diagnosis #1-10 above) which has been stabilized with antipsychotic medications without significant side effects. Facility's Medication Administration Policy documents in part: Procedure: Prior to administering medications, review the resident's Medication Administration Record. Read each order entirely. If there is any discrepancy notify physician.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000822	A. BUILDING: _____ B. WING _____	C 03/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELHAVEN NURSING & REHAB CENTER	11401 SOUTH OAKLEY AVENUE CHICAGO, IL 60643

(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 5 (B)	S9999		