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 01/03/2025

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

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S 000	Initial Comments Facility Reported Incident of 11/19/24/IL182880 11/10/24/IL182881	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.610a) 300.1210a) 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 300.1210 General Requirements for Nursing and Personal Care 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	S9999		

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S9999	Continued From page 1	S9999		

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

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 regulations were not met as evidenced by:

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Based on interview and record review, the facility failed to follow their policy on abuse to protect residents' rights to be free from physical abuse. This failure resulted in:
1-R2 and R3 engaging in a verbal altercation that resulted in R2 pushing R3 causing R3 to fall while in the dining room.
2-R5 hitting R4, resulting in R4 sustaining a swollen lip and R4 was sent to the hospital.

Findings Include:

On 12/31/24, at 10:34 AM, R3 stated yes, R2 pushed R3 from the wheelchair in the dining room and R3 fell on R3's buttocks.

On 12/31/24, at 10:54 AM, R2 stated that R2 has been in this facility for 3 years and R2 has a sitting spot in the dining room. R2 stated that R2 cannot remember the incident on 11/19/24 between R2 and R3, but R2 was sent to Jackson Park Hospital for eight days. R2 stated that R2 served R2's time in the hospital, and R2 is not ready to talk to the surveyor about the incident again.

On 12/31/24, at 10:39 AM, R5 stated that R5 does not want to talk about the incident of 11/10/24. R5 later stated that R5 was having a verbal altercation with R4 over a jacket in the dining room, and R5 hit R4 in the face. R5 stated that R5 was wrong for hitting R4.

12/31/24, at 11:30 AM, R4 stated that R5 punched R4 in the face during a verbal altercation with R5 over a jacket in the dining room, and R4 stated that R4 did not hit R5 with R4's cane. R4 stated that R4 does not have any contact with R5 since the incident, and R4 is safe in this facility.

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S9999	Continued From page 3 On 12/31/24, at 10:48 AM, V11 (Certified Nursing Assistant/CNA) stated that V11 has been in the facility for fifteen years and that pushing is a form of physical abuse. V11 stated that V11 was preparing breakfast trays ready for residents in the dining room when V11 observed R2 pushed R3 from R3's wheelchair and R3 fell on the floor. 12/31/24, at 1:09 PM, V13 (Licensed Practical Nurse/LPN) stated that V13 has been in this facility for one year and half, and that V13 is familiar with R2, R3, R4, and R5. V13 stated that physical, mental, sexual, verbal, and financial are types of abuse, and that the administrator is the abuse coordinator. V13 stated that around breakfast time on 11/19/24, V13 heard commotion between R2 and R3 in the dining room, and V13 observed R3 sitting on the floor in front of R3's wheelchair. V13 stated that R2 stated that R2 pushed/flipped R3 out of R3's wheelchair because R3 was sitting at R2's preferred seat. V13 separated R2 and R3, and the physician was notified with order to send R2 and R3 to the hospital for evaluation. V13 stated that R2 and R3's family members were notified. V13 stated that around 2:00 PM on 11/10/24, V13 heard commotion between R4 and R5 in the dining room. V13 observed R4 and R5 punching each other, and V13 separated R4 and R5 to provide one-on-one monitoring. V13 stated that the physician was notified, with order to send R4 and R5 out to the hospital for evaluation, and R4 and R5 families were notified. V13 stated that there was no staff in the dining room during the incident, but staff should be in the dining room to monitor resident for safety. On 01/02/25, at 11:37 AM, V2 (Director of Nursing) stated that V2 has been in the facility for	S9999		

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about one month, and that the administrator is the abuse coordinator. V2 stated that, now that the administrator is on vacation, V2 is the abuse coordinator. V2 stated that the facility has zero tolerance for abuse, and when there is a resident to resident, or staff to resident abuse, V2 will investigate immediately. V2 stated that V2 is not sure how often the abuse in-service is done, but V2 stated that in-service on abuse is done after an abuse allegation. V2 stated that V2 has not joined the facility when the incidents between R2 and R3, and R4 and R5 occurred. V2 stated that pushing, and punching are forms of physical abuse. V2 stated that it is V2's expectation that staff will visually provide supervision to resident while in a common area like the dining room to prevent incidents that can lead to fall or physical contact.

V10 (CNA), V12 (Housekeeper), and V14 (Social Service Director) all stated that pushing, and punching are forms of physical abuse, and they will report abuse immediately to the administrator-the abuse coordinator.

R2, R3, R4, and R5's section GG (Functional Abilities) shows that R2, R3, R4, and R5 require supervision.

Progress note dated 11/10/24, documents in part: R4 was assessed by staff on duty, and R4 was observed with a laceration to the bottom lip, order to send R4 to the hospital. On 11/19/24, documents in part: "Resident (R3) verbalized some distress, nurse received MD (Medical Director) order for R3 to be sent to the hospital for an evaluation. R2's care plan revision dated 11/19/24, R2 was reported with socially inappropriate aggression towards peer in his wheelchair. R5's care plan revision dated

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S9999	Continued From page 5 12/31/24, R5 exhibited violent behavior towards peer, and R5 becomes easily agitated at least twice weekly. Witness statement dated 11/10/24, documents in part; Upon entering the dining room both residents (R4 and R5) were engaging in a physical altercation." On 11/19/24, documents in part: "I didn't see what happened but observed R3 sitting on the floor and R2 standing over R3." Abuse Policy dated 01/2019 documents in part: It is the policy of this facility to prohibit and prevent resident abuse. R3's Police report dated 11/19/24 documents in part. "Battery Simple" R4's hospital record dated 11/10/24 documents in part; Diagnoses: "Assault, Swollen lip." (B)	S9999		