

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6000822	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/05/2025
NAME OF PROVIDER OR SUPPLIER BELHAVEN NURSING & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 2581664/IL187280	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b) 300.1210d)2)5) 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 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	S9999		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

03/20/25

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S9999	Continued From page 1 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. (Section 3-202.2a of the Act) 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: 2) All treatments and procedures shall be administered as ordered by the physician. 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.	S9999		

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S9999	Continued From page 2 These regulations were not met as evidenced by: Based on interview and record review, the facility failed to ensure that one resident (R1) with a pressure ulcer, received the necessary treatment and services to promote wound healing and prevention of new wounds. This failure resulted in R1's wound worsening and requiring hospitalization for wound infection. Findings include: R1's medical diagnoses include but are not limited to hemiplegia and hemiparesis following cerebral infarction, type 2 diabetes mellitus without complications, aphasia, cognitive communication deficit, essential hypertension, pressure ulcer of sacral region. R1's Minimum Data Set (MDS) dated 01/07/25 has a Cognitive Skills for Daily Decision Making scored as moderately impaired. R1's care plan dated 01/07/25 documents in part, "R1 has an alteration in skin integrity and is at risk for additional and/or worsening of skin integrity issues ...turn and reposition resident from side to side as ordered ...monitor for signs and symptoms of infection and report to MD (medical doctor) as indicated ...administer wound care treatments per MD orders." R1's physician order with a start date of 06/27/24 documents in part, "Turn and reposition from side to side every 1-2 hours every shift for wound prevention. R1's treatment administration record dated 01/2025 and 02/2025 for the turn and reposition order show multiple dates of no documentation.	S9999			

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S9999	Continued From page 3 R1's physician order start date 01/16/25 and end date 01/25/25 documents in part, "Sacrum 1. Cleanse with 0.125% Dakins solution. 2. Apply Collagen, Calcium Alginate to base of the wound. 3. Secure with superabsorbent. 4. Change daily and PRN (as needed) every day shift." R1's treatment administration record for 01/2025 shows no documentation for 01/20/25 and 01/21/25. On 03/04/25 at 12:22pm V8 (Director of Nursing/DON) stated that legally if it's not documented then it's not done. V8 stated that her expectations for staff is to document everything that they do. R1's wound assessment documentation dated 01/31/25 measure 5.5 centimeters length by 4 centimeters width by 2 centimeters depth, odor not present. R1's wounds assessment documentation dated 02/25/25 measures 8 centimeters length by 9.5 centimeters width by 4.2 centimeters depth, odor strong, which shows R1's wound had gotten larger. R1's wound culture results collected on 02/25/25 were positive for many white blood cells, gram negative rods, gram positive rods, proteus mirabilis and Escherichia coli. R1's emergency room report dated 02/25/25 documents in part, "CT (Computed tomography) pelvis with contrast final result ...osteomyelitis at the S5 and proximal coccygeal levels ...Exam is a large approximately 10-centimeter sacral decubitus wound that goes down to muscle, base of this has gray muscular tissue, has foul odor, concern for infection ...Case request operating	S9999		

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S9999	Continued From page 4 room: Debridement sacral wound." On 03/03/25 at 12:17pm V2 (Licensed Practical Nurse/LPN) stated that she would change R1's wound if it became soiled. V2 stated that the treatment cart was located on a different floor, so if she had to change R1's wound dressing, she would improvise with whatever dressings that she had. V2 stated that she noticed R1's wound had an odor and was infected a week prior to R1 being sent to the hospital on 02/25/25. On 03/03/25 at 2:41pm V6 (Wound Care Coordinator) stated that R1's wound had declined. V6 stated that if R1 needed a PRN (as needed) dressing change, the same supplies should be used that are used for R1's routine dressing change. V6 stated that R1 developed a new wound on her anterior lower leg. V6 stated that she thinks R1's new wound was developed due to R1's leg rubbing against the heel protectors. R1's Nurse Practitioner's (NP) progress note dated 02/25/25 documents in part, "Wound specific history of a chronic stage 4 pressure ulcer to sacrum which has been refractory to many different topical treatments, wound vac, and recently failed skin sub due to frequent fecal contamination ...Wound cultures obtained x2 over the last week were rejected by lab, staff states this is due to lab not having staff to pick up samples causing delay in testing ...Seen today for reassessment of sacral wound. Wound cultures retaken today ...contacted ID (infectious disease) NP directly to discuss patient case, ID NP agreed with recommendations for starting broad spectrum IV (intravenous) antibiotic therapy for likely OM (osteomyelitis) of sacral wound."	S9999		

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S9999	Continued From page 5 On 03/04/25 at 11:09am V7 (Wound Care Nurse Practitioner/WCNP) stated that R1's wound had gotten worse over the past month. V7 stated that she suspected that R1's wound was a Kennedy ulcer and to rule out Kennedy ulcer, an infection workup needed to be done. V7 stated that she did multiple wound cultures on R1's wound but they were rejected by the lab due to staffing issues. V7 stated that she did consult with the infectious disease NP because she thought R1 may have osteomyelitis. V7 stated that R1 developed a new wound on her left anterior lower leg. Facility's policy titled "Treatment/Services to Prevent/Heal Pressure and Non-Pressure wounds" dated 11/2/23 documents in part, "Policy: It is the policy of the facility to ensure it identifies and provides needed care and services that are resident centered, in accordance with the resident's preferences, goals for care and professional standards of practice that will meet each resident's physical, mental, and psychosocial needs ...Procedure: 1. The facility will ensure that based on the comprehensive assessment of a resident: 1b. A resident with pressure ulcers or non-pressure wounds receive necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new wounds from developing ...5. Interventions will be implemented in the resident's plan of care to prevent deterioration and promote healing of the pressure and non-pressure wound." Facility's undated job description for Licensed Practical Nurse documents in part, " A. Role Responsibilities - Administrative Duties: 1. Directs the day to day functions of the nursing assistants in accordance with current rules, regulations, and	S9999		

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S9999	Continued From page 6 guidelines that govern the long-term care facility. 2. Ensures that all nursing personnel assigned to you comply with the written policies and procedures established by the facility ...B. Role Responsibilities - Charting and Documentation: 11. Performs routine charting duties as required and in accordance with established charting and documentation policies and procedures. 12. Signs and dates all entries made in the resident's medical record ...Role Responsibilities - Nursing Care: 7. Reviews the resident's chart for specific treatments, medication orders, diets as necessary ...15. Administers professional services such as catheterization, tube feedings, suction, applying and changing dressing/bandages." Facility's undated job description for Certified Nursing Assistant documents in part, "A. Role Responsibilities - Care:...Position resident in correct and in proper body alignment." (A)	S9999			