STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145070	A. Building B. Wing	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Zahav of Berwyn	3601 South Harlem Avenue Berwyn, IL 60402

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145070	A. Building B. Wing	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Zahav of Berwyn	3601 South Harlem Avenue Berwyn, IL 60402

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to prevent a cognitively impaired resident (R2) from obtaining severe burns from a radiator heater connected to the wall after R2 rolled out of bed onto the radiator heater when R2's bed was pushed against the wall for one out of three residents reviewed for accidents and incidents in a total sample of seven. This failure resulted in R2 suffering a first degree burn to the right cheek and second and third degree burns to the right arm and right leg requiring an intensive care unit hospitalization on a burn unit for five days. The Immediate Jeopardy began on 12/13/2025, the administrator was notified at 10:54AM on 12/23/2025 and the Immediate Jeopardy was corrected on 12/24/2025 when the facility moved all bed away from the heating register, completed in-services with all departments regarding keeping all beds away from the wall and checking on the bed position during rounds, and created a monitoring tool that is completed daily to check on the position of resident beds. Findings Include:R2 is a [AGE] year-old with the following diagnoses: burn of third degree of right upper arm, dementia, heat failure, and cerebrovascular disease.On 12/23/25 at 11:05AM, R2 was sitting in a wheelchair at the dining room table. A gauze wrap was covering R2's entire left arm. The gauze was clean and dry. A yellow-colored dried blister was on R2's right cheek bone that was about the size of a quarter. R2 was able to verify name but unable to answer any other questions due to mental status. In R2's room, the bed was about two feet away from the radiator heater with a floor mat on that side of the bed and another floor mat folded up in the corner. A bedside dresser was placed in between the bed and the wall. Two small metal brackets were noted on the radiator heater. The cover to the radiator heater was properly in place and not able to be moved by the surveyor. The radiator was not hot to touch.On 12/23/25 at 12:39PM, V5 (Maintenance Director) stated the facility uses a radiator heating system throughout the rooms where hot water passes through the radiators from a boiler. V5 reported each temperature is set on a thermostat on each floor. V5 stated each floor ‘s temperature is set from 76 to 78 depending on how cold it is outside. V5 denied having any issues with the radiators needing to be replaced or being too hot. V5 denied checking the radiators unless staff report an issue. V5 denied being aware of any burn's residents suffered from being against the radiator. V5 reported completing an in-service recently but could not remember the topic of what in-service was. V5 denied being aware of any staff telling V5 that R2 was burned after being against the radiator.On 12/23/25 at 1:48PM, V11 (Restorative Nurse) stated R2 had a fall on 12/6 that was confusion related due to a urinary tract infection. V11 reported on 12/13, R2 was attempting to get out of bed or stand and fell or rolled out the side. V11 stated R2 was transferred to the hospital then to another hospital to an in intensive care unit due to having burns on R2‘s body. V11 stated R2 had R2's bed up against the wall originally, but the bed was moved away from the wall after R2 suffered the burns. V11 reported R2 is confused and can follow basic instructions. V11 stated V11 was unaware why the bed was up against the wall and reported that is the way the rooms are set up. V11 stated R2 fell in between the bed and the wall and laid on the heating portion of the wall. V11 denied being aware of how long R2 was on the radiator for. V11 reported R2 needs one person assist with bed mobility and transfers. V11 stated R2 needs monitoring due to attempts to try to get out of bed unassisted.On 12/23/25 at 2:13PM, V5 stated V2 (DON) told V5 to complete the in-service on 12/13/25 with staff. V5 reported that V2 told V5 that R2 fell out of bed against the radiator. V5 stated that R2's dresser was put in between the bed and the wall to mitigate the risk of R2 falling onto the radiator again. V5 reported beds were also damaging the outlets and the radiator covers when the beds were too close by knocking them loose. V5 denied checking again if beds were against the radiators after the in-service was given.On 12/24/25 at 10:23AM, V3 (Assistant Director of Nursing/ADON) stated R2 has a wound on the right cheek bone that is closed that is partial thickness or a first-degree burn. V3 reported all of the wounds to the right arm and right leg are full thickness or third-degree burns. V3 stated there are burns to the right forearm, above the right elbow, right shoulder, right thigh, and right lower leg. V3 reported dressing changes are performed as ordered by the wound care physician, which R2 is seen by once a week. V3 reported since R2 is older with frail skin, the skin can be damaged easier. V3 stated the bed is now moved away from the wall and floor mats are in place. V3 was unaware why the bed was up against the wall originally. V3 denied R2 had any wounds before the fall on 12/13.On 12/24/25 at 11:00AM, V2 (DON) stated V2 was notified around 3 AM that R2 fell out of bed. V2 reported the nurse told V2 that R2 had some redness and discoloration so R2 was sent out to the hospital. V2 stated the nurse told V2 that R2 fell on the side of the bed where the radiator was