| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145549 | A. Building<br>B. Wing | 01/03/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Belhaven Nursing & Rehab Center | 11401 South Oakley Avenue<br>Chicago, IL 60643 |

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 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49486<br><br>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:<br><br>1-R2 and R3 engaging in a verbal altercation that resulted in R2 pushing R3 causing R3 to fall while in the dining room.<br><br>2-R5 hitting R4, resulting in R4 sustaining a swollen lip and R4 was sent to the hospital.<br><br>Findings Include:<br><br>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.<br><br>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 [NAME] 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.<br><br>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.<br><br>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.<br><br>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.<br><br>(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 |
|---|---|---|

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | 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.<br><br>On 01/02/25, at 11:37 AM, V2 (Director of Nursing) stated that V2 has been in the facility for 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.<br><br>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.<br><br>R2, R3, R4, and R5's section GG (Functional Abilities) shows that R2, R3, R4, and R5 require supervision.<br><br>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 12/31/24, R5 exhibited violent behavior towards peer, and R5 becomes easily agitated at least twice weekly.<br><br>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.<br><br>Abuse Policy dated 01/2019 documents in part: It is the policy of this facility to prohibit and prevent resident abuse.<br><br>R3's Police report dated 11/19/24 documents in part. Battery Simple<br><br>(continued on next page) |

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| F 0600<br>Level of Harm - Actual harm<br>Residents Affected - Few | R4's hospital record dated 11/10/24 documents in part; Diagnoses: Assault, Swollen lip. |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>49486<br><br>Based on interview and record review, the facility failed to provide appropriate supervision to four (R2, R3, R4, and R5) residents while in the dining room out of four residents reviewed for supervision. This failure resulted in<br><br>1-R2 and R3 engaging in a verbal altercation that resulted in R2 pushing R3 causing R3 to fall.<br><br>2-R5 hitting R4, resulting in R4 sustaining a swollen lip and R4 was sent to the hospital.<br><br>Findings Include:<br><br>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.<br><br>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. R2 stated that R2 was sent to a local hospital for eight days and that R2 served R2's time in the hospital, and R2 is not ready to talk to the surveyor about the incident again.<br><br>On 12/31/24, at 10:39 AM, R5 stated 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, and R5 hit R4 in the face. R5 stated that R5 was wrong for hitting R4.<br><br>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 has not have any contact with R5 since the incident, and R4 is safe in this facility.<br><br>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 on 11/19/24 when V11 was preparing breakfast trays ready for residents in the dining room, V11 observed R2 pushed R3 from R3's wheelchair and R3 fell on the floor.<br><br>12/31/24, at 1:09 PM, V13 (Licensed Practical Nurse/LPN) stated that there was no staff in the dining room during the incident, and V13 stated that staff should be in the dining room to monitor resident for safety.<br><br>On 01/02/25, at 11:06 AM, V14 (Social Service Director) stated that all residents in the facility should be supervised, and there should be visual supervision of residents when in the dining room to prevent resident from physical altercation, fighting, falling and to watch out for triggers.<br><br>On 01/02/25, at 11:37 AM, V2 (Director of Nursing) 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.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | V9 (CNA), V14 (Social Service Director), V18 (CNA), and V19 (CNA) stated that staff should provide visual supervision for residents when in the dining room for safety, to prevent resident from falling and fighting.<br><br>R2, R3, R4, and R5's section GG (Functional Abilities) shows that R2, R3, R4, and R5 require supervision.<br><br>Abuse Policy dated 01/2019 documents in part: It is the policy of this facility to prohibit and prevent resident abuse.<br><br>Facility Policy titled Standard Supervision and Monitoring dated 5/17/23 documents in part.<br><br>Purpose: This guideline emphasizes a proactive intervention promoting enhanced physical and psychosocial well-being.<br><br>Procedure: A staff member that has been assigned to care for the resident will visualize the resident during mealtimes. |