

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145549	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/24/2025
NAME OF PROVIDER OR SUPPLIER Belhaven Nursing & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 11401 South Oakley Avenue 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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45000</p> <p>Based on observation, interview, and record review, the facility failed to a.) provide adequate supervision and monitoring for residents, b.) ensure medications were administered as ordered by the residents' physician, c.) ensure medications were given when the Medication Administration Record was signed, d.) notify physician of residents not receiving medications, e.) ensure medications were locked and secured while unattended, f.) provide sufficient nursing coverage to ensure adequate resident care and support, and g.) provide care and services that meet professional standards. These failures have the potential to affect 125 residents residing in the facility.</p> <p>Findings include:</p> <p>On 01/22/2025, at 8:56 AM, surveyor located on the second floor of the facility with V6 (Licensed Practical Nurse/LPN). V6 states she started her shift today at 7:00 AM and is currently the only nurse working on the second floor. V6 states management is aware, and she is awaiting another nurse to arrive to assist with resident care. V6 states she just began her medication administration pass and has administered medications to one resident so far. At 9:12 AM, R2 located by the nurses' station next to the medication cart receiving his morning medications from V6. V6 states R2 does not have his Benzotropine medication inside the medication cart. V6 observed reordering Benzotropine medication from the pharmacy. V6 states the director of nursing/DON should also be notified to see if R2s' Benzotropine medication is available inside the automated medication dispenser/AMD. V6 states the AMD is a new system that has been implemented recently and the nurses do not have passwords to have access to the AMD.</p> <p>On 01/22/2025, at 9:19 AM, V4 (LPN/Restorative Nurse) observed arriving on the second floor and administering medications to residents. V4 states she is not the nurse scheduled to work and is helping out until the scheduled nurse arrives to work.</p> <p>On 01/22/2025, at 9:35 AM, several residents ambulating via wheelchair are located inside of the second-floor dining room. No staff members are located inside of the dining room monitoring the residents.</p> <p>On 01/22/2025, at 9:36 AM, surveyor makes V3 (Assistant Director of Nursing/ADON) aware that residents are inside of the dining room without any staff members monitoring them. V3 states there is supposed to be someone inside of the dining room monitoring the residents and states she will follow up on this matter.</p> <p>(continued on next page)</p>

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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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 01/22/2025, at 9:38 AM, V7 (Certified Nursing Assistant/CNA) observed walking inside of the second-floor dining room to monitor residents. V7 states she was not aware that she was supposed to be monitoring the residents because she was not aware of the schedule. V7 states if residents are not properly monitored, then they can potentially fall, injure themselves, have a seizure, or get into a physical altercation with one another.</p> <p>Record review of the CNA assignment sheet dated 01/22/2025, documents that V7 is responsible for monitoring the dining room from 9:30 AM-10:00 AM.</p> <p>On 01/22/2025, at 9:44 AM, V5 (LPN) located on the second floor administering medications to residents. V5 states he was scheduled to work at the facility at 7:00 AM. V5 states he was coming from his other job and running behind to work at the facility.</p> <p>Facility timecard dated 01/22/2025, documents that V5 arrived to work in the facility at 9:15 AM.</p> <p>Facility timecard dated 01/22/2025, documents that V6 (LPN) arrived to work in the facility at 7:30 AM.</p> <p>Facility nursing schedule dated 01/22/2025 documents that the facility scheduled three nurses to work on the second floor of the facility from 7:00 AM-3:30 PM and there was one nurse call-off.</p> <p>On 01/22/2025, at 9:52 AM, R3 located at the medication cart receiving his morning medications from V5 (LPN). V5 informs R3 that his Escitalopram medication is not available inside the medication cart. R3 then states it has been 5 days since he received his Escitalopram medication. Surveyor observed on R3s' electronic health record/EHR that his Escitalopram medication was last ordered from the pharmacy on 01/16/2025. R3 states he last received his Escitalopram medication on 01/16/2025.</p> <p>R3's POS/physician order sheet documents the following order: Escitalopram Oxalate Tablet 20 MG- Give 1 tablet by mouth one time a day for depression.</p> <p>R3s' MDS/Minimum Data Set, dated dated dated [DATE], documents that R3 has a BIMS/Brief Interview for Mental Status of 15/15, indicating that R3 is cognitively intact.</p> <p>There is no documentation prior to 01/22/25, to show that R3s' physician was notified that R3s' Escitalopram medication was not available and not administered to R3.</p> <p>R3s' medication administration record/MAR documents that R3s' Escitalopram medication was administered to him on 01/17/25, 01/18/25, 01/19/25, 01/20/25, and 01/21/25.</p> <p>On 01/22/2025, at 10:00 AM, V9 (CNA) and V10 (CNA) observed on the second-floor hallway with a cell phone showing each other videos. V9 then sees surveyor and states she's sorry and knows she's not supposed to be on her phone. V9 and V10 states they are scheduled today to work on the second floor caring for the residents.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 01/22/2025, at 10:10 AM, V2 (Director of Nursing/DON) states she has been working at the facility for one month now. V2 states the facility has an automated medication dispenser/AMD located on the first floor of the facility inside the medication storage room. V2 states she has access to the AMD and the staff nurses do not yet have access to the AMD. V2 states if resident medications are not available for administration, then she expects for the staff nurses to inform her. V2 states V5 (LPN) recently informed her today that R3 does not have his Escitalopram medication inside the medication cart. V2 states since she has been working at the facility, she has not been made aware that residents have run out of their medications and they are not available in the facility for administration. V2 states surveyors' inquires is the first time she is being made aware that R3 has not had his Escitalopram medication for the past 5 days. V2 states if she is made aware of residents' medication not being available, then she is able to follow up with the pharmacy to inquire about the medication and to see if it is available in the AMD. V2 states the physician should also be notified that a residents' medication is not available for administration. V2 states as of now, V5 (LPN) is the only nurse who has made her aware that R3 and R4 did not have their medications inside of the medications cart for administration.</p> <p>On 01/22/2025, 10:30 AM, V6 (LPN) states approximately one hour ago, she informed V2 (DON) that R2s' Benzotropine medication was not available for administration today. V6 states V2 told her that V2 would follow up on this matter.</p> <p>During record review of R2s' electronic MAR/eMAR on 01/22/2025, at 1:07 PM, R2s' MAR documents that V6 administered R2s' Benzotropine medication to him on 01/22/2025.</p> <p>On 01/22/2025, at 2:56 PM, V6 (LPN) states she did not administer R2s' Benzotropine medication to him today and only reordered it from the pharmacy. V6 states she made the nurse practitioner/NP aware already and R2s' Benzotropine medication should arrive to the facility this evening.</p> <p>On 01/22/2025, at 10:41 AM, V8 (LPN) located on the first floor of the facility with a medication cart and performing medication administration for residents. Two residents sitting in wheelchairs located at the medication cart with V8. V8 observed preparing resident medications while her phone is on top of the medication cart and V8 is actively on a video phone call with an unknown male caller. V8 then sees surveyor and abruptly ends the video call. V8 states she was on the phone with her adult son and is aware that she is not supposed to be on the phone while administering medications. V8 states a video call could violate HIPAA privacy laws for residents living in the facility. V8 also states she could make a medication error and residents can experience adverse reactions if she is distracted by a video call while preparing residents' medications.</p> <p>On 01/22/2025, at 2:15 PM, surveyor located on the first floor of the facility and observes a medication cart unlocked and unattended. Surveyor is able to open medication cart and gain access to residents' medications. Surveyor makes V12 aware of an unlocked medication cart. V12 (LPN) states she is responsible for the medication cart that is unlocked and unattended and only left the cart temporarily. V12 states if a medication cart is left unlocked and unattended, then residents can gain access and have adverse reactions and possibly overdose.</p> <p>On 01/22/2025, at 2:35 PM, surveyor located on the second floor of the facility. V13 (CNA) observed entering the nurses' station and washing her hands. V12 then yells out loudly in front of multiple staff and residents I'm not about to do this s***, she is over there flicking blood, I will walk right out of this place!</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 01/22/2025, at 2:45 PM, R1 states V11 (LPN) did not administer his inhaler medication (identified as Ventolin) to him some time last week. R1 states this is his rescue inhaler and he should not have to ask the nurses for this medication. R1 states he has an order for his Ventolin to be left at the bedside and to be able to self-administer it when he needs it in an emergency.</p> <p>R1s' POS documents the following order: Ventolin HFA Inhalation Aerosol Solution 108 (90 Base) MCG/ACT (Albuterol Sulfate)- 2 puff inhale orally every 6 hours as needed for sob (shortness of breath), wheezing unsupervised self-administration ok to leave at bedside.</p> <p>On 01/22/2025, at 2:58 PM, surveyor located at the medication cart with R1 and V6 (LPN). V6 states R1 is not able to self-administer his Ventolin medication and it is kept inside the medication cart for the nurses to administer to R1. Surveyor makes V6 aware of R1s' Ventolin order and V6 reads R1s' Ventolin medication label and states according to the label, R1 is able to self-administer his Ventolin medication. V6 then places R1s' Ventolin medication back inside of the medication cart and states It's 3:00 PM, I'm tired, y'all been at me all day!</p> <p>On 01/22/2025 at approximately 3:30 PM, surveyor makes V2 (DON) aware of the need to speak to V11 (LPN) regarding allegations.</p> <p>On 01/22/2025, at 3:52 PM, surveyor located alone inside the first-floor social services office conducting investigations. V11 (LPN) then enters the room and immediately began yelling to surveyor that he heard surveyor wanted to speak to him about R1 and yells I gave R1 his inhaler medication all the time. V11 continues standing while yelling at surveyor. Surveyor politely asks V11 to have a seat in order to have a formal introduction and interview. V11 then yells to surveyor that he has to get out on the floor to work. Surveyor asks V11 again to have a seat for a formal interview. V11 then sits down in a chair and surveyor makes an introduction and begin to ask V11 a question. Before surveyor finishes the questions V11 interrupts and begin yelling that he's been working at the facility ten years and has never given R1 anyone else's medication. Surveyor asks V11 to allow surveyor to finish asking the question before V11 interrupts so that V11 can hear the entire question. V11 yells to surveyor, Well go ahead then. Surveyor begins to ask another question and V11 interrupts surveyors' question again yelling, I'm tired of people lying. V11 became very rude, loud, and irate. Surveyor is unable to finish interviewing V11 due to his behavior and ends the interview with V11. Surveyor asks V11 to leave the office and inform V2 (DON). Surveyor makes V1 (Administrator) and V2 (DON) aware of V11s' behavior towards surveyor and the potential to exhibit these same behaviors towards residents.</p> <p>Facility census dated 01/22/2025, documents that a total of 57 residents reside on the first floor of the facility.</p> <p>Facility census dated 01/22/2025, documents that a total of 68 residents reside on the second floor of the facility.</p> <p>Facility policy dated 05/17/2023, titled, Standard Supervision and Monitoring documents in part, The facility recognizes supervision and guidance to the resident is an essential part of nursing care in which standard approaches are successful in meeting the residents' physical and psychosocial needs.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Facility document undated, titled HIPAA and HiTECH Privacy documents in part, Information about residents and employees is privileged and must be kept in strict confidence. All resident information should be kept in secure areas so that others do not have access.</p> <p>Facility document undated, titled Use of Personal Cell Phones and Other Personal Electronic Devices documents in part, To avoid disruptions, cell phones and watch devices should either be set to vibrate, low volume, or turned off completely.the use of device should be kept away from residents and family members. Further, video or pictures should never be taken of residents. There is zero tolerance for privacy violations.</p> <p>Facility policy undated titled, Drug Administration- General Guidelines documents in part, 2. Medications are administered in accordance with written orders of the attending physician. 3. Residents are allowed to self-administer medications when specifically authorized by the attending physician. 7. Only the licensed or legally authorized personnel who prepare medication may administer it. This individual records the administration on the residents' MAR at the time the medication is given. In no case should the individual who administered the medications report off-duty without first recording the administrations. 11. If a dose of regularly scheduled medication is withheld, refused, or given at other times than the scheduled time, .an explanatory note is entered. If two consecutive doses of a medication are withheld or refused, the physician is notified.</p>		