STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145549	A. Building B. Wing	03/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belhaven Nursing & Rehab Center	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)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45111 Based on interviews, and record review, the facility failed to provide necessary treatment and services to promote healing of existing wounds for one (R1) of three residents reviewed. This failure has the potential for R1's wounds to get worse. Findings include: R1 is a [AGE] year-old individual admitted to the facility on [DATE]. R1 discharged to a nearby hospital on 02/27/2025. R1's medical diagnosis includes but not limited to: paraplegia, unspecified, colostomy, type 2 diabetes mellitus without complications status, other mechanical complication of cystostomy catheter, subsequent encounter, chronic obstructive pulmonary disease, unspecified. R1's progress notes dated 2/25/2025, further document R1 has multiple sacral wounds and hospital records dated 1/25/2025 document R1 has Fournier's gangrene extending from the perianal region, large right sacral ulcer and necrotizing fasciitis involving gluteal fat. MDS (Minimum Data Set) section C dated 03/04/ 2025, documents R1's Brief Interview for Mental Status (BIMS) as 15/15, indicating R1 has intact cognitive functional abilities. R1 requires partial to moderate assistance with activities of daily living. On 03/15/2025, at 1:53 PM, V5 (Wound care Nurse-RN) stated when there is a new admission, the nurse completing the skin assessment should note where all the wounds are and describe them. Then the nurse should get orders for wound treatment and immediately start treatment to prevent the wounds from getting worse, which can lead to sepsis, and death. V5 stated R1's admission notes and skin assessment completed on 2/25/2025, document R1 has pressure ulcers and needed provider orders for wound care. On 03/15/2025, at 3:24 PM, V8 (Licensed Practical Nurse-LPN) stated she admitted R1 into the facility and R1 did not have any paperwork from the hospital. V8 stated when a resident comes from the hospital as a new admission without any paperwork, the admitting nurse completes assessments and calls the physician for orders. V8 stated the wound care team take care of residents' wounds in the facility and if the wound care team is not available, the nurse takes care of the wound treatments. V8 stated she called R1's physician on 2/26/2025 and got orders for the wound care team to evaluate R1's wounds. V8 stated she documented on the POS (Physician Order Sheet) and nurse progress notes, but she did not complete any treatments. (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
	145549	A. Building B. Wing	03/16/2025

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/15/2025, 5:08 PM, V9 (Wound Care coordinator) via phone stated she did not get a chance to assess R1's wounds because V9 was not at facility the next morning after R1 was admitted to the facility. V9 stated residents with wounds are supposed to be seen right away to prevent a delay in care. If V9 is not in the building, the nurses are supposed to assess and follow up with the wound Nurse Practitioner (NP) for orders and treatment plan. V9 stated the nurses should have cleaned R1's wounds with normal saline and apply dry dressings until V9 can come back to the facility. The nurse should have contacted the wound care NP. V9 stated if there is a delay in wound care, it can lead to wound infection, sepsis, and death. On 03/15/2025, at 4:18 PM V2 (Director of Nursing-DON) stated R1 was admitted to the facility on [DATE], at 11:20 PM. V8 (Licensed Practical Nurse-LPN) got admitting orders from the physician on 2/26/2025, for the wound care team to assess and treat R1's wounds. V2 stated R1 was not seen by V9 (Wound Care Coordinator) on 2/26/2025, because V9 was out of the facility on a wound care treatment training at another facility. The nurses were supposed to take care of resident's wounds on that day. V2 stated she believes when V8 called the doctor for R1's admitting orders for wound care, the physician gave orders to contact the wound care team to evaluate the wounds. V2 is confident that the doctor gave orders to cleanse the wounds with normal saline and apply dry dressings until R1 was assessed by the wound care team. But V8 forgot to put those orders in. V2 stated anytime a resident is admitted with wounds, the physician gives standing orders to clean the wounds with normal saline and apply dry dressings until the resident is seen by the wound care team. V2 said was important for R1's wound treatments to be administered to promote healing and to prevent decline of the wounds which can lead to worsening of the wounds. On 3/15/2025, at 4:54 PM, V10 (Licensed Practical Nurse-LPN) stated on 2/27/2025, during the night shift, R1 kept coming out of his room and stating to V10 that the facility was not taking good care of him. R1 stated he needed to go to the hospital to get medical attention for his colostomy and wounds. R1 stated he had not seen R1's wounds. R1 insisted on leaving, therefore V10 called the ambulance and R1 was transferred to the hospital. Policy titled Guidelines for Physician Orders-(Following Physician Orders) dated 6/18/23 documents: -At the time of admission, the facility must have physician orders for the resident's immediate care. Policy titled Treatment/Services to Prevent/Heal Pressure and Non-Pressure wounds, no date, documents: -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.