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	07/03/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow a physician order and monitor a resident's vital signs for one (R1) out of four residents reviewed for quality of care in a total sample of four. This failure places residents at risk to be provided with inappropriate care and services to meet the resident's physical, mental and/or psychosocial needs. This failure places the resident at risk for more than minimal harm. Findings include: On 07/01/2025, at 12:56 PM, R1 stated that he saw V10 (Nurse Practitioner) about three weeks ago. R1 stated that he informed V10 that R1 has been having a lot of migraines which R1 stated that he never had in his life. R1 stated, I'll be sitting there and physically feel that my blood pressure is high. R1 stated that V10 ordered a medication which has been helping R1. R1 stated that the staff do not check his blood pressure daily. R1 stated that the nurse did not check R1's blood pressure today nor any vital signs. On 07/01/2025, at 11:49 AM, V6 (Registered Nurse) stated that R1 has an order for vital signs daily but no option of recording them. V6 stated that she did monitor R1's vital signs today and wrote them on a piece of paper which V6 threw out in the garbage and does not have the paper anymore. V6 stated that R1 does have a diagnosis of hypertension on his face sheet. V6 stated that R1's last blood pressure recorded in R1's blood pressure log is 138/77 mmHg (millimeters of mercury) dated 6/13/2025. V6 stated that symptoms of high blood pressure a person may experience is dizziness, lightheaded, sweating, pain, headache, flushing, chest discomfort, swelling to extremities. V6 stated that R1's vital signs should have been documented in R1's electronic medical record. R1's current face sheet documents R1 is a [AGE] year-old individual admitted to the facility on [DATE] and has diagnoses not limited to: hypertension, chronic obstructive pulmonary disease, asthma. R1's Minimum Data Set (MDS) Section C, dated 05/14/2025, documents R1 has a Brief Interview for Mental Status (BIMS) of 15 out of 15, indicating R1 is cognitively intact. R1's active physician order sheet/POS documents the following order: vital signs daily every day shift for monitoring. This order is active since dated 01/25/2025. R1's blood pressure log from April 2025 to June 2025. No blood pressure logged from April 2025 to May 2025. For June 2025 only one blood pressure reading (138/77 mmhHg) logged in the blood pressure log dated 6/13/2025. (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	07/03/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's nurse's note dated 6/24/2025, at 7:41 PM, documents in part R1's blood pressure read 143/78 mmHg. No other blood pressure readings noted from April 2025 to June 2025. R1's provider note dated 6/25/2025, 7:35 AM, documents in part cardiology medical necessity: f/u (follow up) consult for cardiac med reconcile, titrating cardiac meds, lab follow up, following volume status, adjusting diuretics as needed, monitoring hemodynamics/symptoms during and post physical therapy, and increased risk for cardiac re-admission. Plan: Essential HTN (hypertension) - No antihypertensive medications on file -- SBP (systolic blood pressure) less than 140 -- Low salt diet advised R1's physician progress note dated 5/20/2025, 4:25 PM, documents in part R1 has a PMHx (past medical history) of COPD (chronic obstructive pulmonary disease), HTN (hypertension). Patient (R1) is drowsy, oriented, calm. Patient reports headaches are improved with Candesartan. He also reports improvements in back pain with medication, he believes this is due to relief of tension and anxiety from headaches. Plan: HEADACHES/MIGRAINES: Candesartan and monitor HTN: Monitor off antihypertensives. Call doctor/nurse practitioner with SBP>170. Facility document dated 06/18/23, titled guidelines for physician orders documents in part It is the policy of the facility to follow the orders of the physician. All physician orders received pertaining to the resident will be implemented and followed throughout the course of the resident's stay in the facility as the orders are received.