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	08/15/2025

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. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement resident-directed care consistent with the resident's comprehensive assessment, professional standards of practice by a.) provide feeding assistance to two (R9, R10) residents b.) help a resident maintain their dignity during mealtime for one resident (R10) in a total sample of 10 residents. This failure places the resident at risk for more than minimal harm.Findings include:On 08/13/2025 at 12:49 PM, R10 sitting on a wheelchair, in the dining area, wearing a towel on his chest, falling asleep. R10 has a plate with pureed food covered with clear plastic in front of him on the table. Staffing seen passing out meal trays. On 08/13/2025 at 12:53 PM, R10 still positioned the same, falling asleep. One staff next to him, uncovered (plastic cover) the plate of pureed food and walked away with three other staff to pass out meal trays. R10 lifts his head a little, attempts to eat by himself, head is tilted to left side, with his right hand, grabbing food with spoon. R10 appears sleepy/drowsy, chin down, holding up spoon in the air and falling asleep. No staff providing feeding assistance to R10.On 08/13/2025 at 12:57 PM, R10 dropping food on the towel and eating with right hand, slowly. Some pureed food noted on his beard/chin area. Eating the small bowl of apple sauce with his mouth, without using a utensil. R10 grabbed spoon and filled with pureed food and place it in the mouth. With head down, falling asleep, appears with food still in his mouth. On 08/13/2025 at 1:01 PM, R10 falling asleep, no staff encouraging or standing next to R10. On 08/13/2025 at 1:02PM, R10's head tilting to his left again and forward. On 08/13/2025 at 1:03 PM, R10 picked up white bowl with a little bit of apple sauce and grabbed with mouth. On 08/13/2025 at 1:05 PM, R10 noted falling asleep, chin to chest. On 08/13/2025 at 1:07 PM, this surveyor questioned R10 how he was doing, R10 easily arousable, stated I need help with my food as saliva noted coming out of his mouth. On 08/13/2025 at 1:10 PM, R9 tilted towards his left side, eating with right hand, regular round spoon, eating dessert off from the plastic bowl, not able to use left hand. Approximately two spoonsful of turkey on the floor next to R9's bed, an assistive device plate noted. An empty cup of what appears like red color liquid (possibly juice) noted. No staff assisting resident eat his meal.On 08/14/2025 at 12:04 PM, R9 able to wheel himself, in the hallway. awake and responsive. Has a reclining wheelchair. On 08/14/2025 at 12:36 PM R10 sitting in front of the table, wearing glasses, wearing a hospital gown over his shirt. No lunch in front of him yet. R10's beard appears unclean, noted with light brown color particles (appears as dry food). On 08/14/2025 at 12:41 PM R10's head down, leaning forward. Staff member placed a lunch tray on the table in front of R10. R10 began to eat with his right hand using a spoon. R10 grabbed a spoonful of the pureed food, and some of the pureed landed on his left side of his mouth. R10 grabbed the chocolate pudding in a small bowl, lifted it up to his mouth and dropped some on his left finger/hand. No magic cup noted on R10's meal tray. No staff providing feeding assistance to R10. On 08/142025 at 1:01 PM V14 (Certified Nursing Assistant) observed another resident put some food on R10's finished plate. V14 removed the plate and asked the server if she had more pureed. On 08/14/2025 at 1:02 PM V14 placed a new plate with pureed food in front of R10 and walked away. R10 began slowly eating with his right hand. R10's head is titled to the left a bit. On 08/14/2025 at 1:06 PM eating more, slowly, chin beard filled with food particles. No staff assisting R10 noted. On 08/14/2025 at 1:10 PM, R10 is still eating, filling mouth with pureed food. Despite having more food still in his mouth.On 08/14/2025 1:11 PM, R10 grabbed food with his hand. V5 (Licensed Practical Nurse) placed a chair next R10 and walked away towards nurse's station. On 08/14/2025 at 1:12PM, V5 walked back to R10, noted with paper towel in her hand and told R10 let me help you. V5 fed him and cued him to take his time. On 08/14/2025 at 1:15 PM, V5 stated that she initiated to assist R10 because V5 saw R10 eat with his hand, and R10 looked like he was struggling. V5 stated I asked the CNA to get me a towel so I can clean him off or something and continue to feed him. V5 stated that it is important to help the residents if they have food stains around their mouths for dignity reasons.On 08/14/2025 at 3:06 PM V2 (Director of Nursing) stated that a resident who needs assistance should not sit there with food particles on their face. V2 stated you would want to wipe their face. R9's face sheet documents R9 is a [AGE] year-old individual with diagnoses not limited to: chronic obstructive pulmonary disease, unspecified, schizophrenia, unspecified, dystonia, unspecified, anxiety disorder, unspecified, essential (primary) hypertension, epilepsy, unspecified.R9's MDS/Minimum Data Set, dated [DATE] documents that R9's cognitive skills for daily decision making are moderately impaired- decisions poor; cues/supervision required. R9's MDS/Minimum Data Set section GG dated 08/05/2025 documents in part R9 requires substantial/maximal assistance

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to a.) ensure drinks consumed are in the appropriate form as ordered by the physician for one resident (R10) b.) provide the appropriate nutrient content as ordered by the physician order for two (R8, R9) out of ten residents reviewed for dietary services. This failure places the resident at risk for more than minimal harm.Findings include:On 08/13/2025 at 12:24 PM R8 stated I'm supposed to get two cheeseburgers as he is showing his diet slip to a staff member. V12 (Dietary Aide) nodded her head no, they didn't make another one. then she looked at surveyor and said give me a minute.On 08/13/2025 at 12:39 PM, R8 standing at the nurse's station, stated that he did not receive another cheeseburger. R8 stated sometimes they do give me my double portions but not today or yesterday. R8's MDS/Minimum Data Set, dated [DATE] documents that R8 has a BIMS/Brief Interview for Mental Status score of 15/15, indicating that R8 has intact cognition. R8's active physician order dated 05/23/2025 documents in part double portions diet, Regular texture, Thin Liquids consistency. for double portion. On 08/14/2025 12:44 PM, R9's lunch tray placed in front of R9, no double portion protein noted on his plate (one scoop of chopped chicken, rice, carrots), and on R9's tray also chocolate pudding in a small bowel, and a cup of juice noted.R9's active physician order/dietary order dated 05/22/2025 documents in part general diet mechanical soft texture, thin liquids consistency, double portion protein for nutrition. On 08/14/2025 at 12:41 PM R10's head down, leaning forward. Staff member placed a lunch tray on the table in front of R10. No magic cup noted on R10's meal tray.On 08/14/2025 at 12:48 PM, R10 eating slowly trying to get some of the pureed food. R10 grabbed a cup off his lunch tray and drank the thin liquid juice. No acute distress noted. On 08/14/2025 at 12:53 PM V14 (Certified Nursing Assistant) stated I am not the one who gave him his tray as V14 grabbed R10's liquid thin juice and provided R10 with thickened liquid apple juice. V14 stated not sure if it is fruit punch juice but it is thin liquid. R10's active physician diet order dated 05/22/2025 documents in part NAS = no salt packet on tray diet, pureed texture, nectar consistency. magic cup with lunch and dinner for diet.On 08/14/2025 at 3:06 PM V2 (Director of Nursing) V2 stated that it is important to follow diet orders because number one goal is always safety. Someone might be on a cardiac or renal, or pureed, mechanical soft diet based on their diagnosis and assessments. V2 stated that if there is an order for a resident to have double portion meal, then they should receive double portion. V2 stated it means what they can tolerate. V2 stated that if a resident who has an order for thickened liquids drinks thin liquids, it can place the resident at risk for aspiration. V2 stated that some complication of aspirating is aspiration pneumonia, choking. V2 stated that if a resident is given thin liquids instead of thickened liquids that is an example of not following diet orders. V2 stated that residents are honored their right to be treated with dignity and respect during mealtimes you would want to make sure they receive their appropriate meal trays.