

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  08/27/2025
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 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</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

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  08/27/2025
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 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, interviews and record reviews, facility failed to administer resident's medications according to physician orders and instructions. This failure affected one out of three residents reviewed for medication administration and has the potential to affect all 26 residents on the second - floor unit receiving medications from the split medication cart. Findings include:On 8/25/2025 at 10:00 AM, Review of the facility's provided census (dated 8/25/2025), showed that 199 residents live within the facility (26 residents on the second-floor unit receiving medications from medication cart titled the split cart). On 8/25/2025 during review of R1's EMAR, (printed on 8/25/2025 at 3:29 PM), observed empty spaces (8/11/2025 at 9 AM, 8/15/2025 at 6 PM, 9 PM and 8/17/2025 at 5 PM, 6 PM and 9 PM) without a checkmark code or any other code documenting if the medications were held, refused, or administered. The undocumented medications included all R1's seizure medications, blood pressure and blood thinning medications, vitamins and supplements, antidepressant, and medication for ulcer prevention. R1's admission record documents in part, R1 was admitted to the facility on [DATE] from an acute care hospital. R1's diagnosis included but are not limited to Spastic Hemiplegic Cerebral Palsy, Lennox-Gastaut Syndrome, Other Seizures, Diabetes Mellitus, Cerebral Infarction, Essential (Primary) Hypertension, Hemiplegia affecting left nondominant side, Bipolar disorder, Major Depressive Disorder, Other Lack of Coordination and Chronic Obstructive Pulmonary Disease. R1's , Brief Interview for Mental Status (BIMS) dated 8/8/2025, documents R1 has a BIMS score of 15, which indicates that R1 is cognitively intact.Reviewed R1, for medication administration and found concern for R1's seizure and other medications administration. The nursing staff, not administering R1's seizure medication and other prescribed medication as prescribed. On 8/25/2025 at 12:40 PM , during the facility's tour of second floor, V3 (Registered Nurse/RN) stated, that the current 2nd floor census is 71 residents, and the unit has three medication carts. V3 stated that each medication cart serves specific residents.On 8/25/2025 at 12:50 PM, observed R1 in the dining room, sitting by the table, dressed well in a white t-shirt and sweatpants, clean, with appropriate behavior, and wearing a face mask. Observed R1 having a rollator walker with bags with R1's belongings inside, hanging on the handle of the rollator. R1 was observed walking independently in the hallways using the rollator walker. On 8/25/2025 at 1 PM, R1, when passed nursing station, pointed out V4 (Licensed Practical Nurse/LPN) to the surveyor and stated that V4 is one of the nurses that did not gave R1 medications for seizures and R1's other medications. R1 stated, that there is another nurse, that skipped R1's seizure medications in the evenings, R1 just could not remember the other nurse's name. R1 said, that R1 did receive all the medications today and stated, that the staff administers medication as the staff pleases, when it is convenient and not on time as ordered. R1 stated, that R1 did not receives R1's seizure medication in the morning but did not remember the exact date of occurrence. R1 also said that V4 (LPN), would not give the medication to R1 and would not explain the reason. R1 stated that V4 was sitting at the nurse's station and ignore R1. R1 stated, that the same situation happened before with the evening nursing staff, sometimes this month, but R1 could not recall the exact date. R1 stated that R1 normally takes the seizure medication twice a day at 9 AM and around 5-6 PM. R1 was concerned and stated, that it is very important to take R1's seizure medications as per physician order, to prevent R1 from having seizures and when missed, there could be a probability that R1 could start having seizures again. On 8/25/2025 at 1:15 PM, observed V4 (LPN), sitting at the second-floor nurse's station, charting on computer. V4 stated that V4 start medication pass around 8 AM. On 8/26/025 at 8:30 AM, observed medication pass on the second-floor unit with V15 (Registered Nurse/RN). Observed V15 preparing R1's medications with no concerns. V15 used proper infection control and administered all R1's medications included but not limited to seizure medications. Observed V15 passed R1's morning medications that consisted of Amlodipine 5mg tablet daily; Lipitor 20mg daily; Keppra 1000mg twice a day; Lisinopril 10mg daily; Phenobarbital 100 mg twice a day; Pregabalin 200mg twice a day; Vitamin B1 100mg daily, Folic Acid 1mg daily, Aspirin 81mg daily and Famotidine 20mg daily. On 8/26/2025 at 09:05 AM, observed V3 (RN) at the nurse's station on the second-floor documenting. V3, stated, that V3 already administered all R2's medication this morning around 8:20 AM. Observed V3 pulling all R2's medications from the medication cart assigned to R2's hallway. V3 stated, that the medications administered to R2 this morning, included but not limited to Candesaratan , Tamsulosin, Docusate Sodium, Folic Acid, Multivitamin with Minerals, Albuterol inhaler, Advair Diskus Inhalation Aerosol, Fluticasone Nasal spray and inhaler, Tiotropium Bromide inhalation capsule. Observed</p>		

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  08/27/2025
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 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times.</p> <p>(continued on next page)</p>

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  08/27/2025
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 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Based on observation, interview, and record review, the facility failed to ensure that residents were provided meals and snacks at appropriate times, in accordance with 42 CFR 483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. These failures have the potential to affect all 199 residents who receive oral meals from the facility's kitchen. Findings Include: On 08/25/2025 at 09:45 AM Surveyor was provided with facility census listing 199 residents residing in the facility. On 08/25/2025 at 1:00pm surveyor observed the Dining Rooms on the 2nd floor that revealed: Food Carts had been brought to the 2nd Floor Dining so staff could start the lunch meal service. Residents had been sitting at the tables waiting for food trays to be passed out. Only some residents received food trays because staff was waiting for the rest of the meals to be sent up from the kitchen. On 08/25/2025 at 1:00pm V16(Certified Nursing Assistant/CNA) said since the new company has taken over kitchen duties food has been sent up the units late. V16(CNA) said she thinks they are short staffed in the kitchen, but it has been an issue with getting meals on the units so they can start at scheduled meals times. On 08/25/2025 at 1:05pm R5 stated the food comes late all the time and they are not doing anything about it. R5 said he has voiced his concerns to staff and during resident council meetings but it hasn't improved the fact that lunch is always served late. On 08/25/2025 at 1:20pm surveyor observed the 1st Floor Dining room that revealed: Residents sitting at tables eating lunch and being assisted by staff. Surveyor observed cheese pizza, veggies, tots, cup of pineapples being served as stated on the monthly food menu. On 08/25/2025 at 1:25pm V12(Central Supplies) said lunch has been coming late to the 1st Floor Unit, it's supposed to come at 12:00pm and at 12:50pm they were still waiting for food trays. V12(Central Supplies) said she normally assist on the 3rd Floor Dining Room and she's not even sure they received their meals yet. On 08/25/2025 at 1:40pm V10(Restorative Aid) said for the last two weeks she has noticed that food is coming up late from the kitchen. V10(Restorative Aid) said it's mainly lunch that comes in the problem, that they might be short staffed in the kitchen so they run behind getting food out on-time. On 08/26/2025 at 8:50am surveyor observed the kitchen with V9(Dietary Director), walk-in fridge was 39 degrees Fahrenheit, freezer 9 degrees Fahrenheit, dry goods items stored and labeled within expiration dates. No signs of trash on the floor or evidence of pest. No concerns with cleanliness or issues with the kitchen being dirty. On 08/26/2025 at 9:00am V9(Dietary Director) said the goal is to have food up to the units so the dietary aids could begin meal services as scheduled. V9(Dietary Director) said breakfast should begin at 8:00am, lunch 12:00pm, and dinner at 5:00pm per the mealtimes schedule posted. V9(Dietary Director) said he only started two weeks ago and is aware that the kitchen has been running behind schedule and sending food out late to the units. V9(Dietary Director) said he's trying to address the issues voiced by residents and is in the process of hiring more kitchen staff. On 08/26/2025 at 11:00am V5(Assistant Director of Nursing/ADON) said she is aware of resident concerns about meals being sent out late from the kitchen, V5(ADON) said the kitchen is run by an independent vendor and they have voiced their concerns to corporate and upper management about the issues they facility is having with the kitchen. V5(Assistant Director of Nursing/ADON) on multiply occasions she has spoken to residents about how late food trays are getting to the units and something needs to be done about the issue. V5(ADON) said it's out of their control since the new vendor has taken control of kitchen duties. On 08/26/2025 at 12:55pm surveyor observed 1st Floor Dining Room, no food trays available. Residents sitting at tables waiting for scheduled meal service to begin. On 08/26/2025 between 8am and 4pm V1(Administrator/ADMIN) and V2(Director of Nursing/DON) said they are aware of the situation with the kitchen sending out food trays late for scheduled meal services. They said concerns have been addressed with V9(Dietary Director) and stated the independent vendor is working to hire more kitchen staff to address the matter of food preparation being delayed and sent out late to the units. Surveyor reviewed Belhaven Meal Times for breakfast, lunch, and Dinner times. The Vendor Policy and Procedure Meal Service Schedule (no date) reads in part: Meals will be served according to a planned schedule that allows no more than 14 hours between dinner the previous evening and breakfast the next day. 1. Procedure: Post meal service schedule in main kitchen and all service areas. A. Posting in kitchen should include service times for all service areas. B. Postings in service areas should include time for that service area only.</p>		