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	02/05/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of records and interviews facility failed to maintain resident rights to be free from all forms of abuse for 2 of 4 residents (R1, R2) reviewed for abuse in the sample of 4. These failures are not in accordance with facility's abuse policy and affected 2 residents (R1, R2) both experiencing physical abuse.The findings include:R1 is a [AGE] year-old resident, initially admitted in the facility on 03/27/2022. R1's medical diagnosis includes hemiplegia and hemiparesis following cerebrovascular disease.R2 is a [AGE] year-old resident, initially admitted in the facility on 01/06/2026. R2's medical diagnosis includes schizophrenia, schizoaffective disorder, major depressive disorder. R2 has intact cognition with BIMS score of 15 dated 01/13/2026.Per V2 (Director of Nursing) clinical notes dated 01/20/2026 documented R2 made contact with R1. R1 complained of pain in her left arm. X Ray was performed on R1's left arm.Per incident report dated 01/20/2026 R2 made contact with R1 during disagreement inside their room. R2 attempted to adjust the heat on R1's side of the room. R1 stated that R2 smells. R2 made contact with R1's leg. R1 reacted by using her Reacher. R2 sustained minor skin alteration to the left side of her nose. Police report was included for incident of simple battery.Per social service notes by V9 (Social Worker) dated 01/20/2026, R2 was sent to the hospital for psychiatric evaluation due to aggression towards R1 and not easily redirected. Per census history, R2 returned to facility on 01/26/2026 on the same floor, different room to R1. Per clinical notes of V8 (Licensed Practical Nurse) dated 01/27/2026, R2 was observed with agitation and aggression. R2 was transferred to hospital for evaluation and treatment and was discharged from the facility.On 02/04/2026 at 01:29 PM, V1 (Administrator/Abuse Coordinator) stated that R1 and R2 had an argument because R1 does not want R2 to be on her side of the room because R2 smells. V1 stated that R1 told him that R2 hit her leg with her hand. In retaliation, R1 hit R2 with her reacher, an equipment used to grab things far from reach using arm. R1 was in her wheelchair when the incident happened. V1 stated that R1 and R2 were roommates during that time it happened on 01/20/2026. V1 stated that R2 was sent to the hospital after the incident and came back to the facility on [DATE] but was discharged the next day 01/27/2026. V1 reviewed facility's abuse prevention policy and facility incident final report. V1 stated that final report concluded that R2 did hit R1 and that it is under the definition of physical abuse. V1 stated that police report documents that the incident that happened was simple battery.On 02/04/2026 at 02:51 PM, V2 (Director of Nursing) stated on the day of the incident R2 told her (V2) that R1 was screaming because she (R2) wanted to turn the heat off. When she (V2) went into the room, R1 told her that R2 hit her on the leg and later changed to her arm. R1 complained of left arm pain and Xray was done. V7 (Family of R1/POA) was informed about Xray result without injury. R1 stated that she feels safe if R2 does not come near her. R2 was admitted in the facility with behavior more verbally than physical aggression. R1 and R2 were roommates since R2 was admitted . V2 stated that R1 has left side weakness and cannot block R2 when R2 hits her on the left (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	side. R2 on the other hand has no limitation as to ambulation, movement and does not have any disability. R2 came back to the facility after the incident and was discharged the next day due to another aggression. Both V1 and V2 stated that R2 does not maintain proper hygiene and has an intimidating characteristic.Abuse Prevention Program dated 03/01/2021:It is the policy of this facility to prohibit and prevent resident abuse, neglect, exploitation, mistreatment, and misappropriation of resident property and a crime against a resident in the facility.Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm or pain or mental anguish or deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental psychosocial well-being. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Physical abuse means hitting, slapping, pinching, kicking, etc.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of records and interview facility the failed to follow abuse reporting policy for 2 out of 4 residents (R1, R2) in a total sample of 4 residents reviewed. This failure has the potential to affect R1 and R2 in timely determination of abuse incidents and providing necessary interventions to prevent possible recurrence.The findings include:R1 is a [AGE] year-old resident, initially admitted in the facility on 03/27/2022. R1's medical diagnosis includes hemiplegia and hemiparesis following cerebrovascular disease. R2 is a [AGE] year-old resident, initially admitted in the facility on 01/06/2026. R2's medical diagnosis includes schizophrenia, schizoaffective disorder, major depressive disorder. R2 has intact cognition with BIMS score of 15 dated 01/13/2026.Facility's initial abuse reportable incident report was submitted by facility dated 01/20/2026 between R1 and R2. Per report it was alleged that R2 made contact with R1. Final report was sent on 02/04/2026 at 11:49 AM, which is the current date. In the final report it was concluded that R2 did made contact with R1 due to disagreement. R1 retaliated and made contact with R2 with her reacher which is an equipment used to grab things.Per social service notes by V9 (Social Worker) dated 01/20/2026, R2 was sent to the hospital for psychiatric evaluation due to aggression towards R1 and not easily redirected. Per census history, R2 returned to facility on 01/26/2026 on the same floor, different room to R1. Per clinical notes of V8 (Licensed Practical Nurse) dated 01/27/2026, R2 was observed with agitation and aggression. R2 was transferred to hospital for evaluation and treatment and was discharged from the facility.On 02/04/2026 at 01:29 PM, V1 (Administrator/Abuse Coordinator) stated that R1 and R2 had an argument because R1 does not want R2 to be on her side of the room because R2 smells. V1 stated that R1 told him that R2 hit her leg with her hand. In retaliation, R1 hit R2 with her reacher, an equipment used to grab things far from reach using arm. R1 was in her wheelchair when the incident happened. V1 stated that R1 and R2 were roommates during that time it happened on 01/20/2026. V1 stated that R2 was sent to the hospital after the incident and came back to the facility on [DATE] but was discharged the next day 01/27/2026. V1 stated that final report was sent today 02/04/2026 because he forgot to send it. Final was sent today to be honest I forgot there were many things going on during that time. I did not follow my policy to send the initial and final report within 5 days. V1 reviewed facility's abuse prevention policy and facility incident final report. V1 stated that final report concluded that R2 did hit R1 and that it is under the definition of physical abuse. V1 stated that police report documents simple battery.Abuse Prevention Program dated 03/01/2021:Abuse allegations involving one resident upon another resident will be reported to IDPH.The investigator will submit a final report of the conclusion of the investigation in writing within 5 working days of the incident.The final investigation report shall contain the following:Name, Age, Diagnosis and mental status of the resident allegedly abused, neglected, or exploited.The original allegation (note day, time, location, specific allegation, by whom, witnesses to the occurrence, circumstances surrounding the occurrence and any noted injuries.Facts determined during the process of the investigation, review of medical records and interview of witnessesConclusion of the investigation based on known factsIf there is a police report, attached the police reportIf the allegation is determined to be valid and the perpetrator is an employee, include on a separate sheet the employee's name, address, phone number, title, date of hire, copies of previous disciplinary actions, and status (still working, suspended or terminated)Attach a summary of all interviews conducted, with the names, addresses, phone numbers, and willingness to testify of all witnesses.The administrator or DON in the absence of the Administrator will review the report. The Administrator or DON in the absence of the Administrator is then (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	responsible for forwarding a final written report of the results of the investigation and of any corrective action taken to the Department of Public Health within five working days of the reported incident.