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	02/17/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interviews and record reviews, the facility failed to prevent R1's fall, failed to care plan R1's need for mechanical lift transfers, failed to have two staff members during a mechanical lift transfer for R1, and failed to notify R1's representative of a fall for one of five residents reviewed for improper nursing care.Findings include: R1's admission Record documents in part diagnoses of osteoporosis, Alzheimer's disease, dementia, dysphagia, displaced fracture of left femur, and history of falling. V29 is R1's responsible party and power of attorney. R1's 12/29/2025 Quarterly MDS (Minimum Data Set) assessment documents in part that R1 is severely cognitively impaired. R1 is dependent on staff for bed-to-chair transfers. R1's 'Care Plan Report' documents in part that R1 is at risk for fall related to generalized weakness, changes in environment, and adjustment to facility (initiated 1/13/2026). Goal included I will have a safe environment maintained through next review and I will have fall interventions in place that will help reduce my risk for falls and injury through the next review. The target date is 5/14/2026. Interventions include to follow facility Fall Protocol and staff to anticipate and meet R1's needs (initiated 1/13/2026). R1's care plan also documents in part that R1 is at risk for self-care deficit and requires assistance with ADLs (Activities of Daily Living) to maintain the highest possible level of functioning (initiated 1/13/2026). Intervention initiated on 1/13/2026 documents in part that R1 may occasionally receive an increase in assist with transfers due to fluctuation in needs. However, during multiple interviews with staff including V4 (Nurse), V5 (Certified Nurse Aide-CNA), V10 (CNA), V11 (CNA), V12 (Anonymous Staff), and V18 (Nurse), staff stated R1 has been dependent with transfers requiring mechanical lifts for more than a year. Focus for mechanical lift transfers was not added to R1's comprehensive report until 2/6/2026. On 2/11/2026 at 2:44 PM, V4 (Nurse) stated hearing a thud while conducting end of shift rounds. When V4 entered R1's room, R1 was on the floor and V11 (CNA) was in the room with a mechanical lift. V4 stated did not witness how R1 got to the floor. V4 stated did not notify V29 or other family members about R1 being on the floor. During a telephone interview with V11 (Certified Nurse Aide) on 2/11/2026 at 4:10 PM, V11 stated being at the facility for a little over a month. V11 stated [V11] took care of R1 on 2/3/2026. V11 prepped R1 to transfer from bed to chair. V11 stated [V11] used a mechanical lift without another staff assisting. V11 stated when R1's legs lifted off the bed, R1 started to slide. V11 realized during the transfer that the machine [V11] was using was the weight machine and not a mechanical lift used for resident transfers. V11 stated when moving R1, R1 kind of slid down slow. V11 paused the transfer and called for help. V11 stated V2 (Director of Nursing) and V3 (Assistant Director of Nursing) happened to be walking by the room. V11 stated V2, V3, along with V11 lowered R1 to the floor. V11 stated [V11] was misinformed about doing a lift alone if comfortable to operate it alone. V11 stated it was no excuse because mechanical lifts are supposed to be operated with two staff members. V11 stated after the incident facility administration in-serviced [V11] on facility's protocol. During an anonymous staff interview on 2/11/2026 at 4:42 PM, V12 (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(Anonymous Staff) stated the facility protocol is to do a two-person assist when using a mechanical lift for transfers. V12 stated CNAs (Certified Nurse Aides) learn that upon hire during orientation. V12 stated V11 received that training. On 2/13/2026 at 11:38 AM, V2 (Director of Nursing) stated V2 and V3 were doing rounds when they heard V11 calling for help. V2 saw V11 transferring R1 on a mechanical lift unassisted. R1 was in the sling off the bed. V2 stated R1 did not look comfortable. V2 stated V2, V3, and V11 lowered R1 to the floor. V2 and V3 then went to grab a different lift to assist R1 off the floor. During a follow-up interview with V2 at 1:31 PM, V2 stated the facility was calling R1's incident an ‘assisted transfer' to the floor. V2 stated facility was not calling it a fall. V2 stated [V2] did not inform V29 or R1's family about staff placing R1 on the floor until 2/6/2026. On 2/13/2026 at 12:46 PM, V3 (Assistant Director of Nursing) stated V2 and V3 were rounding the unit when they heard V11 call for help. V3 saw V11 attempting to transfer R1 with mechanical lift without assistance. V3 stated R1's legs did not look secure on the mechanical lift. V3 stated did not inform V29 or R1's family about the incident. V2 filled out facility's incident report regarding R1's 2/3/2026 incident. V2 documented it as Other incident. It documents in part: Upon making rounds on the unit, writer observed CNA using [mechanical] lift to transfer resident to [chair]. CNA appeared to be need assistance with transfer and writer, along with [Assistant Director of Nursing] assisted resident to the floor safely. V11's statement reads I transferring [R1] in the [lift] when I wasn't comfortable with how [R1's] lower half was positioned in the sling. V3's statement reads While rounding with [V2], we heard help, We entered [R1's room] and observed [V11] attempting to use the [lift] alone. [V2] immediately stated we needed to lower [R1] down due to the position of [R1's] lower body in the pad. Facility notified V29 about investigation on 2/6/2026. Facility's conclusion was that it was not a fall. Stated Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities (Rev. 229; Issued 4/25/25) documents in part: Fall refers to unintentionally coming to rest on the ground, floor, or other lower level, but not as a result of an overwhelming external force (e.g., resident pushes another resident). An episode where a resident lost his/her balance and would have fallen, if not for another person or if he or she had not caught him/herself, is considered a fall. A fall without injury is still a fall. Facility's Guidelines for Incident/Accidents/Falls, dated 6/30/23, documents in part that the nurse will notify the resident's responsible party. The resident's responsible party will be kept informed of any orders received or interventions put into place. Resident Handling Policy ‘Limited Lift' reads The Resident Handling Policy exists to ensure a safe working environment for resident handlers. The policy is to be reviewed and signed by all staff that perform or may perform resident handling. Mechanical Lift Transfer - Full Lift/[redacted brand name] (2 Caregivers). This policy is to be followed at all times. V11 signed this policy on 12/31/2025. V11 also completed a Validation of Competency Mechanical Lift on 12/31/2025 which included placing the equipment in position with the assistance of a 2nd caregiver.