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	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belhaven Nursing & Rehab Center	11401 South Oakley Avenue Chicago, IL 60643

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure resident call lights were responded to in a timely manner for one resident (R7) out of five reviewed for call lights.Findings include:On 03/17/26 at 11:45 AM, R7 complained that his call light does not get answered right away and sometimes it can take the staff over an hour to respond to his call light.On 03/17/26 at 12:53 PM, observed the call light system monitor screen at the 2nd floor nursing station which read R7's room [ROOM NUMBER] minutes. Observed the light outside R7's room to be on.On 03/17/26 at 1:11 PM, observed call light system monitor screen at the 2nd floor nursing station which read R7's room [ROOM NUMBER] minutes. Observed the light outside R7's room to be on.On 03/17/26 at 1:45 PM, observed the light outside R7's room to be turned off. R7 stated someone came inside to turn off his call light but it took them a long time to check on him.On 03/18/26 at 12:46 PM, observed the call light system monitor screen at the 2nd floor nursing station which read R7's room [ROOM NUMBER] minutes. Observed V26 (Licensed Practical Nurse) sitting at the nursing station. V26 stated that when a resident triggers their call light in their room the resident's room number pops up on the call light monitoring system screen and the system keeps track of the number of minutes from which time the resident triggered their call light. V26 stated the light outside the resident's room also lights up once they trigger their call light. V26 observed the call light system monitor screen and stated that means that R7 triggered his call light 62 minutes ago. V26 stated he bet someone already went in to check on R7, but they forgot to turn off the call light in R7's room.On 03/18/26 at 12:48 PM, observed the light outside R7's room to be on indicating R7's call light had been activated.On 03/18/26 at 12:50 PM, observed R7 lying in his bed with a bucket of grayish water on his bedside table. R7 stated V29 (Certified Nursing Assistant) came into his room at 10:50 AM to give him the bucket of water so he can bathe himself, but he is not able to wash his feet on his own so he triggered the call light to get some help. R7 stated he triggered his call light over one hour ago and no one had been inside his room to see what he needed. R7 stated no one has been in his room since V29 brought him the bucket of water at 10:50 AM.On 03/18/26 at 12:54 PM, V29 stated the last time she was in R7's room was around 10:50 AM when she came to bring R7 a bucket of water. V29 stated she was busy helping to pass out meal trays in the dining room. V29 stated that any of the staff can answer the residents' call lights, it is not only the responsibility of the assigned Certified Nursing Assistant (CNA) to do it. V29 stated it is important to answer the residents' call lights right away because they may be in distress and for safety reasons. V29 stated the staff does not know what type of help the resident needs or if they are in any type of danger or unsafe situation unless the staff goes into the resident's room to check on them. V29 stated someone should have responded to R7's call light right away, he should not have had to wait over one hour for help.On 03/18/26 at 1:00 PM, V26 stated call lights should be answered as soon as possible to see what the resident needs to prevent a fall and/or injury. V26 stated the staff does not know what the residents needs unless they check on them. V26 stated that even if it is a resident who pulls the call light a lot the staff still need to check on the resident regardless of how many times they pull it. V26 stated R7 does use his call light a lot but someone should have checked on R7 when he activated his call light. V26 stated that R7 should not have had to (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wait that long for help, that should not have happened. On 03/18/26 at11:00 AM, V2 (Director of Nursing) stated via telephone interview that call lights should be responded to with 15 minutes. V2 stated the purpose of the call light is so the residents can alert the staff to get them to go into the resident's room so the staff can provide assistance to the resident. V2 stated the staff does not know why the residents triggered their call light unless they go check on them. V2 stated if the staff takes longer than 15 minutes to respond to the residents' call light then the potential problem is a delay in providing a service for the residents.R7 diagnosis includes but not limited to: Paraplegia, Encounter for Attention To Colostomy, Contracture, Unspecified Joint, Other Intestinal Obstruction Unspecified As To Partial Versus Complete Obstruction, Urinary Tract Infection, Presence Of Urogenital Implants.R7's MDS (Minimum Data Set) from 01/13/26 indicates intact cognition and substantial/moderate assistance is required for toileting, shower/bathing self, lower body dressing, personal hygiene and for chair/bed to chair transfer.R7's care plan in place which documents in part (R7) at risk for falls related to generalized weakness, paraplegia and interventions include but not limited to place call light within reach and encourage (me) to use it for assistance as needed.Facility provided policy titled Call Light undated which documents in part, call lights are to be answered promptly by staff who see that the call light has been activated.Facility provided document titled Job Description for Certified Nursing Assistant dated 04/01/23 which documents in part under role responsibilities - care: responds to/answers resident call lights promptly.

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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. Based on interview and record review, the facility failed to keep the residents free from abuse. This deficient practice affected one (R6) of three residents reviewed for abuse.Findings Include:Facility Reported Incident submitted to the IDPH (Illinois Department of Public Health) dated 12/09/25 documents in part, R1 reported V21 (Licensed Practical Nurse) snatched his cigarette out of his mouth and broke it on 12/07/25.R6's electronic health record (EHR) shows R6 admitted to the facility 02/13/24 and had a planned discharge from the facility on 03/05/25. R6's diagnosis includes but is not limited to Atherosclerotic Heart Disease of Native Coronary Artery Without Angina Pectoris, Chronic Diastolic (Congestive) Heart Failure, Chronic Obstructive Pulmonary Disease, Hypertension, Hyperlipidemia, Polyneuropathy, Chronic Kidney Disease, Schizoaffective Disorder, Bipolar Type, Rheumatoid Arthritis, Gout, Nicotine Dependence, Major Depressive Disorder, Anemia. R6's MDS (Minimum Data Set) dated 02/05/26 reveals R6 is cognitively intact, uses a wheelchair device for mobility and is dependent on staff for transfers.R6 has a care plan in place which documents in part, R6 has a history of suspected abuse, neglect, exploitation, past trauma and/or other factors that may increase (his) susceptibility to abuse/neglect and that R6 will be treated with respect, dignity, and reside in the facility free from mistreatment (i.e. abuse/neglect).On 03/19/26 at 10:52 AM, R6 stated via telephone interview he was wheeling himself down the hallway on his way to go outside for smoke break. R6 stated his cigarette was in his mouth but the cigarette was not lit. R6 stated he was not trying to smoke in the building, he had the cigarette in his mouth because he needed both of his arms to push himself in his wheelchair. R6 stated when he got close to the nursing station the nurse (V21) snatched the cigarette out of his mouth and broke it and then threw it at him. R6 stated V21 said, you shouldn't have it in your mouth! R6 then reported V21 told him she was going to call the police. R6 stated that is what she was threatening to do, she was trying to scare him, but she did not scare him. R6 stated he thinks the nurse was fired over the issue, he never saw the nurse after that.On 03/18/26 at 9:16 AM, V22 (Certified Nursing Assistant) stated on that day R6 was not smoking in his room, he had a cigarette dangling from his mouth (it was not lit) and he was propelling himself in his wheelchair toward the patio to go outside to smoke at the designated smoking time. V22 stated she was sitting at the nursing station when she saw V21 walk up to R6 and snatched the cigarette out of R6's mouth and broke the cigarette in half. V22 stated V21 did not say anything to R6 before she snatched the cigarette out of R6's mouth. V22 stated V21 then went off on him (R6). V22 stated R6 started to curse at V21 and then V21 told R6 she was going to call the cops on him as a threat to scare him. V21 stated this was around 6:00-6:30 PM. V22 stated she texted the Director of Nursing (V2) right away and notify her what was going on. V22 stated she reported it because the way the nurse snatched R6's cigarette out of his mouth and then threatened him was emotional/mental abuse. V22 stated V2 indicated her she would handle it and she thinks V2 might have called and talked to V21 but V21 did not get sent home that night, V21 finished out her shift. V22 stated based on the training she received on abuse V21 should have been sent home as soon as the abuse was reported. V21 stated she reported it to V2 because she did not have V1's phone number. V22 stated R6 went outside to smoke and calmed down, there was no change in his behavior or mood afterwards. V21 stated the next day when she came into work she wrote a statement, and administration took care of it. V21 stated she thinks that is why the nurse (V21) does not work here anymore.On 03/18/26 at 11:35 AM, V23 (Certified Nursing Assistant) stated via telephone interview she remembers seeing R6 wheeling himself down the hallway with a cigarette hanging out of his mouth. V23 stated R6 was doing this because he needed both of his hands to propel himself in his wheelchair. V23 stated the cigarette was not lit. V23 stated the nurse (V21) saw him by the nursing station and she immediately got up and she snatched the cigarette out of his mouth, broke it and told R6 he was not supposed to have the cigarette in his mouth. V23 stated V21 was being very rude to (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R6. V23 stated R6 was explaining that he had the cigarette in his mouth because he needed both hands to wheel himself outside and that the cigarette was not lit. V23 stated R6 was upset that V21 had broken his cigarette, and he said he was going to report her (V21). V23 stated she heard V21 yelling at R6 that the police were going to come get him. V23 stated V21 was being verbally/mental abusive to R6 by intimidating and threatening him. V23 stated V22 texted V2 that night and told her what happened. V23 stated the next day she wrote down her statement and she gave it to V2. On 03/18/26 at 10:43 AM, V2 (Director of Nursing) stated via telephone interview that mental/emotional abuse would be speaking down to a resident, using humiliation, and/or threats of any kind. V2 stated V1 is the abuse coordinator for the building and should be notified immediately of any abuse allegation. V2 stated if V1 is not available or in the building then the staff should contact V2 so she can follow the proper procedure for abuse. V2 stated if staff-to-resident abuse is witnessed, suspected or reported the staff should be immediately separated from the resident and the staff would immediately be removed from the building. V2 stated this is important because the facility wants to be able to provide safety and protection for the residents from the abuser; they do not want the abuse to continue. V2 stated the incident with R6 and V21 happened a while back so the details are foggy. V2 stated she does not remember the time or dates. V2 stated she does not remember receiving a call or text from V22 (CNA). V2 stated she does remember that R6 came and told her what happened, and she does remember asking V22 and V23 to write down their statement on the day R6 reported the allegation to her. V2 stated if the CNAs had called her the night it happened, she would have followed the process and she would have immediately had the nurse (V21) removed from the building. V2 stated R6 reported that he was on his way to smoke break, and he told V2 that V21 took the cigarette out of his mouth and broke it. V2 stated V21 thought R6 was trying to smoke and she (V21) did not want R6 to light it in the hallway and she was worried he was going to light it. V2 stated she does not remember R6 telling her that V21 had threatened him but if V21 threatened to call the police on R6 that would be considered a threat because it would intimidate the resident and that would be emotional abuse. V2 stated V21 was suspended pending the outcome of the investigation. V1 did the investigation and staff was able to tell them what happened and their story leaned toward what R6 was saying so V21 was terminated.Facility provide copies of V22 and V23's signed written statements which reflect the date of 12/09/25.Three attempts was made to contact V21, however, unable to leave a message because the voicemail had not been set up yet.On 03/19/26 at 2:11 PM, V1 (Administrator) stated he is the abuse coordinator for the facility and the main goal for the abuse program is to prevent abuse, keep the residents safe and free from abuse. V1 stated examples of emotional/mental abuse could be intimidation, humiliation, threatening punishment, and/or making belittling comments. V1 stated abuse can be defined as the willful intent to hurt or cause harm.V1 stated it is his expectation that the staff report abuse immediately if they see it or suspect or hear rumors of abuse. It is not the staff's responsibility to determine if abuse happened or not, only to report abuse. If a staff member sees staff to resident abuse they must separate the victim and the offender. It is important to separate them for their safety to make sure the abuse does not continue. V1 stated if a staff member is involved, they must leave the building immediately and they are put on administrative leave and are not allowed to return pending the outcome of the investigation. If V1 is not in the building when the abuse occurs his number is posted at the front desk and if the staff cannot find V1's phone number, then they go to the next person in the chain of command which would be the Director of Nursing (DON). After contact is made with the DON or the Assistant Director of Nursing (ADON) then one of them would call V1. V1 stated they can call him any time of day (even in the middle of the night). V1 stated R6 came to his office on Tuesday, 12/09/25 and told him that he was pushing himself in his wheelchair down the hallway to go out to smoke on 12/07/25. V1 stated R6 said his cigarette was hanging from his mouth but it was not lit. R6 told me that V21 (LPN) snatched the cigarette out of his mouth and broke it and then threw it at him. R6 was pissed off and frustrated with the nurse for doing that. V1 stated R6 gave the statement to the DON on 12/09/25 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stating it happened on 12/07/25. V1 interviewed V21 over the phone, and V21 denied the whole interaction. Based on the investigation V1 conducted and interviews V1 decided to terminate R6, and she was not allowed to return to work at the facility.V1 stated he thinks V21's actions could be considered intimidating and humiliating, which would be a form of abuse. V1 stated he was not aware of V21 saying she was going to call the police on R6. V1 stated if V21 was also threatening to call the police this could also be intimating and threatening. V1 stated by V21 snatching the cigarette out of R6's mouth that would be considered willful intent and threatening the resident by saying she was going to call the police is also willful intent because she was trying to scare the resident.V1 stated if the CNA (V22) who observed the altercation reported it to V2 right away then she did the correct thing but V2 should have called V1 or reported it herself to IDPH. V1 stated more importantly the nurse (V21) should have been removed from the facility right away based on the abuse policy and abuse protocol. V1 stated the first time he heard anything about the altercation was on Tuesday, 12/09/25 and that is when he reported it to IDPH.Facility provided copies of V21's timecard which showed that V21 worked on 12/07/25 from 3:00 PM to 9:01 PM and from 9:31 PM to 7:30 AM and on 12/09/25 from 3:00 PM to 5:00 PM.V21's employee file reviewed with appropriate background checks conducted and active Illinois License on file. V21's employee file indicates V21 was hired on 08/09/23 and terminated on 12/22/25.Facility provided document titled Your Rights and Protections as a Nursing Home Resident undated, documents in part, at a minimum Federal law specifies that nursing homes must protect and promote the following rights of each resident and (you) have the right to be free from abuse and neglect.Facility policy dated 01/2019 titled Abuse Prevention Program documents in part, this facility will not tolerate resident abuse or mistreatment or crimes against a resident by anyone, including staff members and abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment and willful means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Mental abuse includes but not limited to humiliation, harassment, threats of punishment. If you suspect abuse separate the alleged perpetrator and assure all residents safety and notify the Administrator and Director of Nursing immediately.

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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. Based on interview and record review the facility failed to submit the final investigation for staff to resident abuse to the Illinois Department of Public Health (IDPH) within the required five business days for (R6) out of three residents reviewed for abuse.Findings Include:Facility Reported Incident submitted to the IDPH (Illinois Department of Public Health) dated 12/09/25 documents in part, R1 reported V21 (Licensed Practical Nurse) snatched his cigarette out of his mouth and broke it on 12/07/25. R6's electronic health record (EHR) shows R6 admitted to the facility 02/13/24 and had a planned discharge from the facility on 03/05/25. R6's diagnosis includes but is not limited to Atherosclerotic Heart Disease of Native Coronary Artery Without Angina Pectoris, Chronic Diastolic (Congestive) Heart Failure, Chronic Obstructive Pulmonary Disease, Hypertension, Hyperlipidemia, Polyneuropathy, Chronic Kidney Disease, Schizoaffective Disorder, Bipolar Type, Rheumatoid Arthritis, Gout, Nicotine Dependence, Major Depressive Disorder, Anemia. R6's MDS (Minimum Data Set) dated 02/05/26 reveals R6 is cognitively intact, uses a wheelchair device for mobility and is dependent on staff for transfers.R6 has a care plan in place which documents in part, R6 has a history of suspected abuse, neglect, exploitation, past trauma and/or other factors that may increase (his) susceptibility to abuse/neglect and that R6 will be treated with respect, dignity, and reside in the facility free from mistreatment (i.e. abuse/neglect).On 03/19/26 at 10:52 AM, R6 stated via telephone interview he was wheeling himself down the hallway on his way to go outside for smoke break. R6 stated his cigarette was in his mouth but the cigarette was not lit. R6 stated he was not trying to smoke in the building, he had the cigarette in his mouth because he needed both of his arms to push himself in his wheelchair. R6 stated when he got close to the nursing station the nurse (V21) snatched the cigarette out of his mouth and broke it and then threw it at him. R6 stated V21 said, you shouldn't have it in your mouth! R6 then reported V21 told him she was going to call the police. R6 stated that is what she was threatening to do, she was trying to scare him, but she did not scare him. R6 stated he thinks the nurse was fired over the issue, he never saw the nurse after that.On 03/18/26 at 9:16 AM, V22 (Certified Nursing Assistant) stated on that day R6 was not smoking in his room, he had a cigarette dangling from his mouth (it was not lit) and he was propelling himself in his wheelchair toward the patio to go outside to smoke at the designated smoking time. V22 stated she was sitting at the nursing station when she saw V21 walk up to R6 and snatched the cigarette out of R6's mouth and broke the cigarette in half. V22 stated V21 did not say anything to R6 before she snatched the cigarette out of R6's mouth. V22 stated V21 then went off on him (R6). V22 stated R6 started to curse at V21 and then V21 told R6 she was going to call the cops on him as a threat to scare him.On 03/18/26 at 11:35 AM, V23 (Certified Nursing Assistant) stated via telephone interview she remembers seeing R6 wheeling himself down the hallway with a cigarette hanging out of his mouth. V23 stated R6 was doing this because he needed both of his hands to propel himself in his wheelchair. V23 stated the cigarette was not lit. V23 stated the nurse (V21) saw him by the nursing station and she immediately got up and she snatched the cigarette out of his mouth, broke it and told R6 he was not supposed to have the cigarette in his mouth. V23 stated R6 was upset that V21 had broken his cigarette, and he said he was going to report her (V21). V23 stated she heard V21 yelling at R6 that the police were going to come get him. V23 stated V21 was being verbally/mental abusive to R6 by intimidating and threatening him. V23 stated V22 texted V2 that night and told her what happened. V23 stated the next day she wrote down her statement and she gave it to V2 (Director of Nursing).On 03/19/26 at 2:11 PM, V1 (Administrator) stated he is the abuse coordinator for the facility and the main goal for the abuse program is to prevent abuse, keep the residents safe and free from abuse. V1 stated examples of emotional/mental abuse could be intimidation, humiliation, threatening punishment, and/or making belittling comments. V1 stated abuse can be defined as the willful intent to hurt or cause harm. V1 stated once abuse is reported to V1 he submits an initial report (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to Illinois Department of Public Health (IDPH) within two hours of notification, and the final report must be submitted to IDPH within five business days. V1 stated R6 came to his office on Tuesday, 12/09/25 mid-day and told him that he was pushing himself in his wheelchair down the hallway to go out to smoke on 12/07/25. V1 stated R6 said his cigarette was hanging from his mouth but it was not lit. R6 told V1 that V21 (LPN) snatched the cigarette out of his mouth and broke it and then threw it at him. V1 stated R6 gave the statement to the DON on 12/09/25 stating it happened on 12/07/25. V1 stated the first time he heard anything about the altercation was on Tuesday, 12/09/25 and that is when he reported it to IDPH. V1 stated the final report was submitted to IDPH on Friday, 12/19/25 at 3:40 PM. V1 stated the final report to IDPH should have been submitted on Tuesday, 12/16/25. V1 stated he was late submitting the final report because IDPH was in the facility that week conducting the facility's annual survey and there was a lot going on.Facility provided initial report submitted to IDPH involving R6 and V21 via email which was time/date stamped Tuesday, 12/09/25, 5:23 PM.Facility provided final report submitted to IDPH involving R6 and V21 via email which was stamped time/date Friday, 12/19/25, 3:40 PM.Facility provided policy titled Abuse Prevention Program dated 01/2019 which documents in part, the final investigation report will be completed within five (5) working days of the reported incident and the Administrator is then 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.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on interview and record review, the facility failed to ensure residents are free of any significant medication error for one (R1) of four residents reviewed for improper nursing care. The findings include:R1's admission record / face sheet shows admission date on 7/21/25 with diagnoses not limited to Spastic hemiplegic cerebral palsy, Cerebral infarction, Hemiplegia affecting left nondominant side, Lennox-gastaut syndrome, Essential (primary) hypertension, Other seizures, Hemiplegia and hemiparesis following cerebral infarction affecting left Non-dominant side, Atherosclerotic heart disease, Type 2 diabetes mellitus. MDS (Minimum Data Set) dated 3/5/26 shows R1's cognition is intact.On 3/17/26 At 11:38AM Observed R1 up and about, Ambulatory with walker, alert and oriented x 3, verbally responsive. She stated she has been residing in the facility since July 2025. Observed R1 wearing helmet, she said for safety because of her seizure disorder. R1 stated she missed doses of her anti-seizure medications (phenobarbital, Keppra and Lyrica) due to medications were not available or out of it. She said when she is not taking her anti-seizure medications then she is having seizure episodes. She said she had seizure episode about couple of weeks ago because she missed doses of Keppra, Phenobarbital and Lyrica. On 3/17/26 At 11:54AM V7 (Certified Nursing Assistant / CNA) stated she has been working in the facility for 10 years and regularly assigned on the 2nd floor. She stated she is assigned to R1 and had seizure episode about 2-3 weeks ago. She said she observed R1 Shaking in her wheelchair in the dining room. V7 stated it was a quick seizure activity; she was not hospitalized . On 3/18/26 On 3/18/26 at 9AM V26 (LPN / Licensed Practical Nurse) stated he is following doctor's order and 5 R'S (right resident, medication, route, dose and time) in giving medications to residents. He stated he checked MAR (Medication Administration Record), follow physician order in giving meds. V26 said he then sign / initial MAR after giving medications to document that medications were given. He said if MAR is not signed or initial, it could mean that medication was not given. V26 said he is regularly working on the 2nd floor and has been assigned to R1. He said R1 has seizure disorder and last seizure activity was about 2-3 weeks ago in the dining room. On 3/18/26 at 10:15AM V2 (Director of Nursing / DON) stated nurses should follow doctor's order and 5 rights (right resident, medicine, time, dose, route) in giving medications to residents. She stated nurses are expected to sign or initial in MAR after giving medications to residents to document or validate that medication was administered to the resident. V2 stated if MAR was not signed, it could possibly mean that medication was not given to the residents. She stated standard nursing practice if it is not documented it was not given. V2 stated If anti-seizure medication was not given it could potentially affect the therapeutic level of the medication and could suppress the effectiveness of the medication that could lead to seizure activity. R1?s Nursing Progress Note dated 2/22/26 shows in part: R1 observed in the dining room with jerking movements of bilateral upper and lower extremities lasted 1 minute, R1 assisted to room resident in bed seizure precautions in place.R1's POS (Physician Order Sheet) shows active order not limited: Pregabalin Oral Capsule 200 MG (Pregabalin) Give 200 capsule by mouth two times a day related to OTHER SEIZURES. Scheduled for 9AM and 5PM. Phenobarbital Oral Tablet 100 MG (Phenobarbital) Give 100 mg by mouth two times a day related to OTHER SEIZURES. Scheduled for 9AM and 5PM. Keppra Oral Tablet 1000 MG (Levetiracetam) Give 1 tablet by mouth two times a day for seizures. Scheduled for 6AM and 6PM. March MAR (Medication Administration Record) shows no signature / initial on 3/9/26, 3/16/26 and 3/17/26 indicating Keppra was not given to R1. March MAR shows no signature / initial on 3/16/26 indicating Phenobarbital was not given to R1. March MAR shows no signature / initial on 3/16/26 indicating Pregabalin (Lyrica) was not given to R1. February MAR shows no signature / initial on 2/8/26 and 2/9/26 indicating Keppra was not given to R1. February MAR shows no signature / initial on 2/9/26 indicating Phenobarbital was not given to R1. February MAR shows no signature / initial on 2/9/26 indicating Pregabalin (Lyrica) was not given to R1. Care plan dated 1/26/26 shows in part: R1 is at risk for seizure activity related to: Lennox Gastaut (continued on next page)

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	145549	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belhaven Nursing & Rehab Center	11401 South Oakley Avenue Chicago, IL 60643

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Syndrome. Administer medication as directed and follow pharmaceutical recommendations. Facility's drug administration - general guidelines policy (undated) shows in part: Medications are administered as prescribed, in accordance with good nursing principles and practices and only by persons legally authorized to do so. Medications are administered in accordance with written orders of the attending physician. Only the licensed or legally authorized personnel who prepare medication may administer it. This individual records the administration on the resident's MAR at the time the medication is given. The resident's MAR is initialed by the person administering a medication, in the space provided under the date, and on the line for that specific medication dose administration. Facility's tips for safe medication administration policy (undated) shows in part: Follow good clinical practices for administration of medications: Sign out medications as soon as they are given. Document if the medication is refused and the reason.Facility's medication administration policy (undated) shows in part: To administer all medications safely and appropriately to aid residents to overcome illness, relieve and prevent symptoms, and help in diagnosis. Document medication administration with initials in appropriate spaces on Medication Administration Record (MAR).Facility's guidelines for physician orders (following physician orders) policy dated 6/18/23 shows in part: 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.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to accommodate resident food preferences by not offering menu alternatives or substitutes during weekend meal service.These failures have the potential to affect all 188 residents receiving food prepared in the facility's kitchen. Findings include:On 03/17/26 at 11:05 AM, R7 stated someone from the activity department comes around Monday through Friday to ask him what he wants to eat for lunch and dinner that day. R7 stated on the weekend this does not happen. R7 stated if he receives food that he does not like on the weekend he asks one of the CNAs (Certified Nursing Assistants) to call down to the kitchen to get a substitution however the CNAs tell him that the kitchen does not do substitutions on the weekend so whatever he gets served is what he has to eat.On 03/17/26 at 1:25 PM, R12 stated he can only get a menu substitution Monday through Friday. V12 stated on the weekend he only gets what is posted on the regular menu, no substitutions are available. V12 stated he wished there were menu substitutions available on the weekend to provide some variety in case he does like the regularly scheduled meal being served.On 03/17/26 at 1:31 PM, R13 stated he asked for a menu substitution at lunch, and he received the item he requested. R13 stated Monday through Friday there are menu substitutions available for lunch and dinner that he can order ahead of time if he does not like the main meal being served. R13 stated menu substitutions are not available on the weekends, only during the week. R13 stated if he does not like the food served to him over the weekend, he will ask for something else to eat but the staff tells him they do not have any other food to give him, so he just goes hungry and he does not like that. R13 stated he wants to eat something, and he cannot eat food if he does not like it. R13 stated he feels the kitchen should have substitutions available for him to eat on the weekend.On 03/17/26 at 1:54 PM, R14 stated Monday through Friday the dietary staff gives out menu substitutions in case he does not like the scheduled meal but menu substitutions not available on the weekend. R14 stated on the weekend he has to eat whatever they serve because no substitutions are available. R14 stated he does not know why substitutions are not available on the weekend, but he would like to have menu substitutions available because he does not always like what is being served and does not want to go hungry.On 03/18/26 at 2:07 PM, R16 stated if he does not like what is being served, he can request a menu substitution Monday through Friday but on the weekends no menu substitutions are available. R16 said, you have to eat what they got. R16 stated over the weekend if he receives something he does not like he calls his family for money so he can buy snacks from the vending machine and/or order out for food to be delivered so he has something to eat.R7's MDS (Minimum Data Set) dated 01/13/26 indicates intact cognition.R12's admission MDS in progress dated 03/13/26 indicates intact cognition.R13's MDS dated [DATE] indicates intact cognition.R14' s MDS dated [DATE] indicates intact cognition.R16' s MDS dated [DATE] indicates intact cognition.On 03/17/26 at 1:15 PM, V31 (Dietary Aide) stated menu substitutes are available and offered to residents Monday through Friday. V31 stated there are no food substitutions made or offered to residents on the weekend. V31 stated if a resident does not like the food served to them over the weekend, he will try to give the resident something different to eat but this is dependent on what food is available (if any). V31 said, We try to give the resident something, but it may not be what they want.On 03/19/26 at 11:10 AM, V41 (Activity Aide) stated she works Monday through Friday and every other weekend. V41 stated when she is working Monday through Friday, she meets with the residents on the 2nd floor to tell them what is being served that day for lunch and dinner. V41 stated if they do not want to eat what is being served, she provides them with a list of alternatives/substitutions that are available, they tell her what they want to eat, and she writes their selection down on a form and then gives this to the kitchen. V41 stated she only offers the resident menu substitutions during the week Monday through Friday, not on the weekend. V41 stated she does (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	not know why menu alternatives are not offered to the residents over the weekend, she was told that was the process when she was first hired and that is what she still does. V41 stated on the weekend the residents only get offered what is being served on the posted menu, no alternatives are offered.On 03/19/26 at 11:16 AM, V42 (Activity Aide) stated Monday through Friday she asks the residents on the 3rd floor what they would like to eat for lunch and dinner that day. V42 stated the residents can select the posted menu meal or a menu alternative from a list of available items. V42 stated she does not do this on the weekends, only during the week. V42 stated she was trying to figure out why they do not offer menu substitutions to the residents on the weekends, but she does not know the reason. V42 stated on the weekends residents will come to her and ask if there are any menu substitutions available and she has to tell them they are not being offered on those days. V42 stated this means the only items available for them to eat is the posted menu entree. V42 stated she is sure the residents would like a choice of what they want to eat on the weekends.On 03/19/26 at 10:17 AM, V37 (Regional Food Service Manager) stated menu alternatives are available daily at every meal and the options are posted on every unit. V37 stated the activity department asks the residents what they want to eat for lunch and dinner that day, that information is sent down to the kitchen and then the dietary staff writes on the resident meal ticket what menu alternative they want if any. V37 stated this is done daily. The system is in place so that residents have choices of what they want to eat and to communicate to the kitchen staff if the resident(s) want something else to eat so the kitchen can prepare the requested food for them. V37 stated it is important to give the residents choices and different food options. V37 stated it is unlikely that all the residents are going to like the one dish so that is why the kitchen gives them at least six different choices per meal. V37 stated the kitchen does not want to force the residents to eat something they do not like. V37 said, we want them to have choices.On 03/19/26 at 11:57 AM, V40 (Dietary Manager) stated menu alternatives are offered and available every day. The activity staff tells the residents what we have serving for lunch and dinner and then ask them if that is what they want to eat or if they would like one of the menu alternatives. V40 stated she thinks this is done by the activity staff every day but V40 does not work on the weekends. V40 stated she was under the impression the process for menu selections Monday through Friday is the same on the weekends (Sat/Sun). V40 stated it is important for the residents to have different menu choices in case the resident does not like what the kitchen is serving so the residents have menu substitutions. V40 stated it is important to offer the residents choices because they have a right about what they want to eat. V40 stated the residents should have a choice every day they are served a meal not just Monday through Friday.On 03/19/26, V1 provided list of diet orders for all residents in the facility. The diet order list indicates there are two residents receiving nothing by mouth (NPO).Facility provided policy titled, Menu Selection/Alternative undated which documents in part, residents will be able to choose foods they wish to have from the items available and an alternative menu with choices is available daily.Facility provided policy titled, Dietary Preferences, Nutritional Requirements, and Portion Management undated which documents in part, the facility will make every reasonable effort to accommodate each resident's cultural, religious and personal dietary preferences while ensuring that all meals meet the resident's nutritional requirements and the facility recognizes each resident's right to self-determination in dietary choices and when menu items conflict with (these) preferences appropriate substitutions will be offered when available.Facility provided document titled, Always Available Menu which documents the following items: Cheeseburger on Bun, Hamburger On Bun, Grilled Cheese Sandwich, Peanut Butter & Jelly Sandwich, Deli Sandwich, Chef Salad.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure sanitary conditions during food delivery by not covering food/utensils during transport and by food service staff not wearing hair restraints during meal service and in the kitchen. These failures have the potential to affect all 188 residents receiving food prepared in the facility's kitchen. Findings include:On 03/17/26 at 11:20 AM, R7 stated his food is not always covered and this really bothers him because he does not want anyone talking while they are carrying his meal tray because some of their spit may go on his food. R7 stated his juice, the dessert and silverware are never covered with anything. R7 reports finding two black hairs on top of the bread of his grilled cheese sandwich (meal and date unspecified).On 03/17/26 at 12:35 PM, observed during lunch distribution on the 2nd floor in the unit dining room two Dietary Aides (V31 & V32) portioning out food from a portable steam table and putting food on plates. V31 was not wearing a hair restraint to cover the hair on his head or a beard protector to cover his facial hair.On 03/17/26 at 12:37 PM, observed V28 (Certified Nursing Assistant) and V29 (Certified Nursing Assistant) pouring pink liquid into cups and then putting the cups on the resident meal trays. V28 and V29 stated these trays were being prepared for the residents who eat their meals in their rooms. The drink cups were not covered with a lid or plastic. Observed on resident trays in open cart eating utensils sitting on top of paper napkins. The utensils were not covered.On 03/17/26 at 12:38 PM, V28 and V29 stated the drink cups and silverware are never covered during transport, only the plate of food is covered with plastic wrap.On 03/17/26 at 12:40 PM, observed V32 (Dietary Aide) using plastic wrap to cover plates of food. V32 stated he wraps the plates of food for those residents who eat in their room. Then, observed V32 put the wrapped plates of food on meal trays which were in an opened wheeled cart for transport. Other trays already on the opened wheeled cart had plated food wrapped in plastic wrap, however none of the drink cups were covered with a lid or plastic wrap and the eating utensils were also not covered with anything. There was no cart covering put over the opened carts before leaving the dining room.On 03/17/26 at 1:20 PM, V31 (Dietary Aide) V31 stated all the meal trays are prepped in the kitchen with meal tickets, napkins, utensils, and desserts and they are then delivered to the nursing unit in open carts where the kitchen staff then adds the hot food and the nursing staff add the drinks. V31 stated for any trays going to residents who eat in their room the dietary aides cover their food with plastic wrap. V31 stated they do this for sanitary reasons because stuff can fall into the food during transport. V31 stated the cups of juice drink are never covered and the utensils are also not covered, only the plate of food is covered. V31 stated the meal trays are always transported in open carts to residents' rooms, no cart cover is used.On 03/18/26 at 8:54 AM, observed CNA distributing breakfast trays room by room on the 1st floor from an opened wheeled cart that was not covered. The trays on the cart had plastic wrap over the plate of food but drink cups, utensils and bowls of cereal were not covered. The trays were left unattended as the CNA went into resident rooms to deliver trays and set up residents.On 03/18/26 at 1:10 PM, observed on the 3rd floor hallways open carts with resident trays on them. The main plate of food was covered in plastic wrap but the dessert, container of red salsa, cups of drink and silverware were not covered. The opened carts were not covered in any type of cart cover.On 03/18/26 at 1:12 PM, V27 (Certified Nursing Assistant) stated she has been working in the facility since 2017. She has worked in the housekeeping and dietary department, and she has now been working as a CNA for the past two years. V27 observed one of the open carts in the 3rd floor hallway with meal trays on it. V27 stated the food cart should be covered with a cover which goes over the entire cart for infection control reasons. V27 stated all the items on the tray should be covered because if someone coughs or sneezes it could contaminate the food on the tray and that is not sanitary. V27 stated the kitchen is only covering the plate of food but they are not covering any of the other items on the tray.On 03/19/26 at 9:57 AM, V37 (Regional Food Service Manager) stated all the food delivery carts are (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	open, they do not have doors which can be closed. V37 stated the food delivery carts should be covered in a large plastic cover that goes over the entire cart. V37 stated it is important for the delivery carts to be covered during transportation because the food should not be exposed. V37 stated this is for sanitation issues to prevent cross contamination and minimize risk to the residents. V37 stated he does not want anything falling onto the trays to minimize risk of infections. V37 stated the food delivery carts should be covered when traveling long distances and/or if left unattended by staff and/or if left in areas where the residents could touch or come in contact with the trays. V37 stated if the CNAs are leaving the trays in the hallway in the open food delivery cart while they go into a resident's room to deliver meal tray, then the cart is left unattended.On 03/19/26 at 11:42 AM, in main kitchen observed V31 (Dietary Aide) prepping the lunch trays wearing a hairnet to cover the hair on his bed but did not have a beard protector on to cover his facial hair. Also, observed V44 (Dietary Aide) in the kitchen near the food preparation area without wearing a beard protector to cover his facial hair.On 03/19/26 at 11:45 AM. surveyor asked V40 (Dietary Manager) if V31 and V44 should have beard protectors covering their facial hair. V40 looked at V31 and V44 and stated yes, they should be wearing a beard protector to cover their hair on their face. V40 stated she expects staff in the kitchen to always wear hair restraints when they are in the kitchen and when they are upstairs portioning out the food because they are dealing with food and there is a potential for their hair to fall into the food. V40 stated hair falling into a resident's food would contaminate the food and the residents do not want to see hair in their food, it would make them not eat their food. V40 stated a beard covering should be worn if the staff has a mustache or beard or goatee or any kind of facial hair. V40 stated food carts should be covered with a large plastic cover during transport because the desserts, cereal, bowls, drinking cups and silverware do not get covered. V40 stated the carts get covered to protect the food from cross-contamination so nothing from the air can land on the food. V40 stated for example if someone was coughing/sneezing as they walk by the trays on the cart that could contaminate the food and that is why everything should be covered up. V40 stated once the trays are made in the dining room and go to the hallways for distribution the carts should be covered again with the large plastic covers for the same reason.On 03/19/26, V1 provided list of diet orders for all residents in the facility. The diet order list indicates there are two residents receiving nothing by mouth (NPO).Facility provided policy titled, General Infection Control in Dining Services undated which documents in part, the dining department follows all local, state and federal regulations in order to assure a safe and sanitary department and staff shall wear hair restraints such as hat, hair coverings or nets that are designed and worn to effectively keep their hair from contacting exposed food.Facility provided policy titled, Hair Restraints/Jewelry/Nail Polish dated 07/22/23 documents in part, food and nutrition services employes shall wear hair restraints and beard guards and hairnet, hat or hair restraint will be worn at all times in the kitchen. [NAME] guards or masks will be worn as indicated.