STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000822	A. BUILDING: _____ B. WING _____	12/08/2022

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BELHAVEN NURSING & REHAB CENTER	11401 SOUTH OAKLEY AVENUE CHICAGO, IL 60643

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Facility Reported Incident of October 21, 2022/ IL152833	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 1 300.661 Section 300.661 Health Care Worker Background Check A facility shall comply with the Health Care Worker Background Check Act and the Health Care Worker Background Check Code. This Requirement is not met as evidenced by: Based on interview and record review, the facility failed to follow their policy for conducting healthcare worker background checks on all staff. This failure has the potential to affect all 163 residents currently in the facility. Findings include: On 12/07/22 at 11:30 am, Surveyor and V18 (Human Resources Specialist) conducted a review of the facility's Background checks with the following background checks observed missing: Review of V2's (Director of Nursing, DON) personnel file on 12-07-2022 revealed no fingerprints or background check included/conducted.	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 Review of V3's (Registered Nurse, RN) personnel file on 12-07-2022 revealed no fingerprints or background check included/conducted. Review of V5's (Licensed Practical Nurse, LPN) personnel file on 12-07-2022 revealed no fingerprints or background check included/conducted. Review of V6's (Certified Nursing Assistant, CNA) personnel file on 12-07-2022 revealed no fingerprints or background check included/conducted. Review of V10's (Wound Care Coordinator, Licensed Practical Nurse, LPN) personnel file on 12-07-2022 revealed no fingerprints or background check included/conducted. Review of V11's (CNA) personnel file on 12-07-2022 revealed no fingerprints or background check included/conducted. Review of V12's (LPN) personnel file on 12-07-2022 revealed no fingerprints or background check included/conducted. On 12/07/2022 at 11:45 am, Surveyor interviewed V18 regarding the facility's background checks and V18 stated, "I (V18) don't have them. I (V18) don't know what they (referring to the last facility's Human Resource Specialist) were doing before I (V18) got here." When V18 was asked regarding the importance of conducting background checks for the facility's employees? V18 stated, "I (V18) no that they (referring to conducting background checks) should be done." On 12/08/2022 at 1:35 pm, V2 (Administrator)	S9999		

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S9999	Continued From page 2 stated, "I (V1) was not aware that background checks were not being conducted properly. V18 (Human Resources) is responsible for conducting background checks. I (V1) know they are important to ensure we are not hiring staff with criminal backgrounds and for the safety of the residents." Facility's undated Job Description titled "Human Resource Specialist" documents, in part: "Position Summary: The Human Resources Specialist is responsible for HR administration at the facility, including payroll, new hire orientation, benefits, recruiting etc. The person holding this position is delegated the responsibility for carrying out the assigned duties and responsibilities I accordance with current existing federal and state regulations and established company policies and procedures. Essential Job Functions: ... 5. Verifies and maintains license certifications, criminal background checks, nurse aide registry checks and recertification." Facility's policy dated revised 01/2019 and titled "Abuse Prevention Program" documents, in part: "Check the Illinois Health Care Worker Registry on any individual being hired for prior reports of abuse, ... fingerprint results." (C) 2 of 2 300.610a) 300.1210b) 300.1210d)6) Section 300.610 Resident Care Policies	S9999		

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S9999	Continued From page 3 a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents These requirements are not meet as evidenced	S9999		

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S9999	Continued From page 4 by: Based on observation, interview and record review, the facility failed to follow their practice for falls and send a resident out to the hospital for further evaluation after the resident had an unwitnessed fall. This failure resulted in R313 being evaluated 19 hours later and was subsequently diagnosed with a subdural hematoma. The facility failed to secure the crash cart oxygen tank in a secured oxygen holder at the nurse's station on the first floor and in (R146's) room. This failure has the potential to affect all residents on the first floor. Findings Include: R313 is the subject of this investigation. R313 was sent out to hospital on 10/20/22 and expired in the hospital on 10/28/22. On 10/21/22 the facility reported incident that was sent to the state agency was reviewed. The final report dated 10/26/22 documents, in part, Conclusion: "Resident (R313) has a BIMS (Brief Interview of Mental Status) of 7 and could not state what occurred. Staff reports, resident (R313) had a fall, resident (R313) was observed on the floor near his (R313) bed. R313's admission diagnoses include but not limited to Dementia, Cognitive Communication Deficit, Muscle Wasting and Atrophy, Abnormalities of Gait and Mobility, Anemia, Psychotic Disturbance, Anxiety and Psychosis. R313's (8/12/22) Minimum Data Set (MDS), documents, in part, that R313's Brief Interview for Mental Status (BIMS) score of 7 which indicates R313's has severe cognitive impairment. Functional Status for Bed Mobility and toilet use	S9999		

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S9999	Continued From page 5 3/2 coding (extensive assistance/one-person physical assist). R313 transferred to local hospital on 10/20/22 at 10:47pm by EMS (Emergency Medical Service) unresponsive. R313's Local fire department run sheet, dated 10/20/22 at approximately 10:20pm documents in part, "Dispatch to the scene of the 90-year-old male who is found unresponsive and not breathing by a staff member at the nursing home he (R313) resides in. Per staff they were doing their night rounds and found him (R313) unresponsive. They called 911, upon our arrival patient (R313) found lying in bed breathing at 1 (Breaths) per minute however unresponsive. Primary assessment was completed, however secondary assessment findings were bruises to his chest, upper abdominal area, small bruises to left side neck and right hand. The history of the bruises is unknown, Patient (R313) vitals were within normal range. CSS (Canadian Stroke Scale) was incomplete due to unresponsive. Patient (R313) also had signs of incontinence. Patient (R313) remained unchanged during transport and able to protect own airway. Patient (R313) transferred to local trauma hospital without incident. Progress notes dated (10/20/22) at 3:39 am Late Entry documents Type: General Note: Upon doing rounds the resident (R313) noted on the floor on his (R313) knees in praying position on the side of his (R313) bed. Resident was head to toe assessed and placed back in bed. V/S (Vital Signs) are bp (blood pressure)145/82 t (temperature)96.3 rr (respiration) 16 hr (Heart rate) 71 sao2(spo2, oxygen saturation) 98. Abrasion noted on left knee. Site cleaned and treated with bacitracin. The resident was given prn (as needed) pain medicine. Md (Medical	S9999		

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S9999	Continued From page 6 Doctor) called, a new order for 72 hr (hour)neuro checks and close monitoring put in place and carried out. Progress notes 10/20/22 at 11:31 pm documents Type: Nursing Progress Notes: During rounds resident (R313) was observed unresponsive by CNA (Certified Nursing Assistant), CNA notified writer and writer went and assessed resident. The writer performed sternum stimulation and resident had no reaction. Writer checked vitals: BP (Blood Pressure)-173/83, P (Pulse)-83, T (temperature)-97.2, BS (Blood Sugar)-407, O2 (Oxygen)98. Due to not being responsive resident was sent out via 911 emergency. Resident (R313) taken to local hospital for evaluation and treatment. R313's (10/20/22) Fall Report (no date or time) documents, in part, Incident Location: Residents room, Nursing Description: Upon doing rounds resident visually noted kneeling on the floor, beside his bed, in praying position with call light within reach. Resident Description: Resident stated, "I want to get up." Injuries observed at time of Incident: swelling to left Knee. R313's mental status indicated Alert with periods of (blank space). Predisposing Physiological Factors indicated Confused, Incontinent, Impaired Memory. (Report prepared by V29, Registered Nurse). R313's (10/20/22) Fall Risk Review documented, in part, Conclusion: Total Score 10. (A score of 10 or above represents High Risk. R313's (10/20/22) Emergency Room report documents, in part, diagnoses but not limited to Subdural hematoma. CT (Computed tomography) of head result indicated Large right	S9999		

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S9999	Continued From page 7 holohemisphere acute on chronic or hyperacute subdural hematoma with marked mass effect, midline shift, herniation as described. CT of chest documents in part, Left posterior rib Fracture, possible nondisplaced fracture of the superior endplate of T12 (part of the thoracic spine). Hemoglobin and Hematocrit (H/H) 5.4 and 17.7, (Normal hemoglobin level 13.0-17.0, Normal hematocrit level 39.0-51.0), a clinical indication of bleeding out. R313 was intubated (assistant breathing) and admitted to Neuro Critical Care Unit (NCCU). R313's (10/28/22) hospital discharge summary documents, in part, presenting to hospital after being found unresponsive. He (R313) was intubated for airway protection. Stat CTH (CT of Head) demonstrated a 3.9 cm (Centimeter) mixed density R (right) SDH (Subdural Hematoma) with 2.2 cm MLS (Midline Shift). Neurosurgery team was consulted, no surgical intervention offered given futility (Any treatment that, within a reasonable degree of medical certainty, is seen to be without benefit to the patient). Called to bedside for absence of respirations. Time of Death 3:00 PM. R313 (10/28/22) death certificate stated cause of death was subdural hemorrhage. On 12/6/22 at 10:29 am V22 LPN (License Practical Nurse) stated that R313 had an unwitnessed fall on the previous shift and neuro checks were initiated because of the fall. V22 stated that V35 (Certified Nursing Assistant, CNA) was making rounds in R313's room and noticed R313 not responding to anything, like R313 was asleep. V22 stated that V35 called V22 into R313's room and V22 performed a sternal rub on R313 with no response to tactile stimuli. V22 stated that R313 was unresponsive, a rapid	S9999		

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S9999	Continued From page 8 response was called and 911. V22 stated that the Physician, (V31) DON (Director of Nursing), and family were notified of change in condition. On 12/7/22 at 11:30 am V29 (Registered Nurse) stated that the V30 CNA (Certified Nursing Assistant) said that R313 was in the room on the floor 10/20/22. V29 stated, they did do not remember who the CNA was. V29 stated that V29 went into the room and saw R313 on the floor in a kneeling position. V29 stated a head-to-toe assessment was done and V29 saw an abrasion on R313's knee. V29 stated that R313 had no other bruises anywhere on R313's body. V29 stated that R313 did not tell V29 that R313 had fallen or is in any pain. Surveyor inquired if R313 told V29 that R313 hit R313's knee? V29 stated R313 did not tell V29 that R313 hit R313's knee. V29 stated that V29 saw the abrasion on R313's knee. Surveyor inquired if R313 did not tell you (V29) R313 hit R313's knee could R313 not tell V29 that R313 hit R313's head? V29 stated, "No, R313 would have told me if he (R313) hit his head." V29 stated that V31 (Physician) was called, and orders was given to do neuro checks. V29 stated that since R313 was in a kneeling position, and it was unwitnessed the facility treats the incident as a fall. Surveyor inquired whether R313 should have been sent out to hospital for an evaluation because of an unwitnessed fall and R313's being cognitively impaired? V29 stated, "No R313 was fine." On 12/7/22 at 1:23pm V2 (DON) stated that she (V2) received a call from V22 that R313 was unresponsive and had fallen earlier on the night shift. V2 stated that she was not notified of R313's fall until the change in condition, which was several shifts later. V2 stated that she should have been notified of the initial fall. V22 stated	S9999		

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S9999	Continued From page 9	S9999		

that an unwitnessed fall should have been sent out especially a resident who is cognitively impaired. V2 stated that R313 cannot articulate if he (R313) did or did not hit his (R313) head. V2 stated that sometimes the doctor makes decisions on what the nurse articulate to them. V2 stated, "a reasonable nurse would have sent R313 to the hospital for an unwitnessed fall and if I (V2) was notified of the initial fall, I (V2) would have had R313 sent out to the hospital for evaluation."

On 12/7/22 at 3:40pm, V30 (CNA) stated that R313's call light was on and V30 went into the room to answer the call light. V30 stated that R313 was on his (R313) knees on the floor between bed A and bed B. V30 stated she waited for V29 to come into the room before V30 moved R313 back to bed. V29 came into the room and R313 was put back to bed. V30 stated that R313 was hesitant and nervous to be moved back to bed. V30 stated R313 said, "Oh my knee," when moved back to bed. V30 stated that R313 was very confused. V30 stated that after R313 was put back to bed V30 left out of the room.

On 12/7/22 at 5:20pm V31 (Physician) stated that R313 had a fall then got worse and was sent out to hospital. V31 stated that if a resident is stable, they can watch and do neuro checks in the facility. V31 stated that neuro checks are done to assess for change in condition. Surveyor inquired, if there is a bleed in the head will there be a change in the pupils? V31 stated, "yes there will be a change in the pupils if there is a bleed in the head." V31 stated that he did not recall if V31 told the nurse to send R313 out to the hospital.

On 12/8/22 at 1:35 pm V35 (CNA) stated that on 10/20/22, V35 went to put R313 to bed. R313 was

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S9999	Continued From page 10 sitting on the chair in R313's room. V35 stated that R313 was not looking good. V35 stated that R313 was too sleepy and would not wake up, so V35 went to get (V22). V22 came into the room and R313 was sent out to the hospital. V35 stated that V35 didn't know what happened after V22 went into the room because V35 never went back into the room. V35 just saw R313 leaving out to go to the hospital. On 12/8/22 at 2:30 pm V31 stated that a subdural Hematoma is usually related to an injury such as a fall. V31 stated that R313's Cat Scan said acute on chronic subdural hematoma. V31 stated that it is a possibility that a new bleed could start with an injury. Surveyor inquired of V31, if R313, who has a severe cognitive impairment, should have been sent out to hospital for an evaluation? V31 stated, "Yes R313 probably should have been sent out, I (V31) do not remember if I (V31) told the nurse to send out R313." R313's (10/20/22) Neuro Check Flowsheet documents, in part, Perl (pupils equal and reactive to light), Pupil response left and right B (Brisk, reacts quickly) size (4), which indicates normal response. Last neuros check documented was 10/20/22 at 3:00 pm. All neuro checks documented indicated a normal assessment. R131 (10/20/22) Care Plan documented, in part, "(R313) is at risk for falls as evidenced by the following risk factors and potential contributing Diagnosis: Cognitive Impairment, Communication Deficits, decrease strength and endurance." On 6/24/22 R313 had a fall. On 7/02/22 R313 had a fall. On 10/20/22 R313 had a fall. R313's (10/20/22) Physician order set documents in part, "may cleanse left knee abrasion with	S9999		

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S9999	Continued From page 11 normal saline, pat dry and apply bacitracin ointment. Initiate neuro check per protocol. Facility Registered Nurse Job Description undated documents, in part, Position Summary: The Registered Nurse provides direct nursing care to the residents. The person holding this position is delegated the administrative authority, responsibility, and accountability for carrying out the assigned duties and responsibilities in accordance with current existing federal and state regulations and established company policies and procedures to ensure that the highest degree of quality care is maintained at all times. E. Role Responsibilities- Nursing Care: 8. Implement and maintains establish nursing objectives and standards. Facility Licensed Practical Nurse Job Description undated documents in part, Position Summary: The Licensed Practical Nurse provides direct nursing care to the residents. The person holding this position is delegated the administrative authority, responsibility, and accountability for carrying out the assigned duties and responsibilities in accordance with current existing federal and state regulations and established company policies and procedures to ensure that the highest degree of quality care is maintained at all times. E. Role Responsibilities- Nursing Care: 8. Implement and maintains establish nursing objectives and standards. Facility Certified Nursing Assistant Job Description undated documents in part, provides each of your assigned residents with routine daily nursing care and services in accordance with the resident's assessment and care plan, and as may be directed by your supervisors. The person holding this position is delegated the	S9999		

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S9999	Continued From page 12 administrative authority, responsibility, and accountability for carrying out the assigned duties and responsibilities in accordance with current existing federal and state regulations and established company policies and procedures. Nursing Care Role Responsibility: 27. and ensure that residents who are unable to call for help are checked frequently. Facility's Policy (8/3/17) titled, "Incident, Accident, Falls Policy," documents, in part, Procedure: The nurse will notify the resident's attending physician/ Nurse Practitioner, DON, Administrator and the resident's responsible party. On 12/6/2022 at 11:45 AM Surveyor observed a free- standing oxygen tank at the bedside in R146's room. V16 (Licensed Practical Nurse) was interviewed and asked if she (V16) saw anything out of order. V16 stated, "The oxygen tank is not supposed to sit outside of a stand. It could be hazardous if the tank falls over. It could possibly cause an explosion." R146's (11/8/22) order details documented, in part "O2, 4L/ NC (nasal cannula)/ concentrator ..." R146's (9/1/22) quarterly MDS (Minimum data sheet) indicates that R146 is receiving supplemental oxygen. R 146's (12/2/22) care plan reads in part, "Administer O2 PRN (as needed) for SOB (shortness of breath)." Facility's policy named; Oxygen Therapy (revised 5/2012) reads in part: Oxygen tank must be safely secured in an oxygen tank stand. Never lay	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000822	A. BUILDING: _____ B. WING _____	12/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 13 tank on its side or have it standing freely at the bedside. (A)	S9999		