

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6000822	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/09/2021
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NAME OF PROVIDER OR SUPPLIER BELHAVEN NURSING & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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)	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 Complaint Investigation 2183891/IL134622 Facility Reported Incident of 05-22-21/IL134493	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)6) 300.3240f) Section 300.610 Resident Care Policies 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	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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S9999	<p>Continued From page 1</p> <p>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.</p> <p>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:</p> <p>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.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act)</p> <p>These requirements were not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to ensure a resident with known aggressive behavior did not physically abuse two of three residents (R6 and R8) reviewed for abuse. This failure resulted in R6 being held in a choke hold,</p>	S9999		
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S9999	<p>Continued From page 2</p> <p>hitting his head resulting in a laceration to the forehead that required 13 staples to close.</p> <p>Findings include:</p> <p>Facility's final incident report (for incident of 05-22-2021) documents R5 and R6 had a disagreement and made physical contact with each other. R6 was sent to hospital for evaluation, treated for forehead laceration and returned to facility same day. R5 was sent to hospital for psychiatric evaluation.</p> <p>During interview on 07-08-2021 at 10:10 AM, R6 said, "I saw R5 hit R8. He went around the desk and moved at me in a threatening manner. I put my arms around him (to protect myself). He had his hands around my throat. We fell backwards to the floor. That's when I hit my head. I had to get 13 staples. I heard he (R5) beat up two of his roommates. He's (R5) so young, so full of anger, so violent. Why was he here? Why would you (facility) put me in a position to be injured? You knew this guy has violent tendencies."</p> <p>During interview on 07-08-2021 at 11:07 AM, R8 confirmed R5 hit him.</p> <p>During interview on 07-07-2021 at 11:20 AM, V5 (Certified Nursing Assistant/CNA) said, "I was his (R5) sitter that shift. He was fine all night, then around 4:00 AM, he started pacing in his room, exhibiting threatening behavior towards me. He put his plastic gloves (exam) on, was throwing air punches at me. He said he put the gloves on so he wouldn't leave fingerprints. I told the nurse (V18/Licensed Practical Nurse/LPN). V18 told me to follow him. R5 was threatening R8. He (R5) has a very, very big history of aggression."</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>During interview on 07-07-2021 at 11:49 AM and 5:09 PM, V6 (CNA) said, "I was coming on the first floor to clock out. He (R5) was just out of control. He and the other guy (R6) were in the corner. R5 had R6 in a choke hold. R5's hands were wrapped around R6's neck; R6 could have passed out R5 was holding him so tight."</p> <p>During interview on 07-08-2021 at 2:00 PM, V23 (LPN) said, "R5 did have outbursts, could get violent. I believe he was hearing voices. He would throw air punches at people but would also make verbal threats ('I'm going to beat you're a**; I'll kill you in your sleep'). He threatened both staff and residents. He had a 1:1 sitter to engage him and to re-direct, to prevent anything from happening, to keep him safe as well."</p> <p>During interview on 07-07-2021 at 8:48 AM, V18 (LPN) said, "V5 told me R5 was up, agitated. R5 wanted to smoke, said 'I'm going to smoke and nobody is going to stop me.' R5 was in the hallway, walking into residents' rooms, grabbing stuff (exam gloves). I had him sitting at the Nursing Station, he was jumping up, shadow boxing me, saying crazy things. I went to answer a call light; when I came back R5 and R6 were locked together, like a wrestling hold. A few days before the incident, R5's behavior started to escalate. He was talking crazy ('I'm God; I'm Jesus Christ'). When he puts on his gloves, that means his behavior is escalating."</p> <p>R5's medical record (Face Sheet, Minimum Data Set) documents R5 is a 24 year old with diagnoses including but not limited to Schizophrenia, Unspecified; Bipolar Disorder, and Cognitive Communication Disorder. R5 is moderately cognitively impaired. Care plans for behavioral symptoms and cognitive impairment</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>(updated 05-10-2021) document R5 has behaviors including verbal and physical abuse/aggression; and poor ability to control anger and frustration.</p> <p>Progress Note dated 05-22-2021 at 6:25 AM documents, "Resident 1:1 monitoring. Resident insists on going out to smoke. Staff attempted to redirect resident. Resident became increasingly agitated with staff. Staff continue to redirect resident which proved to be unsuccessful. Staff nurse was preparing PRN med for agitation. When another resident (R6) attempted to redirect resident by touching him, (R5) reached out and became in tangled with each other that resulted them on the ground. Residents sent to the hospital."</p> <p>Progress Note dated 04-13-2021 at 1:52 PM documents R5 became physically aggressive with R5's roommate.</p> <p>Facility's Abuse Prevention Program Policy and Procedure (Revised 01/2019) states under Policy, "This facility will not tolerate resident abuse or mistreatment or crimes against a resident by anyone including staff members, other residents, consultants, volunteers, and staff of other agencies, family members, legal guardians, friends or other individuals."</p> <p>(A)</p>	S9999		