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 _____	C 12/13/2021

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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S 000	Initial Comments Complaint Investigation 2188101/IL139832 2188275/IL140053 2188328/IL140122	S 000		
S9999	Final Observations Statement of Licensure Violations (Findings 1 of 2) 300.1010h) 300.1210b) 300.1210d)3) 300.1210d)5) 300.1220b)3) Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's	S9999		

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S9999	Continued From page 2 comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. These requirements were not met as evidenced by: Based on observation, interview and record review the facility failed to ensure that all pressure ulcers are on the weekly pressure ulcer report, failed to ensure that wound care staff stage wounds appropriately, failed to obtain appropriate treatment orders and failed to implement preventive interventions for one of three residents (R4) reviewed for pressure ulcers These failures resulted in R4 sustaining a stage 4 right shoulder pressure ulcer which required surgical intervention. Findings include: R4's wound assessments include a right shoulder skin tear (identified 9/6/21) measuring 3.5 x 3.0 x 0.1cm (centimeters). R4's (9/7/21) physician orders state to apply to right shoulder Santyl ointment daily, which is a medicine that removes dead tissue from wounds and is used to treat skin ulcers. On 11/23/21 at 9:59am, surveyor relayed concerns regarding Santyl orders received for R4's skin tear. V20 (Medical Director) stated, "A skin tear is superficial, so we need wet to dry dressing. I don't think it needed debridement."	S9999		

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S9999	Continued From page 3 The (9/21/21) functional assessment documents that R4 requires extensive (one person physical assist) with bed mobility. R4's (9/21/21) BIMS (Brief Interview for Mental Status) determined a score of 13, indicating intact cognition. On 11/8/21 at 1:51pm, R4 was observed lying on his back in a fetal position due to severely contracted lower extremities. No repositioning devices were observed in place. R4's upper extremities appeared weak, as R4 had difficulty pulling the string to activate the call light. R4 stated that he lies in bed all day due to "bent up legs" and confirmed he requires staff assistance with turning and repositioning. On 11/9/21 at 12:58pm, surveyor inquired about R4's right shoulder wound. V6 (Wound Care Coordinator) stated, "R4 has a tear that declined." Review of the 11/4/21 pressure ulcer report did not include R4. R4's 11/2/21 (Initial) physician wound evaluation includes: (stage 4) pressure wound of the right shoulder full thickness 6 x 4 x 1cm. The wound is in an inflammatory stage and is unable to progress to a healing phase because of the presence of a biofilm (a thin, slimy film of bacteria that adheres to a surface). Surgical debridement was performed today on this wound. Recommendations: off-load wound. R4's (11/4/21) nurse wound assessment includes right shoulder "skin tear." It was not documented as a stage 4 pressure wound. R4's (3/25/21) care plan includes increased risk for impaired skin integrity with the following preventive interventions: reposition resident	S9999		

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S9999	Continued From page 4 frequently when in bed or wheelchair. The care plan was not updated to include to off-load the wound. On 11/9/21 at 1:04pm, R4 was observed lying in bed. There were no repositioning devices in place. V6 (Wound Care Coordinator) removed the dressing from R4's right shoulder. A large (deep) wound was observed with muscle exposed. Surveyor inquired about the stage of R4's wound. V6 stated, "He (R4) was seen by the Wound Doctor (V9) today. V9 just staged it" and refrained from answering the question. Surveyor inquired again about the stage of R4's wound. V6 responded, "Like I said, it was a skin tear. I think she (V9) did 4 (stage 4)." On 11/9/21 at 1:26pm, surveyor inquired how R4's right shoulder "skin tear" developed into a stage 4 pressure ulcer. V2 (Director of Nursing) stated, "It originally started off as a skin tear from the wheelchair." On 11/16/21 at 3:13pm, surveyor inquired about R4's right shoulder wound. V9 (Wound Physician) stated, "The wound was debrided, so there must have been some biofilm." Surveyor inquired what causes wounds to decline. V9 responded, "I would say there are a lot of reasons why the wound would change; the clinical status or nutritional status of the patient, the treatment itself may not be an appropriate so it might need adjusted, offloading or repositioning is also important, and wound hygiene. All of those things can affect the wound." Surveyor inquired about potential harm to a resident if the wound was not off-loaded and/or appropriate treatments are not implemented. V9 stated, "The wounds can decline."	S9999		

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S9999	Continued From page 5 The (5/19/17) Wound Management Program states a pressure injury is any lesion caused by unrelieved pressure that results in damage to the underlying tissues. The presence of any wounds, injuries, and/or other skin abnormalities will be identified upon admission/readmission or identification of a new wound, pressure injury or other skin abnormality. Residents who are unable to turn and reposition independently will be assisted to turn and reposition every two hours or as appropriate. (A) (Findings 2 of 2) 300.610a) 300.1210b) 300.1210d)1) 300.1210d)2) 300.1210d)3) 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.	S9999		

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S9999	Continued From page 6 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: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. 2) All treatments and procedures shall be administered as ordered by the physician. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. These requirements were not met as evidenced by: Based on observation, interview and record review the facility failed to follow physician orders, failed to ensure that prescribed pain medication	S9999		

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S9999	Continued From page 7 was available, and failed to address pain for one of four residents (R4) reviewed for pain. These failures resulted in R4's pain rated 9 on a scale of 1-10. Findings include: R4's (9/21/21) BIMS (Brief Interview for Mental Status) determined a score of 13, indicating intact cognition. On 11/8/21 at 1:51pm, R4's incontinence brief was inspected by V3 (Licensed Practical Nurse/LPN) as requested. R4 moaned and stated, "That hurts" while being turned. V3 failed to assess R4's pain. R4's (11/3/21) POS (Physician Order Sheets) include Fentanyl (narcotic analgesic) 40mcg (microgram) patch apply every 72 hours related to pain in unspecified joint (start date 11/3/21). On 11/8/21 at 2:05pm, a 12mcg fentanyl patch was observed on R4's right arm. Surveyor inquired about the location of R4's pain. R4 stated, "My hips and legs." Surveyor asked R4 to rate R4's current pain level on a scale of one to ten. R4 responded, "Its 9 right now." Surveyor inquired about pain medication availability. R4 stated, "Sometimes they are out of it." R4's controlled-substance records document that Fentanyl (12mcg) patches were signed out on 11/3/21 and 11/6/21, however a 40mcg patch is prescribed. On 11/9/21 at 9:17am, V2 (Director of Nursing) presented R4's pain medication delivery manifest. Fentanyl 40mcg was not included. Surveyor inquired if R4's Fentanyl 40mcg patches were	S9999		

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S9999	Continued From page 8	S9999		

received by the facility. V2 responded, "No." R4's Fentanyl 40mcg orders were received 6 days prior.

On 11/9/21 at 1:02pm, surveyor asked R4 to rate R4's pain level. R4 responded, "It's a 9."

On 11/9/21 at 1:28pm, surveyor inquired why staff documented in the MAR (Medication Administration Record) on 11/3/21 and 11/6/21 that R4 received 40mcg of Fentanyl (which was unavailable) and 12mcg patches were signed out. V2 responded, "I can't tell you" and confirmed that she was unaware.

On 11/10/21 at 10:55am, surveyor requested R4's current pain level. R4 stated, "It's an 8."

On 11/10/21 at 10:58am, surveyor inquired about R4's pain. V7 (LPN) stated, "R4's pain is about a 7. I gave the Morphine at 9:30. I told him I'll be back to check on him at 11:30." Surveyor stated that R4's pain level was rated "9" for the past 2 days, is currently rated "8" and inquired if the physician was notified of the uncontrolled pain, V7 responded, "No, not yet."

On 11/10/21 at 11:13am, surveyor inquired about R4. V8 (Hospice Nurse) stated, "R4 has ankylosing spondylitis which causes a lot of pain. Our goal of care is to keep him comfortable." Surveyor inquired about R4's pain. V8 responded, "R4 did state that he wanted to die because he's in so much pain."

On 11/23/21 at 9:49am, surveyor inquired about managing pain with Fentanyl patches. V20 (Medical Director) stated, "The transdermal takes a little while because it's a slow release medicine. It may be 3 to 4 days before they take effect."

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S9999	Continued From page 9 Surveyor inquired about potential harm to R4 if pain medication orders were not followed. V20 stated, "Harm is if the pain would not be better." The (undated) Management of Pain policy states pain is defined as whatever the experiencing person says it is, existing whenever the experiencing person says it does. The Nurse will complete a physical evaluation of the resident that includes an objective observation of the painful area. Document of the MAR (Medication Administration Record)/pain flow sheet the effectiveness of pain medication. Effectiveness should be measured 1-2 hours after administration. The (undated) Ten Rights for Administration of Medications includes the right dose: verify against the MAR. (B)	S9999		