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 01/07/2022

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 2189548/IL141691- F689 2189395/IL141480-F689	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210 b) 300.1210 c) 300.1210d)6) 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 each resident's comprehensive resident care plan. Adequate and properly supervised nursing	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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 met as evidenced by: Based on interviews and record review the facility failed to monitor, supervise and prevent a cognitively impaired and total care dependent resident (R1) from serious injury. This failure resulted in R1 obtaining subdural bruising and bleeding with multiple serious traumatic injuries resulting in neck fractures and hospitalization. This failure affects one of four residents (R1) in a total sample of fourteen residents. Findings include: R1 is an 86 year old female resident. R1's diagnoses are, but not limited to: heart failure, kidney disease, hyperlipidemia, cardiomyopathy, lung disorders, major depressive disorder, anxiety disorder, anemia, dysphagia and dementia. Physician order statement (POS) notes R1 is	S9999		

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S9999	Continued From page 2	S9999		

taking a blood thinner.
Minimum data set (MDS) dated 9/14/2021, notes that R1's mental status is impaired. MDS also notes R1 requires extensive two person assistance with transferring and walking.

Care plan dated 9/14/2021, notes R1 is a high risk for falls related to: history of falls, cognitive impairments, decreased safety awareness, unable to use the call light or request staff assistance, requires ADL (activities of daily living) assistance for transfers and mobility, incontinence, decreased strength and endurance, use of anti-psychotropic meds and dementia. R1's care plan dated 9/14/2021, notes staff need to anticipate and meet R1s needs and has the potential for abnormal bleeding due to the daily use of a blood thinner. Care plan intervention dated 10/7/2021, notes to keep R1 in a common area. Care plan intervention dated 12/10/2021, notes R1 requires frequent rounding.

Fall incident report dated 12/8/2021, notes R1 was found by a night nurse on the floor lying on R1's right side in R1's room. The report also notes that R1 is impulsive, incontinent, has impaired memory and is agitated and anxious. Fall incident report dated 12/10/2021, notes R1 was observed laying on the floor on R1's right side. R1 attempted to get out of bed without assistance. R1 was unable to give a description of what happened. Upon assessment R1 was noted with a raised area and discoloration to the right side of R1's forehead. Fall incident report also notes R1 is forgetful, has a gait imbalance, impaired memory and confusion.

Progress note dated 10/5/2021, notes staff witnessed R1 scooting out of bed. Progress note dated 10/8/2021, notes R1 was very anxious

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S9999	Continued From page 3 attempting to get out of bed using the side rail to move to the edge of the bed. Progress note dated 10/9/2021, notes R1 using both hands on side rail scooting toward the edge of the bed. Progress note dated 10/11/2021, notes R1 pulling on side rails of bed, pulling legs out of bed. Progress note dated 10/11/2021, notes R1 is experiencing anxious behaviors and making attempts to get out of bed independently. Due to R1's dementia diagnosis education is not successful. Staff has been educated when R1 appears anxious, R1 should be kept at the nursing station for close supervision. R1 will also be placed on a low bed. Progress note dated 10/13/2021, notes R1 with both legs dangling from bed trying to get out of bed. Progress note dated 12/9/2021, notes R1 sent to local hospital for evaluation of red raised area at the top center area of forehead secondary to fall on 12/8/2021. Progress note dated 12/10/2021, notes R1 returned to facility. Upon making rounds R1 observed lying on right side next to bed. R1 had a raised area with discoloration to right side of head. Progress note dated 12/11/2021, notes R1 has multiple large red swellings on R1's face from falls. Progress note dated 12/12/2021, notes R1 has bruising to the forehead, R1 sent to local hospital for evaluation. Progress note dated 12/13/2021, notes R1 was admitted to local hospital for subdural bleeding. Medical record dated 12/09/2021, notes in part: R1 arrived via 911 with complaint of unwitnessed fall at 11:00PM on 12/8/21. R1's head had bruising. R1 has large right subdural swelling and bleeding and extensive right frontal lateral scalp bruising. R1 has neck fractures.	S9999		

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S9999	Continued From page 4 On 1/5/2022, at 3:26PM, V18 (Licensed Practical Nurse) stated, "a CNA (Certified Nursing Assistant) found R1 on the floor and reported it to V18. We did a full body assessment and put R1 back in bed. No bruises or injuries were observed at that time. No one saw the fall. R1 had a history of falls. Interventions included: bed in low position, frequent rounds, pad on the floor, and stay up later. Typically, staff leave them (fallers) up later and close to the nursing station. R1 is a high fall risk. I was in-serviced on fall precautions. R1 was totally dependent, could not walk or feed self. We fed R1 and crushed R1's medications." On 1/6/2022, at 11:28AM, V2 (Director of Nursing) stated, " the root cause, after speaking to the nurse and observing the environment, R1 turned to R1's right side and fell out of the bed. Staff did an assessment. R1's cognitive status was poor. R1 was not very alert. R1 was confused and demented. R1 fell from bed. R1's fall interventions included; bed in low position and frequent rounding. The nurse said they just left out of the room, heard R1 fall, then went back into the room. The nurse noted a bruise on R1's head. The following day or two, the nurse noted hematoma was larger. The nurse called the doctor and R1 was sent to a local hospital. The emergency room did brain scan that discovered a subdural bleed. R1's care plan noted to keep R1 in the common area to keep an eye on R1. Also, to keep R1 close to the nurse's station for visibility." On 1/6/2022, at 12:35PM, V20 (Medical Doctor) stated, "A subdural hematoma is something that can result from falls, injuries and trauma. Residents have to be careful with taking	S9999		

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S9999	Continued From page 5	S9999		

anticoagulants (blood thinners) and falls; there is a high risk for bleeding. If the resident is on anticoagulants and there is a trauma, then that is reason to send the resident out to the emergency room."

On 1/6/2022, at 1:23PM, V21 (Nurse Practitioner) stated, "R1 was being treated for dementia, cardiac, and kidney disease. The anticoagulants were being used as a preventive measure due to the cardiac issues. In general, anticoagulants with a fall/trauma could cause bruising, bleeding. Generally, if R1 hit R1's head, dependent on duration and dose of the anticoagulant, could cause hematoma."

On 1/6/2022, at 1:38PM, V22 (Medical Doctor) stated, "R1 had a fall, went to the emergency room, came back to the facility and fell in the morning. After the second fall, I was in the facility and assessed R1. I told the nurse to send R1 out to the emergency room. The nurse said R1 just came back from the emergency room. I will keep an eye on R1 and see if there is change in condition. The nurse said I will do an x-ray of the skull. I told the nurse that the x-ray will not tell what is going on inside the brain. I told the nurse to do neuro checks and if there is a change in condition, send R1 to the emergency room."

On 1/6/2022, at 6:24PM, V24 (Licensed Practical Nurse) stated, "The paramedics brought R1 into the room and put R1 in bed. I was in the hallway. I went to the nursing station to sign paperwork with the paramedics. I was away from R1's room for approximately 10 minutes. I went back to the room and saw R1 on the floor, laying on the right side, face touching the floor. R1 was put back in bed. I assessed R1 and took vitals. I called the doctor who ordered a skull x-ray, I started neuro

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S9999	Continued From page 6 checks. R1 did not complain of pain. This happened in the middle of the night, not sure of the exact time. My shift was 10:30PM-6:30AM. R1 was calm, relaxed, alert, and was talking. R1 is a fall risk. Interventions included low bed and floor mats. The interventions were not in place. Bed was not all the way down and the mats were not in place. Yes, I was aware of the interventions. I was waiting for the paramedics to put R1 in bed and to sign the paperwork." On 1/6/2022, at 6:46PM, V25 (Licensed Practical Nurse) stated, "R1 is a fall risk. R1 is sometimes agitated, anxious and confused. R1 needs supervision." On 1/7/2022, at 11:56AM, V27 (Certified Nursing Assistant) stated, "I cared for R1 a couple times. R1 is a total dependent, R1 couldn't assist in R1's care. R1 could try to turn to either side. R1 was a feeder. R1 was a fall risk. I have not been in-serviced on fall risks. R1 needed supervision." On 1/7/2022, at 12:18PM, V28 (Licensed Practical Nurse) stated, "R1 is a fall risk. R1's bed should be in low position and keep R1 visible as much as possible. There should be written interventions to follow. The common area means to have residents near the nursing station or dining room to keep watch over them. R1 liked to scoot out of the bed. R1 needed supervision." (A)	S9999		