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	IL6000822	A. BUILDING: _____ B. WING _____	C 07/28/2022

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

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S 000	Initial Comments Complaint Investigation 2285293/IL148749 2285735/IL149288	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.690a) 300.690b) 300.690c) 300.1210 b)5) 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 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease	S9999	Attachment A Statement of Licensure Violations	

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process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident.

b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident.

c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence.

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

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S9999	Continued From page 2 resident to meet the total nursing and personal care needs of the resident. 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. 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 requirments are not met as evidenced by: A. Based upon observation, interview and record review the facility failed to ensure that (R1 and R5's) fall risk assessments were accurate, failed to implement fall prevention interventions and failed to ensure that supervision was provided to four of five residents (R1, R2, R3, R5) reviewed for falls. These failures resulted in: R1's (7/2/22) fall with mandibular fractures which require surgical intervention & tooth extraction; R3's (6/11/22) facial laceration which required bonding repair; and R2's (7/18/22) fall with an 1- inch open area to the head & head/neck pain.	S9999		

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S9999	Continued From page 3 B. Based upon record review and interview the facility failed to provide an accurate narrative summary to IDPH for R1 (incident date was incorrect), failed to ensure that (R2, R3's) narrative summaries (including incident report, injury follow-up, fall investigation, and/or root cause) were documented and failed to report serious incident/accident within regulatory requirements to IDPH (Illinois Department of Public Health) for three of three residents (R1, R2, R3) reviewed for falls resulting in injury. Findings include: 1. R1's diagnoses include dementia, weakness, acquired absence of right great toe, acquired absence of other right toes, difficulty in walking, abnormalities of gait/mobility and history of falling. R1's (3/23/22) BIMS (Brief Interview for Mental Status) determined a score of 99 (resident was unable to complete the interview). R1's (4/18/22) functional assessment affirms extensive (1-2 persons physical assist) is required for bed mobility, transfer, dressing, toilet use and personal hygiene. One (1) person physical assist is required for walking. Functional limitation in range of motion (which place resident at risk of injury) includes impairment of lower extremity on one side. Balance during walking is marked "not steady." R1's (4/26/22) fall risk assessment determined a score of 7 (moderate risk) however ambulation is marked "independent," gait/balance is marked "normal" and health conditions that predispose resident to be at risk for falls is marked "none" which are incongruent with aforementioned diagnoses and/or functional assessment.	S9999		

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S9999	Continued From page 4 R1's (4/28/22) fall care plan includes the following interventions: anticipate and meet needs, increased supervision when up and keep in engaged supervised activities. R1's (7/2/22) incident report states writer observed swelling on right side of face. Resident unable to give description. Predisposing physiological factors: confused, incontinent. R1's progress notes state (7/2/22) observed swelling to right side of forehead. Doctor was notified received orders to send resident to hospital for evaluation. (7/3/22) Hospital called writer informed that patient has diagnosis of mandible fracture. [R1 did not return to the facility]. R1's (7/3/22) hospital history & physical includes right sided swelling near the mandible. R1's (7/3/22) Facial Bones CT (Computed Tomography) includes reason for exam: trauma. Impression: Comminuted and displaced fracture involving the right mandibular body as well as right mandibular molar. Additional non-displaced fracture involving the left mandibular symphysis as above. Regional soft tissue swelling at the site of both fractures right greater than left. On 7/26/22 at 11:57am, surveyor inquired about R1's (7/2/22) incident. V2 (Director of Nursing) stated the nurse (V6/Licensed Practical Nurse) called me and said the CNA (Certified Nursing Assistant) saw swelling on (R1's) face when sitting in the dining room. (V6) assessed (R1) called the doctor and sent (R1) to the hospital. They (staff) called the hospital for an update and said (R1) had a mandible fracture. We	S9999		

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interviewed the staff to see if (R1) had any incidents they told me no. When I asked the CNA if he had appropriate footwear she couldn't recall. Staff said he had an unsteady gait because he had amputated toes. We determined that it was a fall.

R1's initial & final incident reports submitted to IDPH are dated (7/3/22) however facial swelling (of unknown origin) was identified on 7/2/22 (the day prior).

On 7/26/22 at 2:55pm, surveyor inquired about R1's (7/2/22) incident V1 (Administrator) stated "7/3 that is when this incident would have been reported to me as injury of unknown origin, a jaw fracture. They didn't know exactly what was going on with the resident they just knew it was swelling."

IDPH was notified of R1's (7/2/22) facial swelling on 7/3/22 at 10:50am (over 24 hours after "injury of unknown origin" was identified).

On 7/27/22 at 9:40am, surveyor inquired if R1 walks or is wheelchair bound V8 (CNA) stated "He walks by himself" however (4/18/22) functional assessment affirms R1 requires 1 - person physical assistance. Surveyor inquired about R1's (7/2/22) facial swelling V8 responded when I went into the dining room to take him to his room (because he was sleeping) his face was really swollen. I brought him to the nurse's station and let the nurse know. Surveyor requested a description of R1's swelling V8 replied "It was real, real swollen like real big" (on the right side). Surveyor inquired if R1 was able to recall how the injury was incurred V8 stated "He really don't communicate. I really don't know what happened, I worked the day before

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S9999	Continued From page 6 (6:30am-2:30pm) and his face was not like that." R1's (7/3/22) hospital history & physical includes history of present illness: 70 year old male presenting after unwitnessed fall. Presents with right mandibular angle fracture and non-displaced left mandibular parasymphysis fracture. Plan: recommend surgical intervention for open reduction internal fixation of right mandibular angle and left mandibular parasymphysis with extraction of tooth #31 and any other necessary teeth. 2. R3's diagnoses include Alzheimer's disease, weakness, age related physical debility, lack of coordination and unsteadiness on feet. The facility incident log affirms R3 fell five (5) times within the past 3 months (5/6/22, 5/20/22, 6/11/22, 6/17/22, 7/20/22). R3's (4/19/22) BIMS determined a score of 99. R3's (6/18/22) functional assessment affirms total dependence (2 - person physical assist) is required for transfers and walking did not occur. R3's (7/20/22) fall care plan includes the following fall prevention interventions: (1/1/22) brand name non-slip device to wheelchair. (5/6/22) Resident to be in common area when up. Staff to make sure resident is in common area when up for increased supervision. (5/20/22) Brand name non-slip device re-applied to wheelchair. (6/17/22) Staff to offer frequent round when in room. R3's (6/11/22) incident report states CNA stated that resident fell forward out of the wheelchair hitting her face on the floor before he could get to	S9999		

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S9999	Continued From page 7 her and observed bleeding laceration over right eyebrow. Injury: forehead swelling/laceration. Incident location: Resident's room. R3's (6/11/22) progress notes state resident fell out of her wheelchair and fell face forward onto the floor hitting her face and sustaining a laceration above the right eyebrow and bleeding. Resident sent out to hospital. [There is no follow-up documentation concerning R3's laceration repair upon return to the facility]. R3's (6/11/22) hospital history & physical includes right eyebrow laceration approximately 3 centimeters. Skin closure: glue. On 7/25/22 at 2:55pm, R3 was observed in a wheelchair in her room (near the end of the hallway) propelling herself while unattended by staff. The non-slip device was observed in R3's lap. Surveyor subsequently inquired about R3's fall prevention interventions V3 (Licensed Practical Nurse) entered the room and stated "When she's (R3) in the wheelchair we have the wheels locked" however R3's wheels were not locked. Surveyor inquired if R3 was ambulatory V3 responded "She can stand and she can walk with assist." V3 placed R3's non-slip device on the over bed table and instructed R3 to stand while holding onto her arm (without a gait belt and/or additional assistance). R3 proceeded to move her buttocks forward while leaning on the back of the wheelchair (clearly unable to stand without 2 - person assist). Surveyor inquired where R3's non-slip device was located V3 replied "There it go right there (pointing to the over bed table) she done took it out." Surveyor inquired why R3 was unsupervised by staff while in the wheelchair V3 stated "Her daughter was here." Surveyor inquired if R3's daughter was still	S9999		

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S9999	Continued From page 8 in the facility V3 responded "Not now" and proceeded to place R3 in the supervised dining area (without the non-slip device on R3's wheelchair). On 7/25/22 at 3:08pm (13 minutes later), R3 was observed propelling herself in the wheelchair (in the hallway) while unattended by staff. On 7/27/22 at 3:23pm, surveyor inquired why R3's (6/11/22) laceration was not reported to IDPH V2 (DON/Director of Nursing) stated "The administrator stated that the resident (R3) did not require any staples, sutures or bonding (glue repair) for the laceration." 3. R2's diagnoses include dementia, encephalopathy, lack of coordination and abnormalities of gait/mobility. R2's (5/2/22) BIMS determined a score of 99. R2's (5/2/22) functional assessment affirms 1 - person physical assist is required for transfers, walking, and toilet use. R2's (5/2/22) fall care plan includes the following interventions be sure call light is within reach and encourage to use it for assistance as needed. Respond promptly to all requests for assistance. R2's (7/18/22) progress note states writer heard a loud boom. Went into patient's room, noticed resident supine on the floor next to bed. Resident unable to state what happened in English. Noted resident holding back of head. Body assessment done, noted 1 - inch open area to left top head, no bleeding noted. Assisted resident to standing position, resident unable to stand. Placed back in bed. Ambulance called. [R2 did not return to the	S9999		

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S9999	Continued From page 9 facility]. [There is no documentation regarding R2's injury and/or repair post hospital transfer]. On 7/27/22 at 11:12am, surveyor inquired about R2's (7/18/22) fall. V2 stated they (staff) said the patient tried to get out the bed and he (R2) fell. According to the nurse (V9/Licensed Practical Nurse) they (staff) heard a boom, when she (V9) went into the room he (R2) was on the floor and affirmed the fall was unwitnessed. Surveyor requested R2's (7/18/22) incident report V2 (DON) stated it's no incident report. The agency nurse (V9) called me about the fall, I instructed her to fill out the incident report and she didn't do it. I've been trying to contact this nurse (V9) but was unable to reach her. The progress notes has the fall, I did an investigation, but I didn't write one out because there was no incident report for me to do that. On 7/27/22 at 1:00pm, V13 (IDPH Clerical) stated that the facility did not report any incidents to the department (concerning R2) on or about 7/18/22. On 7/27/22 at approximately 1:05pm, V2 (DON) presented email verifications for (7/18/22) "initial reportable" sent to IDPH (however resident name/documents sent were excluded) and (7/19/22) response email received from IDPH states "Please re-submit this incident as PDF document. This submission was immediately deleted on reception. We do not accept word documents as they can be easily manipulated." Surveyor inquired if the (7/18/22) initial reportable was re-submitted to IDPH as directed V2 affirmed it was not. The (undated) incidents/accidents/falls policy states any incident/accident/fall that meets the reporting criteria of the state/federal regulations	S9999		

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S9999	Continued From page 10 will be reported timely and accurately, to include the initial as well as the follow-up reports. On 7/27/22 at 2:40pm, surveyor inquired about R2's (7/18/22) fall/injury V14 (CNA) stated I was in the middle of doing rounds and I heard a thud. I followed where I heard the noise coming from and found him on the ground. He was sitting on his butt (near the bed), and he was holding his head. As she (V9) looked through his hair she (V9) said it was like a little small gash. He's able to communicate sometimes but you got to kind of guess what he's talking about. He speaks Spanish so there's somewhat of a language barrier. I know a little bit of Spanish and I'm able to communicate the basic things. He was trying to get in the bed, and he fell. I could tell he was having pain by his facial expression, and he was holding his head. R2's (7/18/22) hospital history & physical includes head CT clinical indication: trauma with head and neck pain. Fall to posterior occiput. 4. R5's diagnoses include dementia, cognitive communication deficit, hypertension, muscle wasting/atrophy, restlessness, agitation, weakness, unsteadiness on feet and abnormalities of gait/mobility. The facility incident report affirms R5 fell on 6/24/22 and 7/2/22. R5's (5/13/22) BIMS determined a score of 6 (severely impaired cognition). R5's (5/13/22) functional assessment affirms 1 person physical assist is required with transfers and walking.	S9999		

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S9999	Continued From page 11 R5's (7/2/22) fall risk assessment (post fall) determined a score of 3 (low risk) however history of falls within the last 3 months is marked "no," ambulation is marked "independent," and health conditions that predispose resident to be at risk for falls is marked "none" which are incongruent with aforementioned diagnoses, fall incident(s) and/or functional assessment. R5's (5/13/22) care plan states staff to provide resident with bed in the lowest position and bed mobility positioning devices. Monitor frequently and offer assistance with transfer. R5's (6/24/22) progress notes state resident observed sitting on bedroom floor on buttocks. Resident stated I stood up and sat down on the floor. R5's (7/2/22) incident report states observed resident sitting on the floor next to bed. Resident stated I was sitting on edge of bed and just slid to the floor. On 7/25/22 at 3:07pm, R5 was asleep in bed however the bed was not in low position and positioning devices were not in use. On 7/25/22 at 3:10pm, surveyor inquired about R5's fall prevention interventions V4 (CNA/Certified Nursing Assistant) entered R5's room and stated, "I didn't know he fell" R6 (Roommate) responded "He (R5) was about to fall off the bed on the floor this morning" and advised that R5's mattress was coming off of the bed at the time. Surveyor inquired about the height of R5's bed V4 replied "It don't look like it's in the lowest, it's not even plugged up." Surveyor inquired if V4 could lower R5's bed V4 replied "You can't if you don't see the cord." V5 (CNA) subsequently searched for R5's device to lower the bed and stated "It's a cord but	S9999		

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

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S9999	Continued From page 12 it's not plugged in" proceeded to plug in the device then lowered the bed. On 7/28/22 at 1:38pm, surveyor inquired about the importance of scoring fall risk assessments properly V15 (Medical Director) stated it's certainly important because we want to prevent as many falls as we can. We definitely want to minimize the falls especially with dementia patients or a weak patient. Surveyor inquired about the importance of following fall prevention interventions V15 responded the importance is that this is an action taken, like this was a problem with a plan put in place. To decrease falls we have to implement it, this is an action taken to correct the problem. Surveyor inquired about potential harm to a resident with dementia that has an unwitnessed fall V15 replied fall will lead to injuries, it could be fractures could be injury to the brain or internal bleeding can happen. They may be on the floor for a longer length of time, they could get rhabdomyolysis leading to dehydration, kidney failure or other things. The main injuries would be fractures, laceration, internal bleeding or external depending where they get hurt. The (8/3/17) fall prevention policy states identify risk factors. Implement individualized approaches/interventions based upon resident risk. Staff should visually check residents to ensure safety, assist with care needs, and prevent unsafe transfers whenever possible. Signs and symptoms of fracture include: swelling. (A)	S9999		