Illinois Department of Public Health

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 10/06/2022

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 Facility Reported Incident of 9/19/22 /IL151674	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210 b) 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 care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.	S9999	Attachment A Statement of Licensure Violations	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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S9999	Continued From page 1 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 upon observation, interview and record review the facility failed to follow the fall prevention policy, failed to provide (R1, R3) supervision, and failed to implement fall prevention interventions for three of four residents (R1, R3, R4) reviewed for falls. These failures resulted in R1 sustaining (9/19/22) fall with eyelid laceration, periorbital hematoma, subarachnoid hemorrhage, and subdural hemorrhage. Findings include: The facility fall log affirms R1 fell on 8/26/22 and 9/19/22. R1 is 76 years old with diagnoses which include Alzheimer's disease, weakness, age related physical debility, lack of coordination, hemiplegia, and hemiparesis. R1 was admitted to the facility 8/25/22 transferred to the hospital 9/19/22 (post fall) and did not return. R1's (9/1/22) BIMS (Brief Interview Mental Status)	S9999		

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determined a score of 5 (severely impaired).

R1's (9/1/22) functional assessment affirms (2-person) physical assist is required for bed mobility and transfers.

R1's (8/26/22) incident report states upon making rounds resident observed on floor next to bed. Resident stated she was just moving around the bed and rolled out of bed.

R1's care plan states resident is at risk for falls. Interventions: (8/26/22) Follow the facility fall protocol. Nursing staff will complete a fall risk assessment per facility fall protocol. Low bed provided [side rails and/or floor mats are excluded].

R1's (8/28/22) fall risk assessment determined a score of 11 (High Risk).

On 10/5/22 at 9:25am, surveyor inquired about R1's (9/19/22) incident V2 (Director of Nursing) stated. "The Nurse called me and said she (R1) had a fall that was unwitnessed, so we sent her (R1) out. She (R1) was in the low bed that day." Surveyor inquired if R1 sustained any injuries post (9/19/22) fall V2 responded, "She (R1) had a subdural hematoma."

On 10/5/22 at 12:55pm, surveyor inquired about R1's fall prevention interventions. V10 (Licensed Practical Nurse) stated "Her bed was in low position, and we (Staff) were doing 2 hour rounds on her cause she was confused." Surveyor inquired about R1's (9/19/22) incident. V10 responded, "The CNA (Certified Nursing Assistant) called me to the room and told me that she (R1) was observed on the floor. She (R1) had a laceration to her upper right brow. She was

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next to her bed on the floor laying on the side where the laceration was. She wasn't really able to tell me what happened because she is intermittently confused." Surveyor inquired if predisposing situation factors should be selected on the incident report. V10 replied, "Yes, those are filled out." Surveyor advised that nothing was selected for predisposing situation factors on R1's (9/19/22) incident report V10 stated, "It should have been filled out for low bed."

R1's (9/19/22) incident report states: writer observed resident laying on floor next to bed on right side. Resident unable to give description. Injury: laceration/eyebrow (right). Predisposing physiological factors: confused, incontinent, gait imbalance. [Predisposing situation factors affirm low bed use, side rail use and/or safety mat at side of bed were NOT selected].

R1's (9/19/22) history & physical states patient presented from nursing home after mechanical fall and altered mental status. Diagnoses: traumatic subarachnoid hemorrhage, traumatic subdural hematoma, right periorbital (eyelid) laceration, periorbital hematoma.

R1's (9/19/22) head CT (Computed Tomography) includes trace right sided subarachnoid and subdural hemorrhages.

On 10/6/22 at 1:47pm, surveyor inquired about potential harm to a resident that sustains an unwitnessed fall. V12 (Medical Director) stated, "I would definitely do a CT of the head and send them to the hospital." Surveyor inquired why a head CT would be ordered. V12 responded, "To look for any type of hemorrhage or hematoma."

The facility fall log affirms R3 fell on 8/11/22,

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S9999	Continued From page 4 8/23/22 and 9/3/22. R3 is 71 years old with diagnoses which include dementia, hemiplegia, and hemiparesis (affecting left side). R3's (9/15/22) BIMS determined a score of 99 (Resident was unable to complete interview). R3's (9/15/22) functional assessment affirms (2-person) physical assist is required for bed mobility and transfers. R3's (9/3/22) incident report states writer observed resident laying on floor mat rolling around. Resident unable to give description. No witnesses found. R3's care plan states resident is at risk for falls. Interventions: (9/6/22) Resident will be placed in common area when up. On 10/4/22 at 10:36am, R3 was observed (unsupervised) in the bedroom atop of a modified wheelchair (lying almost completely flat) with left leg dangling over the edge. R3's call light was out of sight (behind the curtain) and out of reach (dangling from the wall). V4 (Licensed Practical Nurse) subsequently entered R3's room, surveyor inquired about safety concerns. V4 stated, "He don't got a call light next to him. He's lying flat in the chair but he's moving side to side. I'll go talk to the Nurse and see what's going on." V4 placed V4's left leg onto the chair and left the room without providing R3 call light access. [R3 was not placed in a common area while up]. On 10/4/22 at 10:41am, V5 (Restorative CNA) entered R3's room surveyor inquired about safety concerns V5 stated "The way he's postured, he's	S9999		

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S9999	Continued From page 5 not sitting up in the chair and the leg is off the chair." Surveyor inquired about the location of R3's call light. V5 responded, "It should be up above the bed." V5 located a call light string (behind the curtain) and attempted to place it near R3 however there was no clip to secure the string. Surveyor inquired if there was a clip on the call light string to maintain placement within reach V5 replied "Not at the moment" and placed the call light string on the bed (out of reach). Surveyor requested to inspect R3's sacral wound. V5 then exited the room without providing R3 call light access and/or repositioning the resident. R4 is 55 years old with diagnoses which include Parkinson's disease, weakness, unsteadiness on feet and difficulty in walking. R4's (9/16/22) fall risk assessment determined a score of 9 (moderate risk). R4's (8/19/22) care plan states resident is at risk for falls, could benefit from use of nonrestrictive side rails. Interventions: place call light within reach. R4's (8/17/22) BIMS determined a score of 13 (cognitively intact). R4's (8/17/22) functional assessment affirms (2-person) physical assist is required for bed mobility and transfers. On 10/4/22 at 10:58am, R4 was lying in bed without call light access. Surveyor inquired about the location of R4's call light. V5 (Restorative CNA) stated, 'It's right here" then grabbed the string which turns R4's over bed lighting on/off. Surveyor advised that the string to which V5 was referring was not for call light access. V5	S9999		

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S9999	Continued From page 6 subsequently located the call light (dangling from the wall) and placed it within R4's reach. The (8/3/17) fall prevention policy states this facility will provide fall prevention assessment, implement interventions to prevent falls as much as possible, and manage post-fall treatment. This facility will achieve these goals through interventions that are implemented based upon the identified risk factors. Reassessment of risk after a fall with modification and/or additional interventions as appropriate. (B)	S9999		