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 02/21/2023

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: #2381231/IL156368 #2380463/IL155450 Facility Reported Incident of 1/19/23/IL155803	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)2) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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: 2) All treatments and procedures shall be administered as ordered by the physician. 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 meet as evidenced by: Based on observation, interview and record review, the facility failed to monitor (R2) who is cognitively impaired and recently had a hip surgery from a fall; and, failed to provide individualized fall prevention interventions for a residents (R2) according to the care plan. As a result of this facility failure, (R2) fell and sustained a right hip fracture which required surgery. Findings include: R2's Face Sheet shows R2 was originally admitted to the facility on 11/12/2015 and readmitted on 1/23/23. R2's diagnoses include but are not limited to Dementia, Osteoarthritis,	S9999		

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S9999	Continued From page 2 Abnormalities of gait and mobility, and Muscle weakness. R2's records reviewed include but are not limited to the following: BIMS (Brief Interview for Mental Status) score dated 10/1/2020 could not be determined due to severely impaired cognition. Fall Risk Evaluation dated 1/19/23 shows a score of 8 (at risk for falls). MDS (Minimum Data Set) section G with effective date 10/1/2020 shows that R2 needs extensive assistance with two persons for bed mobility, transfer, personal hygiene and toilet use. Mobility Devices records a wheelchair. Care Plan dated 1/19/23 states that R2 is at high risk for falls related to medical diagnoses; Intervention states in part to provide a safe environment and bed mobility position devices. However, there was no bed mobility position device observed on R2's bed on 2/14/23. A bed wedge was put in place after the surveyor prompted staff on 2/15/23. On 2/14/23 at 11:25am, R2 was observed in bed. R2's room is one from last room at the end of the hall farthest from the nursing station. Inquired from V12 (LPN/Licensed Practical Nurse) about the fall prevention interventions for R2 and why R2's room is so far away from the nursing station. V12 responded, R2 was previously on the second floor and was recently moved to the third floor. Again on 2/15/23 at 12:45pm, R2 was observed in the same room almost at the end of the hallway far away from the nursing station and not within	S9999		

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S9999	Continued From page 3 view of staff. Nursing progress notes dated 1/19/23 at 12:40pm written by V19 (LPN/Licensed Practical Nurse) states in part: Writer was called to the dining room by staff. Resident was observed lying on her back. Writer was told resident slide out her wheelchair. Body assessment completed no visible injury noted. Resident complained of pain to the right leg, PRN Tylenol 500mg was given for pain. Stat X-Ray ordered for the right hip, knee, and leg. 72-hour neurological check initiated. On 2/15/23 at 10:50am, V19 was interviewed regarding R2's fall and if it was okay to wait till the next day after the fall to get X-Ray on the resident. V19 corroborated the above progress notes and stated: "On that day, I was called to the dining room, and I saw (R2) already on the floor by the wheelchair. I don't remember the CNA (Certified Nurse Assistant) in the dining room at that time. I did body assessment and gave her pain medication. I called for the X-Ray on the day of the fall, but when I got back to work the next day and found that the X-Ray was not done, I told the ADON (Assistant Director of Nursing/V51) about it. I also called the (X-Ray company) and the (X-Ray company) said they could not come because they were backed up. So, the resident was sent to the hospital per doctor's order the next day." On 2/16/23 at 2:02pm, V51 (ADON/Assistant Director of Nursing) was interviewed regarding R2's fall of 1/19/23 and why R2 was not sent to the hospital on the very day R2 fell. V51 responded, when she (V51) was told that the Stat X-Ray was not done on that day (1/19/23), the doctor was called and R2 was sent to the hospital. V51 explained that at the hospital, they	S9999		

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S9999	Continued From page 4	S9999		

found that R2 had a fracture of the hip. V51 was also interviewed about the current fall prevention interventions for R2 after returning to the facility from the hospital with a healing hip fracture. V51 stated, "I know that the resident should be closer to the nursing station to be monitored frequently, but that was the room available after she came back from the hospital. We will find a room closer to the nursing station."

On 2/17/23 at 2:36pm, V51 stated that R2 has been moved to a room closer to the nursing station.

Hospital Records dated 1/21/23 shows X-ray of Femur results: Right Femur and Right Hip X-Rays: Indication: Right hip pain status post fall. There is an acute comminuted and impacted intertrochanteric fracture of proximal right femur with mild varus angulation.

Physician progress notes dated 1/26/23 written by V20 (Medical Doctor/MD) states in part: The patient is an 82-year-old female, long-term resident of the facility. She had a fall in the facility when she landed to her right side sustained right hip pain and the patient was sent to the hospital. She was found to have right hip intertrochanteric fracture and underwent right hip open reduction internal fixation with intermedullary nailing.

On 2/17/23 at 2:20pm, V54 (Medical Director) was interviewed regarding R2's fall injury and the delay in getting X-Ray after R2 complained of pain in the hip. V54 stated, if the X-Ray company did not show up after a few hours, the nurse should let me know and then we can send the resident to the hospital. Inquired from V54 if it was okay for the resident to wait till the next day before being sent to the hospital, V54 responded,

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S9999	Continued From page 5 "No, that should not wait till the next day. Communication needs to exist between the nurse, the lab and the doctor." V54 was asked about fall prevention interventions for a resident who was sent to the hospital due to a fractured hip and returned to the facility. V54 stated, "Interventions need to be in place to prevent another fall. We want to make sure the resident is close to the nursing station so they can see if the resident is trying to get up." Facility's Fall Prevention and Management Program version 080317 states in part: The purpose of our Fall Prevention and Management Program is to: Provide appropriate interventions to prevent falls. Through an interdisciplinary approach, this facility will provide fall prevention assessment, implement interventions to prevent falls as much as possible, and manage pos-fall treatment. #3B states: Implement individualized approaches/interventions based upon resident risk. (A)	S9999		