STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145549	A. BUILDING _____ B. WING _____	09/25/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BELHAVEN NURSING & REHAB CENTER	11401 SOUTH OAKLEY AVENUE CHICAGO, IL 60643

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** Based on observation, interview and record review, the facility failed to provide interventions regarding communication barriers for 1 (R2) out of 3 residents reviewed for resident's rights. This has a potential to affect the rights of one resident (R2) to receive proper services from the facility. Findings include: On 08/22/20 at 01:30 pm R2 stated, Sometimes R1 helps me to translate. There is another guy here who speaks Spanish. I think he is a Mexican guy and he also helps translating things for me. I need a translator. On 09/24/20 R2 stated, It makes me feel bad, because I don't understand what medications they are giving me. My doctor at the clinic didn't prescribed this medicine. My doctor here doesn't speak Spanish and I don't know what medicines they are prescribing me. They had me take two medicines they say is for cholesterol and high blood pressure and those medicines were making me feel dizzy. I fell , like passed out twice because of it. I stopped taking them and I feel better. But I don't know why they are giving me medicines because I don't understand. During interview V4 (Registered Nurse/RN in charge of R2 on 09/22/20), V9 (Licensed Practical Nurse/LPN), V10 (LPN), V11 (Certified Nursing Assistant/CNA), V12 (CNA), V13 (CNA), and V14 (CNA) all denied speaking Spanish. During the resident tour no staff was observed speaking in Spanish with R2. On 09/22/20 at 03:11 pm V4 stated, I don't speak Spanish. If we need to have a deep conversation with R2 we call the activity aide (V15) to translate. She is a Spanish speaker. If for any reason R2 does not understand, most of the time we call his wife. She speaks English. R2's care plan, review date 7/13/20, documents R2's speaks a little English and documents activity director will assist with translation. Care plan does not show intervention to language barrier identified.
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide preventive measures and treatments for the pressure wounds for 6 residents (R4, R6, R7, R8, R9, R10) of 7 residents reviewed for pressure ulcers. Findings include: 1. R4 did not reside in the facility during the survey. Per R4's progress notes, R4 was sent to the hospital and was admitted on [DATE]. R4's Weekly Wound assessment dated [DATE] reads that R4 had a sacral pressure wound that was identified on 9/3/2020. R4's Physician order [REDACTED]. R4's Treatment Administration Records reads that R4 did not receive any dressing treatment on his sacral pressure wound from 9/3/2020 to 9/6/2020. On 9/24/2020 at 12:02 PM. V17 (Wound Care Coordinator) stated, R4's sacral wound was identified on 9/3/2020 and should have been started right away and not wait until 9/7/2020. The correct procedure was when nursing staff first identified the wound, they need to do a skin assessment, notify physician to get treatment order and notify family. Dressing treatment must be done right away. After that, nursing staff notify me; I do the wound assessment. I think I was off during those days. 2. On 9/22/2020 at 1:12 PM. R6 was seen inside R6's room lying on the bed. R6 was alert but unable to be interviewed. R6's Weekly Wound assessment dated [DATE] reads that R6 had a sacral pressure wound. R6 sacrum dressing treatment was not signed as done on the following dates: September 4, 6, 13, 19 and 20; August 7, 8, 9, 22 and 23; and July 12 and 26. 3. On 9/24/2020 at 9:25 AM. R7 was seen inside R7's room. R7's Weekly Wound assessment dated [DATE] reads that R7 had a sacral pressure wound. R7 sacrum dressing treatment was not signed as done on the following dates: September 2, 4, 5 and 6; August 7, 9, 20, 22 and 23; and July 3, 5, 8, 11, 12 and 26. 4. On 9/24/2020 at 9:32 AM. R8 was seen inside R8's room lying on the bed. R8 was alert but unable to be interviewed. R8's Weekly Wound assessment dated [DATE] reads that R8 had a left thigh (ischium), left leg and sacral pressure wound. R8's left ischium dressing treatment was not signed as done on the following dates: September 1, 2, 3, 4, 5 and 6; August 7, 22 and 23; and July 3, 5, 8, 11 and 12. R8 left lateral leg dressing treatment was not signed as done on the following dates: September 2 and 5; August 22. R8's sacrum dressing treatment was not signed as done on the following dates: September 2, 4 and 5; August 7, 9, 21 and 22; and July 26. 5. On 9/24/2020 at 9:40 AM. R9 was seen inside R9's room lying on the bed. R9 was alert and able to express himself during interview. R9 has a Brief Interview for Mental Status of 15, which indicates R9's cognitive status was intact. R9 stated that he has a wound on his buttock and needs to turn by himself in order for the wound not to have pressure. R9's Care Plan on bed mobility reads that R9 needs 2 person assist to turn from side to side in bed due to [MEDICAL CONDITION], obesity and muscle weakness. R9's Weekly Wound assessment dated [DATE] reads that R9 had a left buttock pressure wound. R9's left buttock dressing treatment was not signed as done on the following dates: September 2, 4, 5, 6, 13, 19 and 20; August 7, 8, 9, 12, 22 and 25; and July 5, 9, 12, 22 and 25. 6. On 9/24/2020 at 10:15 AM. R10 was seen together with V16 (Licensed Practical Nurse) inside R10's room lying on the bed. R10 unable to be interviewed. R10 has a low air loss mattress with white bed sheet and blue pad underneath her on the hip and buttocks area. R10's feet have no socks, feet were not being off loaded and no heel protectors were observed. V16 stated, R10 uses a low air loss (LAL) mattress and the blue pad is not supposed to be there. I will take it out. R10 needs feet protection because she used to have a wound on her left foot (showing the foam dressing on the left foot). On 9/24/2020 at 12:02 PM. V17 (Wound Care Coordinator) stated, Regarding R10, she has a left heel wound and her heels needs to be offloaded while in bed. R10 also needs to wear her heel protectors at all times while on bed. R10's Weekly Wound assessment dated [DATE] and 8/6/2020 reads that R10 had a sacrum and left heel pressure wound. R10's sacrum dressing treatment was not signed as done on the following dates: September 2, 4, 6, 13, 19 and 20; August 7, 8 and 22; and July 12 and 26. R10's left lateral heel dressing treatment was not signed as done on the following dates: September 2, 4 and 6; August 7; and July 12 and 26. On 9/25/2020 at 11:28 AM. V2 (Director of Nursing) stated, I will look into the Treatment Administration Record and check if there are treatments not signed. If it was not charted, then it was not done.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to follow policy guidelines for safe handling and storage of food by not discarding expired food, perishable food not dated, perishable food exposed and not sealed properly. These failures have the potential to affect all 153 residents residing in the facility. Findings include: On [DATE] at 11:55 AM. during kitchen review with V3 (Clinical Nutritionist) and V1 (Administrator), the following concerns were observed: In the Dry Storage Room, bin of rice crispy was dated [DATE], corn flakes has no date. Cinnamon streusel coffee powder was dated [DATE]. Basil leaves expiration date was [DATE]. In the walk-in freezer a pitcher of orange colored liquid (according to V3 it was orange juice) was not dated and left open without seal. Hotdog buns were dated [DATE]; after asking V3 for guidelines on how many days hotdog buns are good for consumption, V3 did not provide any documentation. A large

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 1) transparent bag of carrots was observed left open exposed to environment without any date. A slice of small meat inside a transparent plastic wrap was observed and, according to V3 and kitchen staff it was a slice of chicken with no date. V3 was unable to provide an answer if they are using that meat. V1 stated, I do not know why there are expired condiments that are not discarded and when food supply is good for consumption or need to be discarded since I am not a dietary staff. V3 stated, Expired food or condiments need to be discarded and all food must be sealed and dated properly. On [DATE] at 12:40 PM. during follow up review in the kitchen with V3, the following concerns were found: In the dry storage room, opened baking powder was seen with dated ,[DATE] to ,[DATE], an open cake mix with no date and an opened 1 gallon bottled water. V3 stated, I do not know where these came from, but this needs to be discarded. As to the mineral water, I do not know what they used this for, but this needs to be dated too when opened. Food Storage Policy dated ,[DATE] reads: The Dietary Manager or designee will ensure that stocks are rotated accordingly. Upon receipt of the deliveries, the employee will mark the food item with the date. Opened products will be labeled and stored in tightly covered containers. Dry food stores in bins such as flour, sugar will be removed from the original packaging. Bins will be labeled and dated. Stocks must be used before their expiration dates. Stock not used by the expiration dates will be discarded. Cold Food Storage Policy dated ,[DATE] reads: Food will be kept in clean, undamaged wrappers or packages. Cover, label and date all food items removed from their original containers.