

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145958	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/27/2024
NAME OF PROVIDER OR SUPPLIER Bethany Rehab & Hcc		STREET ADDRESS, CITY, STATE, ZIP CODE 3298 Resource Parkway Dekalb, IL 60115	

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)
<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31615</p> <p>Based on interview and record review the facility failed to ensure a resident was treated with dignity for 1 of 1 resident (R2) reviewed for dignity in the sample of 12.</p> <p>The findings include:</p> <p>R2's admission record shows she was admitted to the facility on [DATE] following a fall with a facial fracture. The order summary report shows an order to discharge home on 12/23/24. The facility's 12/22/24 resident assessment and care screening documents R2 was cognitively intact and required partial/moderate assistance with hygiene and showering/bathing.</p> <p>R2's progress notes for 12/21/24 were reviewed and show V14 LPN (Licensed Practical Nurse) documented R2's family reported they were going to take R2 home if the facility could not provide a shower. V14 documented he asked the day shift aide to give R2 a shower and she refused. V14 noted V2 DON (Director of Nursing) was notified. When family member came back reporting that if their mother does not get a shower they will leave against medical advice.</p> <p>On 12/27/24 at 12:00 PM during a phone interview, V13 (R2's son) stated he had requested multiple times for his mother to get a shower and no one would listen to him. He stated on 12/21/24 he spoke with V14 at breakfast time and told me after breakfast the staff would shower his mother. Then it was after lunch, and she still did not get a shower. She had been in the facility and had not received a shower. V13 stated the shower on 12/21/24 was the only one she received in the 2 weeks she was there. He stated that was a basic dignity issue, as (R2) was alert and oriented and knew what was going on, and she began to wonder what was wrong with her, that staff did not want to care for her. V13 stated (R2) kept asking is there something wrong with me? V13 stated he had to threaten the staff to get some action.</p> <p>The December 2, 2024, resident council meeting minutes document residents stated concerns with the CNA's (Certified Nursing Assistants) telling the resident they do not have time to give showers.</p> <p>On 12/27/24 at 2:00 PM, V2 stated she was not familiar with the incident regarding R2, or residents not getting showers. She stated if she had known about the incident, she would have immediately followed up.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 145958
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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's resident rights for people in long-term care facilities pamphlet documents residents have the right to dignity and respect. Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life.</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31615</p> <p>Based on observation, interview, and record review the facility failed to ensure equipment was maintained for an emergency supply cart for 52 residents residing on the north hallway. The facility failed to ensure physician ordered daily weights were obtained for 1 of 5 residents (R3) reviewed for quality of care in the sample of 12.</p> <p>The findings include:</p> <p>1. The 12/27/24 resident list report shows 52 residents reside on the north hallway.</p> <p>On 12/27/24 at 9:00 AM, the north crash cart check list shows a list of items on the emergency cart to be checked daily, including the oxygen tank (full). The last date the list was checked was 12/17/24.</p> <p>On 12/27/24 at 9:40 AM, V7 LPN (Licensed Practical Nurse) stated all items on the list should be checked daily. V7 checked the oxygen tank, and it was empty. V7 stated the cart should have a full tank of oxygen in case there was a code blue, the staff would have to scramble to find a full tank down the hallway, causing a delay in getting oxygen for the resident.</p> <p>On 12/27/24 at 2:00 PM, V2 DON (Director of Nursing) stated the night shift should be checking the cart every night to ensure all of the equipment is on the cart, and the oxygen tank is full. V2 stated in an emergency the staff would need the oxygen, otherwise they would take extra time to get a tank down the north hallway.</p> <p>The facility's 12/2024 policy for crash cart documents the facility will maintain a crash cart that is readily accessible with the necessary items to render medical care on an emergent basis. 1. The night shift shall audit contents of the cart and complete the crash cart checklist daily. 2. Missing items will be replaced immediately.</p> <p>2. R3' admission record showed an initial admitted [DATE] with multiple diagnoses including CHF (congestive heart failure). The 12/27/24 order summary report shows an 11/15/24 order for a daily weight, if a 2-3-pound increase overnight or a 5-pound increase in a week, contact the provider. The order has no stop date. R3's December 2024 medication and treatment records were reviewed and show no results for the daily weight.</p> <p>The weight and vitals summary for 12/27/24, shows R3 had weights completed on 11/17/24 and 11/18/24 for November. The December weights show R3 was weighed on 12/9/24 and 12/20/24. During that time, R3 had an increase of 17.6 pounds.</p> <p>On 12/27/24 at 9:00 AM, R3 was observed sitting upright in bed with oxygen per nasal cannula with no shortness of breath or signs of distress.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 12/27/24 at 1:00 PM, V9 LPN (Licensed Practical Nurse) stated if a resident is a daily weight they are listed in the weight book at the nurse's station. V9 stated the nurse is to double check the book during their shift to ensure it was done. V9 stated when the weight is obtained it is put in the computer. V9 stated R3 was a daily weight due to her congestive heart failure. V9 stated the weight is monitored due to possible increase in fluids or edema. V9 stated after so many pounds, the doctor has to be notified. V9 stated the order did not pop up for her (V9) on the computer.</p> <p>On 12/27/24, at 1:05 PM, V4 CNA (Certified Nursing Assistant) stated the weight book is checked daily for who gets weighed. V4 stated she was aware R3 was on the list. V4 stated when the weight is completed, she (V4) will tell the nurse and put the weight in the book. V4 was looking at the pages in the book and stated it did not look as if R3 was getting her weight done.</p> <p>On 12/27/24 at 1:55 PM, V2 DON (Director of Nursing) stated the CNAs should be completing the daily weights from the list at the nurse's station. The weights should be listed on the paper and reported to the nurse. V2 stated residents with CHF, like R3, need to be monitored for fluid retention, and if there is any increase, it should be brought to the attention of the physician.</p> <p>The facility's 12/2024 weight assessment and intervention policy documents weight will be recorded in the individual's medical record.</p>		