STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145958	A. Building B. Wing	03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany Rehab & Hcc	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34491 Based on interview and record review, the facility failed to ensure a resident was free from abuse for 1 of 8 residents (R1) reviewed for abuse in the sample of 8. The findings include: R1's Admission Record, provided by the facility on 3/25/2025, showed he had diagnoses including, but not limited to, end stage renal disease, stage 5, dependence on renal dialysis, type II diabetes mellitus with diabetic neuropathy, chronic diastolic heart failure, atherosclerotic heart disease, pain in right thigh, pain in right hip, anemia, unspecified dementia-unspecified severity, with other behavioral disturbance, primary generalized osteoarthritis, chronic peripheral venous insufficiency, lumbago with sciatica, peripheral vascular disease, chronic pain, and muscle spasm of back. R1's facility assessment dated [DATE] showed he was cognitively intact, requires substantial/maximal staff assistance for upper body dressing, and partial/moderate staff assistance for lower body dressing. R8's (R1's roommate) Admission Record, provided by the facility on 3/26/2025, showed he was cognitively intact. On 3/24/2025 at 11:47 AM, V9 (Dialysis Center Administrator) said R1 told dialysis staff on 3/18/2025 that staff from (the facility) were rough with him that morning and he felt like he was being physically abused. V9 said she reported the allegation to V1 (facility Administrator) on 3/18/2025. On 3/25/2025 at 1:02 PM, R8 (R1's roommate) said he was in the room and awake the previous Tuesday when the CNAs (Certified Nursing Assistants) were rough with R1. R8 said he heard the whole thing. R8 said R1 was hollering in pain and the CNAs were loud, saying That's what we have to do. We have to get you ready. R8 said R1 was yelling You have my leg up too high. R8 said the CNAs did not stop, they just kept going. R8 said he felt the CNAs were being abusive to R1 because he was telling them that they were hurting him and they did not stop, they just kept going. R8 did not know who the two CNAs were. (continued on next page)

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

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 03/28/2025
NAME OF PROVIDER OR SUPPLIER Bethany Rehab & Hcc		STREET ADDRESS, CITY, STATE, ZIP CODE 3298 Resource Parkway Dekalb, IL 60115	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/26/2025 at 9:48 AM, V17 (CNA) said she was R1's CNA on 3/18/2025. V17 said sometime between 7:00 AM-8:00 AM, she was in the room next to R1's room assisting another resident when V18 (CNA) came in and told her that the EMTs were at the facility to take R1 to dialysis. V17 said she forgot that he had dialysis that morning. V17 said she went in to help V18 get R1 ready. V17 said V18 was already in with R1. R1 was complaining about pain and telling V18 that she must be careful with his right hip. V17 said R1 was already upset when she walked into his room. V17 said V18 asked R1 if they could turn him on his right side to pull his pants up, and asked R1 How are we supposed to turn you on your right side. V17 said they pulled R1's bed away from the wall. She (V17) got on R1's right side and V18 was on his left side. V17 said R1 said I already told you my right hip is f***ing broken and you can't turn me on that side. V17 said she told V18 that R1's right hip is broken, and you have to be careful how you turn him. V17 said they finished getting R1 dressed. V17 said R1 was in pain and irritated when she walked into his room to assist V18 get him ready for dialysis. V17 said when she entered the room, R1's pants were halfway up on his right leg. On 3/26/2025 at 10:12 AM, V16 (R1's daughter) said R1 complained that staff were too rough with him. V16 said R1 has a history of a hip fracture. V16 said R1 has pain in right hip, even after surgery to repair the fractured hip. V16 said R1 is a pretty go with the flow kind of guy. V16 said she is not aware of R1 ever refusing cares, and the facility staff have never voiced any concerns regarding him refusing cares. On 3/26/2025 at 10:33 AM, V19 (Police Officer from local police department) said V1 (Administrator) called her and said it was reported by dialysis center staff that staff were rough with R1, and abuse was mentioned. V19 said she went to the facility on [DATE] and spoke with R1. V19 said R1 told her he was hurting-has hip pain, and the CNAs continued to pull his foot up. V19 said R1 said the CNAs almost dropped him. V19 said she spoke with R1's roommate (R8) and R8 said he heard R1 tell the CNAs they were hurting him. V19 said R8 said the CNAs were rushing because R1 had to go to dialysis. V19 said she spoke with V17 and V18 (CNAs) and V17 said R1 was already irritated when she walked into his room. V19 said V17 told her R1 has a hip fracture and there is no way to provide care without pain. On 3/26/2025 at 11:19 AM, V18 said she was not assigned to R1 on 3/18/2025, and was not familiar with his care. V18 said the nurse was on the hall screaming, looking for R1's CNA. V18 said she asked the nurse if she needed something and was told that R1 needs to be dressed for dialysis because the EMTs (emergency medical technicians) are at the facility to transport him to dialysis. V18 said she went in and started to put R1's pants on him. V18 said R1 told her that his hip was broken. V18 said she stopped and went to get V17. V18 said when she went to turn R1, that is when he told her that his hip was broken. V18 said she told V17 that if a resident's hip is broken, then they do not turn the resident on the side of the broken hip. V18 said R1 got verbally aggressive. V18 said she was in the room the entire process until R1 left with the EMTs. V18 said R1 did not complain of pain, he just said his hip was broken. V18 said R1 did say that V17 was rough with him. On 3/26/2025 at 12:10 PM, V2 (Director of Nursing-DON) said if a resident is upset during cares, then staff should try redirecting them, to calm the resident down and de-escalate the situation. V2 said if a resident is complaining of pain during care, she would expect the CNAs to stop immediately and go get the resident's nurse so the nurse could assess the resident. V2 said she would not expect the CNAs to continue dressing the resident if they were upset and complaining of pain during care. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/26/2025 at 1:13 PM, R1 was interviewed in a local hospital (reason for admission to hospital was not related to abuse allegation). R1 said the two CNAs were rough with him that morning getting him dressed for dialysis. R1 said they were very hurried. R1 said he had a right hip fracture that he had an unsuccessful surgery on. R1 said he still has pain in his right hip. R1 said when they came in to get him dressed, he told them about the fracture to his right hip and that it was less painful if they rolled him onto his right side. R1 said the CNA on his right side was putting my pants on and took hold of his right leg and then yanked the leg up about 45 degrees. It was very painful, and I told her I had a hip fracture and pain. R1 said the CNA said, We have to get you dressed, this is how it's going to be. R1 said he told the CNA to get out of his room if that is how she was going to be. R1 said when he told the CNAs to stop because they were hurting him, they just dropped his leg. R1 said any fast or sudden movement is painful. R1 said I don't need to be abused like that. R1 said he told V11 (Licensed Practical Nurse-LPN/wound nurse) that they yanked his foot up in the air. R1 said he also told the staff at the dialysis center about the incident when he got to dialysis. R1 said he is looking into other facilities because he does not want to go back to the facility after being treated like that. On 3/26/2025 at 2:10 PM, V11 (LPN/Wound Nurse) said R1 did say something to her about the CNAs being rough. He said his hip hurt because the CNAs were rough with him. V11 said she asked R1 if there was anything she could do and R1 told her no that it was already being taken care of. On 3/26/2025 at 2:16 PM, V1 (Administrator) was asked if he interviewed R8 regarding the abuse allegation. V1 said he did not interview (R1's) roommate. V1 said R8 was in the room when he was talking to R1 and overheard their conversation. V1 said R8 did not say anything. V1 said R8 acknowledged that he heard what was going on that morning (3/18/2025), however, he (V1) did not get a complete interview with R8 regarding the incident. V1 said it is important to get statements from all the witnesses in the room during an investigation. The facility's 3/2025 Abuse Prevention and Prohibition Policy showed Each resident has the right to be free from abuse, corporal punishment, and involuntary seclusion. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants, or volunteers, staff of other agencies serving the resident, family members, or legal guardians, friends, or other individuals .This facility prohibits mistreatment, neglect, or abuse of residents .Prevention: The resident has the right to be free from verbal, mental, sexual, exploitation, or physical abuse, corporal punishment and involuntary seclusion. The policy showed Abuse-means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish .

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34491 Based on observation, interview and record review, the facility failed to ensure dressing changes and wound assessments were completed as ordered, failed to ensure a dressing was in place, and failed to identify a wound prior to it becoming an advanced stage for 2 of 3 residents (R1, R5) reviewed for wounds in the sample of 8. This failure resulted in R1 being sent to a local hospital and admitted to the hospital with a diagnosis of wound infections to his bilateral lower extremities. The findings include: 1. R1's Admission Record, provided by the facility on 3/25/2025, showed he had diagnoses including, but not limited to, end stage renal disease, stage 5, dependence on renal dialysis, type II diabetes mellitus with diabetic neuropathy (a type of nerve damage that can occur with diabetes causing pain or numbness in the legs or feet), chronic diastolic heart failure, atherosclerotic heart disease, pain in right thigh, pain in right hip, anemia, primary generalized osteoarthritis, chronic peripheral venous insufficiency, lumbago with sciatica (a condition where pain in the lower back radiates down one or both legs), peripheral vascular disease, chronic pain, and muscle spasm of back. R1's facility assessment dated [DATE] showed he is cognitively intact, requires substantial/maximal staff assistance for upper body dressing, and partial/moderate staff assistance for lower body dressing. On 3/24/2025 at 11:47 AM, V9 (Dialysis Center Administrator) said on 3/18/2025 R1 received dialysis at the dialysis center. V9 said she saw R1's wound dressing on 3/18/2025. It was dirty and smelled like rot. V9 said one of the nurses drew a picture on the wound dressing on 3/18/2025 to see if it would be changed when he came to dialysis two days later. V9 said when R1 returned two days later, the same dressing was on him and the drawing was still on the dressing. V9 said R1 told dialysis staff on 3/20/2025 that he asked the nurse to change his dressing, and they either refused or ignored his request. On 3/25/2025 at 11:25 AM, V9 (Dialysis Center Administrator) said R1 did not show up for dialysis that day (3/25/2025) because the facility sent him to the hospital due to his leg wounds on 3/24/2025. V9 said R1 was admitted to the hospital. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 3/25/2025 at 11:37 AM, V10 (Assistant Director of Nursing-ADON) said R1 was sent out the previous day (3/24/2025) to a local hospital. V10 said V16 (R1's daughter) had called her the previous Thursday (3/20/2025) about his wounds. V10 said V16 wanted to see wound care for R1. V10 said she told V16 that she had already done the dressing change for R1 that day with a police officer present, and the next time the dressing was scheduled to be changed was on Monday 3/24/2025. V10 said V16 took pictures of R1's wounds and sent the pictures to the Nurse Practitioner (NP-V20) that R1 was seeing from the wound care clinic. V10 said based on the pictures that V16 sent the NP, the NP wanted R1 sent to a local hospital for a vascular workup. V10 said the local hospital admitted R1 to the hospital. V10 looked at R1's progress notes in his electronic medical record and said the notes showed R1 was admitted to the hospital with a diagnosis of wound infection. V10 was asked to provide surveyor with R1's last three wound assessments. V10 provided the last three assessments to this surveyor. The wound assessments provided to this surveyor were dated 3/24/2025, 3/20/2025, and 1/20/2025. V10 was asked to provide the wound assessment prior to 3/20/2025. V10 looked through R1's electronic medical record and said she did not see any wound assessment for R1's leg wounds that were completed between the 1/20/2025 and the 3/20/2025 wound assessments. V10 said R1 was not followed by the wound doctor in the facility. He wanted his wound doctor at the wound clinic. V10 was asked when was the last time R1 was seen by his wound clinic doctor. V10 said she was not sure and would look into it further. V10 was asked to provide the notes from R1's last visit with the wound clinic doctor/NP (these notes were not provided prior to exiting the facility on 3/26/2025). V10 said the nurses working the floor do the dressing changes and the skin checks. V10 said the skin checks are not full assessments of the wound and do not document the wound measurements or characteristics of the wound. V10 was asked to bring up R1's electronic Treatment Administration Record (TAR) for March 2025 on her computer. V10 said she did the dressing changes to R1's bilateral leg wounds on 3/20/2025 and 3/24/2025. V10 said R1's March 2025 TAR showed the dressing changes were not signed off as being completed on 3/10/2025, 3/14/2025, and 3/17/2025. V10 said the order is to do the dressing changes every Monday and Friday. V10 said, It is important to make sure that the dressing changes and wound assessments are being completed as ordered, because we need to know if the wound is improving, or if there have been any changes, like signs of infection. To see if what we are doing is helping, or if we need to update the doctor and make changes. On 3/25/2025 at 4:20 PM, V16 (R1's daughter) said she called V10 (ADON) and asked her when she was going to do the dressing changes for R1 next because she would like to be present during the dressing changes. V16 said V10 told her that she had just changed the dressings on 3/20/2025 with V19 (Police Officer from a local police department) present, and the next dressing change would be on Monday 3/24/2025. V16 said she took pictures of R1's leg wounds because she did not like what the wounds looked like. V16 said the wound was open and it looked like raw meat. V16 said she had a cold, so she was not sure if there was any odor from the wound. V16 said she sent the pictures to V20 (Nurse Practitioner from wound clinic) and V20 called her and said this was terrible, she had never seen it that bad. V16 said V20 had been treating R1's wounds for about 15-[AGE] years. V16 said R1 had not been going to see V20 for a while, but he was going to start seeing her again. On 3/26/2025 at 10:05 AM, V16 (R1's daughter) provided photos of R1's bilateral leg wounds from 1/25/2024 and 3/5/2024 from his Wound Clinic visits with V20 (NP from wound clinic), as well as photos that were taken and sent to V20 (NP) on 3/24/2025 when she observed the dressing change done by V3 (ADON) in the facility. (note: No May 2024 photos were provided which was the last time V20 said R1 was seen at the wound clinic). (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 3/26/2025 at 12:25 PM, V20 (NP from wound clinic) said she last saw R1 in May of 2024. V20 said the facility R1 was at was providing the wound care for him. V20 said on 3/24/2025 V16 sent her pictures of R1's wounds and she recommended R1 be sent to a local hospital to manage his vascular issues. V20 said based on the pictures V1 sent her, it looked like there were slough issues and blood circulation issues. V20 said based on the appearance of R1's wounds, dressing changes twice a week is not appropriate. V20 also said based on the pictures and V16's description of the wounds, she felt R1 should have been sent out sooner. V20 said it is important to do the dressing changes as ordered, and do wound assessments at least weekly or more often, to monitor the wounds and determine if the wounds are improving or declining, to monitor for signs/symptoms of infection, so a wound specialist or the resident's doctor can be updated to get a new order if needed. On 3/26/2025 at 1:28 PM, R1 was observed at a local hospital. An IV (intravenous) pole was next to R1's bed with empty antibiotic and antifungal medications listed on the empty bags. R1 said the nurses at the facility were not changing the dressings on his leg wounds. R1 said he had been asking them to change his dressings because his legs were stinging and burning. R1 said the only reason they finally got changed was because they started noticing an odor. R1 said the facility nurses were not assessing his leg wounds either. R1 was not able to identify who all he asked to change his wound dressings. On 3/26/2025 at 10:33 AM, V19 (Police Officer from a local police department) said she went to the facility on [DATE] and went with V10 to see R1's wound dressings. V19 said when V10 removed the dressing from R1's leg, there was a bad odor coming from the wound, even with a face mask on. (note: R1's Weekly Wound assessment dated [DATE] by V3 (ADON) documented no odors were present). On 3/26/2025 at 1:40 PM, V22 (R1's nurse at the local hospital) said R1 was receiving two IV antibiotics and an oral antifungal medication for bilateral leg wound infections. V22 looked at R1's most recent wound notes in his electronic hospital medical record. The notes showed that the hospital was waiting on the final culture and sensitivity results before decreasing R1's IV antibiotic medications. V22 said she did not think R1 had osteomyelitis. The notes showed Proteus mirabilis and Staph Aureus as the organisms identified in R1's leg wounds. R1's care plan initiated on 1/5/2025 showed he had right hip pain. R1's Risk of skin impairment care plan, initiated on 1/5/2025, showed he had a risk of skin impairment, had a diagnosis of peripheral vascular disease and had reopened stasis ulcers to his bilateral lower extremities. Interventions listed on the care plan showed to administer the treatment as ordered and monitor for effectiveness. The interventions showed, Document location of wound, amount of drainage, peri-wound area, pain, edema, and circumference measurements weekly. Evaluate wound for: Size, depth margins, peri-wound skin, sinuses, undermining (a separation of the wound edges from the surrounding healthy tissue creating a pocket under the wound surface), exudates (fluid coming from wound), edema, granulation (new connective tissue that develops at the wound site in the process of healing), infection, necrosis (a pathological process where cells and tissues die prematurely due to injury or disease), eschar (dead tissue), and gangrene (dead tissue cause by an infection or lack of blood flow). The interventions also showed to document the progress in wound healing on an ongoing basis. Notify Physician as indicated. Monitor/document/report to doctor for signs and symptoms of infection: green drainage, foul odor, redness and swelling, red lines coming from wound, excessive pain, fever. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	R1's 1/9/2025 care plan showed he had skin alteration related to vascular wounds to both lower extremities. Interventions listed were to monitor wounds for signs of infection, weekly wound assessments with wound rounds and wound care as prescribed. R1's Weekly Skin Checks from 1/24/2025 through the present showed no new changes. The Weekly Skin Checks do not provide measurements, or wound characteristics. R1's Weekly Wound Evaluations from 1/20/2025 through 3/26/2025 were requested. The only Wound Weekly Evaluations-Non-Pressure that were provided were the evaluations from 1/20/2025, 3/20/2025, and 3/24/2025. The 3/20/2025 Wound Weekly Evaluations-Non-Pressure for R1's left lower extremity and right lower extremity both documented no odor was present (even though V19 said it smelled very bad). R1's March 2025 TAR showed on 3/10/2025, 3/14/2025, and 3/17/2025 the dressing changes were not signed off as being completed. The TAR showed the dressing changes were scheduled to be done every Monday and Friday. The wound orders on the TAR also showed to call physician or go to ER (emergency room) with increased redness, pain, swelling, drainage, warmth, odor, or fever. R1's progress notes from 1/20/2025 through 3/26/2025 were reviewed. The progress notes did not show R1 refusing to allow staff to change the wound dressings or do wound assessments. The facility's 1/2025 policy and procedure titled Skin Identification, Evaluation, and Monitoring Policy showed Licensed Nurse Weekly: A. Complete a Weekly Skin Check to evaluate for changes in skin integrity. B. Document in medical record the finding of weekly skin assessment. a. If wounds are present and previously identified: i. Document integumentary findings in weekly skin assessment. ii. Appearance of the wound, including measurements if the wound is due for a treatment change, if not, assess the dressing and document this in the assessment. iii. Complete weekly re-evaluation of previously identified skin alterations/wounds. iv. Treatment applied/initiated per health care provider order in the medical record. 34891 2. R5's face sheet printed on 3/26/25 showed diagnoses including but not limited to pressure-induced deep tissue damage of other site, diabetes mellitus, chronic kidney disease, spinal stenosis of lumbar region, and cervical disc disorder. On 3/26/25 at 10:10 AM, R5 was lying in bed while V10 (Assistant Director of Nurses) performed wound care. V10 rolled R5 to his side and lifted his shirt. A deep, dime size open wound was observed in the middle of his back. There was no dressing covering the wound. V10 said it is a chronic wound from a surgical procedure. V10 stated she had no idea why the dressing was off and did not receive any reports from floor staff that a new one was needed. V10 said the dressing is important to prevent infection and to help the wound heal. V10 removed R5's left sock and a dark purple wound was noted on the second toe. V10 said she was doing a facility wide sweep on wounds and just found it yesterday. V10 said it is a DTI (deep tissue injury). V10 stated skin checks should be done during all CNA daily cares. Floor nurses should be doing weekly skin checks from head to toe. R5's toe wound absolutely should have been found prior to becoming an advanced stage. Infection and slow healing is a big problem. V10 said R5 had just been seen by the wound physician for the weekly rounds yesterday and assessed the toe as a DTI and measured it at 0.4 x 0.4 x unknown centimeters. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	R5's March 2025 physician order summary report showed an order start dated 3/18/25 for daily wound care to his back including cleansing, calcium alginate, and cover with a dressing. The most recent wound assessment dated [DATE] showed a non-pressure chronic ulcer of the back measuring 1.3 x 0.7 x 0.5 centimeters. R5's March 2025 physician order summary report showed an order start dated 3/25/25 for pressure injury to left second toe and betadine ointment every evening shift. R5's most recent wound assessment dated [DATE] showed a deep tissue injury to the left second toe. On 3/26/25 at 1:14 PM, V12 (Wound Physician) stated R5 should always have a dressing on the back wound. Drainage needs to be contained. The wound ointment needs to stay in place. Without any dressing the ointment can run down his back and irritate normal skin. V12 stated R5's toe wound is vascular in nature and denied any assessment of a DTI. V12 stated he had no control over how facility staff are charting the stage of wounds or wound care orders. V12 stated he was just notified of the open toe area at his visit yesterday. V12 said early treatment is important to lower the risk of infection and reduce the risk of further complications. The facility was unable to supply any documentation of the 3/25/25 visit by the wound physician during the survey. The facility Skin Identification, Evaluation, and Monitoring Policy dated January 2025 states: A licensed nurse will evaluate skin integrity through a physical skin evaluation upon admission, weekly, and when a significant change is identified. The nursing assistant will observe the resident's skin when assisting with activities of daily living and report changes to the nurse.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34891 Based on observation, interview, and record review the facility failed to ensure pressure ulcer assessments were performed, failed to ensure wound treatments were performed, and failed to implement pressure relieving interventions for 1 of 3 residents (R2) reviewed for wounds in the sample of 8. The findings include: R2's face sheet printed on 3/25/25 showed diagnoses including but not limited to left side hemiplegia, diabetes mellitus, obesity, and stage 2 pressure ulcer of the sacral region (area between lower back and upper buttock). R2's facility assessment dated [DATE] showed no cognitive impairment and staff assistant required for toileting, transfers, and bed mobility. The same assessment showed R2 is always incontinent of bowel. R2's pressure ulcer risk assessment dated [DATE] showed a high risk for wound development. R2's weight summary report showed a weight of 260 pounds as of 3/24/25. On 3/25/25 at 8:58 AM, R2 was lying in bed while V13 (CNA-Certified Nurse Aide) was assisting with morning cares. R2 had a low air loss pressure ulcer mattress on his bed. The pressure setting was set between the 88- and 176-pound mark. V13 exited the room to get help with R2's transfer. R2 stated he had a sore on his upper butt that had been there for about one month. R2 said there is a patch that is supposed to be changed every day, but the nurses don't always do it. R2 said the area gets better then gets worse and it is having a hard time healing. At 9:20 AM, V13 and V11 (WCN-Wound Care Nurse) rolled R2 onto his side. A dime size open area was observed on his coccyx area. V11 said the wound physician just saw R2 this morning and changed treatment to a zinc and powder treatment, while leaving any dressing off. V11 stated she had just taken over the wound care nurse position a day ago and was unsure what was being done with the pressure ulcer in the past. R2 had a large baseball size bruise on his right forearm and stated he accidentally hit his arm on the side of his bed while self-propelling his wheelchair. R2's March 2025 TAR (Treatment Administration Record) was reviewed and showed wound treatments were not initiated until 3/15/25 (one week after identified). The same TAR showed treatments were not done on 3/16, 3/17, and 3/18. The same TAR showed monitoring to his right arm bruising not being done on 3/14, 3/16, 3/17, 3/18, 3/20, and 3/21. Several codes on the TAR were referred to see progress notes. R2's progress notes did not reflect any treatment comments related to the codes on the TAR. (continued on next page)

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 03/28/2025
NAME OF PROVIDER OR SUPPLIER Bethany Rehab & Hcc		STREET ADDRESS, CITY, STATE, ZIP CODE 3298 Resource Parkway Dekalb, IL 60115	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/25/25 at 10:58 AM, V11 (WCN) and V10 (Assistant Director of Nurses) said R2 has had the stage two coccyx wound since 3/7/25. It was first identified on that date and an assessment should have been done right away. V10 (ADON) stated there was no assessment done until a week later. V10 stated all open skin areas should be assessed right away and weekly. The initial assessment is important to track progress and to notify the physician for treatment orders. Pressure sores can get infected and get worse if the assessment and orders are not in place. V10 said the wound physician did see R2 just this morning and did an assessment. A verbal treatment order and wound measurements were obtained. V10 said the wound is currently 1.5 x 0.6 x 0 (centimeters) and still a stage two pressure ulcer. (The facility was unable to supply any documentation of the visit by the wound physician during the two-day survey.) On 3/26/25 at 10:42 AM, V10 (ADON) stated pressure ulcer mattresses should be set according to the resident's weight. A mattress that is set too low will not relieve the pressure and the resident will be lying on a hard bed frame. Too high of a setting will cause too much firmness. Air mattress settings should be checked by all the staff during daily cares. R2's March 2025 physician order summary showed an order start dated 5/7/24 for: Air mattress in place to bed set appropriately and in proper working order every shift for prevention. The facility's Pressure Injury Assessment and Treatment policy dated January 2025 states under the stage II pressure injury care strategies: D. Notify health care provider of evaluation findings to determine wound treatment per wound status .F. Monitor and change per physician guidance and as indicated.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. 45540 Based on observation, interview, record review the facility failed to label foods after they were prepared for residents. This has the potential to affect all 77 residents residing in the facility reviewed for food safety requirements. The findings include: The facility data sheet dated 3/25/2025 shows a resident total census of 77. On 3/25/2025 at 8:11 AM, observations of the refrigerator, bread rack, and dry good storage area were made. The bread rack had 8 shelves of bread that were undated but did not have any mold or discoloration noted on them. Multiple containers of food were found to be undated in the refrigerator. A brown sack lunch was sitting on the shelf undated as well. On 3/25/2025 at 8:11 AM, V4 (Cook) identified containers of cream of wheat, tomato sauce, and chicken noodle soup, which were not in their original containers with no opened date or expiration date listed inside of the refrigerator. V4 said all the bread came in on the truck yesterday and should have been labeled upon arrival. V4 said the containers of food in the refrigerator should be labeled with an expiration date. V4 said residents going to dialysis have a lunch prepared by the cook and it goes with the resident to dialysis. V4 identified a brown sack lunch as a dialysis lunch bag, said it wasn't labeled but should be. On 3/24/2025 at 11:47AM, V9 (Dialysis Facility Administrator) said she saw a sandwich with mold on it that was taken out of R1's bag by dialysis staff and it was the only sandwich in his bag on 3/18/2025. The facility provided Food Storage (Dry, Refrigerated, and Frozen) policy, not dated, states . all food items will be labeled. The label must include the name of the food and the date by which it should be sold, consumed, or discharged .