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	08/26/2025

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. (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

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview and record review the facility failed to revise and update the comprehensive care plan after an elopement attempt for one resident (R1) at risk for elopement of three residents reviewed for elopement in the sample of three Findings include:Physician Order Summary Report indicates R1 was admitted to the facility 8/30/24 with diagnoses that include Dementia without Behavioral Disturbance, Diabetes Mellitus, Generalized Anxiety Disorder and Encephalopathy.On 8/22/25 and 8/26/25 R1 was in a wheelchair and noted to self-propel the wheelchair with his feet.Behavior Note dated 8/2/25 at 4:03am indicates At approximately 4am (R1) eloped from the facility through the front door. Alarm went off and (R1) was returned to the facility.On 8/22/25 at 1:46pm V6, LPN (Licensed Practical Nurse) stated she was R1's nurse on 8/2/25. V6 stated R1 required redirection all night due to trying to get to the front doors. V6 stated R1 was always in a wheelchair and was mobile by using his feet/legs to self-propel throughout the facility. V6 stated R1 was really quick You would look down and he'd be gone. V6 stated she reported the elopement incident to the nurse during shift report but did not notify V2, DON (Director of Nursing). V6 stated she should have told V2.No other documentation - including R1's care plan - regarding R1 activating the front door alarms, physical assistance to be brought back into the facility and/or attempting to elope on 8/2/25 was found or presented. On 8/22/25 at 1:15pm V2 was asked whether she was aware of R1's elopement attempt on 8/2/25 - V2 stated No. V2 stated she had not seen the progress note entered on 8/2/25 and was not aware of the incident until it was brought to her attention on 8/22/25.V2 stated V6 should have called her immediately after getting R1 back into the building so she could have assisted staff with immediate interventions to prevent further elopement attempts.On 8/26/25 at 11:15am V3, Care Plan Coordinator stated she was not aware of R1's elopement attempt on 8/2/25 (until 8/22/25) so R1's care plan was not revised with new interventions until after R1's elopement on 8/10/25. V3 stated that staff should be 1:1 with R1 anytime R1 is actively exit-seeking.Current Care Plan indicates R1 is an elopement/risk wanderer as evidenced by: (evidence was not documented) date initiated/revised 8/11/25. Interventions include: 1:1 Supervision related to elopement risk (date initiated 2/24/25); Distract R1 from wandering by offering pleasant diversions, structured activities, food, conversation, television, books (date initiated 8/30/24/revised 8/11/25); Wander alarm wristband (date initiated 11/13/24); Alarm wristband placed on left ankle/check every shift (date revised 7/3/25); Elopement/wandering risk: wanders on unit due to anxiety, agitation, new environment (date initiated 8/30/24/revised 9/2/24).Incident Report dated 8/11/25 indicates that it was reported to the facility administration that R1 was noted to be outside of the facility early morning of 8/11/25. Report indicates R1 was immediately retrieved and returned to the facility and remains on increased staff supervision.On 8/22/25 at V4, CNA stated she was one of two CNA's assigned to R1's unit on 8/10/25. V4 stated R1 is really quick and quiet when he is in his wheelchair, like he is jet propelled. V4 stated R1 was trying to get to the front doors that night and was determined that he had to get to Chicago to get married. Facility Nursing Staff Schedule dated Sunday August 10, 2025 indicates V9, Nurse worked the 3-11pm shift; V4, V5 and V8 (CNA's) worked 10pm to 6am; V7, RN (Registered Nurse) worked 3pm-6am 8/10/25 into 8/11/25.On 8/22/25 V4, V5, V7 and V9 all stated R1 had been actively exit seeking during the evening hours and into the night of 8/10/25. On 8/26/25 at 1pm V8 also confirmed R1 had been actively exit seeking and had to be redirected back to the nursing unit multiple times.All staff interviewed on 8/22/25 indicated R1 becomes fixated on leaving to go to Chicago to get married when he is exit seeking.On 8/26/25 at 11:30am V3, Care Plan Coordinator stated R1 does have increased confusion at times believing he needs to get a wedding in Chicago and indicated these behaviors usually occur during evening/night hours. V3 stated R1's behaviors are fairly recent. V3 stated R1's care plan should have been updated when R1's behavior changed and he had increased confusion with increased exit seeking behaviors.Facility Policy/Elopement dated 6/2025 documents:It is the policy of this facility that all residents are afforded adequate supervision to provide the safest environment possible. All residents will be assessed for behaviors or conditions that put them at risk for elopement. All residents so identified will have these issues addressed in their individual care plans.Procedures for Missing Residents and/or Elopements or Attempted Elopement:Even when all precautions are taken, a resident may walk away from the facility. In such instances, the following checklist shall be put into action immediately: Initially implement increased monitoring of the resident and update their care plan with individualized safety interventions.Behavioral Assessment, Intervention, and Monitoring Policy dated 12/2024 documents: Assessment: New onset or changes in behavior will be documented regardless of

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview and record review the facility failed to ensure one resident at risk for elopement (R1) had sufficient supervision to prevent elopement, failed to address an elopement attempt and failed to implement interventions after an elopement attempt for once of three reviewed for elopement in the sample of three. Findings include:Physician Order Summary Report indicates R1 was admitted to the facility 8/30/24 with diagnoses that include Dementia without Behavioral Disturbance, Diabetes Mellitus, Generalized Anxiety Disorder and Encephalopathy.On 8/22/25 and 8/26/25 R1 was in a wheelchair and noted to self-propel the wheelchair with his feet.Behavior Note dated 8/2/25 at 4:03am indicates At approximately 4am (R1) eloped from the facility through the front door. Alarm went off and (R1) was returned to the facility.On 8/22/25 at 1:46pm V6, LPN (Licensed Practical Nurse) stated she was R1's nurse on 8/2/25. V6 stated R1 required redirection all night due to trying to get to the front doors. V6 stated R1 was always in a wheelchair and was mobile by using his feet/legs to self-propel throughout the facility. V6 stated R1 was really quick You would look down and he'd be gone. V6 stated staff heard the alarm (around 4am), went to the front door and another CNA (Certified Nurse Assistant) was pulling R1 back through the front doors. V6 stated it took less than 30 seconds to get R1 back through the doors. V6 stated she reported the elopement incident to the nurse during shift report but did not notify V2, DON (Director of Nursing). V6 stated she should have told V2.No other documentation regarding R1 activating the front door alarms, physical assistance to be brought back into the facility and/or attempting to elope on 8/2/25 was found or presented. On 8/22/25 at 1:15pm V2 was asked whether she was aware of R1's elopement attempt on 8/2/25 - V2 stated No. V2 stated she had not seen the progress note entered on 8/2/25 and was not aware of the incident until it was brought to her attention on 8/22/25. V2 stated that V6 should have called her immediately after getting R1 back into the building so she could have assisted staff with immediate interventions to prevent further elopement attempts.On 8/26/25 at 11:15am V3, Care Plan Coordinator stated she was not aware of R1's elopement attempt on 8/2/25 (until 8/22/25) so R1's care plan was not revised with new interventions until after R1's elopement on 8/10/25. V3 stated that staff should be 1:1 with R1 anytime R1 is actively exit-seeking.Care Plan indicates R1 is an elopement/risk wanderer as evidenced by (evidence not documented) date initiated/revised 8/11/25. Interventions include: 1:1 Supervision related to elopement risk (date initiated 2/24/25); Distract R1 from wandering by offering pleasant diversions, structured activities, food, conversation, television, books (date initiated 8/30/24/revised 8/11/25); Wander alarm wristband (date initiated 11/13/24); Alarm wristband placed on left ankle/check every shift (date revised 7/3/25); Elopement/wandering risk: wanders on unit due to anxiety, agitation, new environment (date initiated 8/30/24/revised 9/2/24).Incident Report dated 8/11/25 indicates that it was reported to the facility administration that R1 was noted to be outside of the facility early morning of 8/11/25. Report indicates R1 was immediately retrieved and returned to the facility and remains on increased staff supervision.Facility Nursing Staff Schedule dated Sunday August 10, 2025 indicates V9, Nurse worked the 3-11pm shift; V4, V5 and V8 (CNA's) worked 10pm to 6am; V7, RN (Registered Nurse) worked 3pm-6am 8/10/25 into 8/11/25.On 8/22/25 V4, V5, V7 and V9 all stated R1 had been actively exit seeking during the evening hours and into the night of 8/10/25. On 8/26/25 at 1pm V8 also confirmed R1 had been actively exit seeking and had to be redirected back to the nursing unit multiple times.On 8/22/25 at V4, CNA stated she was one of two CNA's assigned to R1's unit on 8/10/25. V4 stated R1 is really quick and quiet when he is in his wheelchair, like he is jet propelled. V4 stated R1 was trying to get to the front doors that night and was determined that he had to get to Chicago to get married. V4 stated the nurse and other CNA's brought R1 back 2 times. V4 stated at approximately 11:10pm/11:15pm R1 was brought back to his room. V4 stated staff was sitting in the TV room, next to the nurses cart so they could see R1 if he came down the hall. V4 stated (R1) must have been watching us because he went the other way around the nurses station so we didn't see him go by. V4 stated then the alarm went off, so they ran to the front doors and saw V5, CNA and V7, RN were already with R1 and bringing him back toward the facility. V4 stated the rest of the night they were 1:1 with R1.On 8/22/25 at 10:00am V2 further stated she was not notified of R1's elopement on 8/10/25 until the following day (8/11/25) when she was notified by an employee not present during the incident. V2 stated an investigation was immediately initiated early in the morning on 8/11/25 and based on initial interviews, R1 had been made a 1:1 for the remainder of the night and made no further attempts to leave the facility.Facility Policy/Elopement dated 6/2025 documents:It is the policy of this facility that all residents are afforded adequate supervision to