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	09/05/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure dependent residents received scheduled showers for 3 of 5 residents (R41, R3, R28) reviewed for activities of daily living in the sample of 48. Findings Include: 1. R41's face sheet showed she was admitted to the facility 1/27/21 with diagnoses to include weakness, unsteadiness on feet, anxiety disorder, dysphagia, hypomagnesemia, hypotension, and generalized osteoarthritis. R41's September 2025 Physician Order Sheet showed, “Shower days: Wednesday and Friday, day shift.” On 9/2/25 at 4:00 PM, V33 (R41's Power of Attorney) said R41 has been having a really hard time getting her showers. V33 said it will be weeks and weeks between R41 receiving showers. V33 said they have made several complaints to the facility regarding the lack of showers and the facility is well aware that it is an ongoing issue for R41. R41's shower documentation showed from 7/1/25 through 9/4/25, R41 received 3 showers. R41's documentation shows the last shower she received was on 7/18/25. On 09/03/2025 at 2:44 PM, V6 confirmed there were no additional shower sheets for R41. R41's medical record showed no refusals of showers from 7/1/25 through 9/4/25. The facility's grievance form dated 5/16/25 showed, “[… R41] does not get her showers when scheduled. Sometimes a whole week will go by without one…. Recommendations/Action Taken: Education provided to staff related to completing showers and activities of daily living cares…” The facility's grievance form dated 5/27/25 showed, “… Only wants shower 1 times a week on Wednesday, has not been getting a shower 1 time a week…. Recommendations/Action Taken: Care plan for shower 1 times a week on Wednesday…” The facility's grievance forms showed 7 additional grievances filed between May 2025 and July 2025 regarding residents not receiving showers as scheduled. The facility's undated document titled “Resident Shower Procedure” Showed, “… Resident bathing is scheduled twice weekly, per resident preference.” (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. R3's face sheet showed he was admitted to the facility 12/20/25 with diagnoses to include urinary tract infection, chronic kidney disease, muscle weakness, atherosclerotic heart disease, neuromuscular dysfunction of bladder, chronic combined systolic and diastolic congestive heart failure, and hypertensive heart and chronic kidney disease with heart failure. R3's facility assessment dated [DATE] showed he has no cognitive impairment and requires substantial to maximum assist for most cares. R3's September 2025 Physician Order Sheet showed, “Shower days: Wednesday and Saturday, Day shift”. On 9/2/25 through 9/4/25, multiple observations were made of R3. R3 was in his bed, hair disheveled and greasy in appearance. On 9/2/25 at 10:57 AM, R3 said, “Things are not good here, they won't get me up out of this bed… I don't get showers because the shower room is cold and the water is cold, you freeze your ass off in there. I told them I want to take a shower, but it has to be warm for me to do that. I haven't showered for a couple of months now.” R3's shower record showed one shower given on 8/9/25. A shower sheet was provided by the facility dated 8/23/25. R3's record showed he received 2 showers in the previous 30 days. 3. On 9/2/25 at 11:20 AM, R28 was lying in bed. R28's hair was greasy, and her skin was dry and flaking. R28 said she prefers bed baths and was supposed to get them every week. The surveyor asked her when her last bed bath was and R28 replied, “You don't want to know.” R28 said it's been 3-4 weeks since her last bed bath but did state that she refused last week because she wasn't feeling well. R28 said that was the only time she refused, and they didn't come try again. R28 said her skin gets itchy and she just feels gross. R28 said the call lights can take a while to get answered. R28 said it really depends on who is working. R28 said it can take a couple minutes, but a week and half ago she waited 1.5 hours. R28 stated, “I really had to poop. It was awful. I think they have a problem here with staffing. I can control my bowel and bladder pretty good, but sometimes the wait is too long, and I have an accident. That's really embarrassing.” R28 said another problem is they might come in at 9:00 PM to change me for the night and I might not see anyone again until morning. R28's Facesheet showed she had diagnoses to include, but not limited to severe morbid obesity, diabetes, pain in shoulder, weakness, need for assistance with personal care, major depressive disorder, anemia, hypothyroidism, hyperlipidemia, sleep disorder, and lymphedema. R28's facility assessment dated [DATE] showed she was cognitively intact; required substantial to maximal assistance for shower/bathing and was dependent for toilet hygiene. R28's Physician Order Sheet dated 9/4/25 showed she had an order for a bed bath once a week on Wednesdays. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R28's Bathing task in the EMR (Electronic Medical Record) showed she last received a bed bath on 8/6/25 and required physical help. There was no entry for 8/13/25. On 8/20/25 it showed the activity itself did not occur. (R28's Progress notes did not contain a note regarding resident refusal, nor was there a shower sheet for 8/13 or 8/20.) R28's Care Plan initiated 1/24/22 showed R28 had bladder incontinence and demonstrates symptoms of functional and urge incontinence related to impaired mobility and diuretic use. The interventions showed R28 used disposable briefs and should be changed every 2 hours and as needed. R28's Care Plan initiated 1/24/22 showed she has an ADL (Activity of Daily Living) self-care deficit and prefers bed bath once a week to be given by specific CNAs per her request. The interventions showed she required assistance of 1 staff for weekly bed bath on Wednesday. The interventions showed she totally dependent on staff for the use of the toilet. On 9/4/25 at 11:35 AM, V2 (Assistant Director of Nursing – ADON) said the CNAs should be checking on our residents every 2 hours because you never know when they have to go. There is no reason why incontinence care shouldn't be provided at night. V2 said if a resident has to sit in urine or feces, they could develop an infection and have led to skin breakdown. V2 said the facility wants to provide residents with dignity and ADL care is an important part. V2 said the residents should be getting a minimum of 2 showers a week. V2 said it is important for adequate hygiene and prevention of infections. V2 said the CNAs (Certified Nursing Aides) should be documenting the showers in the task portion of the EMR (Electronic Medical Record). If a resident refuses, then the CNA should notify the nurse, and I would expect to see the refusal in the progress notes. V2 said if a resident refuses a shower, then the staff should try to come back later and they still reuse, then we need to notify their family. V2 said if residents aren't getting showers their hair could get greasy; skin can become dry and flaky; and they may experience itchiness.

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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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. Based on observations, interview, and record review the facility failed to obtain daily weights for a congestive heart failure resident (R52). This failure resulted in R52 gaining 60 pounds in one month and requiring hospitalization. The facility also failed to ensure follow-up care was completed after a resident fell (R60).This applies to 2 of 5 residents (R52, R60) reviewed for quality of care in the sample of 48. Findings Include: 1.On 9/2/25 at 10:22 AM, R52 was seated in a bariatric wheelchair with oxygen in place at 4 liters per nasal canula. R52 was able to speak, but did get short of breath during the interview. R52 stated, “I'm sick of this fluid. I've gained over 43 pounds, and it just seems to keep going up.” R52 said the facility does weigh her, but she doesn't think it's every day. R52 said she has been seen in the past by Cardiology for issues with fluid retention. R52 was obese and had generalized edema noted. R52 said she was on a “water pill” and the facility had added another recently. At 12:30 PM, R52 was seated in her wheelchair in the dining room, feeding herself a grilled cheese sandwich. R52 started coughing and placed her hand on her chest. The surveyor asked R52 if she was okay and replied, “Yes, I think I just have too much mucous in my chest.” R52 ate some more of her meal. At 1:02 PM, V10 (Agency Licensed Practical Nurse) pushed R52's wheelchair back to her room. R52 slid her butt toward the seat of the wheelchair to provide more mobility between her abdomen and chest. V10 provided breathing treatments and notified V14 (Nurse Practitioner). V14 went in room see R52. R52's Hospital admission Record dated 9/2/25 showed she came to the hospital with shortness of breath that started 3 days ago. The patient reported increased lower extremity swelling and possibly 60-pound weight gain. Due to worsening shortness of breath, she was sent to the emergency room. The patient does report some chest pain along with some productive cough with phlegm. On arrival her oxygen saturation was 89% on room air and she was placed on an open mask. The patient's troponin (cardiac marks for heart tissue damage) was negative and her BNP was normal. This document showed R52's chest x-ray showed mild pulmonary edema. The document showed R52 was admitted with acute on chronic respiratory failure with hypoxia, acute asthma exacerbation, volume overload versus CHF (Congestive Heart Failure) exacerbation, and morbid obesity. This document showed the plan to treat R52's volume overload was strict intake and output, daily weights, intravenous diuretics, and cardiology consult. R52's Facesheet dated 9/3/25 showed diagnoses to include but not limited to acute on chronic respiratory failure with hypoxia, moderate persistent asthma, severe morbid obesity, CHF, Chronic Obstructive Pulmonary Disease (COPD), weakness, lymphedema, need for assistance with personal cares, dysphagia, generalized anxiety disorder, and peripheral vascular disease. R52's Physician Order Sheet dated 9/3/25 showed an order for “Daily weights in the morning,” to start 8/21/25. On 8/1/25, the resident weighed 486.6 lbs. On 9/1/25, the resident weighed 548.4 lbs which is a 12.7% Gain (61.8 pounds). R52's Weight report was missing daily weights on 8/22, 8/23, 8/24, 8/26, 8/27, 8/28, 8/30. R52's weight on 9/1/25 was 548.5 pounds and she showed a 5.4 weight loss on 9/2/25 (weight was 543 pounds). R52's August Medication Administration Record (MAR) did not contain any daily weights. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	R52's Progress Notes were reviewed on these dates and there was no documentation of refusals. R52 was seen by the V14 (Nurse Practitioner) on 9/2, 9/1, and 8/27. R52's Progress notes showed had a pulmonary consult on 8/25/25. On 9/3/25 at 11:50 AM, V11 (Wound Care Nurse) said she had several roles at the facility. V11 said one of those roles was doing post-acute work and working to prevent rehospitalizations. V11 said R52 had several chronic health issues, and she can be non-complaint with diet and fluids. V11 said R52 has severe CHF but has the mindset that she can eat and drink as she pleases and go to the hospital to get intravenous medications to remove excess fluid. Then she feels better, and we start all over. V11 said the V15 (Previous DON – Director of Nursing) was responsible for following the weights. V11 said now she is just making sure the weights are done. V11 said the weights should be obtained as ordered by the provider. V11 said daily weights are important for CHF residents to ensure there is no fluid overload and/or tracking the progress of our interventions. The surveyor asked if the order should include when to call the Provider. V11 looked at the order and replied, “We have a standing order for CHF.” V11 said if the resident gained 2-3 pounds overnight or 5 pounds in a week, then the nurse should notify the Provider. V11 said special cases like V11, the resident may gain weight at a faster rate. The surveyor asked V11 to view R52's Electronic Medical Record (EMR). V11 said there is no good reason those weights shouldn't be charted, unless she refused. V11 said if R52 refused then there should be a progress note that she refused to be weighed. V11 said she didn't see any progress notes showing that R52 refused to be weighed on 8/22, 8/23, 8/24, 8/26, 8/27, 8/28, and 8/30. V11 said the CNA or nurse can obtain the weight. V11 said the weight should be charted in the EMR and the nurse should be checking for trends. V11 said she didn't know why that wasn't happening. V11 said on 9/2/25, V12 (Respiratory Therapist) came to assess R52, and they got the order to transfer her to the hospital. V11 said R52 was admitted to the hospital for shortness of break. V11 said the facility was aware there was a problem with these weights, and they are working on this issue. On 9/3/25 at 3:14 PM, V10 (Agency LPN) said she only works at the facility every couple of weeks for 1-2 shifts. V10 said she works wherever she is needed, so she doesn't have a consistent assignment. V10 said the weights should be taken by the CNA and the nurse enters the weights. V10 said the nurse should be following the physician's orders for daily weights and monitoring for changes. V10 said the nurse should notify the Provider if there is a greater than 3-pound weight gain in 1 day and 5 pounds in a week. V10 said she didn't work for the last week, so she didn't know if anyone looked at the weights. V10 said the nurse should have been making sure the daily weights were completed and reporting weight gain. V10 said she didn't realize R52 had gained so much weight. V10 said weight gain can be a sign of fluid retention and could have contributed to R52's breathing issues. V10 said she was R52's nurse on 9/2/25 and R1 was complaining of shortness of breath in the morning, but her vital signs were stable. V10 said R1's oxygen saturation was 89-90% on 4 liters per nasal cannula. V10 said she did assessments and she was stable. V10 said after lunch she started to get a little worried and gave her breathing treatments. V10 said she notified V14 (NP). V10 said V14 assessed R52 and said she didn't need to go to the hospital at this time. V10 said a few hours later V12 (Respiratory Therapist) did an assessment, and it was decided to send R52 to the hospital for shortness of breath and she started to complain of some chest pain. R52 was starting to lean back in the wheelchair to breath better. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 9/3/25 at 10:23 AM, V14 (NP) said she works at the facility Monday through Friday. V14 said R52's case is very complicated, and she has several comorbidities. V14 said on 8/20/25 she ordered daily weights to track R52's fluid balance. V14 said R52 gained 60 pounds in 6 months, so I thought it was important we get the daily weights on track. V14 said when she orders a daily weight, she expects the order to be followed. V14 said R52 was already on Bumex (a diuretic medication) twice a day so she consulted a Pulmonology. V14 said they were discussing R52's case because she was having more difficulty breathing and felt like she was retaining fluid. V14 said she started R52 on Spironolactone, ordered a bladder scan, and labs. V14 said R52 reported she didn't feel like she was urinating enough, so we started Flomax. She was gaining weight, but on 9/1/25 (the day before she went to the hospital) she was being noncompliant with her fluid restriction, and I had to have a discussion with her. V14 said she ordered Strict Intake and Output for her on 9/1/25 and an Echocardiogram (doppler ultrasound of the heart). V14 said she was trying to explain to the resident that she needs to allow time for the interventions to help, but the resident does have times where she was non-compliant. V14 said V10 (LPN) called me on 9/2/25 and wanted to send her to the emergency room. V14 said she did an assessment and had a conversation with R52, and she didn't feel it was necessary to transfer at that time. V14 said she felt R52 needed to allow time for interventions, but when she started to complain of chest pain. The decision was made to transfer her to the emergency room. V14 said she checked R52's hospital record and she was admitted for shortness of breath, respiratory failure, and CHF. V14 said the daily weights are important part of R52's chronic disease management, but not the only part. V14 said if a daily weight is ordered, it needs to be done. V14 said if the staff are not doing the weights, then she would expect them to explain why and report it to her. V14 said if R52's weights were done as ordered and interventions were performed sooner it's possible the outcome could have been better, but it's hard to know for sure. V14 said R52 had lost weight the last day and she felt the interventions were starting to work. V14 said R52 needed intravenous medications to manage her fluid status at this time. V14 said she agreed that there was an issue with her weights. V14 said her expectation are higher than some others, but when it comes to human life it should be. The facility did not have a policy for obtaining weights for CHF patients or following physician's orders. The facility provided a Care Path Symptoms of Heart Failure diagram. This diagram showed that symptoms or signs of HF included unrelieved shortness of breath or new shortness of breath at rest, unrelieved or new chest pain, wheezing or chest tightness, inability to sleep without sitting up, weight gain or 3 pounds in 3 days or 5 pounds in 7 days, and worsening edema. This diagram showed if oxygen saturations were less than 90% (in addition to the above listed symptoms) then they should notify the Provider. 2. R60's Final Fall Report dated 7/28/25 showed R60 was placed in the TV room directly across the hall from the nurses' station. This report showed that R60 has agitation and restless and a non-pharmacological intervention includes placing her in quiet area with TV to promote a decrease in behaviors and calm the resident. This report showed R60 was reaching for the TV remote and fell onto her left side. A head-to-toe assessment was complete and R60 was noted with left shoulder pain and an order for X-ray was placed. The X-ray results showed a left clavicle fracture. This form showed R60's physician and hospice were notified of the results and splint was placed for immobilization and pain management orders were adjusted. The resident's pain is being controlled and resident wishes to remain in the facility. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 9/2/25 at 11:43 AM, R60 was sitting up in reclined wheelchair. R60 was moving her arms and feeding herself with no difficulty. R60 was no longer wearing a sling to her left arm. R60's Facesheet showed diagnoses to include, but not limited to primary generalized osteoarthritis, chronic kidney disease, hypothyroidism, dysphagia, left clavicle fracture, dementia, generalized anxiety disorder, macular degeneration, peripheral vascular disease, and stroke. R60's Physician's Order Sheet showed an order was placed for a 2 view Xray of the shoulder due to pain from a fall on 7/26/25. These orders showed an order for an external splint to left shoulder if pain noted was entered 7/28/25. R60's Progress Note dated 7/26/25 at 10:12 PM showed R60 fell out of her chair and complained of left shoulder pain during assessment and an X-ray was ordered for Monday. (2 days later). The notes showed did not show evidence that the facility called to check the status of the Xray. R60's progress notes on 7/27/25 showed R60 was experiencing pain, had bruising to the left shoulder, and had limited range of motion to the left arm. These notes showed that R60 was treated for pain, but did not have the sling in place, nor had the Xray been completed. On 7/28/25, R60's X-ray results were reported to the physician and orders for a sling were obtained for additional support. R60's Left Shoulder Xray Report dated 7/28/25 showed an acute displaced fracture of the left clavicle. On 9/2/25 at 2:01 PM, V15 (previous Director of Nursing – DON) said she was notified R60 fell out of her chair on 7/26/25. V15 said she did the investigation on Monday (7/28/25) and she called X-ray to follow-up because they hadn't come yet for the Xray. V15 said the Xray order was placed for Monday and R60 shouldn't have had to wait that long. V15 said V18 (Agency RN) didn't place a stat order, and they didn't ensure the X-ray was completed or the sling order was obtained in a timely manner. V15 stated, “Just because [R60] is on hospice doesn't mean we don't treat people. On 9/4/25 at 10:40 AM, V14 (Nurse Practitioner) said she wasn't here when R60 fell, but if she fell directly on her left side and complained of pain an X-ray order should have been entered to be done immediately. They shouldn't have waited until Monday. That's a delay of care. V14 reviewed R60's chart and said she already had pain medication on board, but it looks like the sling wasn't ordered until after the Xray results. V14 said the facility should have ensured Xray was ordered immediately, completed within 24 hours, and the interventions were placed. V14 said it's important to make sure the fracture isn't displaced or puncturing something. V14 said based on R60's injury there isn't much they can do for her. V14 said R60's care would be more conservative, but it was important to get the Xray results timely. The facility's policy and procedure approved 12/2024 showed, “Fluid Restriction, Policy: Only those resident's that have a practitioner's order will be on fluid restriction. Procedure: 1. Verify medical practitioner order. 2. Notify dietary consultant of order for fluid restriction… 3. Remove the resident's water pitcher and cup from the room. Store in designated area…”

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to consistently provide sufficient staffing to meet the care needs of its residents. This failure has the potential to affect all 68 residents residing at the facility. Findings Include:On 09/02/2025, V1 (Administrator) provided facility assessment dated [DATE] that documented on page 29 of 52, sufficient nursing staffing: the facility will provide help and care needed without the resident waiting a long time (as perceived). The staff will respond to call lights timely. Resident roster provided by facility and CMS form 802 both dated 09/02/2025, showed an in-house census of 68 residents. Review of nursing schedules and daily work log from 08/2025 through 09/04/2025 provided by facility showed several nursing and/or aide staffing shortages as follows: On 08/01, six aides and one trainee were scheduled for day shift but only five aides worked that shift. On 08/02, four aides were scheduled for third shift but only three aides worked that shift. On 08/03, four aides were scheduled for third shift but only two aides worked that shift. On 08/04, seven aides were scheduled for day shift but only four aides worked that shift. On 08/05, five nurses were scheduled for day shift but only two nurses worked that shift. On 08/06, four nurses were scheduled for day shift but only two nurses worked that shift. On 08/07, seven aides were scheduled for second shift but only six aides worked that shift; and five nurses were scheduled for day shift but only two worked that shift. On 08/09, seven aides were scheduled for second shift but only six aides worked that shift.On 08/10, five nurses were scheduled for day shift but only three nurses worked that shift. On 08/11, seven aides were scheduled for day shift but only five aides worked that shift; and four aides were scheduled for third shift but only three aides worked that shift.On 08/13, six aides were scheduled for day shift but only four aides worked that shift.On 08/16, six aides were scheduled for day shift but only five aides worked that shift.On 08/17, six aides were scheduled for day shift but only five aides worked that shift; and seven aides were scheduled for second shift but only six aides worked that shift.On 08/22, four aides were scheduled for third shift but only three aides worked that shift.On 08/23, four aides were scheduled for third shift but only three aides worked that shift.On 08/24, four nurses were scheduled for day shift but only three nurses worked that shift.On 08/25, six aides were scheduled for day shift but only five aides worked that shift. On 08/27, seven aides were scheduled for second shift but only six aides worked that shift.On 08/29, three nurses were scheduled for third shift but only one nurse worked that shift.On 08/30, four aides were scheduled for third shift but only three aides worked that shift.On 08/31, six aides were scheduled for day shift but only five aides worked that shift.Review of resident council meeting minutes for the last six months showed concerns with call lights not being answered in a timely manner during the 03/03/2025 meeting. Unsatisfaction with call light response time during the 04/07/2025 meeting. Concerns with call lights being turned off by staff without providing assistance, long call light response time, aides ignoring lights, aides stating they will come back to assist a resident but do not return, aides not assisting residents they are not assigned to and clinical staff shortages on weekends and holidays during the 07/16/2025 meeting. Concerns with call lights not being answered in a timely manner and residents not being showered on scheduled shower days, and lunch/dinner meals being served late during the 08/20/2025 meeting. Review of grievance forms from May 2025 through current revealed the following: Form dated 05/20/2025 from family council documented concerns with weekend staffing and lengthy call light response times. Anonymous form dated 05/21/2025 documented concern of facility being short staffed because V1 (Administrator) is not nice. R15's form dated 07/21/2025 documented one day this past week, call light was left on for 73 minutes with no follow up done due to unknown date of incident. R1's form dated 08/09/2025 submitted by her spouse indicated thatR1 was left laying in feces for 50 minutes. Findings showed call light had been on for 69 minutes because the aides were on break at the same time and the nurses were passing medications. Photo attached to grievance form showed call light for room [ROOM NUMBER]-A was on for 69 minutes. R1's face sheet documented admission date of 06/30/2025. R1's census log showed she admitted into room [ROOM NUMBER]-A and discharged on 08/21/2025.On 09/02/2025 at 11:20 AM, R28 was observed lying in bed. R28's hair was greasy, and her skin appeared dry and flaking. R28 said she prefers bed baths and was supposed to get them every week. The surveyor asked her when her last bed bath was and R28 replied, you don't want to know. R28 said it's been 3-4 weeks since her last bed bath but did state that she refused last week because she wasn't feeling well. R28 said that was the only time she refused, and they didn't come try again. R28 said her skin gets itchy and she just feels gross. R28 said the call lights can take a while to get

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	145958	A. Building B. Wing	09/05/2025

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview and record review the facility failed to provide the residents with food that is palatable in flavor. This applies to all residents in the facility. Findings Include:The CMS (Centers for Medicare and Medicaid) 671 form dated 9/2/2025 shows there are 68 residents in the facility. The menu for lunch on 9/2/2025 shows a pork and rice casserole was to be served. At 11:40 AM on 9/2/2025, V4 [NAME] was observed adding rice to the pork and rice casserole that was on the steam table. V4 said he needed to use another pan to make enough rice for the casserole. V4 stirred the casserole to combine the new rice added. The temperature was checked the casserole was served to the residents. At 1:00 PM, the rice casserole was tasted by the surveyor, and no flavor could be tasted, the meat was tough to chew, and the rice was clumped and stuck together. There was no color to the dish.On 9/2/2025 at 1:02 PM, V4 said when he made the casserole, he did not have all the ingredients and did not put in the celery and lemon juice. V4 said he tries to add some flavor to the food but has been told by management not to do this.On 9/2/2025 at 1:06 PM, V3 Dietary Manager said the lemon juice and celery was not ordered and could not be used in the recipe. V3 said the residents deserve to have food that tastes good and if they do not like a certain recipe it should be replaced on the menu.On 9/3/2025 at 10:30 AM, during the resident group meeting , the residents (R8, R13, R50, R66) reported the food often lacks flavor. The resident said there is an alternate menu but they are getting tired of hamburgers and hot dogs. The residents said they have complained about the food many times, but do not feel they are being listened to.A review of the facility grievance logs shows on 5/22/2025, R13 complained about her meal stating, I cannot describe what was given to me on my plate to this noon. The most disgusting piece of chicken I've ever seen. I wouldn't give it a dog.The resident council meeting minutes for the last 6 months were reviewed and showed numerous complaints of the food not tasting good enough to eat.The recipe for the pork and rice casserole provided by the facility shows celery and lemon juice were to be added.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to have a system in place to track and trend infections in the facility, failed to have a resident on contact isolation as ordered (R13) and failed to change a residents (R7) wound dressing in a sanitary manner. This applies to all 68 residents in the facility. Findings Include: The CMS (Centers for Medicare and Medicaid) 671 form dated 9/2/2025 shows there are 68 residents in the facility. 1.The facility infection surveillance report for the last 3 months shows a space for the resident name, room number, infection onset, infection, signs & symptoms, status, pharmacy order and comments. The report is not fully complete, missing infection, signs & symptoms, pharmacy orders and comments. On 9/3/2025 at 1:30 PM, V2 ADON (Assistant Director of Nursing) and IP (Infection Preventionist) said the purpose of the report is to be able to track and trend the facilities infections. Currently V2 says she just refers to the residents' records for the information she needs. V2 said it would be better to use the report the way it was intended, and it needs to be completed fully for each resident and infection. On 9/4/2025 at 11:57 AM, V5 Regional Nurse Consultant said the IP should make sure the reports are completed to show all the information needed. The undated policy for infection prevention and control program shows the primary mission is to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The intent of the program is to develop and implement an ongoing infection prevention and control program to prevent recognize and control the onset and spread of infection to the extent possible and reviews and updates the plan… Surveillance activities will be conducted to identify practice, infection trends, and early identification of new infections and potential outbreak situations. 2.The facility face sheet for R13 shows diagnoses to include congestive heart failure, type 2 Diabetes Mellitus and extended spectrum beta lactamase resistance (ESBL a multi drug resistant organism). The facility assessment dated [DATE] for R13 shows her to cognitively intact and requires a wheelchair for mobility and is dependent on staff for transfers. On 9/3/2025 at 1:22 PM, R13 room door shows a sign for enhanced barrier precautions. No sign was present for contact isolation. R13 said the staff have to use a mechanical lift to move her from her bed to her wheelchair because she cannot walk or stand. R13 said she incontinent of her bowels and bladder and the staff have to transfer her to bed to change her. R13 said the staff do not always wear PPE (personal protective equipment) when they care for her. R13 said she has had the same type of urinary infections a few times now. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 9/3/2025 at 1:30 PM, V2 ADON (Assistant Director of Nursing) and Infection Preventionist said R13 is currently still on antibiotics for her infection and has an order for contact isolation. V2 stated, “she is on enhanced barrier precautions, isn't that the same thing?” On 9/4/2025 at 11:57 AM, V5 Regional Nurse Consultant said ESBL is considered a MDRO/multidrug-resistant organism and there is a difference between enhanced barrier precautions and contact isolation. V5 said if there is a Physician order for contact isolation, she should be on contact isolation and the signage for the door should show that. A Physician order dated 8/25/2025 shows R13 is to be maintained on contact isolation for ESBL. The undated care plan for R13 shows resident is on enhanced barrier precautions due to ESBL in her urine. A report provided by the facility to show all resident currently on contact isolation did not include R13. The undated facility policy for contact precautions shows contact precautions are intended to prevent transmission of infectious agents… In addition to standard precautions, use contact precautions to prevent nosocomial spread of organisms that can be transmitted by direct resident contact (hand or skin to skin contact that occurs when performing resident care) or by direct contact (touching) with environmental surfaces or contaminated resident care equipment. Contact precautions may be considered for residents who have infections including a MDRO. 3. R7's face sheet showed last admission date of 06/25/2025 with a past medical history not limited to pressure ulcer of sacral region and left heel. R7's care plan dated 06/25/2025 document resident has actual impairment to skin integrity related to pressure ulcers to sacrum and left heel upon admission. On 09/02/2025, review of R7's active physician orders showed orders for daily wound care to the left heel and wound care treatment to the sacrum region every three days and as needed if wound vac (negative pressure therapy) becomes dislodged. On 09/03/2025 from 9:59 AM to 10:15 AM, observed V11 (Wound Care Nurse) and V25 (Physician Assistant-Certified) perform wound assessments/evaluations to R11's left heel and sacral region. During this observation, a strong malodor was present upon entering R11's room and during wound assessment observation and a fly was observed flying around the room which landed multiple times onto various areas of R11's bed/bedding and throughout her upper and her lower extremities. On 09/03/2025 at 10:13 AM, V25 (PA-C) instructed V11 to obtain a wound culture to R11's sacral wound due to the odor then indicated that R11 may require long-term antibiotic therapy due to her history of wound infections. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 09/03/2025 from 10:20 AM to 10:35 AM, observed V11 (Wound Care Nurse) apply latex gloves without performing any prior hand hygiene then cleansed R11's sacral wound with an antiseptic solution and gauze pads. V11 then opened two small plastic containers of collagen particles and applied contents from both containers to the wound bed then removed these gloves and threw them into the garbage can. V11 did not perform any hand hygiene after removing these gloves, then proceeded to remove another pair of gloves from her pants pocket. V11 applied the gloves, picked up a pair of bandage scissors that she had previously placed on R11's bed and began cutting open a package of clear, silicone adhesive drape and package of black foam. V11 then cut two thin strips of black foam, placed the scissors on R11's bed, then placed the two strips of black foam with a the tunneling (at 6:00 o'clock) of R11's sacral wound. V11 again picked the scissors up from R11's bed and began shaping a large piece of black foam, placed this foam with the wound bed then proceeded to cut the clear, silicone adhesive drape into strips. After V11 had cut several strips of drape, she placed the scissors on the bed then proceeded to apply the strips of drape onto the skin surrounding R11's wound then covered the top of the wound and large piece of black foam with a larger piece of drape. At no time did this surveyor observe V11 place the scissors on a clean surface or sanitize the scissors after removing from R11's bed and/or between use of cutting open packages and the black foam that is placed directly on the wound. On 09/04/2025 at 1:00 PM, V2 (Assistant Director of Nursing & Infection Preventionist) said V11 should have performed hand hygiene between glove changes to prevent infection and/or reinfection especially when working with a complex wound as R7's. V2 then said scissors should not be placed on a resident's bed linens because they are considered “dirty” and should be placed on a clean/sterile area to prevent wound infections. V2 added that V11 should not have cut the black foam with scissors that were not sanitized or V11 should have used a separate pair of scissors to cut the foam. At 1:10 PM, V2 said regarding performing wound care with inadequate pest control, “it could worsen the resident's wound or cause a wound infection.”