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	01/13/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the physician following a fall incident that subsequently resulted in a significant injury and failed to notify physician of a hospital transfer for one of three residents (R1) reviewed for falls in the sample of three. The findings include:R1's face sheet documented admission date of 08/28/2023 with past medical history not limited to left femur fracture, weakness, history of falls, cognitive communication deficit and adjustment disorder with mixed anxiety and depressed mood.R1's fall incident report dated 12/30/2025 at 06:45 PM (1845) indicated that resident had a fall incident in the bathroom. Staff was present at time of fall. Report documented under agencies/people notified that only V2 (Assistant Director of Nursing/ADON) was notified on the same day at 07: 58 PM (1958). Fall report did not document that R1's primary care physician (V4-Medical Doctor/MD) was notified of the fall. Health Status Note dated 12/30/2025 at 07:31 PM (19:31) documented at 6:50 PM, R1 was standing in the bathroom so a certified nursing assistant (CNA) could perform care after resident's bowel movement. Resident could not hold balance and started to lean to the left and CNA assisted him to the floor. Resident stated he started to fall after standing. Resident stated he was holding on to the grab bar then let go.power of attorney and NP nurse practitioner were notified. Note did not indicate which practitioner was notified, how or when they were notified, the number of attempts to contact made, and/or the practitioner's response to R1's fall.R1's physician progress note dated 12/31/2025 at 06:14 PM (18:14) reads in part, [AGE] year-old male residing at [facility] for long-term care reports a fall occurring approximately two days prior to evaluation .On 01/13/2026 at 10:25 AM, V3 (Certified Nursing Assistant) said on day of R1's fall incident, after dinner she had walked past R1's room and saw him entering the bathroom. R1 was seated in his wheelchair. V3 said she put a gait belt on R1 and helped him to stand up and sit down onto the toilet. After R1 was done, he stood up and was holding onto the handrail that was next to the toilet. While he was standing, he was facing the wall and holding on to the handrail. The wheelchair was behind him. V3 said she was standing next to him and had reached to get the wipes on the counter in the bathroom that was next to her when R1 let go of the handrail and fell to the floor on his left side.On 01/13/2026 at 11:18 AM, observed R1 sitting in his wheelchair in the bathroom of his room. Regarding fall incident, R1 said someone helped him get on the toilet. After he finished, he stood up, was holding the bar, lost his balance and fell to the floor and landed on his left side.On 01/13/2026 at 01:27 PM, V5 (Registered Nurse) said she was called to R1's room on day of fall, 12/30/2025 around 6:45 PM. When she entered the room, R1 was on the floor in the bathroom, lying on left side. V5 assessed R1 and found no apparent injuries and had no complaints of pain.On 01/13/2026 at 03:25 PM, V4 (MD) indicated that he saw R1 on 12/31/2025 at the facility for a routine visit and was notified by R1 and a staff member (did not recall who) during this visit that R1 had a fall incident on 12/30/2025. V4 said he was notified at any other time by the (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 01/13/2026
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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility that R1 had a fall on the previous day (12/30/2025). V4 said when he returned to office, he did not see any notification of R1's fall incident. V4 added that he was also not notified of R1's hospital transfer on 01/01/2026 after x-rays were obtained and results showed a fracture.On 01/13/2026 at 04:04 PM, V2 (ADON/assistant director of nursing) said the medical doctor should be notified on the same day after a fall incident and/or change of condition.Review of R1's medical record at facility on 01/13/2026 showed a hospital transfer form was completed on 01/01/2026 that listed V4 as R1's primary care physician. No progress note was found that indicted V4 (MD) was notified that R1 left the facility or was transferred to the hospital. Progress note dated 01/05/2026 at 05:31 PM (1731) indicated R1 arrived in the facility at 05:15 PM in a stable condition. R1's hospital after visit summary provided by the facility on 01/13/2026 documented R1 was hospitalized from [DATE] - 01/05/2026 for a closed left hip fracture. Significant Condition Change and Notification policy with date approved of 12/2024 reads in part: to ensure that the resident's family and/or representative and medical practitioner are notified of resident changes such as but not limited to, an accident or incident with or without injury, that has the potential for needed medical practitioner intervention and transfer of the resident from the facility.Procedures: when any of the above situations exists, the licensed nurse will contact the resident's representative and their medical practitioner.The medical practitioner will be contacted immediately for any emergencies regardless of the time of day. Non-emergency notifications may be made the next morning if the situation occurs on the late evening or night shift. This applies to any day of the week including holidays.Each attempt will be charted as to the time the call was made, who was spoken to, and what information was given to the medical practitioner. In a non-emergent situation, the primary medical practitioner will be called unless he/she has left an alternate name to call. If after two attempts, there is response to calls, the medical director will be contacted.

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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 - Minimal harm or potential for 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** Based on interview and record review, the facility failed to ensure the necessary care and services were given to a resident by not immediately obtaining a diagnostic test (x-ray) following a fall, and failed to ensure there was no delay in evaluation and treatment for a resident following a fall for one of three residents (R1) reviewed for falls in the sample of three. The findings include:R1's face sheet documented admission date of 08/28/2023 with past medical history not limited to left femur fracture, weakness, history of falls, cognitive communication deficit and adjustment disorder with mixed anxiety and depressed mood.R1's fall incident report dated 12/30/2025 at 06:45 PM (1845) indicated that resident had a fall incident in the bathroom and staff was present at time of fall.Health Status Note dated 12/31/2025 at 10:56 AM indicated writer noted a small bruise to R1's left knee and resident complained of pain in left leg and knee. Writer called his primary physician and left an urgent note with medical assistant with the fall information.R1's physician progress note completed by (V4-Medical Doctor/MD) dated 12/31/2025 at 06:14 PM (18:14) reads in part, [AGE] year-old male residing at [facility] for long-term care reports a fall occurring approximately two days prior to evaluation. Resident currently presents lying prone toward the left side and endorses ongoing left lower extremity pain. He reports use of acetaminophen with minimal relief. No imaging studies have been completed to date. Given persistent pain status post fall, diagnostic X-rays of the left hip, femur, and knee have been ordered to evaluate for possible acute injury. The resident will be closely monitored, and if pain persists or worsens, further medical evaluation will be indicated.Health Status Note dated 12/31/2025 at 08:55 PM (20:55) documented, received phone call from [V4's] office and received telephone order for x-ray of left hip, femur, and knee related to fall and acute pain to left lower extremity. Order was documented as being processed via mobile diagnostic provider and in R1's electronic medical record. R1's order details summery dated 12/31/2025 at 08:53 PM (2053) showed x-ray to left hip, left femur, and left knee STAT (immediately) for pain, fall.R1's Situation Background Assessment Recommendation (SBAR) summary for providers dated 1/1/2026 at 12:13 PM reads in part, the change in condition/s reported on this [evaluation] are/were: falls.New testing orders: x-ray.R1's diagnostic report dated 01/01/2026 indicated under findings, acute subcapital left femoral neck fracture. Report was stamped with faxed but did not indicate to whom results were faxed to or the date and time faxed.On 01/13/2026 at 10:25 AM, V3 (Certified Nursing Assistant) said on day of R1's fall incident, after dinner she had walked past R1's room and saw him entering the bathroom. R1 was seated in his wheelchair. V3 said she put a gait belt on R1 and helped him to stand up and sit down onto the toilet. After R1 was done, he stood up and was holding onto the handrail that was next to the toilet. While he was standing, he was facing the wall and holding on to the handrail. The wheelchair was behind him. V3 said she was standing next to him and had reached to get the wipes on the counter in the bathroom that was next to her when R1 let go of the handrail and fell to the floor on his left side.On 01/13/2026 at 11:18 AM, observed R1 sitting in his wheelchair in the bathroom of his room. Regarding fall incident, R1 said someone helped him get on the toilet. After he finished, he stood up, was holding the bar, lost his balance and fell to the floor and landed on his left side.On 01/13/2026 at 01:27 PM, V5 (Registered Nurse) said she was called to R1's room on day of fall, 12/30/2025 around 6:45 PM. When she entered the room, R1 was on the floor in the bathroom, lying on left side. V5 assessed R1 and found no apparent injuries and had no complaints of pain.On 01/13/2026 at 01:53 PM, V6 (Registered Nurse) said on 12/31/2025 at approximately 11:00 AM, she went to assess R1 in his bed. R1 was moaning and had facial grimacing. His feet were off the bed and V6 said she was trying to get his legs back to (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the center of bed. V6 asked R1 where the pain was, and he said that his left knee was hurting. V6 did a skin assessment and found a bruise to his left knee. V6 said she did not recall giving him any pain medicine. V6 said she called R1's primary physician and left an urgent note with his medical assistant with the fall information but did not hear anything back upon the end of her shift at 03:00 PM. V6 then said she was told by another nurse that there was a stat order in place for an x-ray on 12/31/25 but nobody showed up. V6 indicated that they came the next day on 01/01/2026 to do R1's x-rays. Review of R1's electronic medication record on 01/13/2025 showed an order for acetaminophen 650 milligrams (mg) by mouth one time a day for left lower extremity pain at 09:00 AM (start date of 09/11/2023) that was administered on this day by V6.On 01/13/2026 at 03:25 PM, V4 (MD) indicated that he saw R1 on 12/31/2025 at the facility for a routine visit and was notified by R1 and a staff member (did not recall who) during this visit that R1 had a fall incident on 12/30/2025. V4 said during his assessment, he suspected that something was wrong due to R1's position in bed and overall appearance. R1 was lying prone (on stomach) toward the left side and complained of ongoing left lower extremity pain. V4 then said after returning to his office and speaking with his nurse, he phoned in a stat (immediately) order for x-rays of R1's left lower extremity. V4 added that if the facility had informed him at the time of R1's fall and per his professional judgement, he would have ordered stat x-rays due to R1's medical history and limited functionality. V4 also said that he was surprised the x-rays were not done until the next day and believed this caused a delay in R1's fracture being diagnosed and evaluated. R1's hospital after visit summary provided by the facility on 01/13/2026 documented R1 was hospitalized from [DATE] - 01/05/2026 for a closed left hip fracture. On 01/13/2026 at 05:10 PM, during exit conference, both V1 (Interim Administrator) and V2 (Assistant Director of Nursing) indicated that unless a stat order is received for x-rays, if they are not completed within four hours, the facility would contact the physician to inform them of this and ask how the physician would like to proceed. When surveyor informed V1 and V2 that R1's x-ray order was a stat order that was verified by V4 (MD), no further response was given. Physician's Orders policy last revised 04/2021 reads in part: when necessary, telephone orders may be taken by a registered nurse or license practical nurse. All such orders shall be immediately written on the physician order sheet or electronic medical record and a telephone order form and signed by the physician within ten working days. (No directions related to diagnostic testing was documented).