

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 03/10/2026
NAME OF PROVIDER OR SUPPLIER Bethany Rehab & Hcc		STREET ADDRESS, CITY, STATE, ZIP CODE 3298 Resource Parkway Dekalb, IL 60115	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on interview and record review the facility failed to ensure a gait belt was used for a resident during a transfer for 1 of 7 residents (R1) reviewed for quality of care/safety in the sample of 7. The findings include: The Grievance Form dated 2/10/26 for R1 showed R1 was upset that the certified nursing assistants (CNA) on third shift lifted her up by her arms instead of using a gait belt. R1 did not have any injuries. On 3/10/26 at 2:30 PM, V4 (Physical Therapy Assistant) stated when a resident is a one person or two person assist a gait belt should be used. V4 stated it was important for the gait belt to be used because the resident could lose their balance; it is for safety. On 3/10/26 at 3:40 PM, V1 (Administrator) stated a third shift CNA did not use a gait belt when transferring R1. The CNA held R1 up under her arms. V1 stated R1 reported it and she went to talk to her. V1 stated the CNA should have used the gait belt for the safety of the resident and themselves. The Care Plan dated 12/24/25 for R1 showed she has an activity of daily living self care deficit related to impaired balance. R1 required 1 staff participation with transfers with a gait belt. The Face Sheet dated 3/10/26 for R1 showed diagnoses including influenza, chronic obstructive pulmonary disease, type 2 diabetes mellitus, asthma, hypertension, low back pain, hyperlipidemia, obstructive sleep apnea, weakness, acute bronchitis, schizoaffective disorder, hypo-osmolality and hyponatremia, osteoarthritis, bipolar disorder, anxiety disorder, and depression. The facility's Gait Belt policy (no date) showed, always use a gait belt for one and two person transfers. They should fit snugly at the resident waist. Never chicken wing, or transfer a resident by lifting under their arms with your arms.</p>		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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