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	05/22/2026

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 0686 Level of Harm - 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** Based on interview and record review the facility failed to identify pressure ulcers prior to an advanced stage, failed to accurately assess the pressure ulcers and failed to put interventions in place to prevent further skin breakdown for two residents R1 and R3. These failures resulted in R1 developing an unstageable pressure injury to her sacrum on 3/19/26 and R3 developing a pressure injury containing slough (devitalized tissue) to his sacrum on 5/9/26.The findings include: 1.R1's Physician's Order Sheet dated May 2026 shows that she was admitted to the facility on [DATE] with diagnoses including Chronic Kidney Disease, Type 2 Diabetes Mellitus, Mild Cognitive Impairment and Dependence on Renal Dialysis. R1's Skin assessment dated [DATE] shows new skin Issue. Location: Sacrum. Issue type: Moisture associated skin damage (MASD). Progress: New: new wound. MASD: IAD Incontinence Associated Dermatitis. Wound acquired in-house. It is unknown how long the wound has been present. Length 5.7 Width 3.83 (cm) Granulation: 70%. Slough: 30%. Exudate amount: Moderate. Exudate type: Serosanguineous: mixture of serous and sanguineous fluid, typically pale, red, and watery. Additional care: Pressure reducing device for chair. Additional care: Nutrition / dietary supplementation. R1's next Skin assessment dated [DATE] shows Skin issue has been evaluated. Location: Sacrum. Issue type: Pressure ulcer / injury. Progress: Stalled: previously improving wound characteristics plateaued. Pressure ulcer staging: Unstageable pressure ulcer / injury. Unstageable ulcer due to slough and / or eschar. Wound acquired in-house. It is unknown how long the wound has been present. Length 5.95 Width 4.28 (cm) Granulation: 50%. Slough: 10%. Eschar: 40%. Exudate amount: Light. Exudate type: Serosanguineous: mixture of serous and sanguineous fluid, typically pale, red, and watery. Additional care: Nutrition / dietary supplementation.R1's Initial Wound Physician Assessment (done by V6 (Previous Wound Nurse Practitioner) dated 4/7/26 (19 days after wound identified) states, The patient presents today for an initial visit with wounds on the sacrum . The provider has recommended the patient receives NUTRITIONAL SUPPORT with daily supplemental protein supplied 1x daily with a meal. The provider recommends the patient is consulted by a dietitian and food intake is monitored, with intermittent re-evaluations as needed to optimize nutritional status for wound healing . This wound assessment shows the wound is 11-20% adherent yellow slough and 71-80% Moist Black Eschar measuring 6.65 x 7 x 0.1 cm. On 5/22/26 at 1:00PM V3 (RN- Wound Care) stated, (R1) stopped eating and drinking. We turned her and no matter what we did her skin continued to break down. Her albumin was awful. She was incontinent of bowel and bladder- it was a hard area to keep clean. At first the wound bed was moist- it was MASD (moisture associated skin damage) not pressure- we changed the dressing daily and monitored her. She was very immuno-compromised, she was referred to the dietitian, she was just not eating. The wound nurse practitioner doesn't see residents for MASD. Then I think he didn't see her because she was at dialysis. We got a new wound nurse practitioner just a couple weeks ago.On 5/22/26 at 2:05PM V4 (Wound Nurse Practitioner) stated, I saw (R1) twice. The last time I was there she was in the hospital. The time before that she had just come back from dialysis and she was wiped out. She needed to be fed but I am not sure how well she could eat after dialysis. The first time I saw her I asked if she had everything she needed, like supplements and such and I was told yes. I do not know when that stuff was ordered. When I saw (continued on next page)

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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	the dressings after dialysis, they were saturated, but I would expect that as the wounds were draining so much. If the original assessment had slough, then it was not MASD. I have seen MASD with pressure underneath but if there was slough then that is not MASD, that is pressure.The dietary notes dated 3/31/26 state, RD Dialysis/Weight Review: Ht: 66 in, Wt: 143.4 lb (3/25), BMI: 23.1 which is classified as WNL. Wt down 2.2% in 1 month (not significant), wt down 13.2% in 3 months (significant), and wt down 12.5% in 6 months (significant). Current diet is regular diet, regular texture, and regular consistency. Meal intakes generally 0-100% per intake record. No concerns with dialysis noted at this time. Per progress notes, resident with MASD of sacrum. Meds and labs reviewed. Recommend continuing current diet and encourage intake. Recommend adding Renal Supplement - 1 carton once daily. Recommend adding 30 mL Liquid Protein BID. RD to continue monitoring monthly weights and labs as available. Refer to RD as needed. R1's Physician Note dated 4/16/26 states, Abnormal weight loss: weight loss, with a decrease from 143.4 lbs on 3/25/2026 to 119.8 lbs on 4/13/2026, ordered daily weight, dietitian and nutritionist consults and labs . The dietary note dated 4/21/26 states, RD Dialysis/Weight/Wound Review: Ht: 66 in, Wt: 115.6 lb (4/21), BMI: 18.7 which is classified as underweight for age. Wt down 20.1% in 1 month (significant), wt down 30.7% in 3 months (significant), wt down 29.1% in 6 months (significant). Current diet is regular diet, regular texture, and regular consistency. Meal intakes generally 0-100% per intake record. Resident recently admitted to hospice and dialysis was stopped, however, hospice was revoked per family decision. Per progress notes, resident with stage IV pressure wound of sacrum (stable) . Recommend continuing current diet and encourage intake. Recommend adding Renal Supplement - TID/three times a day. Recommend adding 30 mL Liquid Protein TID, 1 packet Arginaid BID/twice a day, and start renal multivitamin to aid in wound healing. Recommend referring MD to poor appetite and possible need for appetite stimulant. Continue daily weights. RD to continue monitoring monthly weights and labs as available. Refer to RD as needed. R1's Physician's Order Sheet dated May 2026 shows that Liquid Protein 30ml three times a day and Arginaid (Wound Healing Supplement) twice a day were not ordered until 5/8/26. (38 days after the dietitian's initial recommendation and 31 days after the wound nurse practitioner's initial recommendation) On 5/22/26 at 3:25PM V2 (Interim Director of Nursing), The dietitian comes in once a month, and she writes her notes, and we email them to the doctor with her recommendations and then we get orders from the doctor. On 5/22/26 V5 (Dietitian) was called for an interview, and a message was left but no return call was received prior to the exit of this survey. 2.R3's Physician's Order Sheet dated May 2026 shows that R3 was admitted to the facility on [DATE] with diagnoses including Hypertensive Heart and Chronic Kidney Disease, Type 2 Diabetes mellitus and Chronic Obstructive Pulmonary Disease. R3's Skin assessment dated [DATE] done by V4 (Wound Nurse Practitioner) shows that R3 had no open wounds. R3's Skin assessment dated [DATE] shows, New skin Issue. Location: Buttocks Issue type: Pressure ulcer / injury. Progress: New: new wound. Pressure ulcer staging: Stage 2 Pressure ulcer / injury - partial thickness skin loss with exposed dermis. Wound acquired in-house. It is unknown how long the wound has been present. Length: 2.49 Width 5.71 Granulation: 30%. Slough: 40% (70%?) Exudate amount: Moderate. Exudate type: Serosanguineous: mixture of serous and sanguineous fluid, typically pale, red, and watery. Other wound bed: pink or red. Surrounding tissue: Fragile. Surrounding tissue: Erythema. Surrounding tissue: Excoriated.On 5/22/26 at 11:30AM R3 was in bed watching TV. R3's incontinent brief was removed and R3 was positioned on his side by V3 (RN- Wound Nurse and V7 (RN). R3 had a large reddened, angry appearing area to his buttocks with a quarter sized odd shaped open area in the center over his sacrum. On 5/22/26 at 1:00PM V3 stated, Oh, why did I click slough for a stage 2? You can't have that. That must have been an error. I must have meant the rest was pink and epithelial tissue. (To equal 100% of wound bed). I don't know how long the wound has been there, so I always write that I do not know how long, that was just my first assessment. The facility policy entitled Pressure Ulcer/Pressure Injury Prevention revised on 3/2022 states, Interventions for the prevention of pressure ulcer/pressure injury will be individualized to meet the specific needs of the resident. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Interventions will consider the assessment of risk and skin condition of the resident. This same policy states, Consider supplementation as indicated by the assessment of the Registered Dietitian.