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	06/22/2026

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 0580 Level of Harm - Immediate jeopardy to resident health or safety 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. Based on interview and record review the facility failed to notify the physician of R2's critical low blood glucose for a resident with history of critical glucose levels and recent diabetic medication changes for 1 of 13 residents (R2) reviewed for physician notification in the sample of 13. This failure resulted in R2 being found with a critical low blood glucose then R2's heart stopping.The Immediate Jeopardy began on (05/09/2026) when R2's critical low blood sugar was not reported to the physician. V1 Administrator was notified of the Immediate Jeopardy on 06/17/2026 at 3:38PM. The surveyor confirmed by interview and record review that the Immediate Jeopardy was removed on 06/17/2026 but non-compliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training.The findings include:R2's Physician Orders dated 05/08/2026 shows, call physician if Blood Sugar is less than 70 milligrams per deciliter or greater than 401 milligrams per deciliter.R2's Vital Sign record dated 05/09/2026 at 7:43AM, shows R2's Blood Glucose was critical low at 55 milligrams per deciliter.R2's Medical Record shows, No physician notification of R2's 05/09/2026 critical low blood sugar.R2's Ambulance Patient Care Record dated 05/10/2026 at 6:55AM, shows, R2 Vital Signs: unable to obtain a blood pressure, no pulse, no respirations, unable to obtain a blood oxygen level. R2's Death Certification shows, Time of Death 05/10/2026 at 7:44AM.R2's Physician Note by V6 DO-Doctor of Osteopathic Medicine, dated 05/10/2026 at 7:48 AM, shows, R2 blood sugar was 32 milligrams per deciliter. R2 sent urgently to the Emergency Department. On 06/16/2026 at 10:03AM, V10 RN-Registered Nurse said on 05/09/2026 R2 did not have any signs or symptoms of low blood sugar. R2 would not get up out of bed. I gave R2 oral glucose and performed another blood sugar check and then gave another thing of oral glucose. R2 ate 25% of breakfast. I administered glucagon intramuscularly and sent R2 to dialysis. The dialysis center was not ready to give R2 dialysis and R2 was sent back to the facility. I gave R2 a drink of juice and started a dextrose intravenous drip in the midline catheter. The power of attorney for health care was notified and was OK with the situation. V3 Nurse Practitioner was in the facility and made aware. I used the facility's standing orders to administer the medication I provided.R2's Medication Administration Record dated May 9, 2026, did not show V10's interventions of oral glucose, intermuscular glucagon, intravenous midline dextrose drip, or notification of V3 Nurse Practitioner.On 06/16/2026 at 10:22AM, V3 NP-Nurse Practitioner said, I was not notified about R2's critical low blood sugar (05/09/2026). I was not in the facility during that time. Many will write they told me, but that is throwing me under the bus, V10 RN did not tell me. There would be orders for an intervention, 15-minute re-check, update physician, and orders for blood glucose monitoring every 2 hours. If I was told, where are my recommendations? Where is the standing order for low blood sugar the nurse claims to follow? If notified that morning (05/09/2026) of a critical low, I would have revised R2's insulins. The last time I wrote orders on R2 was for hyperglycemia (high blood glucose/sugar). I increased R2's insulin. R2's blood sugar was critically high at 398. A normal fasting blood glucose level is 70-100. The long-acting insulin R2 received before bedtime will cause low blood glucose in the morning.R2's MAR-Medication Administration Record dated 05/09/2026 at 9:00PM, shows R2 received 10 units of long-acting insulin.On 06/16/2026 at 11:15AM, V4 RN-Registered Nurse (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145958	A. Building B. Wing	06/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany Rehab & Hcc	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 - Immediate jeopardy to resident health or safety Residents Affected - Few	said, a glucose of 55 is critical low, we must call the doctor. The interventions are based on the physician's order.On 06/22/2026 at 10:51AM, V6 DO said, R2 was discharged from the facility when the staff reported the blood sugar of 32 to me. I was not contacted to provide treatment orders. The call was letting me know R2 had been discharged from the facility. V7 RN and V13 CNA-Certified Nursing Assistant, the staff assigned to care for R2 on 05/10/2026, were not available for interview during the survey. On 06/17/2026 at 3:22PM, V2 DON-Director of Nursing said, the facility does not have a policy for the staff to follow when residents have a critical low blood sugar.The Immediate Jeopardy that began on 05/09/2026, was removed on 06/17/2026 , when the facility took the following actions to remove the immediacy.A house-wide review of all current residents with blood glucose monitoring was completed to ensure the existence of orders of glucagon were present. Completed 6/17/2026.A house wide review of all current residents with blood glucose monitoring was completed to ensure no other critical values requiring physician notification. Completed 6/17/2026.All licensed nurses were immediately re-educated on change in condition and physician notification requirements. Emphasis on timely reporting of abnormal/critical blood glucose results, timeframes and documentation standards. Complete 6/17/2026The facility reinforced change in condition and clear parameters for physician notification of blood glucose results, including defined critical values and required escalation timeframes. Completed 6/17/2026.The facility initiated a 100% audit of all diabetic residents receiving insulin to ensure blood sugar parameters were in place and glucagon orders are in place. Completed 6/17/2026.The facility initiated a 100% audit of all blood sugar results to ensure abnormal/critical values are timely reported to the physician and documented appropriately. Completed 6/17/2026.Audits will occur daily for 14 days then weekly for four weeks then monthly through QAPI.The Director of nursing/designee will review all abnormal glucose results and corresponding physician notifications daily to ensure compliance (monitoring during clinical QA meeting).An Ad Hoc QAPI meeting will be held 6/18/2026 with medical director and team.

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Bethany Rehab & Hcc	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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on observation, interview, and record review the facility failed to report an allegation of abuse for 1 of 18 residents (R1) reviewed for abuse in the sample of 18.The findings include: On 06/15/2026 at 12:30PM, R1 was sitting on the side of the bed with an incontinent brief and strong odor of urine.On 06/15/2026 at 12:30PM, R1 said, the staff do not answer lights. The staff have talked mean to me in the past. I do not know their names; they have no name tags.On 06/16/2026 at 12:30PM, V5 Housekeeping said, R1 was in the bathroom with the call light on. V9 CNA was in another resident's room with the other CNA. I told V9 CNA one of the residents needed help. V9 CNA asked if it was the small one or the fat one. I said, the larger person. Both CNAs laughed, I walked away. I did not need to report the incident. R1's nurse overheard what V9 CNA was saying. The nurse confronted V9. The nurse was going to report V9's actions. Then V9 got loud and started cursing at the nurse. I do not remember who the nurse is. On 06/16/2025 at 12:46PM, V1 Administrator said, I do not know the nurse or the day it happened. It will be challenging to figure out what nurse was on duty. I first heard about V9 CNA and R1 yesterday (06/15/2026) during the State Agency complaint investigation. The facility Abuse Prevention and Prohibition policy dated November 2025 shows, resident abuse must be reported immediately to the administrator. The facility employee or agent, who becomes aware of abuse or neglect.shall immediately report the matter to the facility Administrator.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety 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 monitor a resident's blood glucose levels for a resident with history of critical blood glucose levels and recent diabetic medication changes for 1 of 13 residents (R2) reviewed for Quality of Care in the sample of 13. This failure resulted in R2's blood sugar becoming critically low then R2's heart stopped.The Immediate Jeopardy began on ([DATE]) when R2's critical low blood sugar was not reported to the physician; the facility failed to develop a treatment plan with R2's physician for the critical low blood sugar. V1 Administrator was notified of the Immediate Jeopardy on [DATE] at 3:38PM. The surveyor confirmed by interview and record review that the Immediate Jeopardy was removed on [DATE]. Non-compliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training.The findings include:Normal fasting Blood Glucose/sugar level is 70mg/dl milligrams per deciliter to 100mg/dl (70-100).R2's Face Sheet on [DATE] shows, R2 had multiple diagnoses including Diabetes Mellitus treated with fast acting and long-acting insulin.R2's Vital Sign record dated [DATE] at 7:43AM, shows R2's Blood Glucose was critical low at 55.R2's Medical Record on [DATE] shows no interventions to treat R2's [DATE] critical low blood sugar or Physician notification of R2's [DATE] Critical low blood glucose at 7:43AM.R2's Vital Sign record shows, No Assessment of R2's blood sugar after 5:03PM, on [DATE].R2's Ambulance Patient Care Record dated [DATE] at 6:55AM, shows, R2's Vital Sign: unable to obtain a blood pressure, no pulse, no respirations, unable to obtain a blood oxygen level. R2's Death Certification shows, Time of Death [DATE] at 7:44AM.R2's Physician Note dated [DATE] at 7:48 AM, shows, R2's blood sugar was 32.On [DATE] at 10:03AM, V10 RN-Registered Nurse said, on [DATE] R2 did not have any signs or symptoms of low blood sugar. R2 would not get up out of bed. I gave R2 oral glucose and performed another blood sugar check and then gave another thing of oral glucose. R2 ate 25% of breakfast. I administered glucagon intramuscularly and sent R2 to dialysis. The dialysis center was not ready to give R2 dialysis and R2 was sent back to the facility. I gave R2 a drink of juice and started a dextrose intravenous drip in the midline catheter. The power of attorney for health care was notified and was OK with the situation. V3 Nurse Practitioner was in the facility and made aware. I used the facility's standing orders to administer the medication I provided.R2's Medication Administration Record dated [DATE], did not show V10's interventions of oral glucose, intermuscular glucagon, intravenous midline dextrose drip, or notification of V3 Nurse Practitioner.On [DATE] at 10:22AM, V3 NP-Nurse Practitioner said, I was not notified about R2's critical low blood sugar ([DATE]). I was not in the facility during that time. Many will write they told me, but that is throwing me under the bus, V10 RN did not tell me. There would be orders for an intervention, 15-minute re-check, update physician, and orders for blood glucose monitoring every 2 hours. If I was told, where are my recommendations? Where is the standing order for low blood sugar she is claiming to follow? If notified that morning ([DATE]) of a critical low, I would have revised R2's insulins. The last time I wrote orders on R2 was for hyperglycemia (high blood glucose). I increased R2's insulin. R2's blood sugar was critically high at 398 milligrams per deciliter. A normal blood glucose level is 70-100milligrams per deciliter. The long-acting insulin R2 received before bedtime will cause low blood glucose in the morning. Long-acting insulin given at 9:00PM, will peak at 3:00AM. Where is the glucose check for 9:00PM, insulin? The blood glucose level must be assessed prior to giving any type of insulin.R2's Vital Sign Record shows no blood sugar check on [DATE] at 9:00PM, prior to insulin administration.R2's Vital Sign Record on [DATE] shows, R2's last blood sugar check was documented on [DATE] at 5:03PM.R2's MAR-Medication Administration Record dated [DATE] shows, at 9:00PM, R2 received 10 units of long-acting insulin.On [DATE] at 11:15AM, V4 RN-Registered Nurse said, a glucose of 55 is critical low, we must call the doctor. The interventions are based on the physician's order. The nurse can place verbal orders in the chart for the physician, or the physician can write the orders directly (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	into the chart, remotely if needed. The resident's blood sugar level is checked before meals. If the resident is given insulin before bed the glucose is checked.On [DATE] at 10:51AM, V6 DO-Doctor of Osteopathic Medicine said, on [DATE], I was told R2 had blood glucose of 32 milligrams per deciliter. R2 was sent out urgently. Fasting blood glucose is 70 milligrams per deciliter to 120 milligrams per deciliter. The body cannot go for a prolonged period of time without glucose.On [DATE] at 9:40AM, V8 Medical Director agreed, the heart muscle needs glucose; along with other factors, in theory, after a prolonged period without glucose the heart will stop.On [DATE] at 3:22PM, V2 DON-Director of Nursing said, the facility does not have a policy or protocol for the staff to follow for residents with critical low blood sugar. We are able to provide basic CPR. We do not have emergency medications; we do not have intravenous glucose. V7RN and V13 CNA-Certified Nursing Assistant, the staff assigned to care for R2 on [DATE], were not available for interview during the survey. The Immediate Jeopardy that began on [DATE] was removed on [DATE], when the facility took the following actions to remove the immediacy.A house-wide review of all current residents with blood glucose monitoring was completed to ensure the existence of orders of glucagon were present. Orders were added for any resident not noted to have order. Completed [DATE]All residents will have blood glucose monitored prior to administration of insulin. Orders to reflect glucose monitoring.All licensed nurses were immediately re-educated on change in condition and physician notification requirements, with emphasis on timely reporting of abnormal/critical blood glucose results, required timeframes and documentation standards. Education included verbal competencies. Completed [DATE]All licensed nurses have been educated on hyper/hypo glycemic events to include notifying the physicians, following the physician's orders, increased blood sugar check, monitoring of side effects when medications are changed and critical thinking. Completed [DATE]Licensed staff will not be permitted to work until education is complete.The facility reinforced change in condition and clear parameters for physician notification of blood glucose results, including defined critical values and required escalation timeframes. Completed [DATE].The facility initiated a 100% audit of all diabetic residents receiving insulin to ensure blood sugar parameters were in place and glucagon orders are in place. Completed [DATE].The facility initiated a 100% audit of all blood sugar checks results to ensure abnormal/critical values are timely reported to the physician and documented appropriately. Completed [DATE].Audits will occur daily for 14 days, weekly for four weeks then monthly through QAPI.The Director of Nursing/designee will review all abnormal glucose results and corresponding physician notifications daily to ensure compliance (monitoring during clinical QA meeting).Ad Hoc QAPI meeting will be held [DATE] with medical director and team.