(X6) DATE

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:			
		IL6014872	B. WING		07/2	4/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BETHAN	Y REHAB & HCC	3298 RES DEKALB,	OURCE PAR IL 60115	RKWAY		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	.D BE	(X5) COMPLETE DATE
S 000	Initial Comments		S 000			
	Annual Licensure a	nd Certification				
S9999	Final Observations		S9999			
	Statement of Licens 300.661	sure Violations 1 of 3:				
	Section 300.661 He Check	ealth Care Worker Background				
	Worker Background	oly with the Health Care d Check Act [225 ILCS 46] and orker Background Check Code 955).				
	These Regulations	are not met as evidenced by:				
	failed to conduct a l Background Check	and record review the facility Health Care Worker prior to hire for 2 staff. This ntial to affect all 68 residents ty.				
	The findings include	e:				
		red CMS-671 form on 7/22/24 residents in the facility.				
	(Dietary Aide/Cook) 2/1/24 and the state	d employee file for V14 shows he has a hire date of agency Heath Care Worker d check was not completed				
	(Certified Nursing A a hire date of 4/25/2	d employee file for V15 assistant/CNA) shows she has 24 and there is no state Worker Registry check in her				

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

08/16/24 **Electronically Signed** 

TITLE

Illinois Department of Public Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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	IL6014872		B. WING		07/2	4/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BETHANY REHAB & HCC 3298 RES DEKALB,		OURCE PAR IL 60115	RKWAY			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
\$9999	Continued From parfile.  On 7/23/24 at 8:35 they were aware the background checks to some staff changagency Healthcare should be initiated parfile.  The facility provided Checklist shows pri Worker background Statement of Licens 300.610a) 300.1210b) 300.1210b) 300.1210b) 300.1210d)3)5)  Section 300.610 Real procedures governifacility. The written be formulated by a Committee consisting administrator, the amedical advisory conformities shall complete the policies shall compl	AM, V1 (Administrator) stated by had some issues with staff on the being done on time due ges. V1 stated the state Worker background check prior to hire for employees.  If Post- Offer Employment or to hire the Healthcare of checks should be initiated.  (C) Sure Violations 2 of 3:  The esident Care Policies and all services provided by the policies and procedures shall Resident Care Policy	S9999			
		documented by written, signed				
	Section 300.1010	Medical Care Policies				
	h) The facility	shall notify the resident's				

physician of any accident, injury, or significant

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
	IL6014872	B. WING		07/24/2024	
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BETHANY REHAB & HCC	3298 RES DEKALB,	OURCE PAR IL 60115	RKWAY		
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
health, safety or welfar but not limited to, the promanifest decubitus uld of five percent or more. The facility shall obtain plan of care for the caraccident, injury or char of notification.  Section 300.1210 Ger Nursing and Personal  b) The facility shall care and services to at practicable physical, mwell-being of the reside each resident's compreplan. Adequate and procare and personal care resident to meet the to care needs of the resident to meet the tocare needs of the resident's condition, including and shall be seven-day-a-week based termining care requifurther medical evaluating made by nursing staff resident's medical recommends.	condition that threatens the re of a resident, including, presence of incipient or cers or a weight loss or gain e within a period of 30 days. In and record the physician's re or treatment of such inge in condition at the time.  In a condition at the time of the necessary of th	S9999			

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seven-day-a-week basis so that a resident who

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		IL6014872	B. WING		07/2	4/2024
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 0112	
	IY REHAB & HCC	3298 RES	OURCE PAR			
		DEKALB,	IL 60115			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
\$9999	enters the facility w develop pressure s clinical condition de sores were unavoid pressure sores sha services to promote and prevent new properties. These Regulations Based on observation review the facility fatreat a resident's properties and failed to for 4 of 6 residents reviewed for pressure proplace, and failed to for 4 of 6 residents reviewed for pressure in Stage 2 pressure in Stage 3 pressure in R224 developing a coccyx.  The findings included the following in the follo	without pressure sores does not cores unless the individual's emonstrates that the pressure dable. A resident having all receive treatment and e healing, prevent infection, ressure sores from developing.  are not met as evidenced by:  ion, interview, and record ailed to identify, assess, and ressure injuries before able and Stage 3, failed to revention interventions were in do weekly skin assessments (R51, R224, R3, R62) are injuries in the sample of alted in R51 developing an are injury to his right heel and a nijury to his right scapula and Stage 3 pressure injury to her	\$9999			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BETHANY REHAB & HCC	3298 RES DEKALB,	OURCE PAR IL 60115	KWAY		
PREFIX (EACH DEFICIENCY I	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
unstageable because bed, R51's right heel which is a stage 2 and found as a stage 3. Inon-complaint with conshould have been for wounds should be for open areas, staff shoresidents skin when presidents are sensitive to pressure Ulcer Assessments dated acquired during stay, to his left heel measure depth, described as a mattress was previous company and again with the state of the	nar which she classified as e she couldn't see the wound had a fluid filled blister and R51's right scapula was V8 stated R51 can be are, but still the wounds und much sooner. V8 stated and before they became buld be assessing the providing care.  for Predicting Pressure 13/24 shows R51 is at very e.  If Weekly Wound 7/10/24 show: R51 has an unstageable pressure injury uring 6.0 x 3.0 cm x unknown dark brown eschar. The air usly requested from hospice was requested today.  If during stay, stage 3 a right scapula measuring 0.4 ribed as round in shape with the serosanguineous drainage, ch.  If during stay, stage 2 a right heel measuring 3.0 x and described as an intact fluid the heel.	S9999			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		IL6014872	B. WING		07/2	4/2024
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
DETUA	NV DELIAD & LICO	3298 RES	OURCE PAR	KWAY		
BETHAI	NY REHAB & HCC	DEKALB,	IL 60115			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
\$9999	2. On 07/22/24 at 8 bed. V20 (R224's h the bed. V20 stated until 9 PM. V20 stated until 9 PM. V20 stated wait 1.5 hours for the come in and turn caback, so I have to pwould change her might the nurse four her butt and she wa V20 stated he hadnand no one had cordressing on it.  On 07/23/24 at 08: V20 at the bedside, for a skin check. V2 crack on R224's but to put something or R224 to her right sin R224 had an open area that was visibl stated R224 has his injury there, that R2 stated it now is ope call it a stage 3 sind was a stage 3. V8 should have called let V2 Director of N should have been a should have let me On 07/23/24 at 08:5 the pressure interversion of the open crack. The in color and measure	ge 5 8:58 AM, R224 was sleeping in husband) was sitting beside the was here all day with her red sometimes they have to hem to change her. They all light off then don't come but the call light on again. I myself, if I had the stuff. Last and a crack that opened up on as supposed to get patch for it. I't heard anything yet about it me to assess it or put a  19 AM, R224 was in bed with V8 came in with this surveyor to stated the staff noticed the trand stated they were going in it and never did. V8 rolled de and lowered R224's brief. Is slit in the crack of her coccyx by open and red in color. V8 restory of a stage 3 pressure the staff ound it the doctor and got orders and ursing know. V8 stated she would be it re-opened and previously stated the nurse that found it the doctor and got orders and ursing know. V8 stated there an assessment done and staff know yesterday (Monday). Of AM, V8 stated R224 has all entions in place, not being oned could cause wound to the spoke with the doctor and so the spoke with the	\$9999			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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S9999	Continued From pa	ige 6	S9999			
	was just notified too nurse should have and get treatment of R224's Pressure U dated 7/23/24 show	3 PM, V24 Physician said he day of R224's wound and the called when wound was found orders.  Icer Weekly Wound Evaluation is "re-opened stage 3 occyx measuring 3.5 x 0.6 x				
	R224's Braden Scale for Predicting Pressure Score Risk dated 7/19/24 shows R224 is at very high risk for pressure.					
	3. On 07/22/24 at 10:24 AM, V21 and V22 Certified Nursing Assistants (CNA) went into R3's room to change and clean R3 up. When V21 and V22 rolled R3 to her right side and lowered the bedding, R3 was covered with stool from the middle of her thigh to the middle of her back. R3 had an open wound on her left posterior thigh that was covered in stool. There was no dressing on the wound. V22 stated there was no dressing on R3's thigh and there wasn't one in the bedding. At 10:55 AM, V8 Wound Nurse came into the room to do R3's dressing change. V8 stated there was supposed to be a dressing on her wound, R3 has stage 3 pressure injury.					
	Evaluation was date shows R3 has a St	ressure Ulcer Weekly Wound ed 7/8/24 (2 weeks ago) and age 3 pressure injury on her een present since admission.				
	posterior thigh pres wound cleanser, pa	ers dated 6/21/22 shows "Left sure injury: Cleanse with the at dry, apply Calcium Alginate, sing. Everyday shift and as care."				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		IL6014872	B. WING		07/2	4/2024
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BETHAN	IY REHAB & HCC	3298 RES DEKALB,	OURCE PAR IL 60115	RKWAY		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
S9999	Continued From pa	age 7	S9999			
	On 07/24/24 at 09: has pressure, skin weekly. V8 stated s V3 Assistant Direct doing the skin assection on 07/24/24 at 11: pressure wound as unable to do R3 and they were up in the 4. On 07/23/24 at in bed, leaning to h R62's air mattress R62's outer edge or resting directly on the mattress machine of there was a detach bed. R62 stated shout needed help methought she had so On 07/23/24 at 08: bed is not on. I thin beeping. I'm not so works, the light is of bed, but not on prebutton on pressure no light turned on.	37 AM, V8 stated if a resident assessments should be done she was out last week sick and for of Nursing (ADON) was essments.  53 AM, V3 stated she did sessments last week, but was d R51's assessment because chair.  08:32 AM, R62 was sitting up er left side, eating breakfast, was completely deflated and f both her feet and heels were he deflated mattress. R62's air did not have any lights on and led cord hanging under the ne was able to move her arms oving her legs. R62 stated she one wounds on her bottom.  35 AM, V16 CNA stated "the k it's broken, it had been ure why it's not on. The bed on to the remote to move the ssure unit." V16 turned the machine box on and off, but V16 saw the plug hanging rneath and said she was not				
	with this surveyor a the mattress is defl be moved out of th metal frame. V17 V16 came in and g	50 AM, V8 came into the room and said the bed is not working, ated. V8 state R62 needs to e bed, she is laying on the Licensed Practical Nurse and ot R62 out of the bed.  7 AM, V8 stated R62's air				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BETHAN	NY REHAB & HCC	3298 RES DEKALB,	OURCE PAR IL 60115	RKWAY		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
\$9999	mattress is for her not acquire any moderate and moderate	wound to heal and for her to bre pressure injuries.  Pressure Ulcer Weekly Wound 7/12/24 (11 days ago) shows pressure injury to her sacrum.  Ure Ulcer/Pressure Injury lated 3/2022 shows "A facility monitor, and interventions to reduce, or remove underlying a pressure ulcer is present, to heal it and prevent the ditional pressure ulcers. The deriventions for the prevention ressure injury will be set the specific needs of the eels, float, if possible, manage ing toileting at regular intervals; continent care, utilizing roducts, pressure redistributing rehair and bed, skin checks din Nurses, daily observations of the by CNAs."  (B)  Sure Violations 3 of 3:  Resident Care Policies  shall have written policies and ing all services provided by the policies and procedures shall Resident Care Policy	\$9999			

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		IL6014872	B. WING		07/	24/2024	
	PROVIDER OR SUPPLIER		OURCE PAR	TATE, ZIP CODE KWAY			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
\$9999	of nursing and othe policies shall comp. The written policies the facility and shall by this committee, and dated minutes.  Section 300.1210 (Nursing and Person b)  The facility care and services to practicable physical well-being of the releach resident's complan. Adequate and care and personal corresident to meet the care needs of the releach releach releach releach releach releach releach releac	er services in the facility. The ly with the Act and this Part. It is shall be followed in operating I be reviewed at least annually documented by written, signed of the meeting.  General Requirements for mal Care  shall provide the necessary of attain or maintain the highest I, mental, and psychological sident, in accordance with a prehensive resident care I properly supervised nursing care shall be provided to each the total nursing and personal esident.  subsection (a), general anclude, at a minimum, the be practiced on a 24-hour, basis:  s, including oral, rectal, enous and intramuscular, shall stered.	S9999				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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S9999	Continued From pa	age 10	S9999			
	watching TV. R223 in color. When ask R223's face appea was a horrible start being discharged fi even ready for me medications. I got and they didn't' hav Saturday morning (time was and 8 out and upset, why not medications can be R223's Face sheet	shows R223 was admitted to				
	R223's Face sheet shows R223 was admitted to the facility on 7/18/24.  R223's Hospital History and Physical dated 7/5/24 shows "Metastatic breast cancer with metastases to the iliac and femoral bone and liver. Plan: As needed pain control."					
	pain Thursday nigh had told the nurse. said she was workineeded a code to get friday it was still the my medications, ar medications becaute into the machine. I was any problems friday my medication midnight. I woke us 2:00 AM, in pain, a pain medication. Furthroughout day due evaluation and I was	47 PM, R223 stated she had at and all-day Friday and she R223 stated "the nurse she ng on the medications and get into the medications. On e same, they were working on and I couldn't get any pain se they needed a code to get don't recall being told there with my medication orders. ons were delivered at p Saturday morning around and was finally able to get my friday my pain was a 6-7 et o my physical therapy as doing quite a bit. The dime my pain level or where				

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NAME OF PROVIDER (	OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BETHANY REHAB	& HCC	3298 RES DEKALB,	OURCE PAR IL 60115	KWAY		
PREFIX (EAC	H DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
my pain medicat wait for My pain uncomform (day after Shock) anemia, nephrecoxycodo doubt the her bong We will comfort rehability. On 07/2 Nurse see Resider oxycodo admissi the pharm saturda. R223's anemia, nephrecoxycodo admissi the graph (day admissi the pharm saturda). R223's anemia, nephrecoxycodo admissi the see anemia, nephrecoxycodo admissi the graph (day admissi the pharm saturda). R223's anemia, nephrecoxycodo admissi the pharm saturda.	ions and I jipharmacy, was pretty ortable."  Physician Per admissio CMV virus, anxiety, chotomy. Plan one as she I at she is explesions. I assist with able and enation."  3/24 at 10:4 tated according and delemacy delivery, but there Physician Coxycodone  Controlled Strong and the coxycodone  I on 7/20/24  3/24 at 12:5 urses need ancy box for pharmacy to II nurses, in the coxycodone	t asking about getting my ust kept getting told I had to and they didn't have a code. bad, I was very  rogress Note dated 7/19/24 n) shows "Assessment: Septic Metastatic breast carcinoma, ronic pain, status post right: We will certainly prescribe has been taking it. There is no experiencing some pain given think it is very appropriate. making sure she is courage her with her  49 AM, V18 Licensed Practical ding to R223's Individual di Substance Record, R223's ered on 7/19/24 (day after evered on 7/20/24. V18 stated ers every evening Monday to is no Sunday delivery.  Proders for July 2024 shows was ordered on 7/19/24.  Substance Record shows be a dose of oxycodone until	S9999			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '			(3) DATE SURVEY COMPLETED	
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NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
BETHANY REHAB & HCC 3298 RESC DEKALB, II			OURCE PAR IL 60115	RKWAY			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE	
\$9999	box.  On 07/23/24 at 12:5 Supervisor stated R showed discontinue The hospital called supposed to be con faxed a prescription Nursing (ADON) sp order. V19 stated w be delivered, the nu medication from em pharmacy. V19 stat been assessing R2: hospital if there was orders on discharge  On 07/24/24 at 10:4 spoke with a nurse (7/19/24) around no hospital orders had mistake. R223 stat order and faxed the nurse could have ca night if the resident with an order, the n medication from the  On 07/23/24 at 12:4 pain and usually as afternoon and in ea  R223's Medication of that since Oxycodor taken the medication  R223's Care Plan s related to left breas and to liver. Monitor	55 PM, V19 Post Acute Nurse (223's oxycodone ordered ed on the hospital paperwork, and notified us it was attinued and electronically and the Nospital and got an while waiting for medications to be used to the hospital and got an while waiting for medications to be used to the pain and got the pain and ed the nurses should have 23's pain and calling the sany question about R223's ed.  15 AM, V3 ADON stated she at the hospital the next day be now, and the nurse stated the oxycodone discontinued by the ed the nurse gave a verbal or pharmacy. V3 stated the alled hospital to clarify that was having pain. V3 stated urse could have gotten the	S9999				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		IL6014872	B. WING		07/24/2024	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BETHANY REHAB & HCC 3298 RESOURCE PARKWAY DEKALB, IL 60115						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
S9999	Continued From pa	ige 13	S9999			
		te R223's need for pain relief diately to any complaint of				
	Medication Kit Police Machine, containing drugs, is available to	Il Care Pharmacy Emergency by shows "A Stat Safe g a limited but broad rand of for immediate use. The Stat ailable to licensed nursing				
	have a pain patch y 7:00 AM. My pain i I'm supposed to ha forward in her whee surveyor her lower her back the patch	10:19 AM, R67 stated "I don't yet. I have been waiting since is now a 7, it's low back pain. we a pain patch. R67 leaned elchair and showed this back and pointed to where on was supposed to go. There rived on R67's lower back.				
	for July 2024 shows (Lidocaine) Apply to topically in the more schedule. Apply 6:0 R67 has diagnoses	dministration Record (MAR) as an order "Lidoderm patch 5% of per additional directions ning for pain and remove per 20 AM. The same MAR shows of lumbago with sciatica and an fractures to her second and a.				
	helps a lot with my morning yet. V16 ( came into the room back of her pants a	AM, R67 stated the pain patch pain. I don't have one on this Certified Nursing Assistant and assisted R67 to lower the and show this surveyor, there observed on R67's back.				
	Nurse, when asked stated she had not	AM, V17 Licensed Practical I about R67's pain patch, done R67's patch yet. When tch was due, V17 stated it's				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				) DATE SURVEY COMPLETED	
	IL6014872	B. WING		07/2	4/2024	
NAME OF PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE			
BETHANY REHAB & HCC 3298 RESOURCE PARKWAY DEKALB, IL 60115						
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
by the night nurse. and apply the patch of t	at it had already been signed off V17 stated she would check on.  45 AM, V3 ADON stated of be given as ordered and on edications should not be signed ered.  AM, V1 Administrator said the ve a policy on pain.  Al Care Pharmacy Policy and shows "It is our purpose to ty quality care and services facility to provide and maintain num quality of live within the ent's physical and psychological dications, including non-legend urtics, headache remedies, I be given only upon written	\$9999				

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