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	IL6014872	A. BUILDING: _____ B. WING _____	C 02/07/2025

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S 000	Initial Comments Investigation of Facility Reported Incident of 01-26-2025/IL185475	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 300.1210d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal	S9999		

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care needs of the resident.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

These Regulations are not met as evidenced by:

Based on interview and record review, the facility staff failed to provide feeding assistance and supervision, Cardiopulmonary Resuscitation (CPR) to a resident that was a full code. Failed to recognize the resident's code status, failed to immediately perform life-saving interventions once the resident's code status was identified, for 1 of 3 residents (R1) reviewed for advanced directives in the sample of 3. No CPR was provided to R1 until after emergency medical services arrived at R1's bedside.

This failure resulted in R1 experiencing a delay in life-saving medical care and subsequent death.

The findings include:

R1 was no longer in the facility during this investigation. R1 expired in the facility on 1/26/25.

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R1 who was admitted on 01/22/25 care plans showed she has a chewing/swallowing problem related to facial pain from her burn wounds. Alternate small bites and sips. Use a teaspoon for eating. Do not use straws. Monitor for shortness of breath, choking, labored respirations, lung congestion. Monitor/document/report to Nurse/Dietitian and Doctor as needed for difficulty swallowing, holding food in mouth, prolonged swallow time, repeated swallows per bite, coughing, throat clearing, drooling, and pocketing food in mouth. R1's care plans showed she has a nutritional problem, or potential nutritional problem due to facial burns-eating is hard at times and soft foods are best at this time. R1 is on an altered diet at this time. R1's care plans also show she requires one staff participation to eat. R1's ADL (activities of daily living) care plan initiated on 1/23/25 showed: R1 requires one staff participation to eat.

R1's facility assessment dated 1/25/25 showed she had severe cognitive impairment and required supervision or touching assistance with eating.

R1's Speech Therapy Discharge Summary showed "(R1) was always positioned fully upright for intake with V3 (Speech Language Pathologist-SLP) and appeared to tolerate upright position well...Patient was able to follow simple, bodily directions and functional tasks on feeding self. SLP posted swallow protocol above patient's bed for staff to follow (mechanical soft diet with nectar-thick liquids, sit as fully upright as patient tolerates and 20 minutes after meals, feed on right side of mouth due to burn on left side, small bites/sips, no straws, nasal cannula oxygen during meals only..."

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R1's swallow protocol provided by the facility on 2/5/25 showed:
1. Mechanical soft diet and nectar thick liquids.
2. Push softer foods.
3. Meds crushed in applesauce
4. No straws
5. Feed/spoon food/ liquid on right side of the mouth.
6. Sit as upright as patient tolerates. Keep up 20 minutes after meals.

R1's progress note dated 1/26/25 showed:
"Patient in lying in bed comfortably with eyes closed and oxygen intact, while writer medication cart is by her door. Writer started setting up medication for the evening at (4:00 PM). While writer setting up the medications a call from a family member of (R1) asking about her, writer mention that (R1) has been sleeping on and off, ate 25% of her lunch, resting comfortably. At (4:30 PM) 2 family members arrive and go into her room and closed the door. The room door has been wide open during writer's shift for close observation by the staff. At (4:15 PM), a gentlemen approached me (V4) wanting information on (R1), I question who he was, he then informed me that he was the son. He then asked writer how (R1) was doing, I explained that she has been sleeping on and off during the day and exhibited facial expression of pain and was given a (Norco). He then said that explains why she looks very sleepy. (5:00 PM) more members showed up to visit, the granddaughter (V9) and the boyfriend (V10) and closes the door. All this time writer is next to (R1's) room setting up medications. At (5:30 PM) writer at the nurse's station is approached by granddaughter boyfriend stating, "she is choking." Writer enters the room and noticed the bed at 45-degree semi fowlers position, while son was pushing his mother in to a

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sitting position pushing her forward, while granddaughter pushing her by the arm, and son's wife pulling on her arms. I immediately ask to allow me to assess her, and I placed the bed on a 0-degree position and patient sitting upright. Writer notice food around her mouth and drooling from the left side. Writer proceeded to clean her mouth and remove any food particle still in her mouth. Patient responsive and breathing, no sign of universal sign of (choking) or unable to breath. I just listen to a gargling noise from her mouth. I mentioned that I believed (R1) aspirated and would like to call 911 to take her to the ER (Emergency Room). (5:35 PM) while writer calling 911, boyfriend approach nurses' station waving his hand across his neck, I ask what happen, he stated "she stop breathing." Writer rushed for the crash cart, but when I entered the room the son and granddaughter was holding her and the bed now completely flat. I was going to start CPR, when at (5:41PM) EMT (Emergency Medical Technicians) arrives and (initiated) CPR... Document signed by funeral home for the release of body. Patient teeth were given to funeral staff, which she was not wearing during eating."

On 2/4/25 at 12:54 PM, V4 (Licensed Practical Nurse-LPN/Agency Nurse) stated he was standing by his medication cart right by R1's room on 1/26/25 around 5:00 PM. V4 stated one of the CNAs (Certified Nursing Assistants) took R1's meal tray into her room and came right back out. V4 stated he could hear R1's family saying she needed to wake up and eat. V4 stated a short while later, V10 (one of R1's visitors) came out of R1's room and informed V4 that R1 was choking. V4 stated he went into check on R1, and she had food in and around her mouth. V4 stated R1's bed was not in the upright position. V4 stated R1's son (V8) was trying to push R1 from behind,

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V8's wife (V25) was grabbing R1's hands and R1's granddaughter (V9) was pushing forward on one of R1's shoulders, to try to put R1 into an upright position. V4 stated he placed R1's head of bed in the upright position and removed food from R1's mouth. V4 stated he could hear R1 gurgling, so he informed R1's family that he was going to go call 911 and send her out to a local hospital, because he believed she had aspirated. V4 stated no other staff were in R1's room when he went out to call 911. V4 stated he went out to call 911 and was just finishing up with the call at 5:35 PM, when V10 came out of the room and informed him that R1 was not breathing. V4 stated he grabbed the crash cart, located in the room behind the nurse's station and went back into R1's room. V4 stated R1's bed was in the flat position, and her family was leaning over her. V4 stated he was about to start CPR (cardiopulmonary resuscitation) when the paramedics entered the room. V4 was asked about his statement in the facility's investigation regarding being informed that R1 was not breathing at 5:35 PM and was getting ready to start CPR when the paramedics arrived at 5:41 PM (6 minutes later). V4 was asked what he was doing from 5:35 PM until 5:41 PM. V4 stated he has a disability and does not run quickly. (note: R1's room was located directly in front of the nurse's station).

On 2/4/25 at 2:23 PM, V6 (Certified Nursing Assistant-CNA), V6 (CNA) stated she was busy with another resident so V7 took R1's tray into her room. V6 stated she asked V7 if she (V6) needed to go in and feed R1. V6 stated V7 told her no, the family stated they were going to try to feed her. stated she was not sure what time it was that one of R1's family members informed her and V4 that R1 was not breathing. V6 stated she went in

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to check R1's vitals and there was no pulse and no respirations. V6 stated CPR was not started until the paramedics arrived. V6 was unable to say how much time had elapsed between being informed R1 was not breathing and the paramedics arriving.

On 2/5/25 at 10:15 AM, V5 (Registered Nurse-RN) stated she worked on 1/26/25. V5 stated V4 came up to her when she was passing medications to residents and told her that she needed to come with him to verify. V5 stated she asked V4 to verify what, and V4 told her to verify a resident's death. V5 stated she went with V4 to R1's room and R1 had already passed. No heart rate, no respirations. V5 stated this all happened before the paramedics arrived at the facility. V5 stated V4 did not call a code or initiate CPR so she thought R1 was a DNR (Do Not Resuscitate).

On 2/5/25 at 12:00 PM, V12 (Post acute Nurse-on call nurse on 1/26/25) stated V12 (Post-Acute Nurse/she would expect the staff to feed R1. if a resident is a full code and goes into cardiac arrest; no pulse, not breathing, she would expect the nurse to initiate CPR as soon as they make sure that the resident's airway is cleared, and they verify that the resident is a full code. V12 (Post-Acute Nurse/Nurse on-call on 1/26/25) stated she would expect the staff to feed R1. V12 stated R1 had swallow precautions and was on a mechanical soft, nectar-thickened liquid diet. V12 stated R1 has to be sitting at a 90-degree angle when eating. V12 stated if it says on staff required for eating, R1 should have a nurse or a CNA feeding her.

On 2/5/25 at 12:17 PM, V7 (Certified Nursing Assistant-CNA) stated she was the one that took the tray into R1's room during the dinner meal on

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1/26/25. V7 stated R1's family was in the room, and she believes it was R1's granddaughter (V9) that told her that she could leave the tray on the bedside table, and she would try to get R1 to eat something. V7 stated she was not aware if R1 was a "feeder" or not. V7 stated she was not aware if R1 had special swallowing precautions with eating, or if R1's family had received any education regarding safe feeding techniques for R1.

On 2/5/25 at 12:40 PM, V3 (Speech and Language Pathologist) stated staff should have been the ones to feed R1, to implement the swallow precautions, and to monitor her for signs of difficulty swallowing, aspiration, etc. Staff would be better at feeding R1 due to how sick she was. V3 stated with R1's facial and neck burns, R1 was slow to chew and swallow foods. V3 stated instructions for R1's swallow precautions were listed on a sheet on her wall. V3 stated R1's family was not provided education on how to feed R1, or what to watch for while feeding her. V3 stated V8 had been in the room one time when she was feeding R1 small bites of nectar-thick liquids. V3 stated she informed V8 of what interventions were going to be in place, however, no education on how to feed R1, with a return-demonstration was given, to ensure V8 understood the precautions.

On 2/5/25 at 1:08 PM, V22 (Regional Director of Operations) stated the facility did not have a policy and procedure for assistance with feeding residents with swallow precautions. At 1:21 PM, V1 (Administrator) provided the facility's Skills Checklist showing feeding assistance and other tasks the nurses and CNAs would have to show competency in during orientation.

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On 2/6/25 at 10:05 AM, V11 (the facility's Medical Director/R1's physician) stated the nurse should have started CPR immediately when no respirations or pulse were present. V11 stated "You must start CPR immediately to achieve the best outcome. Ten minutes is way too long to wait and could definitely affect the outcome of a resident." V11 stated the nurse is obligated to start CPR immediately on a resident that is a full code. If the family did not want to continue CPR, then they (the facility) would have that conversation with the family.

On 2/6/25 at 11:00 AM, V14 (Paramedic from a local fire department) stated the initial call came in from the facility at 5:32 PM. V14 stated they (paramedics) arrived at the facility at 5:39 PM. V14 stated initially they were stopped in the hallway by a male nurse, informing them R1 had passed away. V14 stated he advised the nurse that the paramedics still needed to go in and assess the resident, per their protocol. V14 stated when he walked into R1's room, he did not believe there were any staff in the room, only family. V14 stated CPR was not being performed on R1 when he entered the room. V14 stated he asked if R1 was a DNR and was told she was a full code. V14 stated he informed R1's family that CPR was going to be initiated. V14 stated V8 (R1's son) stated he did not want the paramedics to perform CPR on R1. V14 stated he asked if any of the family members were R1's POA (Power of Attorney) and were told they were not. V14 stated he informed V8 that according to protocol, CPR must be initiated because R1 was a full code, and none of the family members were her POA. V14 stated he informed V8 that they would start CPR and notify the hospital doctor to inform them of the family's wishes. V14 stated CPR was initiated at 5:43 PM. The local hospital

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was notified to let them know that R1's next of kin did not wish to continue with life-saving measures. The doctor at the hospital allowed the paramedics to discontinue CPR. V14 stated CPR was discontinued at 5:51 PM. V14 stated if there is no DNR, he would expect CPR to be started. It is important to start and initiate life-saving measures. Six to ten minutes is a long time to wait to start CPR. There would be no blood return to the brain and brain death/cell death occurs.

On 2/5/25 at 7:58 AM, a message was left on V8's (R1's son) voicemail informing him who this surveyor was and that I wanted to see if he had any concerns regarding the events surrounding R1's passing. Surveyor's phone number left on voicemail. No return call was received prior to exiting the facility on 2/7/25 at 2:00 PM.

R1's Transfer/Discharge Report, printed on 2/4/25, showed R1 was a Full Code.

R1's Order Summary Report, printed by the facility on 2/4/25, showed R1 was a Full Code.

R1's progress note dated 1/26/25 showed: "Patient lying in bed comfortably with eyes closed and oxygen intact, while writer medication cart is by her door. Writer started setting up medication for the evening at (4:00 PM). While writer setting up the medications a call from a family member of (R1) asking about her, writer mention that (R1) has been sleeping on and off, ate 25% of her lunch, resting comfortably. At (4:30 PM) two family members arrive and go into her room and closed the door. The room door has been wide open during writer's shift for close observation by the staff. At (4:15 PM), a gentlemen approached me (V4) wanting information on (R1), I question who he was, he then informed me that he was the

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son. He then asked writer how (R1) was doing, I explained that she has been sleeping on and off during the day and exhibited facial expression of pain and was given a (Norco). He then said that explains why she looks very sleepy. (5:00 PM) more members showed up to visit, the granddaughter (V9) and the boyfriend (V10) and closes the door. All this time writer is next to (R1's) room setting up medications. At (5:30 PM) writer at the nurse's station is approached by granddaughter boyfriend stating, "she is choking." Writer enters the room and noticed the bed at 45-degree semi fowlers position, while son was pushing his mother into a sitting position pushing her forward, while granddaughter pushing her by the arm, and son's wife pulling on her arms. I immediate ask to allow me to assess her and I placed the bed on a 0-degree position and patient sitting upright. Writer notice food around her mouth and drooling from the left side. Writer proceeded to clean her mouth and remove any food particle still in her mouth. Patient responsive and breathing, no sign of universal sign of (choking) or unable to breath. I just listen to a gargling noise from her mouth. I mentioned that I believed (R1) aspirated and would like to call 911 to take her to the ER (emergency room). (5:35 PM) while writer calling 911, boyfriend approach nurses' station waving his hand across his neck, I ask what happen, he stated "she stop breathing." Writer rushed for the crash cart, but when I entered the room the son and granddaughter was holding her and the bed now completely flat. I was going to start CPR, when at (5:41PM) EMT (emergency medical technicians) arrives and (initiated) CPR. The son requests for (EMT) to stop CPR and EMT got on the phone and spoke with doctor from (local hospital), which he announced her death @ (at) (5:51 PM). The son was talking to EMT about autopsy and at (6:55

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PM) the body was released by (County Coroner). The son and wife remained in the room because granddaughter left with boyfriend @ (6:40 PM). I spoke with the son, and he wanted (a local funeral home) to come get the body which they (arrived) and released the body at (7:25 PM). Son spoke with funeral staff regarding (autopsy). Document signed by funeral home for the release of body. Patient teeth were given to funeral staff, which she was not wearing during eating."

The 1/26/25 ambulance run report from the local fire department showed the call came in at 5:32:47 PM on 1/26/25. EMS (Emergency Management Service) was dispatched at 5:33:20 PM. The report showed paramedics arrived at patient's side at 5:42 PM. The incident notes from the local fire department showed EMS was dispatched to the facility for a female who aspirated and became unresponsive. The notes showed no CPR was being provided to R1 when the paramedics arrived at R1's side.

R1's Skilled Nursing Note dated 1/23/25 showed "Requires skilled nursing services...burn victim...Eating performance is extensive assistance...Complaints of difficulty or pain when swallowing."

R1's Nutrition Comprehensive Data Collection assessment dated 1/22/25, showed she had a chewing/swallowing problem related to facial pain from her burn wounds. Interventions included monitoring for shortness of breath, choking, labored respirations, lung congestion, and to monitor, document, report to nurse/dietitian/Doctor/as needed for difficulty swallowing, holding food in mouth, prolonged swallowing time, repeated swallows per bite, coughing, throat clearing, drooling, and pocketing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014872	A. BUILDING: _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY REHAB & HCC	3298 RESOURCE PARKWAY DEKALB, IL 60115

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 12 food in mouth. The facility's 12/2024 policy and procedure titled Cardiopulmonary Resuscitation Policy showed "5. Depending on the underlying cause, the chances of surviving sudden cardiac arrest may be increased if CPR is initiated immediately upon collapse." (AA)	S9999		