

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6001127	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/22/2015
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NAME OF PROVIDER OR SUPPLIER BRENTWOOD SUB-ACUTE HEALTHCARE CEN	STREET ADDRESS, CITY, STATE, ZIP CODE 5400 WEST 87TH STREET BURBANK, IL 60459
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(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
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S9999	<p>Final Observations</p> <p>Complaint Investigation 1594984/IL80044 - No Findings</p> <p>Incident Report Investigation IRI of 9-12-15/ IL80184 -</p> <p>Statement of Licensure Violations</p> <p>300.690b) 300.690c)</p> <p>Section 300.690 Incidents and Accidents b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence. This requirement is not met as evidence by:</p> <p>Based on record review and interview the facility failed to notify IDPH (Illinois Department of Public</p>	S9999	<p style="text-align: center;">Attachment A Statement of Licensure Violations</p>	
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Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

10/12/15

Illinois Department of Public Health

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S9999	<p>Continued From page 1</p> <p>Health) of accident/incident which resulted in the death for one of three residents (R7) reviewed for respiratory care and service in the sample of eight.</p> <p>Findings include:</p> <p>R7's Incident/Accident Report (9/12/15) includes but not limited to: Incident/Injury: swelling head/neck, unresponsive. Findings: While rendering tracheostomy care patient began swelling in face and neck became unresponsive. CPR (Cardiopulmonary Resuscitation) initiated. 911 called. Patient transferred to hospital. Patient expired due to complications related to tracheotomy care. Investigation ongoing at this time. IDPH (Illinois Department of Public Health) was notified of the incident via facsimile on 9/15/15 at 8:06pm.</p> <p>On 9/21/15 at 4:45pm, E1 (Administrator) stated that the administration was unaware of R7's (9/12/15) incident which occurred on the weekend. On Monday (9/14/15) it was brought to their attention and an investigation was initiated. IDPH was subsequently notified via phone on 9/14/15.</p> <p>On 9/22/15 at 11:00am, E9 (Respiratory Therapist) affirmed that she did not notify her immediate supervisor and/or administration regarding the 9/12/15 incident which resulted in R7's death. E9 stated, "I was called to the room. He was not my actual person to care for on my shift. Now we know we all have to report." On 9/22/15 at 11:32pm, E8 (Respiratory Therapist) stated, "The Nurse called the Doctor. I left my boss a message after the patient (R7) left the facility. When we send a patient out we have to leave (E7/Respiratory Therapist Manager) a message." E8 affirmed that the message left for</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>E7 was on an in-house answering machine, not a cell phone.</p> <p>On 9/22/15 at 12:54pm, E2 (Director of Nursing) stated that reportable incidents/accidents with serious injuries are reported (to IDPH) immediately or within 24 hours of notification. The follow-up is reported within 5-7 days. E2 advised that the 9/12/15 incident was not brought to her attention until Monday morning (9/14/15). The facility's incident/accident policy and procedure (June 2013) includes but not limited to; All incidents that are considered to be, or that have the potential to be, significant and/or serious are reported timely to the facility administrator and to risk management and in accordance with any Federal and State law. Definitions: Incidents, Accidents and Unusual Occurrences; Any event not consistent with routine resident care. Any event reportable to Federal and State agencies in accordance with State and/or Federal law; and Any event involving a resident with negative or harmful results or outcomes. Significant/Serious Incidents include; Unusual or unexplained death. Response to All Incidents, Accidents, or Unusual Occurrences: When an incident, accident, or unusual occurrence, hereafter "Incident" is discovered, the employee making the discovery notifies his or her immediate supervisor or the Administrator. The Administrator or Director of Nursing notifies the appropriate agency as required by State and/or Federal law and/or regulations.</p> <p>(B)</p>	S9999		
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