

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL0001127	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/28/2023
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NAME OF PROVIDER OR SUPPLIER BURBANK REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6400 WEST 87TH STREET BURBANK, IL 60450
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S 000	Initial Comments Complaint Investigations: 2398077/IL164873 2397704/IL164429 2397458/IL164140	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210a) 300.1210b) 300.1210c) 300.1210d)6) Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	<p>Continued From page 1</p> <p>plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.</p> <p>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.</p> <p>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:</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review the facility failed to implement interventions to monitor a resident with cognitive deficits and impulsive behaviors and failed to utilize assist of two people for bed mobility and repositioning. This affected 3 of 6 (R9, R10, and R16) residents reviewed for safety and fall prevention. This failure resulted in R16 falling, sustaining a laceration requiring 6 staples and having an acute fracture of left proximal humeral with displacement. R10 slid out of bed and developed an open and raised area on her forehead.</p> <p>The findings include:</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>1.R16 is 89 years old with diagnosis including but not limited to Dementia with Behavioral Disturbances, Major Depressive Disorder, Osteoarthritis, Insomnia, History of Left Arm Humerus Fracture, Palliative Care, Cognitive Communication Deficit, Difficulty in Walking, Need for Assistance with Personal Care, History of Falling, and Weakness.</p> <p>On 11/14/23 at 11:45AM V18 (Licensed Practical Nurse/LPN), said I saw R16 sitting in the edge of the bed folding her clothes. V18 said about 8:00PM I gave R16 her medications and then the Certified Nursing Assistant (CNA) assisted R16 into the bed. V18 said when R16 was in bed, the bed was in the lowest position. V18 said I was at the nurses' station and the CNA was in the hallway. V18 said R16 is a fall risk. V18 said R16 normally gets up unassisted and does stuff. V18 said R16 "will constantly get up." V18 said from the nurses' station I heard a noise, and I went to see, then I saw R16 on the floor. V18 said R16's head was on shoes and there was blood on the floor. V18 said R16 was "right by the bed." V18 said the bed was not in the lowest position when I went into the room. V18 said R16 can use the bed remote. V18 said R16 needs "constant watching." V18 said I don't remember the CNA's name who was working with me. V18 said R16 had a laceration on the scalp, and she was screaming about her left arm. V18 said we do not use symbols on the unit to know who a fall risk is.</p> <p>On 11/14/23 at 12:20PM V21 (CNA) said on first rounds with R16 she was sitting up folding her clothes and I put her to bed. V21 said when I did rounds R16 got back up and I put her back to bed. V21 said I was in another room, then I heard a crash and when I found R16 she was</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>backwards. V21 said when I went in the room R16 was on her back and she had hit her head. V21 said the room she is in now, is not the same room she was in when she fell, she was further down the hallway. V21 said R16 will get up and walk around the room. V21 said R16 did not have floor mats when she fell. V21 said I think R16 just got up and tripped on her shoes.</p> <p>On 11/15/23 at 12:06PM V26 (Medical Doctor) said R16 has behavioral falls. V26 said R16 had an arm fracture a couple years ago. V26 said R16 gets agitated, has delusional thoughts. V26 said R16 is a high fall risk. V26 said floor mats should be in place and the bed remote should not be in her reach. V26 said if the staff don't know the patient, they may have given her the remote.</p> <p>On 11/14/23 at 11:07AM V12 (Assistant Director of Nursing/ADON) said we expect staff to follow the care plan. V12 said the purpose of the fall interventions are to prevent a fall from occurring. V12 said she was the fall coordinator when R16 fell. At 1:49PM V12 said R16 fell out of bed in her room. V12 said R16 fell between 1:00AM and 2:00AM. V12 said R16 had a laceration to her head and her left shoulder was swollen. V12 said R16 received 6 sutures. V12 said the root cause of R16's fall she was disoriented and demented, and she got out of bed unassisted. V12 said at time of the fall R16 had a fall mat and a low bed. V12 said R16's bed goes down to the floor and her bed was in the lowest position on the floor. V12 said R16 was a fall risk and needs supervision. V12 said R16 can't remember she needs assistance and can be impulsive. V12 said frequently means to make rounds as often as needed, there is nothing special about frequently. V12 said the staff should put the resident bed in the lowest position and V16</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>should not be given the bed remote. V12 said R16 could lift the bed and then it would not be in the lowest position, placing R16 at risk for falls. V12 said when investigating the falls handwritten staff statements are gathered. V12 said she in-serviced the staff on the falling leaves program to identify residents at risk for falls. At 2:44PM V12 presented an undated Inservice Education Report. V18's signature is not included.</p> <p>On 11/14/23 at 2:23PM V24 (CNA) said fall interventions for residents at risk for falls includes putting the bed in the lowest position and placing the bed remote on the side rail, with the buttons facing outward because we don't want the person to move the bed up and down.</p> <p>On 11/15/23 at 2:35PM V32 (Director of Nursing/DON), said if the intervention is to keep the bed in the lowest position, then do not give the resident the bed remote.</p> <p>R16's Fall Risk Observation dated 8/15/23 documents balance problems while standing or walking and a score of 22 level High Risk.</p> <p>R16's care plan dated 11/15/20 documents she is at risk for falls. Interventions include dated 8/26/23 place floor mat on the floor next to bed. Dated 8/25/23 and 8/26/23 Observe frequently and place in supervised area when out of bed. 1/26/22 keep bed in lowest position.</p> <p>Fall Event completed by V18 dated 10/13/23 at 10:40PM documents R16 on the floor in her room. Fall unwitnessed. R16's usual ambulatory status is assist of two with or without a device. Can ambulate has unsteady gait needs supervision. (Floor mat not documented.)</p>	S9999		

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S9999	<p>Continued From page 5</p> <p>Progress Notes dated 10/14/23 at 11:40AM documents R16 observed on the floor in her room next to her bed. On her back with a pair of shoes supporting her head. Laceration to scalp and unable to move left arm and left shoulder swollen and tender. (Floor mat not documented.)</p> <p>Progress Notes dated 10/14/23 at 9:15AM documents R16 has left humeral fracture.</p> <p>Progress Notes dated 10/14/23 at 12:38PM documents R16 returned from emergency room with 6 staples to top of head. Area raised and bruised.</p> <p>R16's hospital records dated 10/14/23 Laceration Repair, scalp, 2cm length x 5cm depth. 6 staples. X-ray left shoulder dated 10/14/23 Impression: Acute fracture of left proximal humeral diametaphysis with mild displacement.</p> <p>2.R10 is 84 years old with diagnosis including but not limited to Respiratory Failure, Cognitive Communication Deficit, Need for Assistance with Personal Care, History of Falling, Dependence on Renal Dialysis, Tracheostomy, Gastrostomy, Dementia with Behavioral Disturbances.</p> <p>On 11/14/23 at 10:07 PM V13 (CNA) said I was working by myself with R10. V13 said I was turning R10 in the bed and she slid onto the floor. V13 said I was changing R10's brief and when I turned her to the right side away from me, she slid. V13 said R10 slid while I was turning her. V13 said R10 was on an air mattress and the air mattresses are slippery. V13 said it is always supposed to be two CNAs on R10's unit. V13 said there was no one to help me that night. At 1:07PM the surveyor asked V13 if the air mattress moved when R10 slid out of bed, and</p>	S9999		
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S9999	<p>Continued From page 6</p> <p>V13 said "yes, it's supposed to be clamped, it was not."</p> <p>On 11/14/23 at 2:24PM V23 (CNA) said if a resident needs 2-person assistance I ask someone to help me. V23 said if the person is 2 persons assist, you must go get someone to help to prevent someone from getting hurt. V23 said you can get the nurse, but you cannot do that person's care by yourself, you must get someone else. V23 said if I needed help, I would wait for the help and report to the supervisor that I am waiting for assistance.</p> <p>R10's Fall Risk Observation dated 9/7/23 indicates a score of 20, High Risk.</p> <p>R10's Functional Abilities Assessment dated 9/7/23 is dependent on staff for rolling in bed.</p> <p>R10's care plan dated 7/8/23 identifies R10 at risk for falls related to mobility and cognitive impairment. R10 unable to independently change position while in bed and requires total assistance of two.</p> <p>R10's Progress Notes states nurse notified by CNA that R10 slid over bed while CNA was providing cares. Small open area to left side of forehead with bump.</p> <p>R10's Fall Event report dated 9/27/23 at 5:30AM reports witnessed fall in resident room. During care R10 rolled onto left side and rolled unto floor mat. R10 usually unable to ambulate.</p> <p>3.R9 is 73-year-old with diagnosis including, but not limited to Anoxic Brain Damage, End Stage Renal Disease, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, Chronic</p>	S9999		

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S9999	<p>Continued From page 7</p> <p>Respiratory Failure with Hypoxia, Weakness, Need for Assistance with Personal Care, Dependence on Respiratory Ventilator Status, Dependence on Renal Dialysis, and Gastrostomy Status.</p> <p>On 11/9/23 at 1:17PM V14 (Licensed Practical Nurse) said I was in R9's room flushing her feeding tube between 10:30 and 11:00AM. V14 said R9 was in the bed and connected to the ventilator. V14 said she had not seen R9 move her arms and legs. V14 said R9 was on an air mattress, and it was inflated "regular." V14 said I then left R9's room. V14 said the treatment nurse then entered R9's room after V14 left. V14 said while in the other room with the CNA, she heard "commotion". V14 said when I came out of the room, I saw R9 on the floor. V14 said she was assigned to R9 and there was one agency CNA, who's name V14 does not know. V14 said when she got to R9's room she saw the Respiratory Therapist, an agency nurse, and 2 other staff she did not know by name. V14 said R9 had a hematoma on the side of her head. V14 said R9 had not been restless or fidgety before the fall.</p> <p>On 11/9/23 at 1:46PM V15 (Nurse Supervisor) said she was called to the unit regarding R9's fall. V15 said I was not there when R9 fell. V15 said I spoke to R9's son and he said his mother does not move. V15 said R9 does not normally move.</p> <p>On 11/9/23 at 2:03PM V7 (Respiratory Therapist) said I heard a ventilator disconnect alarm going off. V7 said when I saw R9 she was in the right side of her bed on the floor, laying on her right side. The surveyor asked how R9 could have fallen, V7 said "a cough and a slide" and that R9 could reach for things. V7 said no one saw the fall. V7 said the ventilator alarm had sounded</p>	S9999		

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S9999	<p>Continued From page 8</p> <p>because the ventilator tubing had come off. V7 said I don't remember how the mattress was when R9 was on the floor.</p> <p>On 11/9/23 at 2:12PM V5 (Infection Preventionist) said I heard an overhead page and when I got to the room I saw R9 on the floor on the right side of the bed, closest to the window. V5 said V14 was the assigned nurse working with R9 and an agency CNA was assigned. V5 said no one was in the room when R9 fell. V5 said R9 was on an air mattress and "they seem slippery to me." V5 said R9's baseline is that she can't move. The surveyor asked V5 how R9 could have fallen, V5 said R9 "coughed and with the air lifting she plopped over." V5 said R9 had a lump on her head. V5 said it was real shocking to me that R9 had fallen. V5 said we had a few falls with people on air mattress. V5 mentioned the air mattress again and said, "I think they can be slippery."</p> <p>On 11/9/23 at 2:27PM V19 (LPN) said I covered for wound care team on 9/2/23. V19 said about 45 minutes to an hour before R9 fell I had applied cream to her buttocks. V19 said the agency CNA had assisted her in turning R9 to apply the cream to her buttocks. V19 said after completing the treatment R9 was left on her back in the bed. V19 said I can't remember how the pillows were used to position R9. V19 said R9 was on a low air loss mattress. The surveyor asked V19 about the settings on R9's air mattress pump. V19 said "I glanced at them" but could not report what the settings were. The surveyor asked R9 what safety interventions were in place when she left R9's room and V19 said she may have had floor mats, but I can't remember. V19 said the CNA stayed in the room when I left.</p> <p>On 11/9/23 at 11:49AM V20 (CNA) was contacted</p>	S9999		

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S9999	<p>Continued From page 9</p> <p>for interview. The facility provided V20's name and phone number as the assigned agency CNA for R9 on 9/2/23. V20 said no one fell when I was working at the facility. V20 said I did not assist in getting anyone off the floor. V20 said I don't know who R9 is.</p> <p>On 11/14/23 at 11:07AM V12 (ADON) said according to staff after R9's son left her room she became upset. V12 said R9's son left around 11:00AM. V12 said the CNA was walking past R9's room and saw R9 on the floor. V12 said it was an agency CNA, I am not sure of her name. V12 said R9 had a raised area to the right eye. V12 said she investigated R9's fall. V12 said I spoke to V16 (Wound Nurse) about the fall. V12 said I don't have the root cause of R9's fall documented.</p> <p>11/16/23 at 12:51PM V16 said I was not working the day R9 fell. V16 said I did not respond to R9's fall or see R9 on the floor.</p> <p>On 11/15/23 at 2:35PM V32 (DON) said regarding R9 the nurse wrote R9 tried to get up and that something happened. V32 said we have had "reports that people have been falling out of the bed because the air mattress are going up and doing it." V32 said with R9 we questioned if the air mattress was the cause of her fall.</p> <p>The facility provided a typed, witness statement denotes V18's statement regarding R9's fall. Statement denotes V18 was notified that R9 fell out of bed. The statement is unsigned. There were no other witness statements provided for R9's fall. (On 11/16/23 a new, typed, unsigned, witness statement was provided on 11/16/23 with V14's name.)</p>	S9999		

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S9999	<p>Continued From page 10</p> <p>On 11/15/23 at 3:40PM V18 (LPN) said I did not see R9 on the floor. V18 said I was not the nurse for R9 on 9/2/23. V18 said if I was the nurse assigned, I would have documented in the record. (No documentation was found written by V18.)</p> <p>Review of R9's orders dated 9/1/23 includes pressure reducing mattress.</p> <p>R9's Functional Abilities Assessment dated 8/31/23 documents R9 is dependent on staff for dressing and rolling in bed. R9 is unable to sit up or walk.</p> <p>R9's care plan dated 9/1/23 stated R9 requires 2 staff assistance for turning and repositioning. R9 is prescribed anticoagulant therapy. R9's care includes floor mats, but intervention is dated 9/2/23.</p> <p>R9's Fall Risk Observation and fall event both dated 9/2/23 documents she had an unwitnessed fall.</p> <p>R9 Communication Form notes she was transferred to the hospital on 9/2/23 with a "raised bump" to the right side of her head.</p> <p>The Facility Incident Report dated 9/2/23 indicated R9 observed on the floor next to the bed. Noted with swelling to right side of the bed.</p> <p>R9's hospital records dated 9/2/23 R9 was found face down on the ground. R9 had a large hematoma to the right side of her head. R9's hospital diagnosis include Fall and Blunt Head Trauma.</p> <p>"A"</p>	S9999		

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