STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001127	A. BUILDING: _____ B. WING _____	C 03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURBANK REHABILITATION CENTER	5400 WEST 87TH STREET BURBANK, IL 60459

(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
S 000	Initial Comments Complaint Investigations: 2592234/IL188093 2592082/IL187903	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b)4)5) 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 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	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001127	A. BUILDING: _____ B. WING _____	C 03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURBANK REHABILITATION CENTER	5400 WEST 87TH STREET BURBANK, IL 60459

(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 1	S9999		

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 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.

4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene.

5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001127	A. BUILDING: _____ B. WING _____	C 03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURBANK REHABILITATION CENTER	5400 WEST 87TH STREET BURBANK, IL 60459

(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 2	S9999		

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.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, and record review, the facility failed to develop and implement effective safety interventions, including frequent monitoring, for two dependent, immobile, ventilator-dependent residents at high risk for falls to prevent them from falling out of bed. This failure affected two of three residents (R1 and R3) reviewed for accidents and safety. As a result, R1 fell from the bed and sustained a C2 fracture.

Findings include:

1.) R1's diagnosis include but are not limited to Anoxic Brain Damage, Respiratory Failure, Tracheostomy, Gastrostomy, Dependence on Respiratory [Ventilator] Status. A new diagnosis of Displaced Fracture of Second Cervical Vertebra dated 3/12/25.

R1's cognitive assessment date 2/1/25 identifies she is severely impaired. R1's functional ability

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001127	A. BUILDING: _____ B. WING _____	C 03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURBANK REHABILITATION CENTER	5400 WEST 87TH STREET BURBANK, IL 60459

(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 3	S9999		

assessment dated 2/1/25 indicates R1 has impaired in range of motion to upper and lower extremities. Additionally, R1 is identified to be dependent on staff for all Activities of Daily Living. Section O identifies R1 has a tracheostomy and a ventilator, requires suctioning and continuous oxygen.

On 1/31/25 fall risk observation completed identifies is at high risk for falls.

R1 progress note dated 3/8/25 at 1:10PM written by V13 (Respiratory Therapist) states during rounds I heard a vent alarm and went to R1's room. Saw R1 on the floor, notified staff.

R1's progress notes written by V7 (Registered Nurse/RN) state on 3/8/25 at 1:08 PM, upon entering the room writer observed resident on the floor laying on her left side. Writer noted resident spitting up intermittent small amounts of tan colored liquid.

MDS assessment dated 2/1/25 section C identifies R1 is unable to answer questions and staff identifies R1 as severely impaired. Section GG identifies R1 is dependent on staff for all cares.

R1's care plan identifies she is a nonverbal trach patient. Interventions include dates 3/10/25 and 3/12/25. Interventions dated 10/30/24 anticipate and meet the resident's needs. Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs. There are no other interventions until 3/10/25.

R1's fall investigation states in part, was likely caused by a combination of forceful coughing and involuntary movements. Despite being immobile

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001127	A. BUILDING: _____ B. WING _____	C 03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURBANK REHABILITATION CENTER	5400 WEST 87TH STREET BURBANK, IL 60459

(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 4	S9999		

and ventilator-debilitated, unexpected muscle activity led to a loss of stability.

R1's hospital records dated 3/8/25 documents displaced fracture left lateral mass C2.

R1 was transferred to the hospital on 3/8/25 for evaluation following a fall and readmitted to the facility on 3/11/25. The facility reported to the state surveying agency on 3/8/25 that R1 sustained an acute displaced fracture of the left C2.

On 3/25/25 at 10:33AM an unidentified staff member exited R1's room, bed no longer lowest position, door mostly closed. Position of the door impairs view of resident from nurses' station, the blind on the window was closed, blocking view of R1 from nurses' station.

On 3/25/25 at 11:44AM R1's door remains mostly closed to impair view of R1 from nurses' station.

On 3/25/25 at 12:07PM V1 (Licensed Practical Nurse/LPN) and V2 (Certified Nursing Assistant/CNA) were providing care to R1. V2 said R1 cannot help at all with her care. V1 said R1's hands, arms, and legs are totally contracted. V1 said she has been like this the whole time she has been here. V1 said R1 is total care dependent on staff. Surveyor observed R1 is on an air mattress during care.

On 3/25/25 at 1:26PM V12 (Restorative Nurse) said R1 can't do anything on her own, she is passive for what staff assist her with. V12 said R1 cannot turn and reposition without assistance. V12 said R1 is dependent on staff with everything. V12 said if the resident is at the edge of the bed and coughs, she can fall.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001127	A. BUILDING: _____ B. WING _____	C 03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURBANK REHABILITATION CENTER	5400 WEST 87TH STREET BURBANK, IL 60459

(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 5	S9999		

On 3/26/25 at 10:30AM V2 (CNA) said R1 was her normal that day. V17 (CNA) and I had just changed her around 12:45PM. V2 said we had left her in the center of the bed. V2 said R1 was in a smaller bed (regular hospital bed) before. V2 said when R1 fell she fell on the left side of the bed, closer to the door. V2 said I have never seen or known R1 fall before. V2 said prior to the day, I have found R1 along the side of her bed, like she moved. V2 said all the residents on this unit will cough and need to be repositioned because they move on the bed.

On 3/26/25 at 11:14AM V18 (Case Manager) said when I came to the facility, I asked the nurse how R1 fell. V18 said I see R1 often she does not move, and she doesn't have cognition function. V18 said they really didn't give me an answer.

On 3/26/25 at 11:32AM V7 (RN), said I was told that R1 was noted on the floor, on her left side. V7 said I was notified by a Respiratory Therapist. She was the first in the room. V7 said when I assessed R1 I saw a raised area on the left side of her head. V7 said I was sitting at the nurses' station when they told me. V7 said I didn't hear anything at the nurses' station, to alert me that R1 needed help. V7 said R1 is on a ventilator, she was on an air mattress, and had no side rail in use. V7 said for the patients on the unit, their body moves when they cough, I think that is what happened to R1. V7 said when they cough the air mattress makes them move while in bed. V7 said R1 had an air mattress. V7 said I have seen her cough and be moved on the mattress. V7 said R1 was sitting in a regular hospital bed at the time. V7 said the bed was in the lowest position, but not all the way to the floor, and there were no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001127	A. BUILDING: _____ B. WING _____	C 03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURBANK REHABILITATION CENTER	5400 WEST 87TH STREET BURBANK, IL 60459

(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 6	S9999		

floor mats at the time. V7 said R1 was not able to communicate what happened. V7 said R1 sustained a bump on her head from the floor. V7 said prior, to the fall, nothing was reported, nothing about coughing or increased fidgeting. V7 said I think everyone is a fall risk on that unit. V7 said I think they all should have floor mats and low beds because there are no rails to prevent them from sliding off the beds. V7 said positioning for a patient on a vent includes the head of the bed elevated, and when they cough the body moves. V7 said their position and condition increases the risk for falls.

On 3/27/25 at 11:12AM V14 (Nurse Practitioner) said I saw R1 upon return from the hospital, she was nonverbal and at baseline, I had no changes for her. V14 said I was told she fell from maybe a forceful cough because she doesn't move. V14 said R1 had a coughing spell and she slid off the bed.

On 3/27/25 at 11:33AM V15 (Respiratory Therapist) said R1 is on a ventilator (vent) and cannot support her own breathing. V15 said R1 has alarms on the vent triggered by high pressure. V15 said high pressure alarms can mean they need suction, coughing, or a disconnect. V15 said respiratory distress will cause an alarm. V15 said a hard forceful cough will probably trigger the alarm to go off for high pressure. V15 said I have been an RT for 30 years. V15 said I have never heard of a vent patient falling out of bed because of a hard cough. V15 said coughing can cause the patient to move.

On 3/27/25 at 11:49AM V13 (Respiratory Therapist) said I was coming from another room, and I heard the alarm going off. V13 said I saw

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001127	A. BUILDING: _____ B. WING _____	C 03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURBANK REHABILITATION CENTER	5400 WEST 87TH STREET BURBANK, IL 60459

(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 7	S9999		

R1, she was on the floor, and I called the nurse. V13 said R1 remained connected to the ventilator while on the floor. V13 said I had seen R1 earlier that day and R1 was at baseline, there were no changes in her. V13 said R1 usually does not have a lot of secretions. V13 said R1 does cough an average amount. V13 said I have seen R1 cough. V13 said sometimes R1 has a strong cough. V13 said the alarms are loud alarms and can be heard on the unit. There was high pressure, and the alarm goes off, secretions and patient movement will cause the alarm to sound. V13 said there is no way to know how long the alarm was going off. V13 said it was not time to treat R1, I was coming out of the other room and heard the alarm from R1's room. V13 said sometimes R1 coughs strongly. V13 said I have not known a patient to cough so hard to fall out of bed. V13 said if someone on a ventilator is coughing the alarms will go off because it causes a high-pressure alarm. V13 said the nurse was at the desk. V13 said you can hear alarm in the hallway.

2.) R3's diagnosis includes, but are not limited to Respiratory Distress, Acute Respiratory Failure, Anoxic Brain Damage, Hypertension, Tracheostomy and Gastrostomy, and Dysphagia.

Incident report dated 3/20/25 R3 was found on the side position on the floor.

Incident report dated 3/25/25 notes Incident discussed. R3 experienced a coughing episode that caused a sudden movement and loss of balance. Coughing can trigger involuntary movements, especially in residents who are already physically compromised. Interventions: bed bolsters will be added onto bed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001127	A. BUILDING: _____ B. WING _____	C 03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURBANK REHABILITATION CENTER	5400 WEST 87TH STREET BURBANK, IL 60459

(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 8	S9999		

R3's MDS dated 1/2/25 cognitive assessment identifies R3 is severely impaired. R3 is dependent on staff for all cares. R3 treatments include suctioning and tracheostomy care.

R3's care plan interventions were initiated on 11/7/24 include on 11/7/24 anticipate and meet the resident's needs. Educate about safety reminders and what to do if a fall occurs. No other interventions for fall prevention were added until 3/21/25.

On 3/26/25 at 10:12AM R4 (R3's roommate) said when R3 fell I was in my bed watching TV. It was in the later evening. I heard a sound and turned to look and R3 was on the floor. R4 said R3 does cough, but I don't recall her coughing before I heard the sound and saw her on the floor. R4 alert and oriented to person, place, and situation. R3 was observed to have visible vibration, as to be coughing, upper body bending upwards from resting position in bed with head of bed elevated. R3 did this three times but remained in the same location of the bed.

On 3/26/25 at 11:58AM V9 (CNA) said I had seen R3 around 8:45PM-9:00PM and was in the middle of the bed and positioned correctly, head up, and I left her on her back. V9 said R3 was not coughing more than usual, but her usual amount. V9 said during rounds I heard R4 (R3's roommate) calling for help. V9 said I saw R3 on the floor on the window side of the bed. V9 said we placed bolsters on her bed after the fall. V9 said when R3 was on the floor, the bolsters were not in the bed. V9 said R3 had a regular hospital bed that goes up and down. V9 said R3's bed was not the one that goes to the floor, but she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001127	A. BUILDING: _____ B. WING _____	C 03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURBANK REHABILITATION CENTER	5400 WEST 87TH STREET BURBANK, IL 60459

(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 9	S9999		

was in the lowest position. V9 said R4 said she heard a noise; she did not describe the noise to me. V9 said R3 had the bolsters (which she described as pads and was not sure of the device name) were still on the bed and they cover the entire length of the mattress on each side. V9 said they look like small wedges and are a separate piece from the mattress. V9 said I have seen when R3 coughs she leans forward. V9 said I was the CNA providing care to R3 on the day she fell. V9 said I was the last to position her before the fall, except it is possible RT (respiratory therapy) provided respiratory care. The surveyor asked how R3 fell despite the use of the bolsters. V9 did not give an answer.

On 3/26/25 at 12:39PM V11 (RN) said on 3/20/25 R3 was in the bed, she had been coughing and we called RT earlier. V11 said RT did come right away, and they did not report any concern with R3. V11 said when I spoke to R4 (R3's roommate) she said R3 was "jerking and coughing." V11 said I believe that is how R3 fell. V11 said when R3 "jerks" she lifts up her head and she moves up. V11 said "jerks up" is what caused R3 to move and fall. V11 said I have not a patient cough hard enough to fall out of bed before. V11 said when on a trach with secretions they cough a lot. V11 said R3 did not have the pads before the fall, the ones like a triangle. V11 said we added the pads (bolster pads) after the fall occurred. V11 said R3 had an air mattress on the bed, and she had a regular size bed. V11 said R3's bed went all the way to the floor. V11 said R3 fell towards the window side of the room (right side) and was on her side when I saw her. V11 said R3 was unable to indicate what had happened. V11 said R3 is nonverbal, she had not fallen before to my knowledge.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001127	A. BUILDING: _____ B. WING _____	C 03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURBANK REHABILITATION CENTER	5400 WEST 87TH STREET BURBANK, IL 60459

(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 10	S9999		

On 3/26/25 at 2:07PM V6 (Director of Nursing/DON) said R3 had a fall on 3/20/25. V6 said the root cause of R3's fall was a cough. V6 said I spoke to the roommate, myself. V6 said the roommate, R4, said she heard R3 cough, and she heard a noise. V6 said for immobile residents, we have to round on them and keep them positioned in the bed. V6 said no one notified me R3 coughs so hard to move. V6 said we explained to R3's mother that R3 has involuntary movements. V6 said R3 did not have bolsters before the fall, R3 was not care planned for bolsters. V6 said V11 was instructed to add the bolsters and V11 replied I was going to go get them for R3. V6 said both R1 and R3 had air mattress the day they fell. The surveyor asked V6, can an air mattress pose a fall risk on patient who can't move? V6 replied, the air mattress is possible to cause a fall risk, if it is not positioned right, depending on the settings, they are smooth. V6 (DON) said we feel the root cause for both R1 and R2 made her position out of normal, and she can't control her body and caused her to fall. V6 said the staff said R1 had brown stuff coming out of her mouth. V6 said no one had ever said that R1 moves when she cough or has hard coughs. V6 said I have never seen her cough like that, hard to move her. V6 said R1 can't move, she is dependent on staff. V6 said R1 coughed herself out of alignment. V6 said V13 (RT) said they had checked on R1, and she had been fine. V6 said the vent alarmed and V13 responded and saw R1 on the floor. V6 said R1 sustained a C2 fracture, and the hospital doctor said there was nothing needed to treat. V6 said R1 does have a fracture. V6 said based on R1's fall risk assessment she was a high fall risk.

On 3/27/25 at 11:12AM V14 (Nurse Practitioner)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001127	A. BUILDING: _____ B. WING _____	C 03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURBANK REHABILITATION CENTER	5400 WEST 87TH STREET BURBANK, IL 60459

(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 11	S9999		

said I saw R3 after the fall. V14 said I did not notice a change, R3 was still at baseline. V14 said I was told R3 had the same cause of the fall as R1. V14 said R3 has a trach, and she could have coughed. V14 said I was not told that either R1 or R3 were coughing hard. V14 said I have been in nursing (Nurse and NP) almost 20 years, I have not seen a patient cough hard to fall out of bed. V14 said these are the first two patients, I have been notified that the coughing contributed to a fall. V14 said I think a vent alarm will trigger when altered breathing, coughing, need suction is needed. V14 said you would think the alarm would sound. V14 said if the alarm is sounding, I would expect they notify respiratory, call me if can't rectify the situation, to finish coughing. I would expect they stay in the room until the patient is stable. V14 I would think, if they stayed with the patient they would keep them safely in the bed. V14 said cough sounds can be different with a trach patient, there can be jerking movement. V14 said if they are on air mattress, they can be slippery.

On 3/27/25 at 11:33AM V15 (Respiratory Therapist) said R3 has a tracheostomy on room air with only aerosol, just moisture. V15 said R3 can support her own respirations. V15 said when a person has a tracheostomy and a vent, you will not here them cough because the air does not pass the vocal cords.

The facility Fall Guideline dated 8/2024 states the purpose is to consistently identify and evaluate residents at risk for falls and those who have fallen to treat or refer for treatment appropriately and develop an organization wide ownership for fall preventions to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001127	A. BUILDING: _____ B. WING _____	C 03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURBANK REHABILITATION CENTER	5400 WEST 87TH STREET BURBANK, IL 60459

(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 To achieve each resident's maximum potential of physical functioning period to prevent or reduce injuries related to falls. The intent of this guideline is to ensure facility provides an environment that is free from hazards over which the facility has control and provides appropriate supervision to each resident as identified through the following process: identification of hazards and risks, evaluation, implementation, monitoring, and analysis. "A"	S9999		