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 09/03/2019

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 Investigation 1996318/IL115228	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)2) 300.1210d)3) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1	S9999		

care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

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:

2) All treatments and procedures shall be administered as ordered by the physician.

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

These requirements were not met as evidenced by:

Based on record review and interview the facility failed to follow physician orders for medication administration and failed to notify the physician that medications were not administered as ordered for one of five residents (R5) in the sample. These failures resulted in R5 sustaining a pain level of "10" and hospital transfer.

Findings include:

The (4/14) change in condition physician notification guidelines state: the nurse should not hesitate to contact the attending physician at any time for a problem which in his or her judgment requires immediate medical intervention. Any calls to or from physician will be documented in the nurse's notes indicating information conveyed

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S9999	Continued From page 2	S9999		

and received.

R5's POS (Physician Order Sheet) includes: pain monitoring every shift. Acetaminophen 500mg (milligrams) 2 tablets every 8 hours as needed for pain (start date: 8/25/19); Percocet 10/325mg every 6 hours as needed for pain (start date: 8/25/19); Valium 5mg every 8 hours for spasm (start date: 8/25/19); Gabapentin 300mg every 8 hours for pain (start date: 8/26/19).

R5's progress notes include: (8/25/19) 5:41pm, new admit. Post-surgical patient from (Hospital Name). Last pain medication given at 3:00pm per nurse on duty at (Hospital Name). (8/26/19) documented at 7:33am. At approximately 8:30pm, writer was called in patient room. Patient was screaming on the phone to her daughter stating she was in pain. Patient asked if she could have a strong pain pill. Writer tried to explain that her medication is not here yet and that from her just getting here it will take a while for the medication to come from pharmacy. Writer (Nurse) told patient that I would see if there is anything I can give for pain now until medication arrives. Patient was given Tylenol 1,000mg at 10pm. At approximately 3am, patient was complaining of pain and asked if her medication came. Writer explained to patient that some medication came in but not the pain medication nor the Valium. Patient began screaming stating she's calling her daughter and wants to leave the facility. Patient then asked for more Tylenol; writer told patient that she only can get it every 8 hours. Patient began to scream and holler. (8/26/19) 12:08pm, resident noted crying and agitated complained of pain and numbness. 12:45pm, Order obtained from physician to send resident to hospital per family request.

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On 8/28/19 at 3:07pm, V2 (Director of Nursing) stated, "(R5) was complaining of not being able to get her pain medication. The night nurse told me she was given Tylenol. Her Percocet, Gabapentin and Valium did not arrive until the morning." Surveyor inquired if R5's doctor was notified that she endured pain because her prescribed medications were unavailable. V2 responded, "That was not done." V2 affirmed that the facility has an emergency box of medications and stated, "If the medication is in there, they are able to get medications from there."

The (undated) facility (emergency box) inventory list includes Gabapentin 300mg.

On 8/29/19 at 11:45am, V12 (Licensed Practical Nurse) stated, "On 8/25/19 (7pm-7am shift) R5 was real aggressive and agitated. She wasn't happy with anything I did. I explained to her that the only medication I could give her was Tylenol because she was a new admission the medications were not here. I would say her pain was probably like a 7, a 6 or 7 maybe. After I gave her the Tylenol she told me she was ok. Around 4am the CNA (Certified Nursing Assistant) went in to change her and she started to curse me out." Surveyor inquired if Gabapentin, valium, and/or Percocet were available for administration. V12 stated, "They didn't come yet. When you do an admission, you put medications in. It takes the pharmacy time to bring them. While I was there the meds didn't come. All I was able to give her was the Tylenol." Surveyor inquired if Gabapentin, Valium and/or Percocet were in the emergency box. V12 responded, "I'm not even sure of that. I never had an emergency that I had to go to the emergency box. Like I said, I had given her the Tylenol." Surveyor inquired if the physician was notified on

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8/25/19 and/or 8/26/19 of R5's pain and unavailable medications. V12 responded, "No, I didn't call the doctor."

On 8/29/19 at 12:54pm V13 (Medical Director) stated, "(R5) does have chronic pain syndrome and chronic low back pain. She was status post laminectomy and spinal fusion." Surveyor inquired about the potential harm to R5 if the prescribed medications were not administered as ordered.V13 stated, "The patient was not on any life threatening medications if it was missed. Mainly pain control if she was not on the medication."

R5's (August 2019) MAR (Medication Administration Record) affirms that Acetaminophen is not documented as administered. Gabapentin was scheduled for midnight and 8am administration; neither dose is documented. On 8/25/19, R5's pain assessment is not documented. On 8/26/19, R5's pain level was documented "10" at 10:16am. Percocet and Valium were not administered until that time.

The (2/14) Medication Administration Policy states: medications must be administered in accordance with a physician's order. Documentation of medication administration is recorded on the Medication Administration Record (MAR).

(C)