

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 02/26/2023
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NAME OF PROVIDER OR SUPPLIER  BURBANK REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5400 WEST 87TH STREET BURBANK, IL 60459
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S 000	Initial Comments  Complaint Investigation  2390963/IL156067	S 000		
S9999	Final Observations  Statement of Licensure Violations  300.610a)  300.1210b)  300.1210d)1)  300.1210d)2)  300.1610a)1)  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	S9999	Attachment A Statement of Licensure Violations	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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S9999	<p>Continued From page 1</p> <p>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.</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> <ol style="list-style-type: none"> <li>1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.</li> <li>2) All treatments and procedures shall be administered as ordered by the physician.</li> </ol> <p>Section 300.1610 Medication Policies and Procedures</p> <p>a) Development of Medication Policies</p> <ol style="list-style-type: none"> <li>1) Every facility shall adopt written policies and procedures for properly and promptly obtaining, dispensing, administering, returning, and disposing of drugs and medications. These policies and procedures shall be consistent with the Act and this Part and shall be followed by the facility. These policies and procedures shall be in compliance with all applicable federal, State and local laws.</li> </ol> <p>These requirements were Not Met as evidenced by:</p> <p>Based on observation, interview, and record</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>review, the facility failed to ensure that residents with pain had their prescribed pain medication available for 2 of 9 residents (R1, R3) reviewed for pain management. This failure resulted in R3 experiencing bilateral knee pain and generalized pain at an "8," on a scale from 1-10.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. On 2/26/23 at 9:46 AM, R3 was lying in an air bed with the head of the bed elevated. V5 (Licensed Practical Nurse/LPN) entered R3's room to obtain vital signs before preparing her morning medications. V5 asked R3 if she was having any pain. R3 replied, "Oh yes, I have pain especially in my knees. But I'm sore everywhere. I would like my pain pill." R3 rated her pain at an "8" (on a 1-10 scale, with 10 being the worst pain you have ever felt). V5 checked the narcotic box for R3's pain medication (Norco 10 mg - 325 mg tablets), but it was not there. V5 stated, "She don't have none, I'll have to check and see what she's talking about. Let me check one more time. (V5 was unable to find Norco for R3). She's out of Norco. I'll have to find out what's going on with that." V5 entered R3's room and administered a cup for of medications. V5 did not have Norco. R3 looked in the cup and asked V5, "What's this?" V5 replied, "These are your morning mediations." R3 asked where her pain medication was. V5 replied, "I have to find out where your pain medicine is." R3 stated, "I ain't supposed to run out of Norco."</li> </ol> <p>At 1:20 PM, R3 was in bed, grimacing and complaining of bilateral knee pain. R3 stated, "I still haven't got any pain medication. I'm not sure what is happening with that. And I'm still having pain at an 8. I used to go get steroid injections in my knees, but I haven't been able to do that in a while. So, I need the Norco for my pain. This isn't</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>a new pain, I've been having it for a while." At 1:29 PM, V5 (LPN) said R3's Norco will be delivered in the next shipment from pharmacy. A nurse should re-order a resident's medications when they get to the last 4-5 tablets. R3 should not have run out of Norco. The pharmacy said that we did not need a new prescription and they will send another 30 tablets.</p> <p>R3's undated Face Sheet showed diagnoses to include, but not limited to heart failure, dysphagia, anxiety, dementia, morbid obesity, bilateral osteoarthritis of the knee, weakness, and need for assistance with personal care.</p> <p>R3's facility assessment dated 1/17/23 showed she had moderate cognitive impairment; and required extensive staff assistance for bed mobility, dressing, and personal hygiene.</p> <p>R3's Care Plan initiated 12/13/21 showed, "Resident at risk for pain and discomfort r/t (related to) osteoarthritis, BLE (Bilateral Lower Extremity) edema, and impaired mobility... Approach: Encourage resident to request pain medication before pain becomes unbearable... Administer medications as ordered..."</p> <p>R3's Physician Order Report dated 2/26/23 showed an order for Norco 10-325 mg tablet orally BID (twice a day) PRN.</p> <p>R3's February 2023 Medication Administration Record showed R3 had not received Norco since 2/24/23 at 6:37 PM.</p> <p>On 2/26/23 at 1:50 PM, V6 (Pharmacist) said the nurses should re-order medications when the resident has three days of medication remaining. R3 should not have run out of Norco. She could</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>experience unnecessary pain if there is a delay in her receiving her pain medication. The nurse should re-order medications through the EMR or via telephone/fax. R3 had a refill ordered today, but this was the first time the pharmacy was contacted for a Norco refill since the last supply was sent out on 2/6/23. The pharmacy dispenses 30 tablets of Norco at a time for R3, so the order lasts about 15 days.</p> <p>The facility's Ordering and Receiving Non-Controlled Medications from the Dispensing Pharmacy Policy dated 10/25/14 showed, "Medications and related products are received from the dispensing pharmacy on a timely basis. The facility maintains accurate records of medication order and receipt... Procedures: A. Ordering Medications... 3. Sending refills via an electronic reorder request through an electronic medical records program and ordered. 5. Reordering of medications is done in accordance with the order and delivery schedule developed by the pharmacy provider... Reorder medications four (4) days in advance of need... to assure an adequate supply is on hand..."</p> <p>2. R1's face sheet showed she was admitted to the facility on 7/26/18 with diagnoses to include palliative care, atrial fibrillation, protein-calorie malnutrition, hypertension, constipation, major depressive disorder, pain in left hip, and rheumatoid arthritis. R1's facility assessment dated 11/20/22 showed she has no cognitive impairment and requires extensive assistance from staff for all care.</p> <p>R1's care plan started on 5/26/22 showed, "Resident is admitted to hospice care due to overall decline in health... Resident will</p>	S9999		

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S9999	<p>Continued From page 5</p> <p>experience death with dignity and continued pain management daily through next review... Administer pain medications as ordered... Communicate with hospice team any changes in resident condition..." R1's care plan started 7/30/20 showed, "... R1 is at risk for alteration in comfort/pain related to generalized weakness and diagnosis of rheumatoid arthritis and other disease process... R1 will have relief of pain with each reported/observed pain episode... Administer medications as needed as ordered... "</p> <p>R1's current physician order sheet showed an order dated 7/13/22 for "Hydrocodone-acetaminophen..5-325 mg... three times a day, 6:00 AM, 2:00 PM, 10:00 PM".</p> <p>R1's February 2023 eMAR (Electronic Medication Administration record) showed R1's Hydrocodone-acetaminophen 5-325 mg was "Not Administered: Drug/Item Unavailable" on 2/6/23 at 10:00PM, 2/7/23 at 6:00 AM, 2/9/23 at 2:00 PM, 2/24/23 at 6:00 AM, and 2/24/23 at 2:00 PM.</p> <p>R1's 2/24/23 nursing progress note showed, "Resident in bed, HOB (head of bed) elevated, no distress noted, respiration even and non-labored. Resident complains of being tired, mild-moderate pain generalized, last Norco (Hydrocodone-acetaminophen) administered last evening. Author to contact hospice for Norco refills..."</p> <p>On 2/26/23 at 3:00 PM, V3 (Assistant Director of Nursing/ADON) said the residents should not run out of their pain medications because the facility has 2 nurse practitioners and a physician that are in the facility nearly every day of the week between the 3 of them. V3 said if the nurses notice they are running out of a medication they</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>should let the Nurse Practitioner, or the Physician know so they can complete a new prescription if that is what is needed. V3 said the facility also has a convenience supply of medications that include Hydrocodone-acetaminophen which is accessible to the nurses if they contact the physician and let them know the resident is out of medication. V3 said she would have expected the nurses to notify the physician and to substitute pain medications until the new supply of Hydrocodone arrived.</p> <p>( B )</p>	S9999		