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 _____	06/29/2023

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 Annual Licensure Survey Complaint Investigation #2394485/IL160416 Facility Reported Incident of May 30, 2023 / IL160708	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 3 300.1210b) 300.1210d)2)3) 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 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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 are not meet as evidenced by: Based on interview and record review, the facility failed to acknowledge and transcribe hospice orders that were provided for one resident (R299) at the start of hospice care. This failure affected one out of four residents reviewed for receiving hospice care in the facility and led to R299 receiving a hemodialysis treatment after the order for hemodialysis was discontinued; placing R299 at increased risk of hemodynamic instability. This failure led to R299 expiring during hemodialysis treatment. Findings include: R299 was a 92 year old female who was admitted to the facility 5/20/2020 with diagnoses that included Hypertensive heart and End Stage Renal disease. On 6/27/23 at 12:57PM, V46 Family member said, [R299] came in [to the facility] for a minor stroke and was getting therapy. We (the family) realized she was declining and unable to tolerate the dialysis. They kept trying to dialyze her and she didn't have any fluid to take away, she was so small. We discontinued dialysis and put her on hospice on a Friday. The nurse came in next day on Saturday morning while we were visiting and said she was scheduled for Dialysis. We informed her that we signed a DNR (Do Not Resuscitate) and hospice papers and that dialysis was discontinued. The nurse told us that she did not receive that in report and that she (R299) had to go anyway.	S9999		

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S9999	Continued From page 2 When they took her back, I think she was on the machine for under an hour and she died while they were giving dialysis on May 30, 2020. Dialysis Services were observed to be given on-site in the facility through a Contracted Provider. Hemodialysis note dated 5/30/2020 indicated that R299 was received for 12:00PM scheduled appointment which was ordered to last three hours. The Dialysis Note documented that R299 was received cooperative and disoriented, with diminished lung sounds and no edema (swelling) identified. "Received patient with minimal response to verbal stimuli patient hypotensive instructed tech to bolus 500 [milliliters] ns (normal saline) at start of treatment. BP (blood pressure) improved. No respiratory distress noted no S/S (signs/symptoms) of pain will continue to monitor." Blood Pressure taken prior to treatment start at 11:54AM was 91/48mmHg (millimeters of mercury). Treatment was initiated at 11:58AM- bp was 88/47mmHg and it was noted "Treatment started. BP low, RN (Registered Nurse) aware." During treatment at 12:01PM, bp was 87/48mmHg. At 12:02PM bp was 83/46mmHg and noted "bp low, 500 milliliters of saline given per RN, [patient] is resting, quiet, bp will be retaken. 12:07PM bp 160/73mmHg- Noted blood pressure improving. 12:37PM BP 97/39mmHg- Noted "Bp dropping RN aware". 1:07PM bp 80/48mmHg- Noted "Bp in the 80's patient given another 200 milliliters of normal saline bolus. 1:37PM- Noted "unable to obtain BP tried to bolus patient with [Normal Saline] unable to. Both art (arterial) and venous needles clotted. Noted patient with no RR (respirations) listen for heart tone unable to detect. No carotid pulse present. Treatment terminated. [Patient] is [Do Not	S9999		

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Resuscitate] will call NH (nursing home) RN (registered nurse).

On 06/28/23 at 11:40AM V44 Hospice Clinical Director said, "R299 was admitted to hospice services on 5/29/2020 and the hospice nurse provided orders to the facility nursing staff. There was an order to stop dialysis when R299 was admitted. Once the contract was signed by the facility, the hospice company assumed or took over care and management for R299 with a hospice physician in place, however, the facility nursing staff is expected to provide direct care and assessments. It was the facility's responsibility to transcribe orders and communicate any changes with R299 to the Hospice nurses or Hospice Physician."

On 6/28/23 at 12:00PM V2 Director of Nursing said, we provided a document that authorized start of hospice services for R299. According to this, services were initiated on 5/29/2020. The process is that the hospice nurse writes the orders, gives them to the nurse on duty and discusses the plan of care with the facility nurse. The orders should be placed immediately in the electronic record by the facility nurse because it reflects whether the resident will be receiving restrictive or comfort care measures. If there was an order to discontinue dialysis care, that order should have been implemented immediately. Furthermore, looking at the dialysis notes and seeing that R299 was unable to tolerate dialysis twice that same week, I would not have sent her again, and would expect the nurses to question the primary or the dialysis nurse to contact the nephrologist for further orders prior to starting another treatment.

On 06/29/23 at 12:51PM V39 Dialysis Supervisor

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S9999	Continued From page 4 said, I provided the facility with the dialysis notes for R299 and reviewed them. Based on these notes on 5/30/2020 I see prior to the treatment, R299 was minimally responsive and blood pressure was low. She was given a bolus of fluid to increase the blood pressure. The blood pressure increased, and treatment was initiated. During the treatment, the blood pressure went down to high 80s and was dropping. At that time and they weren't removing any fluid. R299's heart stopped, and the access lines clotted. They called the facility nurse to the dialysis room, and she was taken off of the machine and was turned over to the facility. In the event a patient is received in dialysis with a change in status, we expect the nurses to monitor and when they become unstable, reach out to the nursing home for guidance and be in communication with the nephrologist. The notes do not indicate that the dialysis nurse called the nephrologist. The notes do not indicate that R299 was on hospice. Because we are contracted with the facility, anytime there is a change in patient status, the facility would tell us if they were stopping dialysis treatments or if the patient is going on hospice. We have access to the facility's Electronic Medical Record, and they have access to ours as part of our collaboration of care. On 06/29/23 at 6:44PM V47 Nephrologist said, "I work with the company administering dialysis at the facility. The dialysis nurses are in constant contact with the nephrologist whenever they are providing treatments. If a patient is unstable, such as not being able to tolerate the treatment, or having to cut the treatment short, they should call the nephrologist to let them know. We usually recommend holding dialysis until the resident is stable because the fluid changes that occur	S9999		

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S9999	Continued From page 5 during the dialysis treatment has the potential to cause more harm than good. Unstable is not the way to go. If the patient is not tolerating, they may show signs of hypotension (low blood pressure), becoming unconscious or showing mental status change. Treatment usually causes a routine drop in blood pressure, which is why it is constantly being monitored. These vitals presented in [R299's] case indicate chronic hypotension. To give treatment would not be contraindicated, but if the patient has been physically declining and not able to tolerate treatments prior to this one on 5/30/2020, I would question the benefit. I get involved when sometimes patients are placed on hospice and request dialysis treatments to continue but it is very rare. If I was the physician at the time, I would not have allowed [R299] to continue dialysis treatments due to previous intolerance and starting hospice care." The facility presented a Hospice care agreement which was signed by R299's POA (Power of Attorney) and a hospice liaison. Physician Order Sheet dated 5/30/23 was reviewed and did not contain any orders that were initiated by hospice, and an order for dialysis services given three times weekly remained in place. Care Plan at the time of discharge did not indicate hospice services were in place. Nursing progress notes were reviewed from admission to discharge and did not indicate hospice orders were received on 5/29/2020. On 5/30/2020 at 2:00PM nurse wrote "Dialysis nurse made writer aware resident was unresponsive. Upon assessment writer observed no rise or fall in chest. Unable to obtain vital, no apical pulse noted. Resident pronounced at 1:31pm by [Hospice Nurse]. Daughter made aware, no postmortem arrangements at this time."	S9999		

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S9999	Continued From page 6 Hospice admission orders dated 5/29/2020 were reviewed and included an order to "Stop Dialysis". (A) 2 of 3 300.1210b) 300.1210d)6) 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 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: 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. These requirments are not met as evidenced by: Based on observations, interviews, and record	S9999		

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S9999	Continued From page 7 reviews the facility failed to not ensure a resident was adequately supervised; failed to not ensure a quadriplegic resident with a history of falling out of bed with two staff providing care received two person assistance when receiving incontinence care; and failed to ensure safety practices were applied for this resident when beginning to fall out of bed. These failures resulted in R28 experiencing a fall and sustaining an acute fracture of her right leg. Findings include: R28 is a 78-year-old female with a diagnoses history of Displaced Fracture of Right Leg, Subsequent Encounter for Closed Fracture, Functional Quadriplegia, Dementia, and Weakness who was admitted to the facility 08/31/2018. R28's Functional Ability Assessment dated 05/18/2023 documents she is Dependent, and helper does all of the effort, resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity for rolling left and right or the ability to roll from lying on back to left and right side and return to lying back on the bed. R28's Quarterly Minimum Data Set Assessment dated 06/21/2023 for Functional Abilities and Goals documents she is dependent on staff for rolling left and right from lying on back. R28's Current care plan documents she is at risk for falling related to impaired mobility, incontinence and antidepressant medication use with interventions including 2 Person assist with cares. Staff in serviced (initiated 06/23/2023).	S9999		

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S9999	Continued From page 8 Fall Report from 01/01/23 - 06/27/23 documents R28 had a change in plane while in her bedroom on 06/22/23 at 9:00 PM with location marked as resident bathroom. R28's progress note dated 06/06/2023 06:07 PM documents: upon doing rounds with the Certified Nursing Assistant (CNA), both writer and CNA provided care. While giving care to patient, both writer and CNA turned patient underestimating patient's weight, patient then shifted all the way to the right of the bed with legs hanging off. Writer and CNA caught patient before patient could fall and held onto patient for safety. Patient then repositioned back all the way in bed by writer and CNA. Redness noted to face and right side of body due to patient being up against side rails. Nurse Practitioner made aware with new orders for neuro checks and right-side x-ray for precaution. R28's progress note dated 06/23/2023 12:14AM documents: Patient is a 78-year-old bed bound patient with dementia and functional quadriplegia just returned from hospital after feeding tube was reinserted had 5 small emesis of dark brown emesis. As aide was cleaning patient she slid out of the bed and was helped gradually to the floor.; at 12:14 AM Resident noted on 6/22/2023 @9pm by Certified Nursing Assistant (CNA) then Nurse coughing with vomiting of dark brown watery liquid around 5 episodes; while resident was having emesis with CNA present, resident started sliding out of bed, CNA broke resident fall by gradually lowering resident to the floor and called for Nurse. R28's progress note dated 06/24/2023 01:20 PM documents: Resident remains an extensive with one person assistance with activities of daily	S9999		

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living; at 07:17 PM During rounds Certified Nursing Assistant (CNA) stated that resident had bowel movement. CNA also noted that resident had some edema to right lower leg, ankle, and foot. When writer assessed, slight discoloration and edema was noted to lower right leg, ankle, and foot. Physician was made aware of edema to foot, right lower leg, and ankle post fall 6/23/23. Orders were given to get x-ray to right lower leg, ankle, and foot.

R28's x-rays dated 06/25/23 documents she sustained an acute fracture of her right leg.

R28's hospital record dated 06/26/2023 documents she apparently fell from bed at nursing home. Unclear how this happened as she has functional quadriplegia and is not able to move. She apparently fell from bed and sustained a leg fracture.

On 06/27/23 at 01:21 PM V34 (Certified Nursing Assistant) stated R28 had just been brought back from the hospital on 06/22/23 because of her tube feeding. V34 stated when residents come back from the hospital, they have a lot of linen with them. V34 stated she was removing stickers from R28 and observed a little poop on her then initiated changing her and removing her linens. V34 stated R28 was turned towards her while she was standing next to R28's bed. V34 stated R28's diaper and linens were tucked in back of her to prevent the diaper from scratching her skin. V34 stated R28 began coughing badly and she asked her if she was ok. V34 stated she noticed R28 began vomiting. V34 stated she reached for a towel that she placed on R28's headboard to place it under R28 to catch the vomit. V34 stated as she grabbed for the towel R28 was sliding down towards her with the bottom half of her body

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sliding first. V34 stated she was standing near R28's head. V34 stated she grabbed the top of R28's body and fell with her trying to break her fall. V34 stated she fell on her knees and R28's knees and legs landed on the floor with the top of R28's body including arms, shoulder, and head landing in her arms. V34 stated normally there is one Certified Nursing Assistant (CNA) present when changing or reposition R28 on the evening shift. V34 stated sometimes two CNA' may need to assist with providing care to R28 depending on the comfort level of the staff. V34 stated we do need two people because sometimes R28 starts coughing and will begin jerking. V34 stated sometimes within 30 minutes to an hour R28 would slide down in her bed from coughing or jerking. V34 stated sometimes R28 has spasms and begins jerking.

On 06/28/23 at 12:53 PM V2 (Director of Nursing) stated fall risk evaluations are done on admission. V2 stated when providing care, the first priority is keeping the resident safe. If V34 (Certified Nursing Assistant) was unable to get a towel while keeping R28 safe then the priority should have been to keep her in a stable position and keep her safe.

(B)

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300.1210b)
300.1210d)6)

Section 300.1210 General Requirements for Nursing and Personal Care

b) The facility shall provide the necessary

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S9999	Continued From page 11 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. 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. These requirments are not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to follow their policy and procedures to prevent falls by not ensuring fall risk assessments were performed quarterly to reassess residents fall intervention needs and the facility failed to not ensure a resident was adequately supervised. These failures resulted in R58 falling out of bed and sustaining a head injury. R58 is an 89 year old female with a diagnoses history of Dementia with Behavioral Disturbance, History of Falling, and Need for Assistance with Personal Care who was admitted to the facility 05/21/2020. R58's progress note dated 04/06/2023 12:30 PM	S9999		

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documents: writer was summoned to resident's room by a loud noise from resident's room, where resident was lying supine and touching the back of her head, her wheelchair by the side of her head and her walker upside down, upon assessment, resident stated that she wants to pick up a bag with her clothes inside. Resident complained of headache on a scale of 3/10, a raise bump noted to the back of her head, resident was assisted to her wheelchair by two staff, Nurse Practitioner was made aware of resident's status, order to send resident to hospital for further evaluation post fall; at 01:08 PM resident with unwitnessed fall today, states she did hit her head and admits to headache. Resident is currently on a blood thinner; at 7:24 PM Writer spoke with hospital emergency room nurse; resident being admitted for fall observation.

R58's Current care plan documents she is at risk for injury related to dementia; at risk for falling related to dementia, unsteadiness on feet, weakness with interventions including Observe frequently and place in supervised area when out of bed (effective 04/06/23); Keep personal items and frequently used items within reach (effective 11/15/2020).

Facility Incident/Accident Report from 01/28/23 - 06/28/23 documents R58 had an unwitnessed fall while self-ambulating without staff assistance; Intervention included being sent to the hospital emergency room for evaluation, upon return to facility care plan updated to observe frequently when out of bed.

Fall Report from 01/01/23 - 06/27/23 documents R58 had an unwitnessed fall 04/06/23 at 11:45 AM.

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S9999	Continued From page 13 R58's Admission Fall Risk Assessment dated 05/21/2020 documents she was a high risk for falls with fall risks including a history of one or two falls in the past 3 months, requiring assistance to ambulate, confinement to wheelchair, disorientation x3. R58's Fall Risk Assessment dated 05/02/2021 documents she was a high risk for falls with fall risks including a history of three or more falls in the past 3 months, requiring assistance to ambulate, confinement to wheelchair, use of antidepressants and anti-hypertensives. R58's Fall Risk Assessment dated 12/15/2021 documents she was a high risk for falls with fall risks including a decrease in muscular coordination, use of three or more medications such as diuretics and hypoglycemics in the past 7 days, requiring assistance to ambulate, confinement to wheelchair, use of antidepressants and anti-hypertensives, declined in neuromuscular function, and decline in cognitive/psychiatric function. R58's Fall Risk Assessment dated 02/22/2022 documents she was a high risk for falls with fall risks including intermittent confusion, use of one or two high risk medications in the past 7 days, history of one or two falls in the past 3 months. R58's Fall Risk Assessment dated 04/06/2023 documents she was a high risk for falls with fall risks including intermittent confusion, requiring assistance to ambulate, confinement to wheelchair, use of three or more medications such as antidepressants, anti-hypertensives, anxiolytics, cardiovascular dysrhythmia, and decline in cognitive/psychiatric function.	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 _____	06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 14 On 06/28/23 at 03:14 PM V14 (Restorative/Fall Nurse) stated from what staff tells her R58 attempts to be very independent at times and could be a bit of a handful. V14 stated based on this information and personal observation, R58 requires limited to moderate assistance with some activities of daily living such as toileting and dressing. V14 stated R58 requires one person assistance with transferring from her wheelchair to another surface. V14 stated R58's room being right across from the nurses station allows sufficient supervision. V14 could not answer when asked how was R58 able to have an unwitnessed fall when in a room across from the nurses station if her room location allows adequate supervision. V14 stated fall risk assessments are performed on admission, quarterly, and as needed. V14 stated quarterly fall risk assessments are done to determine if there are any changes in a resident's condition, to see if their needs have changed, and if they've had falls within their quarterly assessment time frames. V14 stated any changes identified during fall risk assessments may have an impact on resident's fall interventions. V14 stated R58 requires a mechanical lift for transfers. (B)	S9999		