STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145211	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Burbank Rehabilitation Center	5400 West 87th Street Burbank, IL 60459

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40102 Based on interview and record review, the facility failed to notify the physician of a resident not having any urine output from the urinary catheter for an entire eight-hour shift. This affected one of three residents (R2) reviewed for physician notification in a total sample of six. This failure resulted in R2 retaining 1,450 mL (milliliters) of urine in the bladder (maximum capacity is [PHONE NUMBER] mL) and needing to be treated for a urinary tract infection and an acute kidney injury at the hospital. Findings Include: R2 is a [AGE] year-old with the following diagnosis: quadriplegia, neuromuscular dysfunction of the bladder, dysphagia, and encounter for gastrostomy. A Nursing note dated 5/18/24 documents R2 refused breakfast and lunch. R2 reported not feeling well vital signs were stable. A Nursing note dated 5/19/24 documents a physician was not notified at 12:57 PM that the urinary catheter was leaking and R2 was exhibiting confusion. A Physician note dated 5/19/24 documents the nurse reported vital signs of 85/60, heart rate of 119 after giving medication 30 minutes ago to help raise the blood pressure. Orders were given to send R2 to the hospital via 911. The nurse also reported the urinary catheter was leaking, an order was given to change the catheter. This was not completed before R2 left for the hospital. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Actual harm Residents Affected - Few	The Hospital Records dated 5/19/24 document R2 came to the hospital for persistent low blood pressure and tachycardia along with altered mental status. Upon assessment, R2's bladder was palpable at the umbilicus. A comprehensive metabolic panel was drawn and shows the BUN at 71 (normal is 6-20 mg/dL) and creatinine at 1.24 (normal is 0.51-0.95 mg/dL). Both levels are high indicating a kidney injury. A complete blood count was also drawn, and the white blood cells were 20.7 (normal is 4.2-11.0 K/mcL). This is elevated indicating an infection in the body. The urinary catheter was completely dry and had not likely been draining for some time. The catheter was removed and replaced, and urine began pouring from the patient once the catheter was removed. The catheter output in the emergency department is documented as 1450 mL. The urge to urinate for women is when the bladder is about 500 mL full. The maximum bladder capacity can range from [PHONE NUMBER] mL. (These numbers were found on live science.com) The elevated kidney levels (BUN and creatinine) are likely post renal and pre-renal. R2 was admitted to the hospital with a diagnosis of severe sepsis, acute kidney injury, and low sodium levels. The Medication Administration Record (MAR) dated 05/2024 documents changing the urinary catheter for blockage and/or leaking does not have any documentation that it was completed. R2 had the original urinary catheter inserted on 4/17/24. There's also an order to monitor output every shift. On 5/18/24, there is documentation on the dayshift that there was a small amount of output of 400 mL and the night shift documented a small amount of 0 mL. There is no documentation that the catheter was changed, or the physician was notified for the output of 0 mL on 5/18/24. On 5/21/24 at 12:59PM, V4 (Certified Nursing Assistant/CNA) stated V4 was changing R2 around 12PM on 5/19 and noticed at the catheter leaking and told the nurse. On 5/21/24 at 2:23PM, V5 (Nurse) stated V4 notified V5 of R2's catheter leaking when they went to change R2. V5 reported calling the on-call physician and got orders to change the urinary catheter but this was not completed due to R2 needing to leave the facility via 911. V5 stated R2 was admitted to the hospital with sepsis and acute kidney injury. V5 reported a physician should be notified of a change in condition so they can put in orders to help the resident. On 5/21/24 at 3:19PM, V10 (Nurse Practitioner) stated if the catheter is not draining out any urine, V10 would expect staff to flush the catheter with normal saline sterile technique to see if they could get any urine to drain into the bag. V10 reported if that doesn't work, then staff should change the catheter and if that still doesn't work, then the nurse practitioner or physician needs to be notified. V10 stated retaining urine can cause altered mental status in females especially. V10 reported the urine can also back up into the kidneys and cause kidney failure and sepsis. On 5/21/24 at 3:25PM, V2 (Director of Nursing/DON) stated if zero is charted on the MAR for output then the resident had no urine documented. On 5/21/24 at 5:02PM, V12 (Primary Physician) was asked what the expectation of the staff is if there is no urine output for an entire shift. V12 replied V12 would expect the nurse to assess the patient and notify the physician and replace or flush the catheter to see if it is working properly. V12 stated if none of those things work, then there would be an order to send the person to the hospital. (continued on next page)

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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Actual harm Residents Affected - Few	On 5/22/24 at 12:21AM, V13 (Nurse) stated if a nurse can't get the urinary catheter to drain then the nurse has to call the doctor. V13 reported V13 didn't call the doctor that night. V13 said, I don't remember needing to because I charted a small output but not the exact amount. V13 was unaware why zero was charted for the urine output. The Physician Order Sheet documents an order to provide catheter care every shift, change the urinary catheter for blockage and/or leaking as needed, and monitor output every shift. These orders were placed on 4/17/24. The Care Plan dated 4/26/24 documents R2 requires an indwelling urinary catheter related to neurogenic bladder. Interventions include to assess the drainage and record the amount, type, color, and odor. Observe for leakage. The policy titled, Notification of Resident Change in Condition, dated 11/2016 documents, Policy: It is the policy of the facility to promptly notify the resident, their legal representative and attending physicians of changes in the resident's health condition .Standards: 1. A licensed nurse shall promptly inform the resident, consult with the resident's physician, and if known, notify the resident legal representative or an interested family member of: . significant change in resident's physical, mental, or psychosocial status, i.e. Mental or psychosocial status in either life-threatening conditions or clinical complication. 2. The licensed nurse is to use professional judgment in determining changes in condition based un assessment and findings or signs and symptoms of change, which could lead to deterioration treated. 3. Clinical change and condition is determined by resident visualization, medical record review, clinical assessment, findings, and care plan review. The policy titled, Catheter Care - Urinary, dated 09/2005 documents, The purpose of this procedure is to prevent infection of the resident's urinary tract . General Guidelines: 1. Observe the resident's urine level for noticeable increases or decreases. If the level stays the same, or increases rapidly, report it to your supervisor.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0690

Level of Harm - Actual harm

Residents Affected - Few

Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 40102

Based on interview and record review, the facility failed to assess, change, or flush a resident's urinary catheter after the resident did not have any urine output from the catheter for an entire eight-hour shift. This affected one of three residents (R2) reviewed for catheter care in a total sample of six. This failure resulted in R2 retaining 1,450 mL (milliliters) of urine in the bladder (maximum capacity is [PHONE NUMBER] mL) and needing to be treated for a urinary tract infection and an acute kidney injury at the hospital.

Findings Include:

R2 is a [AGE] year-old with the following diagnosis: quadriplegia, neuromuscular dysfunction of the bladder, dysphagia, and encounter for gastrostomy.

A Nursing note dated 5/18/24 documents R2 refused breakfast and lunch. R2 reported not feeling well vital signs were stable.

A Nursing note dated 5/19/24 documents a physician was not notified at 12:57 PM that the urinary catheter was leaking and R2 was exhibiting confusion.

A Physician note dated 5/19/24 documents the nurse reported vital signs of 85/60, heart rate of 119 after giving medication 30 minutes ago to help raise the blood pressure. Orders were given to send R2 to the hospital via 911. The nurse also reported the urinary catheter was leaking, an order was given to change the catheter. This order was not completed due to R2 leaving the facility via 911.

The Hospital Records dated 5/19/24 document R2 came to the hospital for persistent low blood pressure and tachycardia along with altered mental status. On arrival, R2 was febrile to 101.3 F. Upon assessment, R2's bladder was palpable at the umbilicus. A comprehensive metabolic panel was drawn and shows the BUN at 71 (normal is 6-20 mg/dL) and creatinine at 1.24 (normal is 0.51-0.95 mg/dL). Both levels are high indicating a kidney injury. A complete blood count was also drawn, and the white blood cells were 20.7 (normal is 4. 2-11.0 K/mcL). This is elevated indicating an infection in the body. The urinary catheter was completely dry and had not likely been draining for some time. The catheter was removed and replaced, and urine began pouring from the patient once the catheter was removed. The catheter output in the emergency department is documented as 1450 mL. The urge to urinate for women is when the bladder is about 500 mL full. The maximum bladder capacity can range from [PHONE NUMBER] mL. (These numbers were found on live science.com) The elevated kidney levels (BUN and creatinine) are likely post renal and pre-renal. R2 was admitted to the hospital with a diagnosis of severe sepsis, acute kidney injury, and low sodium levels.

The Medication Administration Record (MAR) dated 05/2024 documents changing the urinary catheter for blockage and/or leaking does not have any documentation that it was completed. R2 had the original urinary catheter inserted on 4/17/24. There's also an order to monitor output every shift. On 5/18/24, there is documentation on the dayshift that there was a small amount of output of 400 mL and the night shift documented a small amount of 0 mL. There is no documentation that the catheter was changed/flushed or that the physician was notified for the output of 0 mL on 5/18/24.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Actual harm Residents Affected - Few	On 5/21/24 at 12:59PM, V4 (Certified Nursing Assistant/CNA) stated on 5/19/24 while providing incontinence care around 12PM R2's urinary catheter began leaking so V4 told V5. On 5/21/24 at 2:23PM, V5 (Nurse) stated V4 told V5 that the urinary catheter was leaking while R2 was being changed. V5 reported R2 had a low blood pressure and elevated heart rate so the physician was contacted and notified about the vital signs and leaking catheter. V5 stated V5 did not get a chance to change to urinary catheter before R2 left for the hospital because the doctor wanted R2 sent out via 911. V5 reported calling the hospital after R2 left and R2 was admitted to the hospital with sepsis and acute kidney injury. V5 stated if no urine is coming out of the catheter and collecting in the bag then the catheter should be changed out. V5 denied being told by V13 (Nurse) that R2 had no output in the urinary catheter. On 5/21/24 at 3:19PM, V10 (Nurse Practitioner) stated if the catheter is not draining out any urine, V10 would expect the staff to flush the catheter with normal saline to see if they could get any urine to drain into the bag. V10 reported if that doesn't work, then the staff should change the catheter and if that still doesn't work, then the nurse practitioner or physician needs to be notified. V10 stated the causes of urine not draining into the bag would be dehydration due to a resident not making enough urine or a blockage of the catheter causing them to retain the urine. V10 reported retaining urine can cause altered mental status in the females especially. V10 stated the urine can also back up into the kidneys and cause kidney failure and sepsis. V10 reported R2 has a neurogenic bladder so R2 either needs to be straight catheterized or have a permanent catheter due to the retention. V10 stated signs of retention would be a distended abdomen, pain in the abdomen, or no urine collecting in the back. V10 said, There should not be zero documented for urinary output during a shift. V10 reported a body is constantly in the state of making urine so even if a person is dehydrated, the body should be able to produce some urine as long as there are no problems with retention. On 5/21/24 at 3:25PM, V2 (Director of Nursing/DON) stated R2's urinary catheter was placed on the day R2 was admitted from the hospital (about one month ago). V2 reported R2 was sent to the hospital for elevated heart rate and low blood pressure and was admitted with sepsis and acute kidney injury. V2 stated R2 had an order to change the catheter for a blockage or leaking. V2 reported when zero is charted in the MAR for urine output, it means the resident didn't have any output. V2 stated if a resident doesn't have any output, then the nurse should flush the catheter or change out the catheter to see if the resident has urine in the bladder. V2 reported if the catheter is obstructed then the urine can leak around the catheter. V2 said, If they are retaining urine, they can end up with kidney issues, a bladder rupture, or an infection. On 5/21/24 at 5:02PM, V12 (Primary Physician) stated if someone had no urinary output in an entire shift V12 would assume that there was some kind of blockage in the catheter due to a possible malposition. V12 reported V12 would expect the staff to contact whoever is on call and flush the catheter to see if they get any urine output. V12 stated if the resident still doesn't get any output, then they need to attempt to replace the catheter. V12 said, If urine isn't draining from the bladder into the catheter, it can result in obstructive uropathy and post renal acute kidney injury. V12 reported a kidney injury like this can only be corrected by relieving the obstruction. V12 stated no resident should be retaining urine with a catheter in place. V12 reported V12 would expect the nurse to assess the patient and notify the physician and replace or flush the catheter to see if it is working properly. V12 stated if none of those things work, then there would be an order to send the person to the hospital. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	On 5/22/24 at 12:21AM, V13 (Nurse) stated V13 was the nurse on night shift on 5/18 for the 11PM to 7AM shift. V13 reported charting small output but was unaware why zero milliliters were also charted. V13 stated if there's output then then staff has to chart it. V13 reported someone not having any output with a urinary catheter in place may have it blocked or that the catheter isn't working anymore. V13 reported the catheter could have something wrong in the tubing so a nurse has to flush it or change it to get urine flowing again. V13 stated if nothing was draining out, that means R2's bladder was probably getting full. The Care Plan dated 4/26/24 documents R2 requires an indwelling urinary catheter related to neurogenic bladder. Interventions include to assess the drainage and record the amount, type, color, and odor. Observe for leakage. The Physician Order Sheet documents an order to provide change the urinary catheter for blockage and/or leaking as needed and monitor output every shift. These orders were placed on 4/17/24. The policy titled, Catheter Care - Urinary, dated 09/2005 documents, The purpose of this procedure is to prevent infection of the resident's urinary tract . General Guidelines: 1. Observe the resident's urine level for noticeable increases or decreases. If the level stays the same, or increases rapidly, report it to your supervisor .7. Maintain an accurate record of the resident's daily output, per facility policy and procedure .12. Empty the collection bag at least every eight hours .14. Observe the resident for signs and symptoms of urinary tract infection and urinary retention. Report findings to the supervisor immediately.