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	01/12/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49666 Based on interview and record review the facility failed to implement fall prevention interventions for a resident identified at risk for falls for one (R1) out of three residents reviewed for accidents in a total sample of three residents. Findings include: R1's face sheet documents that R1 is a [AGE] year-old individual with diagnoses not limited to: respiratory failure, dysphagia, oropharyngeal phase, cognitive communication deficit, other reduced mobility, anxiety disorder, unspecified. R1's face sheet documents in part R1 was initially admitted to the facility on [DATE] and discharged from the facility to the hospital on 10/20/2024. On 01/11/2025, at 11:44 AM, V7 (Licensed Practical Nurse) states that nurses work 12-hour shift. V7 states that she cannot recall who was the CNA (certified nursing assistant) working with her the date that R1 fell from her bed. V7 states that she floats. V7 reports that she remembers before leaving off the unit, she did her last round, and V7 states that she saw R1 lying in bed. V7 states about 15 minutes or 20 minutes later, the CNA came to get V7 in the lunchroom and V7 was informed that R1 was on the floor. V7 states that she came to the unit, the respiratory therapist (V7 cannot recall the name) informed her that she found R1 on the floor. V7 states that she conducted a head-to-toe assessment, and her vitals were ok. V7 states R1 did not suffer any visible injuries. V7 continues R1 had a little cut on her leg. V7 reports the provider was notified and ordered for R1 to be set out since the fall was unwitnessed. V7 was asked how was R1 when V7 was working with her that morning. V7 states that R1's vitals were stable, was alert, and is nonverbal. V7 states that she denies helping the CNA provide care to R1. V7 continues to report R1 did not exhibit any behaviors during the shift. (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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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/11/2025, at 1:24 PM, V6 (Certified Nursing Assistant) states that she worked 7:00 AM-3:00 PM shift on 10/19/24, and a double shift on 10/20/2024. V6 was asked what happened that day when R1 was found on the floor. V6 states honestly, I was charting in the nurse's station, and then V9 (respiratory therapist) came to me. V6 states she needed assistance because she walked in and saw R1 on the floor. V6 states that R1 barely spoke English and was mainly Spanish speaking. V6 reports that when R1 would need water, or when she needs to be changed, if she needed to get on the bed pan, V6 states R1 would say [NAME] (bathroom) and Agua (water). V6 states that when R1 needed the suction, she used her hand to gesture to point to her trach, and V6 states that she would go get respiratory therapist. V6 reports that R1 was able to move her arms and R1 was not able to move her legs. V6 reports that R1 would turn side to side using her upper body, she would use the side rails to help turn. V6 states when she would talk, it would be very low and in Spanish. V6 states that does not remember R1 having any behaviors. V6 states that she didn't think R1 was a fall risk because R1 came from the hospital and normally they (residents) will have a wristband from the hospital showing that they are fall risk, and if they (residents) are fall risk, they will give us mat to place on the ground. R1 did not have floor mats. V6 states that when she saw R1 on the floor, lying like on her side and she did not see any bleeding, the bed was low. V6 states that she remembers the resident because she worked with the resident for two days and V6 continues to state not noticing any changes during those two days working with R1. Surveyor asked V6 if she needed assistance to provide care to R1. V6 replied no R1 wasn't that big, she turned good, and wasn't hard to turn and provide care to. V6 states I honestly feel like she was reaching for something, and she liked using her bedside table. She used to ask for two boxes of tissue. I always put the table next to her. V6 states that respiratory therapy and nurses go in, and they might not have placed the table next to her. V6 states that R1 was able to use the call light. V6 states that R1's call light was not turned on when the fall happened. V6 reports that R1 was on the vent and V6 thinks she started hearing the beeping, and V9 (Respiratory Therapist) came out of the office and started to see what was beeping about. V6 states that R1 was on her bed when V6 last checked on her 30 minutes prior. V6 reports that the nurse went in to see R1 after V6, she was asking her if she had any pain, checking vitals. V6 reports that R1's bedside table was away from the resident's bed, the call light was on the side next to R1 on the floor. V6 reports V9 was trying to hook R1 back up, and the nurse assisted V6 in putting her back on the bed. V6 states that R1 appeared a little shook up, V6 states R1 said she (R1) was not in a lot of pain, she was alert. V6 states R1 was sent to the hospital. On 01/11/25, at 1:56 PM via telephone V9 (Respiratory Therapist) states that when she heard R1's alarm sound V9 responded right away. V9 states that she found the patient on the floor. V9 states that she does not remember how the area looked because she (V9) was to assess the patient (R1). V9 reports that R1 was older women, small lady. V9 states that she assessed R1, and she (R1) was not in distress. V9 states that she does not remember if R1 had fall floor mats and where R1's bedside table was located. V9 states that as the respiratory therapist she does not use the bedside table because she has all respiratory items on a different table. V9 states that was the first time working with R1 and she did not have any problems that day with R1. V9 states that R1 didn't call her a lot that day, V9 states but she kept close eyes on her, V9 states because she was a little bit confused and R1 had a lot of secretion. She would make eye contact. She reacts when I said something. I think she was Spanish speaking. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/11/2025, at 2:27 PM, V4 (Licensed Practical Nurse/Restorative Nurse) states that she is the fall prevention coordinator and the restorative nurse. V4 states that she works Monday through Friday 9:00 AM-5:00 PM. V4 reports that she didn't get to assess R1 yet since R1 was admitted over the weekend. V4 states that upon admission, the admitting nurses initiate the fall risk care plan if a resident is assessed as being a fall risk. V4 states that she then reviews the care plans to make sure they are accurate. V4 states that the higher the score is the higher the risk they are at falling. V4 states that R1's risk score of 16 means R1 is a high fall risk. V4 states that R1's fall risk assessment should have had interventions checked off and there were none checked off. V4 states that standard fall prevention practices include bed in lowest position, make sure they have the right footwear, making sure everything is within the patient's reach, make sure that staff are toileting them when necessary, checking on them every two hours or as needed. V4 states that if the resident does not have items within their reach a fall can occur, because if they are reaching for it, they can roll over and fall out the bed, there is a possibility. R1's care plan reviewed and there is no fall risk related care plan and interventions noted. R1's fall incident report dated 10/20/24, documents in part R1 unable to give description. Predisposing environmental factors noted R1 was seen in the last two hours is checked off and call light within reach is not checked off. Resident (R1) was sent to the hospital will implement fall mats upon return. R1's fall risk assessment dated [DATE], documents in part that R1's fall risk score is 16 and no interventions were checked off. One of the interventions not checked off documents in part resident needs a safe environment with: personal items within reach. R1's hospital records dated 10/18/2024, reviewed and no documentation of R1 having any behaviors or falls in the hospital. R1's respiratory note dated 10/20/2024, 3:01 PM, documents in part find pt. (patient) on the floor face down, suctioned trach and orally /blood-tinged secretions from the trach. R1's progress noted dated 10/20/2024, 4:00 PM, documents in part approximately around 3:30 PM, writer (V7) was informed by respiratory staff that resident was on the floor. Upon coming into resident's room writer noted resident on the floor face down. There were no signs of active bleeding and resident was alert and orient. APN (advanced practice nurse) ordered for resident to be sent to ER (emergency room). R1's progress note dated 10/21/2024, 11:21 AM, documents in part spoke with hospital ER (emergency room) staff nurse. Resident admitting DX (diagnosis): hyperkalemia and leukocytosis. Facility document dated 08/2024 titled Falls Guidelines documents in part fall prevention is achieved through an IDT (interdisciplinary team) approach of managing predicting factors and implementing appropriate interventions to reduce risk for falls. Understanding contributing and predicting factors that present will assist with determining individualized care approaches. Identification of resident risk for accidents on admission: observe resident in environment. Involve interdisciplinary team on development and implementation of interventions to reduce accidents.