Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 04/02/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145211	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/11/2026
NAME OF PROVIDER OR SUPPLIER Burbank Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - 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** Based on interview and record review, the facility failed to ensure residents received adequate supervision and assistance during care in accordance with their assessed needs and care plans. This failure applied to two (R1 and R2) of three residents reviewed for accidents. These failures resulted in falls while being provided care that required emergent hospital transfer. R2 required three staples for the laceration to the left scalp and R2 also had a left shoulder contusion. Findings include: R1 is an [AGE] year-old resident admitted to the facility on [DATE] with the diagnoses, including but not limited to morbid obesity, lack of coordination, chronic obstructive pulmonary disease, dementia, and hypertension. The facility reported incident documents that on [DATE], a resident slid on the floor during care. EMS (Emergency Medical System) was notified. The resident later became unresponsive. CPR (Cardiopulmonary Resuscitation) was initiated. The facility is awaiting the coroner's report. Minimum Data Set (MDS) assessment of 09/15//2025 documents the following:Section C, the BIMS (Brief Interviewed Mental Status) score was 10/15, indicating moderate cognitive impairment.Section GG: R1 is dependent on toileting hygiene, rolling left and right, shower, dressing, and lying to sitting. The helper does all the effort. The 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. On [DATE] Unable to interview V8 (Certified Nursing Assistant) called and left a message. The statement provided by the facility noted that R1 fell during care. V8 written statement noted, on [DATE], approximately 8:26 PM, V8 was providing care to R1. R1 was positioned on her side as part of her routine evening care. V8 stated, while I was finishing. I noticed her leg began to move downward, and R1 started to slide towards the edge of the bed. R1 then slid to the floor into a seated position while holding onto the side rail. R1 did not appear to strike her head or any hard surface. On [DATE] at 10:16 AM, V4(Licensed Practical Nurse/LPN) said, I don't recall a lot from the incident because it was a long time ago, but I went into the room as soon as I was called. R1 was on the floor and was not very responsive, and I told one nursing assistant to call 911 and another to call the supervisor. I did not see any noticeable injury, and I assessed R1 on the floor and after R1 was assisted to the bed by a mechanical lift. R1's vital signs were lower than the initial ones, but R1 was still breathing, and EMS got to the room, and I gave a report to them, and I had to print out her paperwork, and when I came back to the room, the paramedics had started CPR. I think CPR lasted approximately 20 minutes. I called the family after the paramedics told me that R1 had expired. I made all the notifications, and the police were also called. One of the police officers came to talk to me, and another one spoke with the family when they got here. The police recommended that I not talk to the family because of the way they were acting with us. The other police officer was with the family. On [DATE] at 2:30 PM R1's roommate said, R1 fell in the room, and the staff helped her right away, and I do not remember much, because it was a long time ago. On [DATE] at R1's Family member said, he spoke with R1 (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 - Actual harm Residents Affected - Few	approximately 7:30 PM, and someone was in the room to assist R1, and disconnected the call. R1's family member said that R1 never complained or said that she was not feeling well, and around 10:30 PM, he received a phone call to come to the facility. The family was not able to see R1 and only touched R1 over the bag and spoke with the police, and did not communicate with staffing on the incident. R1's family member said that R1 fell because only one nursing assistant provided care to her, and she required 2 nursing assistants. R1's family member said I did not get the death certificate yet. I do not know if the death was of a natural cause. I have many questions on how R1 was assessed and when CPR was initiated. Following the fall, R1 became unresponsive, and CPR was initiated by EMS. The facility was awaiting the coroner's report at the time of the survey. The relationship between the fall and the resident's death could not be determined at the time of review. 2. R2 is [AGE] years old resident admitted to the facility on [DATE] with the diagnoses including, but not limited to hypoxic ischemic encephalopathy, respiratory failure on a ventilator/tracheostomy, acute embolism and thrombosis of the femoral vein, thoracic aortic aneurysm, and R2 is incontinent of bowel and bladder and receives enteral nutrition. Facility reported incident documents that on [DATE], R2 was observed lying on his back on the floor beside the bed. A laceration was noted on the left side of the head with active bleeding a scratched noted on the left side of the neck. R2 was sent to a local hospital. Hospital records reviewed, and R2 had a laceration to the left scalp requiring three staples and a left shoulder contusion. Minimum Data Set (MDS) assessment of [DATE] documents the following:Section C 1000(Cognitive skills for daily decision making) score is 3 (indicating severe impaired decision making)Section GG: R1 is dependent on toileting hygiene, rolling left and right, shower, oral care, dressing, and lying to sitting. The helper does all the effort. The 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. On [DATE] at 12:22 PM V13 (Certified Nursing Assistant) said, I was doing rounds, and I was giving R2 peri-care by myself. R2 was at the edge, and he fell out of bed towards the door. I turned R2, and he slid out of bed. R2 required two person assist but I could handle him by myself. I could do it myself, and I had been doing that. I was suspended for not having 2 assists. I have received education after. I know that I was supposed to provide care with two, but I did with one. I know now, and I follow the care plan. V12's (Registered Nurse)[DATE] nursing notes stated, I was called into the room by V13, and during patient care, due to the resident having a fall with injury to the left side of his head. The resident left the facility with 911 emergency assistance, going to a local Hospital for evaluation. Upon assessment, the R2 was noted lying on his bedroom floor next to the bed on his back. R2 had a laceration to the back left side of his head with active bleeding. I cleaned the site and wrapped it with a fluff gauze roll and 4x4 to stop the bleeding. R2 also had a scratch on the left side of his neck that was cleaned and bandaged to prevent infection. Pupils not responsive to light, skin was warm to the touch. R2 was alert to self, remains non-verbal. Trach to ventilator stable. Heart rate elevated at 110, blood pressure 128/63, respirations 24. The responsible party was made aware of the condition and transfer. On [DATE] at 2:34 PM, V9 (Restorative Director/Licensed Practical Nurse), said both R1 and R2 fell out of bed while receiving care, and both residents were supposed to have 2 assists instead of one. Both certified nursing assistants provided care alone, resulting in falls. On [DATE] 2:54 PM, V2 (Director of Nursing), I expected the staff follow the care plan and ensure the safety of residents. V2 said, I understand that based on MDS (Minimum data set) assessment, both resident R1 and R2 required 2 assists during care, and one nursing assistant provided care. I provided education to the staff to follow the plan of care. Facility policy titled, Fall Guide (revised on 8/2024), which includes: Purpose: To consistently identify and (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	evaluate residents at risk for falls and those who have fallen to treat or refer for treatment appropriately, and develop an organization-wide ownership for fall prevention to:To achieve each resident's maximum potential of physical functioning.To prevent or reduce injuries related to falls.To enhance residents' dignity and self-worth.To rehabilitate residents to their fullest potential of functionFalling is an unintentional change in position coming to rest on the ground floor or onto the next lower surface. The fall may be witnessed, reported by the resident or an observer, or identified when a resident is found on the floor or ground. Falls include any fall, regardless which setting it may have occurred.The intent of this guideline is to ensure this facility provides an environment that is free from hazards over which the facility has control and provides appropriate supervision to each resident as identified through the following process:1. Identification of hazards and risksEvaluationImplementationMonitoringAnalysis