STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145211	A. BUILDING _____ B. WING _____	08/19/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0607 **Level of harm -** Actual harm **Residents Affected -** Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow their abuse policy by not immediately reporting to a supervisor that a resident (R1) had the appearance of swelling and redness to right arm. This failure resulted in a 2-day delay before initiating an abuse investigation and before R1 was assessed for injury and identified to have sustained a severely displaced [MEDICAL CONDITION] humeral neck (right arm) with soft tissue swelling. Findings include: During interview with V6 (Certified Nurse Assistant/CNA) on 8/18/19 V6 stated, I didn't get a chance to report it to the nurse; not at that time. There wasn't a nurse there. Her right arm was red and appeared to be swollen. One of the nurses called off so I didn't get a chance to report it. I had been off for 3 days, so I didn't know if that was her usual or not. She just made a sound when I moved her. She didn't say she was in pain. She does that when she is turned. I moved her as carefully as possible. It was that Friday night that I worked. During interview with V2 (Director of Nursing) on 8/18/20 regarding R1's bruise, V2 stated, No, the first time I heard anything V1 (Administrator) told me about it. I didn't hear anything from the staff. During interview with V6 on 8/19/20 regarding patient care on R1, V6 stated, I changed her incontinence brief twice on my shift. I didn't notice anything on her at first. Then when I changed her both times, I noticed redness to her arm. When asked about reporting any changes with a resident, V6 stated, If I have a patient and I changed them the first time and then see something I would report that. If I see anything that causes me alarm, I would report that to the nurse as soon as I see it. There was no nurse on the unit at the time. I only had R1 that night. I would have asked the nurse how long the resident had that; but I didn't know what was going on. I would have gone off the unit to tell someone. By the time I got through finishing up my rounds the nurse was not there. I worked 11pm-7am shift; that was Saturday morning. During interview with V2 on 8/19/20 regarding staff report of any change in resident condition, V2 stated, They should report any abnormalities, bruises, skin tears, falls; they should report it to the nurse immediately, as soon as they notice something is wrong. The nurses should chart every shift on the residents. A progress note should be charted. I can't tell you why the nurses did not chart anything; I don't know why no one charted; there is no excuse for that. During interview on 8/20/20, V1 stated nothing was reported by V6 on Friday (7/31/20). When questioned about policy on bruises of unknown origin, V1 stated, To report to the nurse and then investigate. When asked about an abuse investigation being started for R1 Friday (7/31/20) V1 stated, The investigation started on 8/3/20 at 11:55 am when the nurse was aware of the situation. At 9:54 AM, V14 (Physician) was interviewed. V14 stated, The facility has the third eye when caring for the residents and I was notified on Monday (August 3rd). I get contacted when there is any change of status. During interview at 10:20 AM, V2 was aked if V6 reported R1's redness to her right arm to any staff on Friday 7/31/20 11-7 shift; V2 stated, No she didn't. V2 was asked if an abuse investigation was started for R1 on Friday (7/31/20); V2 stated, No we didn't know anything on Friday the 31st. Nothing was started until Monday when the nurse found out. During record review noted from 7/24/20 7am-7pm shift - 8/2/20 7am-7pm shift there are no assessments documented from nursing staff on R1. Record review documents: On 8/2/20 at 8:15pm V9 (Licensed Practical Nurse) documented R1 had a bruise to the right arm and x-ray ordered. At 3:03 AM V9 documented R1 had a severely displaced fracture on the right arm per x-ray. MD notified; to see primary MD in am. On review of R1's progress notes, on 8/3/20 V14's note states R1 x-ray showing fracture; unknown if she had a fall. Nothing documented at this point. R1's 8/2/20 Radiograph of the Right Humerus states: humeral neck with severely displaced fracture. Soft tissue swelling identified. V6's General Orientation Checklist For All New Employees affirms completion of Abuse and Neglect Policy on 12/21/17. The Abuse Prevention Policy dated February 2017 states: This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of [REDACTED]. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property and mistreatment of [REDACTED]. reports and allegations of abuse, neglect, exploitation, misappropriation of property and mistreatment, and making the necessary changes to prevent future occurrences; - filing accurate and timely investigative reports. Procedures: V. Internal Reporting Requirements and Identification of Allegations Employees are to report any incident, allegation or suspicion of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property they observe, hear about, or suspect to the administrator immediately, to an immediate supervisor who must then immediately report it to the administrator or to a compliance hotline or compliance officer. In the absence of the administrator, reporting can be made to an individual who had been designated to act in the administrator's absence. Reports will be documented, and a record kept of the documentation. Supervisors shall immediately inform the administrator or person designated to act in the administrator's absence of all reports of incidents, allegations or suspicions of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property. Upon learning of the report, the administrator or designee shall initiate an incident investigation. Any allegation of abuse or any incident that results in serious bodily injury will be reported to the Illinois Department of Public Health immediately, but not more than two hours of the allegation of abuse. Any incident that does not involve abuse and does not result in serious bodily injury shall be reported within 24 hours. The nursing staff is responsible for reporting the appearance of suspicious bruises, lacerations, or other abnormalities of an unknown origin as soon as it is discovered. The report is to be documented on a facility incident report and provided to the nursing supervisor, administrator or designated individual. Following the discovery of any suspicious bruises, lacerations or other abnormalities of an unknown origin, the nurse shall complete a full assessment of the resident for other bruises, laceration or pain. The resident's physician and representative, if necessary, shall be notified of any incident or allegation of abuse, neglect, exploitation, mistreatment or misappropriation of resident property.
F 0658 **Level of harm -** Actual harm **Residents Affected -** Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide care and services according to accepted standards of practice by not immediately investigating suspicious redness and swelling to resident's (R1) right arm. This failure resulted in a delay in treatment of [REDACTED]. Findings include: During interview with V6 (Certified Nurse Assistant/CNA) on 8/18/19 V6 stated, I didn't get a chance to report it to the nurse; not at that time. There wasn't a nurse there. Her right arm was red and appeared to be swollen. One of the nurses called off so I didn't get a chance to report it. I had been off for 3 days, so I didn't know if that was her usual or not. She just made a sound when I moved her; she didn't say she was in pain. She does that when she is turned. I moved her as carefully as possible. It was that Friday night that I worked. During interview with V2 (Director of Nursing) on 8/18/20 regarding R1's bruise, V2 stated, No, the first time I heard anything, V1 (Administrator) told me about it. I didn't hear anything from the staff. During interview with V6 on 8/19/20 regarding patient care on R1, V6 stated, I changed her diaper twice on my shift. I didn't notice anything on her at first. Then when I changed her both times, I noticed redness to her arm. When asked about reporting any changes with a resident, V6 stated, If I have a patient and I changed them the first time and then see something, I would report that. If

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

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.

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F 0658 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) I see anything that causes me alarm, I would report that to the nurse as soon as I see it. There was no nurse on the unit at the time. I only had R1 that night. I would have asked the nurse how long the resident had that; but I didn't know what was going on. I would have gone off the unit to tell someone. By the time I got through finishing up my rounds, the nurse was not there. I worked 11pm-7am shift; that was Saturday morning. During interview with V2 on 8/19/20 regarding staff report of any change in resident condition, V2 stated, They should report any abnormalities, bruises, skin tears, falls; they should report it to the nurse immediately, as soon as they notice something is wrong. The nurses should chart every shift on the residents. A progress note should be charted. I can't tell you why the nurses did not chart anything. I don't know why no one charted; there is no excuse for that. During interview on 8/20/20 V1 stated nothing was reported by V6 on Friday (7/31/20). When V1 was asked about facility policy on bruises of unknown origin, V1 stated, To report to the nurse and then investigate. When V1 was asked about when the abuse investigation started for R1, V1 stated, The investigation started on 8/3/20 at 11:55 am when the nurse was aware of the situation. During interview at 9:54 AM, V14 (Physician) stated, The facility has the third eye when caring for the residents and I was notified on Monday (August 3rd). I get contacted when there is any change of status. During interview at 10:20 AM, V2 was asked if V6 reported R1's redness to her right arm to any staff on Friday (7/31/20 11-7 shift); V2 stated, No she didn't. V2 was asked if an abuse investigation was started for R1 on Friday (7/31/20); V2 stated, No we didn't know anything on Friday the 31st. Nothing was started until Monday when the nurse found out. Record review did not show an incident report documented for R1 for 7/31/20. During record review from 7/24/20 7am-7pm shift - 8/2/20 7am-7pm shift, there are no assessments documented from nursing staff on R1. Record review indicates: On 8/2/20 at 8:15pm V9 (Licensed Practical Nurse) documented R1 had a bruise to the right arm and x-ray ordered. At 3:03 AM V9 documented R1 had a severely displaced fracture on the right arm per x-ray. MD notified; to see primary MD in am. On review of R1's progress notes, on 8/3/20 V14's note states R1 x-ray showing fracture; unknown if she had a fall. Nothing documented at this point. R1's 8/2/20 Radiograph of the Right Humerus states: humeral neck with severely displaced fracture. Soft tissue swelling identified. V6's General Orientation Checklist For All New Employees affirms completion of Abuse and Neglect Policy on 12/21/17. The Certified Nurse Assistant Job Description states: Job Summary: The purpose of this position is to assist the nurses in the providing of resident care primarily in the area of the daily living routine. Job Requirements: 5. Knowledge of JACHO, OBRA, IDPH, and HFS regulations as related to duties. Main duties: H. Report any changes in resident's condition - e.g. eating habits, behavior, temperature, etc. to the charge nurse of the unit. L. Complete assignment report to charge nurse at the end of every shift. P. Detect and report situations that have a high probability of causing accidents or injuries to residents and/or staff. V6's Job Description Acknowledgement, signed on 8/14/17, states: Administrative functions: Report all changes in the resident's condition to the Nurse Supervisor/Charge Nurse as soon as practical. The Charge Nurse Job Description states: Organize and assign all jobs to be done on his/her shift so that the work load is evenly divided among his/her employees on the basis of staff size and qualifications, pass medications at the appropriate times, and care for the clinical nursing needs on residents on his/her wing. Job Requirements: 7. Knowledge of JACHO, OBRA, IDPH, and HFS regulations related duties and responsibilities Main duties: O. Direct charting in his/her shift and make monthly detailed evaluation of all resident charting so that charts reflect progress and condition of residents in the EMR system. Q. Make rounds and observe individual residents who are experiencing episodes of acute illness, deterioration in health status, recent injury, recovering from surgery, etc. so as to be acquainted with the resident's status, both physically and emotionally and to ascertain that the staff is rendering proper care. U. Prepare incident/accident reports, events and observations using the EMR system. W. Detect and correct situations that have a high probability of causing accidents or injuries to residents and/or staff. The Abuse Prevention Policy date February 2017 states: This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of [REDACTED]. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property and mistreatment of [REDACTED]. reports and allegations of abuse, neglect, exploitation, misappropriation of property and mistreatment, and making the necessary changes to prevent future occurrences; - filing accurate and timely investigative reports. Procedures: V. Internal Reporting Requirements and Identification of Allegations Employees are to report any incident, allegation or suspicion of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property they observe, hear about, or suspect to the administrator immediately, to an immediate supervisor who must then immediately report it to the administrator or to a compliance hotline or compliance officer. In the absence of the administrator, reporting can be made to an individual who had been designated to act in the administrator's absence. Reports will be documented, and a record kept of the documentation. Supervisors shall immediately inform the administrator or person designated to act in the administrator's absence of all reports of incidents, allegations or suspicions of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property. 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