STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0055434	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURBANK REHABILITATION CENTER	5400 WEST 87TH STREET , BURBANK, Illinois, 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) COMPLETION DATE
S0000	Initial Comments Annual Licensure Survey	S0000		09/10/2025
S9999	Final Observations Statement of Licensure Violations 1 of 3: 300.682a)1)2)3)4) 300.682b) 300.682c) 300.682d) 300.682e) 300.682f)1)2)3)4)5) 300.682h) 300.682i) Section 300.682 Nonemergency Use of Physical Restraints a) Physical restraints shall only be used when required to treat the resident's medical symptoms or as a therapeutic intervention, as ordered by a physician, and based on: 1) the assessment of the resident's capabilities and an evaluation and trial of less restrictive alternatives that could prove effective; 2) the assessment of a specific physical condition or medical treatment that requires the use of physical restraints, and how the use of physical restraints will assist the resident in reaching his or her highest practicable physical, mental or psychosocial well being; 3) consultation with appropriate health professionals, such as rehabilitation nurses and occupational or physical therapists, which indicates that the use of less restrictive measures or therapeutic interventions	S9999		09/11/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0055434	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURBANK REHABILITATION CENTER	**5400 WEST 87TH STREET , BURBANK, Illinois, 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) COMPLETION DATE
S9999	Continued from page 1 has proven ineffective; and 4) demonstration by the care planning process that using a physical restraint as a therapeutic intervention will promote the care and services necessary for the resident to attain or maintain the highest practicable physical, mental or psychosocial well being. (Section 2-106(c) of the Act) b) A physical restraint may be used only with the informed consent of the resident, the resident's guardian, or other authorized representative. (Section 2-106(c) of the Act) Informed consent includes information about potential negative outcomes of physical restraint use, including incontinence, decreased range of motion, decreased ability to ambulate, symptoms of withdrawal or depression, or reduced social contact. c) The informed consent may authorize the use of a physical restraint only for a specified period of time. The effectiveness of the physical restraint in treating medical symptoms or as a therapeutic intervention and any negative impact on the resident shall be assessed by the facility throughout the period of time the physical restraint is used. d) After 50 percent of the period of physical restraint use authorized by the informed consent has expired, but not less than 5 days before it has expired, information about the actual effectiveness of the physical restraint in treating the resident's medical symptoms or as a therapeutic intervention and about any actual negative impact on the resident shall be given to the resident, resident's guardian, or other authorized representative before the facility secures an informed consent for an additional period of time. Information about the effectiveness of the physical restraint program and about any negative impact on the resident shall be provided in writing. e) A physical restraint may be applied only by staff trained in the application of the particular type of restraint. (Section 2-106(d) Act) f) Whenever a period of use of a physical restraint is initiated, the resident shall be advised of his or her right to have a person or organization of his or her choosing, including the Guardianship and Advocacy Commission, notified of the use of the physical restraint. A period of use is initiated when a physical restraint is applied to a resident for the first time under a new or renewed informed consent for the use of physical restraints. A recipient who is	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0055434	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURBANK REHABILITATION CENTER	5400 WEST 87TH STREET , BURBANK, Illinois, 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) COMPLETION DATE
S9999	Continued from page 2 under guardianship may request that a person or organization of his or her choosing be notified of the physical restraint, whether or not the guardian approves the notice. If the resident so chooses, the facility shall make the notification within 24 hours, including any information about the period of time that the physical restraint is to be used. Whenever the Guardianship and Advocacy Commission is notified that a resident has been restrained, it shall contact the resident to determine the circumstances of the restraint and whether further action is warranted. (Section 2-106(e) of the Act) If the resident requests that the Guardianship and Advocacy Commission be contacted, the facility shall provide the following information in writing to the Guardianship and Advocacy Commission: 1) the reason the physical restraint was needed; 2) the type of physical restraint that was used; 3) the interventions utilized or considered prior to physical restraint and the impact of these interventions; 4) the length of time the physical restraint was to be applied; and 5) the name and title of the facility person who should be contacted for further information. h) The plan of care shall contain a schedule or plan of rehabilitative/habilitative training to enable the most feasible progressive removal of physical restraints or the most practicable progressive use of less restrictive means to enable the resident to attain or maintain the highest practicable physical, mental or psychosocial well being. i) A resident wearing a physical restraint shall have it released for a few minutes at least once every two hours, or more often if necessary. During these times, residents shall be assisted with ambulation, as their condition permits, and provided a change in position, skin care and nursing care, as appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that a resident was free from restraints that were not needed to treat an identified medical symptom. This failure affected 1 resident (R55)	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0055434	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURBANK REHABILITATION CENTER	5400 WEST 87TH STREET , BURBANK, Illinois, 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) COMPLETION DATE
S9999	Continued from page 3 reviewed for restraints in a sample of 53 residents. Findings include: R55's face sheet documents in part the following diagnosis: unspecified dementia without behavioral, psychotic or mood disturbance, arthritis, acculturation difficulty, reduced mobility, and chronic kidney disease. On 8/18/2025 at 12:23 PM, R55 was observed sitting in a (specialized geriatric) chair, receiving feeding assistance from V16 (Medical Records/Staffing). A lap tray was affixed via clips to R55's wheelchair that was unable to be removed by the R55 and prohibited access to the resident's lower half of R55's body. V15 (Licensed Practical Nurse) affirmed that V15 is assigned to care for R55. V15 observed the lap tray and stated that the tray was not restraint. When asked if V15 could slide from the chair (potentially causing asphyxiation), V15 stated, "No, (R55) has a cushion in place to prevent (R55's) moving or sliding down". V15 removed the lap tray and R55 was observed sitting on a pommel cushion within the chair. R55 was observed tugging at the pommel cushion in between R55's legs. V15 observed R55 tugging at the pommel cushion and V15 affirmed that the pommel cushion would prevent willful repositioning within R55's chair. R55 was unable to remove the pommel cushion. V15 was unsure if there were any orders for the lap tray, pommel cushion, care planning for the lap tray/pommel cushion, informed consent for the lap tray/pommel cushion or assessments for lap tray/pommel cushion use completed and would have to ask V2 (Director of Nursing). V15 was unsure if any prior interventions that were used before the initiation of the lap tray and pommel cushion. V15 stated, "I don't know why they applied (the lap tray and pommel cushion) to (R55's) chair—hospice did it. They (hospice) gave (R55) a new chair and all of that was on it for us to use a couple weeks ago". On 8/18/2025 at 1:02 PM, R55 was observed in the dining room next to V2 (Director of Nursing) and V3 (Assistant Director of Nursing). The lap tray and pommel cushion were still affixed to R55's chair and R55 was observed pulling at the lap tray. V3 asked R55 to remove the lap tray using a translation app, and R55 was unable to remove the tray. R55 was visibly confused and unable to sensibly answer any questions. V2 stated that the lap tray and pommel cushion were not restraints and explained that the use of the lap tray and pommel cushion was "an enabling device, not a restraint" to prevent falls. V2 affirmed that R55 could not remove the lap tray/pommel cushion from the wheelchair at will	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0055434	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURBANK REHABILITATION CENTER	5400 WEST 87TH STREET , BURBANK, Illinois, 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) COMPLETION DATE
S9999	Continued from page 4 and that the devices would restrict R55's movement. V2 denied that the facility had orders from a provider, a plan of care, removal schedule, assessment for use/safety, informed consent. V3 stated that V3 would remove the pommel cushion and lap restraint (indicating these devices were not needed related to a medical need). Record review of R55's electronic health record, including but not limited to, physician orders, care plan, uploaded documents, consents do not identify the use of the pommel cushion/lap tray, informed consent, a plan of care/removal schedule, or assessment for use/safety (including other interventions used prior to restraint use) related to the pommel cushion/lap tray. R55's minimum data set (5/22/25) does not document any use of restraints. On 8/19/2025 at 10:00 AM, the facility provided documentation that a plan of care had been created that identifies the lap tray as a restraint, orders were obtained from R55's physician documenting in part, "Lap (cushion) for safety and positioning: special tray set up - apply Lap Tray to (specialized geriatric) Chair for meals and personal and/or diversional activities daily. Remove when not in use, at least every 2 hours, and at bedtime", and an assessment was completed that determined the lap tray was a restraint on 8/18/2025, after the surveyor's observations. No documentation was provided to the rationale for pommel cushion use on 8/18/2025 and no further documentation was provided prior to the exit of the survey. On 8/20/2025 at 11:00 AM, R55 was observed participating in an activity within the activity room. The lap tray was being used, and no pommel cushion was observed. No lap (cushion) was observed. Facility policy titled "Physical Restraint Policy" (effective 2/2014) documents in part, "Purpose: To achieve a restraint free environment to improve or maintain quality of life and processes re implemented to pursue this goal. Restraints shall not be used for the purpose of punishment or for staff convenience. Periodic assessments shall address the resident's status in an effort to reduce or eliminate restraints whenever possible and assure the least restrictive method is used which allows the resident to function at their highest practicable level. Definitions: Physical restraints are any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot easily remove and that restricts	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0055434	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURBANK REHABILITATION CENTER	5400 WEST 87TH STREET , BURBANK, Illinois, 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) COMPLETION DATE
S9999	Continued from page 5 freedom of movement or normal access to one's body. Policy Specifications: 1. Residents who are admitted with a physician's order for restraint use shall have a Restraint Observation performed. A physician order will be obtained for the release of the restraint with supervision during the assessment process, as appropriate, or an order to discontinue use. 2. A licensed nurse will initiate a physical restraint assessment and consult with appropriate health professionals. 3. The use of restraints will be reviewed by the interdisciplinary team (IDT) prior to initial application and monthly thereafter. Restraint use data will be provided to the physician for review and prior to ordering/re-ordering restraint use. 4. A physician order for a restraint will be valid for thirty (30) days. After 30 days, the Restraint Observation must be completed to determine if the restraint is required further. Physician orders for restraint shall be complete and specifically define the type, reason, duration, and justification for use. 5. Restraint observations are performed additionally with changes (i.e. change in type of restraint or change in the resident's condition which affects how the resident responds to current treatment). 6. Less restrictive measures shall be considered prior to use of restraints. 7. The IDT is responsible to participate in care planning interventions which work toward restraint reduction and use of least restrictive devices. 8. When a new restraint is first initiated, the resident's response to the use of the restraint will be documented in the progress notes each shift for 72 hours. 9. When alternatives to use of restraints are ineffective, the physician will be contacted and further directions/ orders requested to maintain a safe environment for the resident. If alternative measures have been unsuccessful and a determination that a physical restraint is necessary, then the use of the restraint including the resident’s possible negative outcomes and benefits must first be	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0055434	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURBANK REHABILITATION CENTER	5400 WEST 87TH STREET , BURBANK, Illinois, 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) COMPLETION DATE
S9999	Continued from page 6 explained to the resident, family member or legal representative and written consent of use obtained. 10. If the resident, family member or legal representative agrees to this treatment alternative, then the restraining device may be used for specific periods for which the restraint has been determined to be an intervention and treatment. In the event the resident's legal representative is not available to sign the consent; a licensed nurse may accept the legal representative's verbal authorization until the singed authorization can be received. Such authorization shall be documented in the nurse's notes. 11. Residents or their responsible party may refuse the assessed recommendation and physician orders for restraint usage. This refusal should be documented in the resident's clinical record. 12. The decision to use restraints is never based solely on the resident's representative's request of use. In the event a request is made for restraint by the resident's representative that is in conflict with the interdisciplinary care team's recommendations, the physician and administrator will be notified to participate in a safe resolution. 13. Residents who are restrained will be temporarily released from the restraint at least every two (2) hours and more often as necessary such as for ADL care, activities, and meals. 14. In emergencies when immediate physical restraint or seclusion is needed for the protection of the resident or others, restraint or seclusion may be authorized by a licensed nurse not to exceed eight (8) hours. A physician's order to continue to restraint or seclude must be obtained in order to continue the restraint beyond the eight (8) hour period. 15. The resident's legal representative will be notified prior to the initial order, at the time of the order, or within twenty-four (24) hours of the emergency restraint. The initial notification and resident's medical condition, requiring the restraint, will be documented in the progress notes. 16. The care plan will reflect specific circumstances and medical symptoms for restraint use and time frames. In the event restraint use is altered, the care plan will be revised. 17. Direct care staff is informed of the resident's care plan, interventions, including the justification	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0055434	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURBANK REHABILITATION CENTER	5400 WEST 87TH STREET , BURBANK, Illinois, 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) COMPLETION DATE
S9999	Continued from page 7 for restraint use. 18. The resident's response to the use of the restraint and goals identified in the plan of care will be documented at least quarterly and with significant change in condition. Documentation will reflect attempts towards restraint reduction and least restrictive restraint utilization." Facility policy titled, "Resident Rights Guidelines" (10/2023) documents in part that residents have the "right to be free from physical (except if you are at risk of harming yourself or others) and chemical restraints. Physical restraints are any manual method, or physical mechanical device material or equipment attached to or near the body that cannot be removed easily. Physical restraints prevent freedom of movement or normal access to the residents own body…" "B" Statement of Licensure Violations 2 of 3: 300.2220a)1) Section 300.2220 Housekeeping a) Every facility shall have an effective plan for housekeeping including sufficient staff, appropriate equipment, and adequate supplies. Each facility shall: 1) Keep the building in a clean, safe, and orderly condition. This includes all rooms, corridors, attics, basements, and storage areas. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to maintain sanitary conditions within the carpets on the cardiac unit, complex unit, and joint units. This failure affects all 59 residents that reside within the carpeted units. Findings include: Record review of facility census (dated 8/18/2025) documents in part that 13 residents reside within the cardiac unit, 11 residents reside within the complex unit, and 35 residents reside within the joint unit. On 8/18/2025 at 10:30 AM, observed large black stains appearing to be black dirt covering approximately 75% of the flooring in the halls of the complex unit. 3	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0055434	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURBANK REHABILITATION CENTER	5400 WEST 87TH STREET , BURBANK, Illinois, 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) COMPLETION DATE
S9999	Continued from page 8 pink stains approximately 1 foot in diameter were observed in the complex unit hallway. V14 (Wound Care Coordinator) observed the unit flooring and affirmed it was stained. V14 stated, “I think the pink stains are (Brand name drink mix)?” On 8/20/2025 at 12:34 PM, a tour was conducted of the complex unit with V24 (Housekeeping Manager). The same stains observed from 8/18/2025, including the unidentified pink stains. V24 estimated that black dirt stains covered at least 80% of the surface area of the complex unit and V24 believed the pink stains were from (Brand name drink mix) or another type of punch. Surveyor observed the cardiac and joint units with V14 and most of the carpeting in both units were covered in black stains. V24 estimated that 80-90% of the carpet in those units were covered in dirt stains. V24 affirmed that the facility does not have a carpet cleaner or other cleaning products to be able to clean the carpet and only is able to vacuum the carpets. V24 affirmed that V24 has worked for the facility for over a year and could not recall any time when the carpets were cleaned since V24’s employment with the facility. Facility policy titled, “Housekeeping Services Policy” documents in part, “…It is the policy of this facility to maintain a clean, order free, comfortable and orderly environment in all healthcare and public areas, which meet the sanitation needs of the facility and residents’ rights for a safe, clean, comfortable home-like environment... 4. The department shall routinely clean the environment of care, using accepted practices, to keep the facility free from offensive odors, the accumulation of dust, rubbish, dirt and hazards…” "C" Statement of Licensure Violations 3 of 3: 300.2080a) Section 300.2080 Menus and Food Records a) Menus, including menus for "sack" lunches and between meal or bedtime snacks, shall be planned at least one week in advance. Food sufficient to meet the nutritional needs of all the residents shall be prepared for each meal. When changes in the menu are necessary, substitutions shall provide equal nutritive value and shall be recorded on the original menu, or in a notebook marked "Substitutions", that is kept in the kitchen. If a notebook is used to document substitutions, it shall include the date of the substitution; the meal at which the substitution was	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0055434	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURBANK REHABILITATION CENTER	5400 WEST 87TH STREET , BURBANK, Illinois, 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) COMPLETION DATE
S9999	Continued from page 9 made; the menu as originally written; and the menu as actually served. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to prepare and serve meals according to the written menu and recipes. The facility also failed to provide nutritionally adequate substitutes when a food item was unavailable. This failure affects all 94 residents that receive meals from the kitchen. Findings include: Facility provided document titled “Kitchen Diet Order Audit” documents in part 94 residents consume food from the kitchen. On 8/18/2025 at 10:56 AM, R51 explained that the kitchen regularly gets R51’s meal ticket wrong and that not following menu/meal tickets is an ongoing issue within the dietary department. R51 stated, “they (dietary department) will give you food that’s listed as an allergy, or not give you items like they are supposed to. One time, I got just two pieces of bread, that’s it. Another time, I got pork sausage—I am allergic to pork. The cook told me to just take the sausage off the plate and not eat it. I brought up my concerns to the dietary staff and cooks when these issues happen, and they brush me off. It happens to most of the residents, they don’t know what they are doing and don’t follow the menu.” Record review of facility menu titled, “Burbank SS 2025 – Week 4” documents in part that the meal to be served for Monday, 8/18/2025 consists of the following: baked pollock (fish), potato wedges, assorted vegetables, white dinner roll, mousse lemon pudding with topping and a margarine cup. On 8/18/2025 at 12:09 PM, observation of dining services plating food in the kitchen was completed. Fried fish (unidentified) fillet, potato wedges, assorted vegetables and lemon meringue pie was plated for the residents. No dinner roll or margarine cup was plated on the residents’ trays. When asked why the facility was not providing the dinner roll or margarine cup, V17 (Cook) replied, “the rolls didn’t proof in time for them to cook”. V17 affirmed that the facility’s residents did not get any substitute for the	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0055434	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURBANK REHABILITATION CENTER	5400 WEST 87TH STREET , BURBANK, Illinois, 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) COMPLETION DATE
S9999	Continued from page 10 missing rolls or margarine cup. V17 was unsure why the facility prepared a different dessert than what was listed on the menu. On 8/18/2025 at 12:14 PM, tray cart for the joint unit wing was observed with V21 (Certified Nursing Assistant). V21 affirmed that no residents received a dinner roll or a margarine cup on their lunch trays. On 8/18/2025 at 1:12 PM, V19 (Interim Dietary Manager) affirmed that the dietary manager for the facility was not in the facility and V19 was providing coverage while the dietary manager was out. V19 reviewed the written menu and affirmed that the residents should have received dinner rolls, cup of margarine, lemon mousse pudding with topping and baked pollock and the residents were not served those items as directed in the facility's menu. V19 stated that the department should have at least provided a comparable substitute for the missing items and any changed items off the menu must be approved by the dietician. V19 affirmed that there was no evidence that the dietician was aware of the menu changes and approved of the menu changes. No further evidence was provided prior to the exit of the survey. Record review of facility menu titled, "Burbank SS 2025 – Week 4" documents in part that the meal to be served for Tuesday, (8/19/2025) consists of the following: pork chop/loin smothered (in gravy), rice brown pilaf, vegetable blend of peas and carrots, a dinner roll, a cup of margarine, and a honeybun yellow cake. The recipe for the pork chop documents in part that the chop is to be coated in a flour mixture and pan fried. On 8/19/2025 at 11:40 AM, tray pass was observed. Residents were served a baked pork loin cut with gravy (which was transparent and water thin consistency). The menu and recipe for the pork chop to be served was reviewed with V26 (VP of Culinary) and V26 affirmed that the meal was not prepared correctly. V26 stated that the pork chop should have been fried with a batter, per the recipe. V25 (Visiting Dietary Manager) observed the gravy's thin consistency and affirmed that gravy should be a thick, opaque consistency. V25 stated that V25 was unsure how the gravy was prepared to achieve water-thin consistency, but that V25 would make a new batch of gravy that would be the correct consistency. On 8/20/2025 at 1:03 PM, V27 (Registered Dietician) affirmed that V27 is the registered dietician that is contracted for the facility. The deviations from the menu and lack of substitution of food items that was	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0055434	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURBANK REHABILITATION CENTER	5400 WEST 87TH STREET , BURBANK, Illinois, 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) COMPLETION DATE
S9999	Continued from page 11 observed during the survey (8/18/2025 and 8/19/2025) were reviewed with V27. V27 stated that V27 was not aware of any foods that the facility did not provide the residents and did not approve any menu changes for the menu during the survey period. V27 stated, “I knew about the changing the baked fish to fried fish, but it was after they had already served the meal”. V27 explained that V27 should be notified for any needed changes to the menu to ensure the facility is substituting nutritionally equivalent food items and the expectation is that if the facility does not have a food item available, they should be substituting items that are nutritionally equivalent. V27 stated that it is important that the facility follows the menus and recipes to ensure that all residents have a similar standard of nutrition and so the facility can ensure their nutrition needs are monitored and accurate. Facility provided policy titled “MENU PLANNING” (6/2023) documents in part, “It is the Policy of Extended Care LLC. that nutritious menus be planned in advance, followed and changes posted…” Facility provided policy titled “MENU SUBSITUTIONS” (6/2023) documents in part, “It is the Policy of Extended Care LLC. that Menu substitutions will be made after discussion with the director of food and nutrition services whenever possible. Situations may need to be made for uncontrollable situations (i.e.. Inventory emergency when a food item is temporarily unavailable… 1. Kitchen staff will consult with the director of food and nutrition services or designee on any needed menu substitutions…” "C"	S9999		