STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145684	A. BUILDING _____ B. WING _____	**08/26/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MANORCARE OF HOMEWOOD	**940 MAPLE AVENUE HOMEWOOD, IL 60430**

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 0600 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to keep a resident free from verbal abuse as evidenced by staff yelling at one (R1) of three residents reviewed for abuse. Findings Include: On 8/24/20 at 10:12 AM, V2 (Director of Nursing) stated that the corporate office would have the information regarding V4's (Registered Nurse) termination. V2 stated Regarding the incident on March 28, 2020; management staff came in to do room changes and was in the Facility until the evening. Then V3 (Regional Director of Operations) came to me and said to go to Human Resources regarding one of my nursing staff. I saw V4 in the office and he said he had yelled at R1 and that he was sorry. V3 told me that she heard what was going on and went into R1's room and witnessed the nurse (V4) yelling at the resident. At that point, V4's statement was taken and he was immediately suspended during the investigation. After the investigation, we decided it was not the right behavior; he could have excused himself. We decided V4 should be terminated. V3 had gone back to speak with the resident and he was not in any distress and did not want to go out to the hospital at the time of the incident. Review of suspension and termination paperwork regarding the incident between V4 and R1 documents that V4 was suspended on 3/28/20 until his termination on 4/6/20. R1's care plan states behavior: Resistive/non-compliant with treatment/care (specify) related to: Cognitive Impairment Date Initiated: 03/19/2020. Allow for flexibility in ADL routine to accommodate mood, preferences, and customary routine. Date Initiated: 03/19/2020. If resists care, leave (if safe to do so) and return later Date Initiated: 03/19/2020. Cognitive loss as evidenced by but related to [DIAGNOSES REDACTED]. Approach/speak in a calm, positive/reassuring manner. Date Initiated: 03/22/2020. Explain each activity/ care procedure prior to beginning it. Date Initiated: 03/22/2020.

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.