STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145913	A. BUILDING _____ B. WING _____	**08/18/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
APERION CARE BURBANK	**5701 WEST 79TH 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 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to follow their abuse prevention policy by not conducting resident abuse screenings and failed to develop and implement abuse care plans and interventions for residents at risk for abuse and with a history of aggresive behaviors for four (R1, R2, R3, and R4) residents; the facility also failed to initiate an investigation for abuse for one resident (R1) reviewed for abuse. Findings include: On 08/17/20 at 3:00PM V2 (Director of Nursing) stated it was reported from CNA's and nurses that R1 and R4 were arguing because R1 was making racial slurs towards and yelling at R4. V1 stated that she believes R4 had a mentally psychotic diagnosis. V1 stated R1 always had behaviors and was sometimes resistant to care and verbalized racial slurs. V1 stated that R1's physician was notified of R1's behavior. V1 stated that interventions for R1's behaviors included offering him food, offering him someone to talk to or back rubs. V1 stated administration attempted to place R1 in a room with a compatible roommate. On 08/17/20 at 3:13PM V4 (Licensed Practical Nurse) stated that after being notified by nursing staff of a physical altercation incident between R1 and R4, she recalls R1's nose was bleeding. V4 stated the nursing staff called her to the room and she examined and interviewed R1 and R4. V4 stated R1 reported that R4 hit him and R4 admitted hitting R1. On 08/17/20 from 4:01PM - 4:39PM V3 (Social Services Coordinator) stated R1 had a history of [REDACTED]. V1 (Administrator) stated administration attempted to put R1 in a room that with a resident that was compatible with him. V1 stated R4 was a good roommate choice for R1 because R4 was a mild mannered easy going resident. V1 stated R4 contacted the police himself the night of the physical altercation with R1 and appeared to be concerned about R1 stating he found R1 on the floor and he needed help. V1, V2 (Director of Nursing), and V3 stated R1 had a history of [REDACTED]. V1 stated that there was no risk of abuse for R1 or R4. V1, V2, and V3 stated that R1's behavior and mood was primarily pleasant and had been known mostly to exhibit aggressive behavior with staff during care but it was reported he would engage in racially abusive language towards other residents. On 08/18/20 at 12:00PM V1 (Administrator) stated he was not aware of any accusations of physical abuse by staff from R1 and has not conducted any investigations for staff abuse against R1. V1 stated R1 had a [DIAGNOSES REDACTED]. V1 stated R1 should have had a behavior care plan long before June. On 08/18/20 at 4:13PM V1 (Administrator) stated that abuse and neglect screening triggers and are completed based on previous history of abuse from community or prior to admission and also based on social services interviews conducted. V1 stated that no abuse screenings were triggered for R1, R2, R3, or R4. On 08/18/20 at 4:43PM V1 (Administrator) stated that when residents have a history of abuse in the community or in the hospital or if during an interview with the resident or the family, concerns are expressed that the resident is at risk for abuse then the abuse screening would be triggered. V1 stated that all the dementia patients in the facility exhibit verbally aggressive behavior disturbances but not all of them trigger abuse screenings. V1 stated that possibly all residents with behavioral disturbances may need to be screened for abuse. V1 stated that verbally and physically aggressive behaviors would increase a residents risk for abuse. R1's most current care plan documents: R1 was exhibiting verbal aggression including racial slurs towards residents as well as physical and verbal aggression and sexually inappropriate behavior towards staff. Interventions include: Administer medications and observe for adverse side effects, if noted, report to MD; Intervene as needed to protect the rights and safety of resident and/or others; Report to MD any changes or frequencies in behaviors; Has a [DIAGNOSES REDACTED]. Interventions include: Provide psychiatric management to monitor psycho-active medications, provide support and enhanced structure. R1 at risk for falls related to weakness and tiredness. Interventions include: identification and removal of potential causes of falls, implement facility fall protocol, observe for increased weakness and tiredness, notify physician of any changes. R1's progress note dated 04/12/20 documents R1 reported to staff that he was hit by staff. R1's progress note dated 05/01/20 documents R1's social services discussed with V9 (Resident Representative) R1's ongoing consistent behaviors of physical and verbal aggression towards staff and socially inappropriate language including racial slurs towards staff and residents. R1's progress note dated 05/08/20 documents R1 had a room change due to behaviors and incompatibility with his roommates; R1 is receiving anti-depressive daily and antipsychotic medication twice daily and has a [DIAGNOSES REDACTED]. R1's progress note dated 06/09/20 documents: R1 was moved to a different room due to incompatibility with his roommate as evidenced by yelling racial slurs and inappropriate comments to his peer; R1 is not always easily redirected and will deny his behaviors when counseled; the social worker informed V9 (Resident Representative) prior to the room change and made her aware of R1's behaviors. R1's communication skills evaluation progress note dated 06/09/20 created by V4 (Licensed Practical Nurse) documents: R1 was anxious. Not recent change in mood. R1 is currently experiencing unwanted behavior(s); Chronic repetitive behavior(s) noted; Chronic disruptive behavior noted. R1's progress note date 06/10/20 documents: R1 was noted with stitch over his left eye reopened with small amount of blood to site and complaints of nose pain. Physician was made aware and a new order was given to send R1 to hospital emergency room for evaluation. Administration and Family made aware of the incident. Abuse investigation report dated 06/10/20 documents an investigation of an allegation of R1 involved in a physical altercation with R4 and sent the hospital for a psych and further evaluation; R1 and R4 resided in the same room, no staff witnessed the alleged altercation; R4 was the alleged aggressor; R1 sustained injuries; R1 has a [DIAGNOSES REDACTED]. R1's COMS (communication skilled evaluation) dated 06/03/20 documents R1 was exhibiting signs of mild cognitive impairment including confusion, disorganized thinking, requiring cues, short term memory loss. R1's COMS assessment dated [DATE] documents R1's mood anxious with chronic disruptive behavior. R1's hospital record dated 06/10/20 documents R1 was punched in the face and experienced facial swelling and fracture of nasal bone consisting of multiple bone fragments and [MEDICAL CONDITION] septum and cheek bone. On 08/17/20 at 11:00AM R2 stated he has seen residents attacking each other before in the facility. R2 stated he has seen a resident attack staff before. R2 stated some residents shouldn't be in the facility because they are a danger to themselves and others. R2 stated at times residents with dementia who have physically aggressive behaviors were placed in the dining room to be closely observed for preventing physical altercations with residents, however they would still attack each other at times. R2's Face Sheet documents he has a [DIAGNOSES REDACTED]. R2's Care Plan documents he shows signs and symptoms of depression related to low socialization and recurrent [MEDICAL CONDITION]; has limited physical mobility related to weakness, functional limitations, non-ambulatory and dependent on staff for care. R2's MDS (Minimum Data Set) quarterly mood assessment interview dated 06/26/20 documents R2 expressed little interest or pleasure in doing things half or more of the days (7-11days); has trouble falling or staying asleep or sleeping too much; and feels tired or has very little energy several days (2-6 days). On 08/16/20 at 1:00PM Observed R3 was verbally aggressive towards V11 (Licensed Practical Nurse) while trying to collect his lunch tray stating that he had not touched his tray of food because his hands were not cleaned and demanded his tray not be touched. R3 aggressively stated to V11 not to rush him. R3's Face Sheet documents he has a [DIAGNOSES REDACTED]. R3's most current Care Plan documents he has a history of verbal and physical aggressive behavior towards staff; resistive to ADL (activities of daily living) care; experiences delusions and hallucinations; has impaired cognitive function and a [DIAGNOSES REDACTED]. little energy, poor appetite or overeating half or more of the days (7-11 days). R3's MDS (Minimum Data Set) quarterly behavior assessment

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 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) dated [DATE] documents he has delusions. R3's progress note dated 07/30/20 documents R3 is exhibits verbal aggression and physical aggression towards staff during care at times. R4's Face Sheet documents he had a [DIAGNOSES REDACTED]. R4's most current Care Plan documents he had a mood problem related to a history of depression, paranoia, anxiety, and agitation; has ineffective coping and acts sad and depressed related to [DIAGNOSES REDACTED]. R4's physician progress notes [REDACTED]. R4's progress note dated 06/10/20 documents R4 was physically abusive to another resident stating his roommate started yelling and he did not want to hear it so he handled it. Then called the police; the police followed up with no report filed; R4's physician was notified and implemented an order for [REDACTED]. Abuse risk screenings were not completed for R1, R2, R3, or R4. Abuse policy received 08/17/20 states: Training and Orientation of Employees Including: o Staff obligations to prevent abuse. o Dementia management and resident abuse prevention. o How to assess, prevent and manage aggressive, violent and/or catastrophic reactions of residents in a way that protects both residents and staff. o Resident Assessment: o As part of the resident social history evaluation and MDS (Minimum Data Set) assessments, staff will identify residents with increased vulnerability for abuse, neglect, exploitation, or who have needs and behaviors that might lead to conflict. The facility's incident/accident report's policy received 08/18/20 states: An incident/accident report is completed for allegations of abuse registered by residents. Physical or mental mistreatment (abuse actual or suspected) of a resident is considered an 'incident' whether or not actual injury has occurred.