STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145479	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Atrium Health Care Center	1425 West Estes Avenue Chicago, IL 60626

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** 44314 Based on interview and records review, the facility failed to provide safe and adequate care for a resident (R1) of 3 residents reviewed for incontinence care and bed mobility, who requires two person-assist for incontinence care and bed mobility. This failure resulted in R1 falling out of bed, hitting his head on the bedside dresser, being transferred to the hospital on 2 different occasions post fall, and being diagnosed with post-concussion syndrome. Findings include: R1's Face Sheet documents resident is a [AGE] year-old with diagnoses including but not limited to: Quadriplegia, chronic embolism and thrombosis of deep veins lateral upper extremity, schizo-affective disorder, cocaine abuse, iron deficiency anemia, pain, unspecified, low back pain, essential (primary) hypertension, constipation, nasal congestion, allergy, unspecified, changes in skin texture, pain in left shoulder. MDS section C (dated 03/08/2024) documents that R1 has a BIMS score of 15, indicating that R1's cognition is intact. MDS section GG (dated 03/08/2024) documents that R1 was scored as 1; indicating that R1 is dependent for personal hygiene. (1): Dependent is defined as; Helper does all of the effort. 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. Care plan (updated 05/19/2024) documents that R1 is at risk for falls related to incidence of use of psychotropic medication or new medication that may cause dizziness. (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	R1's Restorative Functional Assessment (dated 03/06/2024) documents, Resident has maintained current level of functioning when performing daily ADLs (activities of daily living), resident is with DX (dagnosis). of Quadriplegia and remains dependent on staff times 2 when performing bed mobility, maneuvering and repositioning while in bed. Remains dependent on staff when performing transfers from surface to surface with (mechanical) lift and 2 persons assist from staff for safety. Resident is non-ambulatory and uses motorized wheelchair for locomotion on and off unit with supervision from staff. Able to communicate needs to staff verbally in a clear voice, able to understand and be understood. Has decreased range of motion (ROM-range of motion) o BUE/BLE (Bilateral Upper Extremities/Bilateral Lower Extremities) related to DX (diagnosis) of quadriplegia, incontinent of B/B (bowel and bladder). Dependent on staff when performing daily ADLs to maintain dressing, bathing, grooming and personal hygiene care. Supervision Policy (dated 2023) states: To ensure the facility provides an environment that is free from accident hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents. The facility affirms that all residents will be supervised based on their individual needs. On 06/05/2024 at 10:40am, during a complaint investigation, surveyor observed R1 lying in bed, with the call light within reach. R1 was observed to have two bilateral side rails to prevent R1 from falling out of bed. R1's personal items were observed to be within reach. R1's bed was observed to be in high position, and when surveyor attempted to lower the bed into lower position, the bed did not move into lower position. On 06/05/2024 at 10:40am, R1 stated, On 05/19/2024, there was only one certified nursing assistant (C.N.A) and he came to change me. He turned me on my right side, and he basically dropped me on the ground. The side rails were not on my bed either when the fall took place. The side rails were placed after I had the fall. As I was falling to the ground, I hit my head on the dresser. I told them I hit my head. I went to the hospital. When I went to the hospital, they did a CT scan, and it was negative. When I returned from the hospital, I was in a lot of pain. My head would not stop hurting. I felt nauseous and loopy, and my head was hurting severely, non-stop. I requested to be sent to the hospital again. They sent me back to the hospital on 05/21/2024. When I got to the hospital, they managed my pain, they gave me pain medication, and they told me in the hospital that I had concussion from hitting my head during the fall. Most of the time, when the C.N. As perform ADL care, it is usually one C.N.A assisting me. After the fall, it's usually one C.N.A. that cleans me. Depends on what shift it is, sometimes it's two C.N.As, depending on what shift it is. What's crazy is that when he was turning me, I was telling the C.N.A, [NAME] [NAME], you're going to drop me, and he told me, Oh I'm not going to drop you., and then I rolled off the bed. The thing is that my bed will not go any lower, it's broken and won't go to a lower position, so I am always at this height. I fell from this height because my bed will not go any lower to the ground. There was no mat when I fell . I never had a landing mat here. I am still experiencing headaches. On 06/05/2024 at 11:27am V3 (certified nursing assistant) stated, I take care of R1 for a while now. R1 is a two-person assist for ADL/incontinence care, as well as transfers. R1 is a two-person assist for everything. I have been taking care of R1 for a while and R1 has always been a two person assist for bed mobility and everything else. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 06/05/2024 at 12:34pm V6 (restorative nurse) stated, Prior to the fall incident on 05/19/2024, R1 was a two-person assist for incontinence care and transfers. On 05/19/2024 when R1 fell , he should have been cared for by 2 staff members. After R1's fall occurrence, R1 is still a 2-person assist for incontinence care and transfers. It was not safe for one C.N.A to provide R1 incontinence care because R1 is a quadriplegic and R1 needs a 2 person assist. After the fall, we put 2 half side rails for R1's bed, for support and repositioning. When R1 is rolled to either his right or left side, the bilateral half side rails will prevent R1 from rolling out of bed, and R1 can feel a little more secure. R1 does not have landing mats ordered because R1 is a two-person assist and he is a quadriplegic, so the landing mats are not needed. On 06/06/2024 at 11:03am V1 (administrator) stated, I was not aware that R1 experienced a concussion from the fall he had. They did not tell me that he had a concussion. I know that R1 was sent out to the hospital and R1's CT scan was negative, but I did not know that he had a concussion. On 06/06/2024 at 12:11pm V2 (director of nursing) stated, R1 requires the assistance of 2 staff members for ADL care and transfers. When the fall occurred on 05/19/2024, there was an overnight C.N.A. that was providing care for R1. According to the report that I received, there was only one C.N.A. that was providing care for R1, when he fell . It is not safe for one staff member to provide ADL/incontinence care for R1. On 06/06/2024 at 12:20pm V11 (R1's physician) stated, It is ok for one CNA for incontinence care. He needs help and one person is enough. I don't think that he needs bed rails. On 06/06/2024 at 6:23pm V9 (certified nursing assistant) stated, R1 had a fall on 05/19/2025 while I was providing care for him, and it was about 5:30am or 5:40am. It was the first time I was working with R1 on the 3rd floor. I have seen other people caring for R1, and usually there is only one staff member providing incontinence care for R1. In the process of doing R1's incontinence care, in the process of trying to clean R1, I turned R1 to his right side, which is the R1's stronger side of the body. After I was done cleaning R1's right side properly, I tried to put a diaper on behind him, and in the process of putting the diaper behind R1, the bed flipped, and R1 fell out of bed, falling to the right side of the bed. R1 hit his head on the dresser while he was in the process of falling out. I tried to stop him from falling and I tried to prevent the fall, but I could not because of his weight. This was the first time I ever took care of R1. I have seen one person work with R1 before. From what I have seen, it's usually only one person caring for R1. I think there was a rail on the left side of the bed. I never seen two people caring for R1, it's always just one person providing care to R1. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R1's Progress Note (dated 05/19/2024) documents, Prior to the incident at 5am resident was seen lying in bed comfortably, alert and oriented x3 and verbally responsive. At 5.45am during morning ADLs care, the CNA called for the nurse and upon getting to resident's room, resident was observed on the floor in a right lateral position next to the bed. Physical assessment completed BP (blood pressure) 132/78, P (pusle) 80, R (respirations) 18, Spo2 97% on room air, Temp (temperature) 98.2 F temporal. Pain assessed, verbalized pain at 7/10 on pain scale. Neurological assessment initiated. Resident remains alert and oriented x3. Resident stated that he hit his head when he fell . Range of motion on all extremities within normal limit. Resident skin remains intact. Resident transferred back to bed by two person assist via (mechanical) lift. Resident is wheelchair bound, required assistance of two person with grooming and ADLs. Head to toe assessment done, no discoloration, no injury, no swelling noted, at the moment. Dr. notified with orders to send resident to community hospital for evaluation. Ambulance contacted and ETA (estimated time of arrival) is 60 mins (minutes). Resident's POA (Power of Attorney) contacted on. DON (director of nursing) made aware. Resident remains comfortable in his room, call light within reach. Staff will continue to monitor. Awaiting ambulance for pickup. Endorsed to incoming nurse to follow up. R1's Progress Note (dated 05/19/2024) documents, At 12:40 pm, resident arrived from the hospital via ambulance and accompanied by 2 crew members. Alert /oriented x3 and verbally responsive. Per hospital reports: the following labs was done with negative result: CBC with diff and lactic acid. imaging test done are: ct cervical spine wo (without) contrast, ct head wo contrast, EKG 12 lead, rhythm strip, xr (xray))ankle rt 3+ views, xr femur 2+ view, xr forearm rt (right) 2+ views, xr humerus rt 2+ views and xr tibia fibula rt 2+ views. Resident head to toe assessment done. V/s (vital signs) taken BP (blood pressure) 148/98 Pulse 66, O2 95% RA (room air), Resp (respirations) 18, Temp (temperature) 98.6. Resident's contact (mother) notified. Resident is in his room on his chair with call light placed within reach. No follow up appointment. 72 hrs (hours). post ER (emergency room) visit initiated. R1's Progress Note (05/21/2024) documents, 72 hours post fall: Resident received in bed, AO (alert/oriented) x3, verbally responsive and able to make needs known. medication taken whole and well tolerated with no adverse effects noted. Resident complains of pain and rates it a 6 on the scale of 0-10, says his head and face hurts. Pain medication given to help alleviate pain. Continuous monitoring during this shift. R1's Progress Note (dated 05/21/2024) documents, Transfer to hospital: Resident's family member called to express concern about resident complaint of pain and demands resident should be sent to the hospital. Resident is in stable condition right now and all vitals are within resident's normal limit, but resident complains of banging headache and face pain. Physician has been notified and has given order to be sent to community hospital for further evaluation. Ambulance has been called and ETA states 4pm for pick up. DON notified, incoming nurse also notified and will follow up. R1's Progress Note (dated 05/21/2024) documents, At 8pm, a call was placed to hospital ER. Per ER (emergency room) nurse, resident will be returning to the facility later tonight and resident has been cleared but has Post concussion syndrome. Pick up time is 9.30pm. Endorsed to incoming nurse to monitor return. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R1's Progress Note (dated 05/21/2024) documents, At 10.15pm, resident returned to the facility via ambulance on a stretcher. Resident head to toe assessment done. V/s taken BP 132/72, Pulse 72, O2 97% RA, Resp 18, Temp 98.2. Resident has orders for Bacitracin 500 unit apply topically twice a day. Resident also has orders for Butalbital acetaminophen caffeine every 4hrs for 10 days and PRN (as needed) . MD (physician) notified, order noted and carried out. Resident's mother notified. Resident is in his room on the bed, plan of care ongoing and call light call light placed within reach. DON notified. No follow up appointment. 72 hrs post ER visit initiated. R1's Progress Note (dated 05/31/2024) documents, Resident may have bilateral half side rail for repositioning and support as per MD's order. R1s Physician Order (dated 05/21/2024) states: Butalbital 50 mg (milligrams)-acetaminophen 325 mg-caffeine 40 mg-codeine 30 mg cap. Give 1 tablet by oral route every 4 hours as needed. Episodic tension-type headache, intractable. R1's Emergency Department Record (dated 05/21/2024) states: Patient's headache is likely due to post concussive syndrome from his fall the other day (pg.1). Post-concussive syndrome is a group of symptoms that affect your nerves, thinking, and behavior. PCS develops shortly after a concussion and can last for weeks to months (pg.8).