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	07/05/2024

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 0600 Level of Harm - 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** 45110 Based on interviews and record reviews, the facility failed to keep two (R8, R10) of six residents free from abuse. This failure resulted in R8 and R10 sustaining a swollen and bruised eye. Findings include: 1. R10's clinical record document in part the following: R10 is a fifty-year-old with the medical diagnosis of schizophrenia, hypertensive heart disease with heart failure, acute ischemic heart disease, abnormalities of gait and mobility, and essential hypertension. R10's minimum data set brief interview of mental status dated 5/1/24 scored [8], indicates cognition is mildly impaired. R10's care plan: -2/5/24: R10 has a diagnosis of mental illness, impaired decision making, inability to understand course of treatment. -5/15/24: R10 has not been the perpetrator of abuse, and he will remain safe, free from abuse and mistreatment. R10's After Visit Summary from emergency room dated 5/12/24: -R10 was seen for assault, injury to head/eye -Apply timolol maleate 0.5% solution to left eye -Acetaminophen to decrease pain -Apply ice to eye 15-20 minutes every hour R11's clinical record indicates in part: -R11 is a fifty-seven-year-old male admitted [8/21/21] with schizophrenia, deaf, non-speaking, restlessness, and agitation. MDS dated [DATE] indicates R11 is cognitively intact. Abuse risk assessment dated [DATE], R11 has a history of aggressive behavior. (continued on next page)

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

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	07/05/2024

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 0600 Level of Harm - Actual harm Residents Affected - Few	R11's care plan documents the following in part: -8/21/21: R11 has a history of physical aggression. R11 exhibits physical aggression behavior toward staff members when agitated, shoving, and pushing staff away. -4/19/23- R11 was readmitted to facility after being sent out for becoming physically aggressive toward another resident and staff. -6/7/23 - R11 was sent out after an episode of aggression -7/30/23- R11 was physical aggressive to another resident. [R11 has a documented history of aggressive behavior.] On 7/2/24 at 12:20 PM, R10 stated, I was hit in my eye for no reason by another resident. I went to the hospital, and I was okay. That man is not here any longer and I feel safe being here. On 7/2/24 at 12:33 PM, V18 [R10's Family Member] stated, The nurse called me on 5/12/24, and told me that R10 was hit in the eye by another resident and was sent to the emergency room . Later I was told by the facility nurse that R10 returned back to the facility, and he was okay. On 5/13/24, I came to visit R10 and noted his left eye was black, purple, and swollen around his eye. R10 told me R11 hit him in the eye for no reason. On 7/2/24, at 12:46 PM, R12 [R10's roommate] stated, R10 and I were roommates on 5/12/24. Around 5PM, the certified nurse assistant clean R10 up and placed a gown on him. R10 took his under brief off and walked out the room. R10's gown was open at the back side, and I could see buttocks. Another resident R11, (R11) cannot talk and is deaf. R11 walked R10 back into the room, then R11 walked out. A few minutes later, R10 walked back out the room with his gown on and open in the back. R11 for the second time walked R10 back into the room and pushed down on his shoulders, to make R10 sit down in the chair. R10 tried to get back up, then R11 hit R10 in his eye. I have not been abused at this facility, and I feel safe being here. On 7/2/24 at 12:53 PM, V15 [Certified Nurse Assistant] stated, I worked on 5/12/24, on first shift. Before I left, I cleaned R10 up and placed him on a gown and under brief, because he wanted to take a nap. I was not there when the incident occurred with R10 and R11. On 7/3/24 at 3:11 PM, V9 [Certified Nurse Assistant] stated, I was R10's CNA on 5/12/24, I worked second shift. R12 [R10's roommate] told me that R10's gown was open at the back side, and his buttocks was exposed, R10 kept walking in and out of their room. Another resident R11, (R11) cannot talk and is deaf. R11 walked R10 back into the room, then R11 walked out. A few minutes later, R10 walked back out the room with his gown on and open in the back. R11 walked R10 back into the room again and pushed R10 to make him sit down in the chair. R10 tried to get back up, then R11 hit R10 in his eye. R10 is a quite resident that like to walk around. R11 is aggressive and will hit staff and other residents. R10 and R11 both was sent out to the hospital. R10 ended up with a black eye, and R11 was discharged to anther facility. (continued on next page)

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	07/05/2024

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 0600 Level of Harm - Actual harm Residents Affected - Few	On 7/3/24 at 10:35 AM V7 [Social Service Director] stated, I am familiar with R11 and his behaviors. R11 has a documented history of aggressive behaviors towards other residents and staff. R11 was easily agitated and striking out hitting others. On 5/12/24, R10 was coming out his room without all his clothing on. R11 got agitated that R10 would not stay in his room and struck him in the eye. R11 and his family agreed for R11 to discharge to another facility due to his aggressive behaviors. On 7/3/24 at 9:15 AM, V2 [Director of Nursing] stated, R10 walks around the unit, and R10 is quiet and easily re-directed. R10 does not have a history of aggressive behavior. The investigation findings were R11 got agitated with R10 trying to make him stay in his room. R10 came back out of his room and R11 took R10 back into his room and hit him in the eye. R10 was sent out to the hospital for treatment and evaluation. R10 eye was dark, black, red, and swollen. R11 was sent out for a psychological evaluation due to his aggressive behavior. R10 returned with no new orders, R11 returned to the facility as well. We moved R11 to another floor and monitored him closely for behaviors. R11 have a documented history of aggressive behaviors, prior to hitting R10. R11 would be aggressive towards other residents and staff members. R11 was discharged to another facility that was equipped to handle aggressive behaviors, R11 and his family agreed to the transfer. On 7/3/24 at 10:52 AM, V1 [Administration] stated, The incident between R10 and R11 was substantiated. During the investigation it was found that R11 did hit R10 in the eye. V11 was transferred to another facility, R11's family and R11 agreed another facility would be better for R11 due to aggressive behaviors. All staff complete abuse training upon hire, annually and as needed with an event of abuse occurrence. The last abuse training was about a two weeks ago. Reviewed facility's in-service dated 6/27/24, staff educated on abuse of all types and reporting abuse. Policy documented in part: Abuse Prevention Program dated 11/23 -This facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, corporal punishment, involuntary seclusion. -Abuse is any physical or mental injury or sexual assault inflicted upon a resident. -Physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment. -Residents who allegedly abused another resident will be removed from contact with other residents during the course of the investigations 40061 2. R8's 05/09/2024 MDS (Minimum Data Set) Assessment documents in part that R8 was cognitively intact. (continued on next page)

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	07/05/2024

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 0600 Level of Harm - Actual harm Residents Affected - Few	R8's Social Service - Abuse Risk Assessment created 04/22/2024 documents in part: Due to current situation the resident has the potential for abuse, monitoring and evaluation needed [NAME] to extreme behavior of pacing, wandering and entering area without permission. R8's comprehensive care plan contains a focus for abuse. Goal effective 05/09/2024 documents in part: [R8] will remain safe, will be treated with respect, dignity and reside in the facility free of mistreatment (i.e., abuse/neglect) through next review. R9's 03/21/2024 MDS (Minimum Data Set) Assessment documents in part that R9 is cognitively intact. R9's Care Plan Activity Report documents in part a focus of R9 having socially inappropriate behavior. Resident exhibits socially inappropriate behavior as evidenced by making threats, screaming, shouting and making demands. Resident become physically agitated towards staff and peers (effective 01/04/2024). The goal was for R9 to show a decrease in episodes of socially inappropriate behaviors towards peers and staff. Facility's initial Facility Reported Incidents form dated 06/02/2024 10:22 AM documents in part: On 06/02/2024 at approximately 8:00 AM on the third floor [R8] alleged that [R8] was hit in the face by [R8's] roommate [R9]. Swelling and discoloration noted to resident's right eye. First aid provided per physician order. V6 (Quality Assurance Nurse) filled out R8's Statement form dated 06/02/2024. It documents in part: [R8] told this writer that [R9] hit [R8] on the face while [R8] was going through [R9's] stuff. V6 filled out R9's Statement form dated 06/02/2024. It documents in part: [R9] stated to this writer that [R9] hit [R8] because [R8] was going through [R9's] belongings and [R8] had no business doing that. V24's (Minimum Data Set/Care Plan Nurse) written statement dated 06/07/2024 documents in part: On June 2nd, 2024, at about 7:30 AM at the end of my night shift and on my way out; [R9] called my attention to see the swollen eye of [R9's] roommate [R8]. Upon interview, [R9] admitted that [R9's] roommate was going through [R9's] stuff and that triggered [R9] to punch [R8] in the face. Facility's investigation summary for the final Facility Reported Incident documents in part: Conclusion: Based on records review, and interviews, the facility was able to substantiate that the alleged incident occurred. On 07/02/2024 at 12:36 PM, V13 (Nurse) stated R8 was alert and oriented to person, place, and time. R8 had behaviors of going through other people's belongings and taking things. V13 stated R9 was alert and oriented to person, place, time, and situation. V13 stated R9 was easily mad and agitated. V13 stated R8 and R9 were roommates. V13 witnessed them screaming at each other before for whatever reason. V13 did not witness R8 and R9's incident but saw R8 about two days after the incident. V13 stated R8's eye was swollen up to the lateral side of the eyebrow. There was purple discoloration underneath the eye. On 07/02/2024 at 1: 43 PM, V15 (Certified Nurse Assistant) stated R8 was alert and oriented. R8 had behaviors of going through other people's belongings to steal things. (continued on next page)

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	07/05/2024

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 0600 Level of Harm - Actual harm Residents Affected - Few	On 07/02/2024 at 1:48 PM, V17 (Certified Nurse Assistant) stated R9 was alert and oriented. R9 was manipulative and liked fighting. On 07/03/2024 at 9:40 AM, V6 (Quality Assurance Nurse) stated first interviewing R9 after the incident. R9 informed V6 that R8 kept going through [R9's] belonging to take things but wouldn't stop. V6 stated during the interview R9 said [R9] hit R8. R9 demonstrated hitting R8 with a closed fist. After R9's interview, V6 interviewed R8. R8 had discoloration underneath the eye and minimal swelling. R8 stated going through R9's belongings. R9 came up to R8 and then R9 hit R8. V6 stated facility ordered a facial x-ray for R8 and hospital evaluation but R8 declined hospitalization . R8's Order Info documents in part an order that started on 06/02/2024 at 10:57 AM to Apply icepack to right lower black eye. R8's Progress Note dated 06/02/2024 at 8:08 AM document in part X-ray of facial bones. On 07/03/2024 at 9:53 AM, V24 (MDS/Care Plan Coordinator) stated V24 was leaving and in the elevator after working night shift when R9 brought R8 to V24. R9 said to look at R8's face which was swollen. R9 stated hitting R8. R9 stated R8 was bothering [R9] in bed. R8 went to R9's side and started going through R9's stuff. On 07/03/2024 at 10:56 AM, V1 (Administrator) stated R8 was alert and oriented to person, place, and time. V1 stated R8 was at risk for abuse because R8 had behaviors of wandering and stealing other people's belongings. V1 stated R9 was alert and oriented to person, place, and time. R9 was verbally aggressive to everybody including other residents. V1 stated the facility's investigation showed that R8 was going through R9's belongings. R9 got upset and hit R8.

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	07/05/2024

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** 39779 Based on observation, interview, and record review the facility failed to ensure safe practices when turning a resident in bed during resident care for 1 (R7) of three residents reviewed for falls. The facility also failed to ensure fall preventions were added to the care plan after R7's fall. This failure resulted in R7 falling out of bed and sustaining a laceration to the scalp. Findings Include: R7 has diagnosis not limited to Quadriplegia, Osteomyelitis, Hyperlipidemia, Muscle Spasm, Constipation, Postherpetic Polyneuropathy, Type 2 Diabetes Mellitus, Angina, Anxiety Disorder, Thiamine Deficiency, Vitamin D Deficiency, Bipolar Disorder, Schizophrenia, Chronic Pain, Pressure Ulcer of Sacral Region Stage 4, Pressure Ulcer of Left Buttock, Stage 4 and Essential (Primary) Hypertension. R7's MDS (Minimum Data Set) Section C - Cognitive Pattern BIMS (Brief Interview for Mental Status) score is 15 indicating intact cognitive response. Section GG - Functional Abilities and Goals: Functional Limitations in Range of Motion; 2. Impairment both sides. A. Upper extremity. B. Lower extremity. Mobility: A. Roll left and Right: The ability to roll from lying on back to left and right side and return to lying on back on the bed. Dependent. During record review R7 has two documented falls from the bed. Document Titled Accident/Incident Log Form document in part: R7 falls dated 04/09/24 no injury and 05/29/24 laceration. Progress note dated 04/09/24 06:33 am document in part: Resident observed in bed at 4 am sleeping with no distress or any discomfort noted at this time. Staff responded to resident while yelling out for help at 5:30 am. Resident was observed lying on the floor in a supine position next to his (R7) bed. Resident is alert and oriented x 3. When asked what happened, resident stated My pillow fell could not control my movement and fell to the floor and hit my head. Dr. (doctor) called with order to transfer resident to hospital for further evaluation. Progress note dated 05/29/2024 07:04 am document in part: Resident alert and oriented x 2-3 with no distress or any discomfort noted at this time. Writer was in resident room for wound care treatment. During repositioning resident slip to the floor. Head to toe assessment completed, a laceration was noted to the middle of the head with mild bleeding. Site was cleansed with normal saline and pressure applied the site. Dr. notified with order to send resident to the hospital for further evaluation. Progress note dated 05/29/24 08:04 am document in part: Resident received on bed, alert and oriented x 2. Upon nurse-to-nurse report, resident has pending order to be transferred to ER (emergency room) due to fall. Progress note dated 06/06/24 07:21 pm document in part: Re-admitting R7 from hospital. Resident discharge with laceration of the head. (continued on next page)

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	07/05/2024

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	Document titled: Facility Reported Incidents Initial: dated 05/29/24 document in part: During repositioning resident accidentally slip to the floor. Head to toe assessment completed, a laceration was noted to the middle of the head with mild bleeding. Site was cleaned with normal saline and pressure applied to the site. Doctor notified with order to send resident to hospital for further evaluation. Document Titled Accident document in part: Summary: Severity: Incident resulted in hospitalization and temporary harm. Outcome: Laceration. Accident Type: Fall. V22 (Licensed Practical Nurse) witness statement document in part: Writer was in resident (R7) room for wound care treatment. During repositioning residents slipped to the floor. Head to toe assessment completed, a laceration was noted to the middle of the head with mild bleeding. Site was cleanse with normal saline and pressure applied to the site. Doctor notified with order to send resident to hospital for further evaluation. V9 (Certified Nurse Assistant) witness statement document in part: I was with the nurse (V22 Licensed Practical Nurse) to help to turn the resident (R7) to be able to clean his wounds. The resident (R7) was flipped to my end and had a grip on him (R7) for the nurse to clean his wound. I held him after he was clean on that side, flipped him back towards the side of the nurse. She (V22) held him for me to turn to her side to have a grip on him (R7) but unfortunately, he flipped out of the grip from the nurse while she was trying to turn for me to be able to hold or have a grip on the resident for her to treat the other part of the resident wound. Document Titled Facility Reported Incidents Final: date 06/04/24 document in part: Incident Description: Resident sustained a laceration to the mid-part of the head. Based on the facility investigation during repositioning, resident had a fall and bump his head against a drawer which resulted in him having a laceration to the mid-part of the head. Resident care plan and assessment will be updated upon readmission. Care Plan document in part: At risk for falls related to dx (diagnosis) of quadriplegia and he totally dependent on 2-person assistance in bed-mobility, transfer, and toileting. Updated: 10/12/22: Fall with no injury noted 10/11/22; sent to the hospital for evaluation Updated: 04/09/24: Fall with c/o (complaint of) hitting his head noted; sent to the hospital for evaluation. Updated: 05/30/24: Fall with injury noted on 05/29/24; sent to the hospital for evaluation. Interventions: Anticipate resident needs in relation to present ADL (Activities of Daily Living) function. Effective 04/10/24. Evaluate pattern of falls if fell more than once. Effective 04/10/24. Investigate cause of fall immediately. Effective 10/17/23. Medication regimen review as it relates to falls. Effective 04/10/24. Monitor for side effects of psychotropic medications such as dizziness, drowsiness, etc. Effective 04/10/24. Notify MD for any behavioral changes that may contribute to falls. Effective 04/10/24. Provide education on safety techniques. Effective 04/10/24. Provide low bed as ordered. Effective 04/10/24. Provide reality orientation. Effective 04/10/24. Review with interdisciplinary team the continued need for psychotropic drug use. Effective 04/10/24. R7's Fall Risk assessment dated [DATE] document in part: History of Falls (Past 3 Months) Fall 1-2x's. Gait and Balance: Not able to perform function. History of Falls: 2. Total: 12 High Risk! (continued on next page)

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	07/05/2024

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	R7's Hospital Record dated 05/29/24 - 06/06/24 document in part: Wound 05/29/24 scalp. History: R7 presented from NH (Nursing Home) with fall. HEENT (Head, Eye, Ear, Nose, Throat) Comments: Scalp laceration. On 07/02/24 at 12:18 PM R7 was observed lying in a bariatric bed (a specialized bed made specifically to accommodate larger and heavier patients. It is wider than regular medical beds) on a low air loss mattress. Surveyor asked R7 about his fall and R7 responded I don't want to talk about it. On 07/03/24 at 10:24 AM Surveyor entered R7 room and asked to get clarity about his fall that occurred on 05/29/24. Surveyor asked R7 was he in the bed that he is currently in when the fall occurred, R7 responded yes. The surveyor asked did he fall off the right side of the bed near the window, R7 responded yes. The surveyor asked R7 did the nurse move away from the bed when the fall occurred, R7 responded yes. That's enough. R1 refused to answer any additional questions. On 07/02/24 at 12:20 PM V20 (Certified Nurse Assistant) stated When R7 need changing he is a 2 person assist and a feeder. When R7 did have a fall, he had a Laceration to the center of head that was not too deep. R7 is on fall precautions, lower bed and cushion supports by the side of the body. On 07/02/24 at 01:28 PM V21 (Registered Nurse) stated R7 is a 2 person assist. R7 had a fall last month and had a cut in the middle of the head. The nurse cleaned the cut with normal saline and dressed it before the ambulance came. On 07/02/24 at 01:36 PM Per telephone interview V22 (Licensed Practical Nurse) stated I was in there in R7 room with (V9) certified nurse assistant and we were changing R7 position. I was by the window side of R7 bed trying to come to the door side. We turned R7 already and R7 just slipped out of the bed. I was trying to go to the other side of R7 bed when he slipped out and fell out of the bed to the floor. R7 was on his side turned toward me and slipped out of my hand and fell down. I am not sure if R7 was in the same bed that he is in now, I go there to do the wound dressing. R7 was by the edge of the bed when R7 slipped out of my hand. R7 was too heavy and fell out of the bed. We assessed R7 and the laceration was on top of R7 head. I assessed R7 while he was on the floor. We held onto R7, put one hand under R7 arm pit and one arm under R7 legs to put him back in bed. I put a gauze and pressure to R7 head to cover the laceration up, called the doctor then the ambulance. R7 hit his head on the floor and drawer. I don't know how R7 got the laceration rather it was on the drawer or on the floor. R7 is not a fall risk. R7 is a 2 person assist. I did not see any mats on the floor. I was just doing wound care. (continued on next page)

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	07/05/2024

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	On 07/02/24 at 01:49 PM Per telephone interview V9 (Certified Nurse Assistant) stated At about 05:30 am it was time to care for R7. V22 (Licensed Practical Nurse) also come around to take care of the resident wounds as well as empty urine bag. V22 was there to clean R7 wound. R7 was turned towards me in the bed on the (left) door side. The nurse tried to clean R7 then I tried to turn R7. In the process when I tried to turn R7 over I was trying to walk to the other side of the bed while the nurse held onto R7. I shouted hey, hey, hey because R7 was falling. We have to pull R7 close. I was going behind V22 and that space was so narrow. When I was trying to trade places with V22, R7 moved. R7 can move a little. V22 was holding onto R7 wrist and waist. I was behind V22 when she (V22) was trying to move out to trade places with me. R7 was almost flipping off the bed and V22 was trying to hold onto R7 when he fell . Before I got there, R7 was almost on the floor and before I could get positioned to prevent R7 from falling to the floor he (R7) was falling. We put R7 back in bed with our arms under R7 arm pit and the other person picked him (R7) up from the legs. R7 doesn't get out of the bed so I don't consider him a fall risk. R7 is able to move his arms. On 07/03/24 at 08:53 AM V2 (Director of Nursing) stated according to V22 (Licensed Practical Nurse) they (V22 and V9 Certified Nurse Assistant) were going to dress R7 wounds. V22 and V9 were both on each side of R7's bed. V22 said she (V22) was going to move to the other side of the bed and trade places with V9. There was a mistake and the resident (R7) slipped and hit his head on the bed side table drawer. They were supposed to be doing a 2 person assist. I expect if the resident is a one person or 2-person assist they are supposed to do it accordingly. They turned and repositioned the resident (R7) and when V9 were exchanging places with V22 that is when the resident fell out of the bed. This could have been avoided if the nurse could have been standing there completing before attempting to change places with V9. That is the same bed that R7 was in when the fall occurred. R7 jerks and is in a bariatric bed. There was an In-service given to the staff, certified nurse assistance and nurses. R7 cannot turn by himself but he has spontaneous movements that the staff is aware of. R7 is a quadriplegic and is considered a fall risk. R7 was on the low air loss mattress." Surveyor asked when R7 returned from the hospital why was he not interviewed. V2 responded, when R7 came back he (R7) is the type of person that will not speak to you. R9 sustained a laceration to the scalp when he fell . On 07/03/24 at 09:24 AM V24 (MDS/Care Plan Coordinator) stated if a resident has a fall that would be a change in condition. We update the care plan if there is a new intervention. When the standard does not work, we update the intervention every three months. After R7's last fall the care plan is not reflecting any new interventions. On 07/03/24 at 09:30 AM V6 (Restorative Nurse/Infection Preventionist/Quality Assurance) stated R7 fall was discussed in the meeting and from my understanding V22 (Licensed Practical Nurse) was trying to do wound treatment for R7 and there was another staff with her (V22). From the understanding she (V22) did one side of the wound treatment and was going to the other side of the bed when the bed moved and R7 fell . The low air loss mattress moved. The resident (R7) was close to the edge of the bed when the mattress moved and that is how R7 accidentally fell . R7 is a 2 person assist and has no side rails. R7 does not move by himself and has to be turned by someone. R7 would be considered a fall risk. R7 has had 2 falls. I am not sure how R7 fell out of the bed in April. (continued on next page)

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	07/05/2024

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	On 07/03/24 at 11:04 AM V26 (MDS Nurse) stated R7's fall was reviewed but V24 (MDS/Care Plan Coordinator) did not put it in the care plan intervention. The care plan focus was updated but there were no interventions in writing. The staff received an in-service. In the care plan focus it has R7 is a 2 person assist. There were two staff rendering care when R7 fall happened. According to our policy the care plan is completed quarterly, with a change, fall, skin break down or anything. Document Titled Record of Inservice's dated 05/29/24 document in part: Turning and Repositioning with 2 persons assist. Policy: Titled Facility Policy Regarding Resident Falls undated document in part: Overview: This facility is committed to minimizing resident falls so as to maximize each resident's physical, mental, and psychosocial well-being. It is this facility's policy to act in a proactive manner to identify and assess those residents at risk for falls, plan for preventive strategies, and facilitate as safe an environment as possible. All residents' falls will be assessed, and the resident's existing plan of care will be evaluated for needed changes. Policy: For residents who have been identified at risk for falls upon admission, the interdisciplinary plan of care shall include initial interventions to prevent injuries and accidents from falls. Facility Response to a Resident Falls with an Injury: The Fall Risk Assessment shall be reviewed and revised as needed. The resident's plan of care shall be updated if additional care interventions as necessary. Quality Improvement Measures for Resident Falls: Based on recommendations from the Quality Improvement Committee, facility-specific staff training shall be provided for all appropriate staff. Titled Transfer and Bed Mobility undated document in part: Policy: Proper body mechanics are essential to maintain health and wellness of the resident and the employees. Procedure: 2. Before repositioning resident make sure that resident is positioned in the center of the bed. 6. Before beginning the activity, mentally practice the skill so that you can foresee any possible problem areas. 8. When you begin the movement, be sure to keep your feet shoulder width apart to give yourself a stable base to work with. 9. Make sure to keep the person or object ass close to your body as possible. Titled Resident Care Planning undated document in part: Policy: Each resident has a resident care plan that is current, individualized, and consistent with the medical regimen. Following interdisciplinary team conferences completed quarterly and as needed, the interdisciplinary team update goals and actions that were discussed. Each discipline is responsible for reassessing the resident's care plan needs and reactivating care plans upon his/her return. Staff will utilize care plans to assure that each resident's need are met through appropriate and individualized staff interventions in a timely manner.