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	11/22/2024

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 - 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** 49666 Based on interview and record review, the facility failed to prevent and protect residents from resident-to-resident physical abuse. This failure affects one (R1) resident out of eight residents reviewed for abuse. As a result of this failure, R2 pushed R1 to the floor. Findings include: Facility reported incident/FRI dated 07/06/2024, documents that the facility reported an altercation between R1 and R2. FRI documents that R1 reported R2 pushed R1 and R1 fell to the floor. R1's face sheet documents that R1 is a [AGE] year-old female with diagnoses not limited to: schizophrenia, depressive disorder, recurrent, mild, hypothyroidism, essential (primary) hypertension. R1's MDS/Minimum Data Set, dated dated dated [DATE], documents that R1 has a BIMS/Brief Interview for Mental Status score of 15/15, indicating that R1 is cognitively intact. R2's face sheet documents that R2 is a [AGE] year-old male with diagnoses not limited to: schizophrenia, restlessness and agitation. R2's MDS/Minimum Data Set, dated dated dated [DATE] documents that R2 has a BIMS/Brief Interview for Mental Status score of 09/15, indicating that R1 is moderate cognitively impaired. On 11/20/2024 at 4:29 PM via telephone V9 (Certified Nursing Assistant) stated that she did not witness the altercation between R1 and R2. V9 stated that she just came from the soiled room, I (V9) quickly got there. When I (V9) got there, R1 was on the floor, and the nurse was there. V9 stated that R2 was separated and sent to his room or nurse's station. On 11/20/2024 at 2:15 PM, V4 (Social Services Director) stated R2 doesn't speak too much; he just looks at you and nods at you. V4 stated that R1 reported to her that when she (R1) was walking away, he (R2) grabbed her (R1) and pushed her (R1) down. V4 reports that both residents (R1 and R2) are ambulatory residents. V4 stated with her (R1) behavior, she can provoke people. V4 reports that both have care plans in place regarding behavior and stated that both of their care plans were updated post the incident. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/20/24 at 3:23 PM V8 (Licensed Practical Nurse) stated that she was the nurse on duty the night shift that the incident occurred. V8 stated that in the morning about 5:30 AM, R1 came to the nurse's station for her morning medications. V8 proceeded to state R1 went back. After 5 minutes R1 came back to V8 and said that R2 would not give up his space for her. V8 stated that she told R1 that she cannot ask someone to move if he (R2) got there before her. V8 stated that she gave R1 options (go to her room or look elsewhere to seat). V8 proceeded to state after 5 minutes she heard yelling. V8 stated that she saw R1 getting in R2's face, both with raised voices. V8 stated that she went to the day room and saw R1 going towards R2, and then R1 turned her head and she dropped on her knees. V8 stated that R1's hair was caught on the ring that R2 was wearing. V8 stated that she asked R2 what happened, and he didn't answer and walked away. V8 reports that V8 and R1 had a good relationship. V8 stated that R1 is alert and oriented x3 (person, time, place). V8 stated that R1 does taunt residents and some interventions in place are room changes as needed, redirecting R1. V8 stated I have to be honest, that morning there was nobody in the day room, because it was early morning. V8 stated that R1 and R2 maybe just them two were the dayroom. On 11/21/2024 at 2:07 PM, via telephone V1 (Administrator) stated that she is the abuse coordinator. V1 stated that staff separated R1 and R2 and placed on different units. V1 stated that all residents have the right to be free from abuse and neglect. V1 stated that she went over R1's statement with R1 and R1 didn't sign it until it read what she wanted it to know. I read everything back to her. V1 was questioned if R1's statement about R2 pushing her, is an example of physical abuse. V1 responded yes, it is an example of abuse and that is why V1 reported the incident. R1's progress note dated 7/6/2024 07:02 AM documents in part At 5:35 AM, resident (R1) came by the nursing station during for her morning medication. About 5 minutes later she came back and said co-resident (R2) did not want to give up his space for her. This writer (V8- Licensed Practical Nurse) told her to go to her room or seat elsewhere and she said ok and left. Five minutes later, this writer heard yelling from the day room and the writer hurried there to see co-resident (R2) trying to get away from R1 while she was going towards him. Co-resident (R2) raised his hand to shield himself from her (R1) and his hand got caught in her (R1) hair. R1 pulled away, turned fast, turned around, and fell to the ground. The writer immediately separated them and helped detangled his (R2) hand from R1's hair. V2 made aware as well as the administrator (V1). The incident was reported to the Police Department. R1's care plan dated 7/3/2024, documents in part, R1 may be a risk for abuse related to poor esteem, feelings of powerlessness and helplessness, history of alleged abuse/mistreatment. R2's care plan dated 12/20/2020, documents in part, R2 exhibits physically aggressive behavior towards staff/others 07/06/2024, R2 presents with recent incidents of physical aggression directed towards others. Goal: Resident will show a decrease in number of episodes of physical aggressive behavior. Facility reported incident/FRI dated 07/06/2024, documents in part V9 observed R1 on the floor with the nurse by her side. V9 and the nurse helped R1 up and the nurse informed V9 that R1 had an altercation with R2. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility document dated 03/08/2016, titled Abuse Prevention Program documents in part, this facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, corporal punishment, and involuntary seclusion. Abuse is any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means in a facility.