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	02/23/2025

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** 45111 Based on interview and record review, the facility failed to ensure that two (R1, R2) residents were free from abuse. This failure resulted in R1 and R2 verbally and physically abusing each other in a total sample of four residents reviewed for abuse. Findings include: R1 is a [AGE] year-old individual with medical diagnosis that include but not limited to schizoaffective disorder, bipolar type, bipolar disorder, current episode manic without psychotic features, unspecified. R1's MDS (Minimum Data Set) section C dated 01/15/2025 documents R1's Brief Interview for Mental Status (BIMS) as 15/15 indicating R1 has intact cognitive function. R2 is a [AGE] year-old individual with medical diagnosis that include but not limited to Chronic pain syndrome, Poisoning by heroin, undetermined, initial encounter, Personal history of other malignant neoplasm of rectum, rectosigmoid junction, and anus. R2 MDS (Minimum Data Set) section C dated 12/02/2024, documents R2's Brief Interview for Mental Status (BIMS) as 15/15 indicating R2 has intact cognitive function. On 02/22/2025, R1 was not residing in the facility during this investigation. On 02/22/2025, at 10:16 AM, R2 was observed in his room sitting on a chair in front of his television with his head on his bedside table. R2 was observed to be irritable. When R2 was asked about his previous roommate, R2 stated he is done, he is gone, he is gone, how many times do I have to say he is gone? I do not want to talk about it. I have talked about it enough. R2 then put his head back down on the bedside table and declined to speak to surveyor. Facility Reported incident Report (FRI) final, dated 02/10/2025, documents: On 02/05/2025, at approximately 3:00 PM, R2 alleged he was hit in his abdomen and on his thigh by R1. R2 hit R1 back. R2 stated R1 got upset when R2 told R1 that R1's TV was too loud and to turn it down. Staff (no names) heard yelling from R1 and R2's room. Based on the known facts from medical record review and interviews, the allegation of abuse is founded. (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 02/22/2025, at 1:29 PM, V11 (Housekeeper) with interpreter (Spanish) V12 (Housekeeper) stated she was working in the hallway and was passing by R1 and R2's room when she saw R1 hitting R2 on the feet. V11 stated the television in R1 and R2's room was on, and it was loud. R2 was mad with R1 because the television was too loud. V11 stated after she saw R1 punching R2. She ran to the nursing station and informed the CNAs (Certified Nursing Assistants) (no names provided) and the nurses (no names provided) that R1 was punching R2 and both R1 and R2 were screaming at each other. V11 stated staff went to R1 and R2's room to check on the residents and took R1 out of the room. On 02/22/2025, at 11:20 AM, V6 (Certified Nursing Assistant-CNA) stated he was assigned R1 and R2 on 02/05/2025. V6 was completing his hourly rounds and was on the other side of the unit when he heard code purple (which means resident altercation). By the time he got to R1 and R2's room, there were other staff members intervening. V6 stated R1 and R2 were arguing and shouting to each other about the television volume. R2 was stating R1's television volume was high, and that is what the argument was about. V6 stated the nurse (cannot remember the name) was already in the room talking to R1 and R2 and they were separated. On 02/22/2025, at 1:29 PM, V9 (Registered Nurse) via phone stated it was around 2:00 PM, when V9 was called by V11 (housekeeping) and informed that R1 and R2 were having a verbal argument. V9 stated she went to the room to check and when she got here, she found the residents separated. She checked to see if both residents were ok. V9 stated R1 stated R2 hit him and R2 stated R1 hit him. Both residents were placed on a 1:1 and V1 (Administrator), V2 (Director of Nursing-DON) and social services were notified. On 02/22/2025, at 12:21 PM, V10 (Social Services Director) stated R1 was brought to V10's office to get him off the floor after getting into a physical altercation with R2 (roommate) because R1's television was too loud. On 02/22/2025, at 2:33 PM, V1 (Administrator) stated V10 (Social Services Director) notified her of R1 and R2's altercation on 02/05/2025. R1 and R2 were separated. Physicians were notified, police were called, and family was notified. V1 stated the initial reportable to IDPH (Illinois Department of Public Health) on 02/05/2025. V1 stated if any time a resident hit another resident, it is a form of abuse. R1 was removed from the room and taken to the social services office. R1 was petitioned out for further assessment and treatment. V1 stated the police were called because of the allegation of physical abuse. After the police interviewed R1 and R2, the facility was given a case number that stated, simple battery. V1 stated any forms of abuse can affect the resident emotionally and mentally even when there are no physical injuries. On 02/22/2025, at 3:25 PM, V2 (Director of Nursing -DON) stated residents are not supposed to hit each other, because that's a form of abuse. To prevent the altercation, social services could have put interventions in place, such as offering both R1 and R2 earphones which could have prevented the altercation. Witness statements dated 2/5/2025 document R1 and R2 have verbal and physical confrontation regarding R1's TV being too loud. R1's progress notes dated 2/6/2025, document R1 had a physical altercation with R2. R1 continued to be agitated, verbally aggressive and threatening to cause harm to R2. R1 continued to be non- compliant and disrespectful. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's progress notes dated 2/5/2025, document altercation between R1 and R2 was reported to police and case number #JJ139411 provided. R2's progress notes dated 2/5/2025, document V9 (Registered Nurse-RN) was called to R2's room by staff (no name). Upon entering the room, R2 and R1 were engaged in a verbal altercation with R2 stating R1's TV (television) volume was too loud. When R2 asked R1 to reduce the volume, R1 hit R2 on the lap. V9 separated R1 and R2. R2's progress noted dated 2/6/2025, document R2 was in an alleged physical altercation with R1. R2's progress notes dated 2/11/2025, document R2 denied being the aggressor, but admitted his actions were a form of defense due to R1's demanding behavior. Police report dated 2/5/2025 #JJ139411 document simple battery. Policy titled Abuse Prevention Policy dated 10/24/2022 documents: -Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. Physical abuse is the infliction of injury on a resident that occurs other than by accidental means. Physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment. Verbal abuse is the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or families or within hearing distance regardless of an individuals' age, ability to comprehend or ability.