STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145479	A. BUILDING _____ B. WING _____	09/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement their abuse policy by failing to identify and report an allegation of abuse for one of three residents (R7) reviewed for abuse in a sample of nine. Findings include: Facility's Fall Occurrence Report Investigation dated 09/01/2020 documents: Resident (R7) [DIAGNOSES REDACTED]. On assessment resident noted with a superficial cut to left eyebrow. Prior to incident per staff resident was resting in bed and calm. R7's Progress Note dated 09/01/2020 (signed 09/03/2020) documents R7 returned to the facility after evaluation and treatment at local hospital for superficial cut on left eye brow, abrasion on the bridge of his nose and a small cut on the inside left lower lip. On 09/16/2020 at 10:18 AM via telephone, V9 (Assistant Director of Nursing) stated, I came to work (09/01/2020) and the 2nd Floor Nurse paged me to come upstairs. I ran upstairs. She told me the CNA (Certified Nursing Assistant) met the resident (R7) on the floor (found resident on the floor) with blood on his head. I went to see him, he was lying on the bed with a dry dressing covering his head. I asked him what happened. He said, 'I told you I want to leave (facility). You won't let me leave. I told you I'm going to keep falling. I'm going to tell them at the hospital that you jumped me.' I informed the Administrator about the statement he (resident) made to me. I told him because that's what I'm supposed to do. I told him what the resident said. I wrote two statements; I gave them to the Administrator. On 09/16/2020 at 12:07 PM in the facility's Conference Room, V1 (Administrator) stated: He (R7) told V9, 'I'm going to tell someone at the hospital you hit me. She did inform me of his allegation that day, I believe I think. She (V9) did give me a vague statement several days after the initial incident; the more detailed statement was sometime last night (09/15/2020). I didn't do an investigation because he said he was planning to say he was going to make an allegation. If he had come to me after and made an allegation of abuse, I would have investigated it. No one informed he was alleging abuse. Facility's Abuse Prevention Training Program policy and procedure (dated 11/22/2017) documents: II. IDENTIFICATION AND INTERNAL REPORTING B. Internal Reporting. Employees are required to report any allegation of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property they observe, hear about, or suspect to the administrator immediately, to an immediate supervisor who must then immediately report it to the administrator. Reports will be documented and a record kept of the documentation. V. REPORTING & RESPONSE C. Initial Report. An initial report to the State licensing agency, Illinois Department of Public Health, shall be made immediately after the resident has been assessed and the alleged perpetrator has been removed. E. Final Report & Follow Up. Within five days after the report of the occurrence, a complete written report of the conclusion of the investigation, including steps the facility has taken to respond to the allegation, will be sent to the Department of Public Health.
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** Based on interview and record review, the facility failed to implement their abuse policy by failing to identify and investigate an allegation of abuse for one of three residents (R7) reviewed for abuse in a sample of nine. Findings include: Facility's Fall Occurrence Report Investigation dated 09/01/2020 documents: Resident (R7) noted on floor by door entrance. On assessment resident noted with a superficial cut to left eyebrow. Progress Note dated 09/01/2020 (signed 09/03/2020) documents R7 returned to the facility after evaluation and treatment at local hospital for superficial cut on left eye brow, abrasion on the bridge of his nose and a small cut on the inside left lower lip. On 09/16/2020 at 10:18 AM via telephone, V9 (Assistant Director of Nursing) stated, I came to work (09/01/2020) and the 2nd Floor Nurse paged me to come upstairs. I went to see him (R7); he was lying on the bed with a dry dressing covering his head. I asked him what happened. He said, 'I told you I want to leave (facility). You won't let me leave. I told you I'm going to keep falling. I'm going to tell them at the hospital that you jumped me.' I informed the Administrator about the statement he (R7) made to me. I told him because that's what I'm supposed to do. I told him what the resident said. I wrote two statements; I gave them to the Administrator. On 09/16/2020 at 12:07 PM in the facility's Conference Room, V1 (Administrator) confirmed V9 related to him that (R7) told V9, 'I'm going to tell someone at the hospital you hit me.' She did inform me of his allegation that day, I believe .I think. She (V9) did give me a vague statement several days after the initial incident; the more detailed statement was sometime last night (09/15/2020). I didn't do an investigation because he said he was planning to say he was going to make an allegation. If he had come to me after and made an allegation of abuse, I would have investigated it. No one informed he was alleging abuse. Facility's Abuse Prevention Training Program policy and procedure (dated 11/22/2017) documents: IV. INVESTIGATION As soon as possible after an allegation of abuse, neglect, mistreatment, misappropriation of resident property, or exploitation, the administrator or designee will initiate an investigation into the allegation.
F 0760 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to follow the medication pass schedule as documented in their Facility Policy. This failure resulted in 1 resident (R4) receiving a scheduled medication at the imprope time. The failure also has the potential risk of R4 experiencing a hypoglycemic episode. Findings include: On 9/15/2020 at 2:30 PM in the 3rd Floor Nurse's Station, V7 (Licensed Practical Nurse) was seen with multiple medication cups containing multiple medications. V7 stated, I am running late with my medication pass. These medications are scheduled either 12:00 noon or 1:00 PM. V7 stated, Medications should be given 1 hour before and 1 hour after. I also have insulin to give to R4, which was scheduled at 1:00 PM. But I do not know where he is right now. Insulin should be given with meals as written in the order. I did not see R4 inside R4's room. Facility staff identified R4, who was found sitting on the chair at the activity area near the Nurse's Station. R4 was alert and able to verbalize himself. R4 stated that he cannot remember when the last time he received his insulin medication. R4 also stated that he ate his lunch around 11:30 AM to 12:00 noon and that was the last time he ate. At 2:45 PM, V7 took R4's blood sugar and the result was 275. V7 stated it was high and then via syringe aspirated 5 ml of Admelog insulin and injected it on R4's upper arm. V7 stated, Yes, this is late to give insulin. On 9/15/2020 at 4:15 PM in the Conference Room, V2 (Director of Nursing) stated, With regards to Medication Administration Pass, the facility follows certain time like three times a day or TID and each medication pass has a certain time: 9:00 AM, 12:00 Noon and 5:00 PM. We have a medication pass schedule written and it is also seen in the order itself. The facility follows the 1 hour before, 1 hour after rule. It means that if the medication order is set at 12:00 noon, it should be given between the hours of 11:00 AM to 1:00 PM. There are medications that have specific times to give and it must be followed. For example insulin medication; if the order written is with meals, it must be given when the resident is about to eat his or her meal. There will be a risk of [DIAGNOSES REDACTED] when time schedule order is not followed. On

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 0760 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) 9/16/2020 at 11:44 AM. V8 (Attending Physician) stated R4's insulin is scheduled three times a day at 9:00 AM, 12:00 noon and 5:00 PM. V8 stated, It must be given at meal times as written in my order. It means that insulin must be given with meals because food makes blood sugar go up and the insulin will prevent blood sugar to go up. When insulin is given without food or not during meal time, it has a risk of resulting to [DIAGNOSES REDACTED], meaning low blood sugar. And having low blood sugar is not good for anyone with diabetes. R4's Medical [DIAGNOSES REDACTED]. R4's Physician order [REDACTED]. Inject 5 units by subcutaneous route 3 times per day with meals. Schedule: Every Day at 8:00 am; 12:00 pm; 5:00 pm. Medication Administration Policy (undated) reads: Complete Medication Administration Pass within 2 hours (1 hour before/1 hour after).