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 _____	**08/20/2020**

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.

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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** Based on interview and record review, the facility failed to supervise and protect a resident (R2) from physical abuse of another resident (R3). As a result, R3 pushed R2 resulting in R2 falling to the ground and sustaining a left [MEDICAL CONDITION]. This failure affected one (R2) of 4 residents reviewed for abuse in total sample of 5 residents. Findings include: R2 is an alert, oriented, ambulatory [AGE] year old female who requires limited assistance with her dressing, toilet use, and hygiene but otherwise is independent with her activities of daily living (ADLs). R2 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. R2's care plan addresses concerns with poor hygiene, diminished motivation and not recognizing a problem when it exists. R2 left on 5/19/20 per the MDS with return anticipated but never returned. On 8/11/20 at 3:40 PM, V12 (R2's brother/guardian) stated he is upset that his sister was not protected from R3. V12 stated he googled R3 and found out that R3 was a convicted felon with murder, attempted rape and kidnapping charges in his past. V12 stated that he should have been told of R3's background and believes that R3 should never have been in the nursing home. R3 is an alert, oriented, ambulatory [AGE] year old male who requires limited assistance with hygiene but otherwise independent with his ADLs. R3 was admitted on [DATE] with [DIAGNOSES REDACTED]. R3 is an identified offender spending significant time in prison for the murder of his father and the attempted sexual assault and kidnapping of his mother per the criminal history analysis report (CHAR) and care plan. R3 is care planned for his verbal and physical aggression toward other residents and staff, his non-compliance with medication, non-compliance with his course of treatment and activities of daily living. R3 is impulsive, has poor boundaries with others and no insight into his mental illness. R3 is no longer in the facility. R3 left on 5/13/20 returning to the facility on [DATE] per MDS and nurses' notes. R3 was given an involuntary notice and told he would be sent back to the hospital and not allowed back to this facility. The hospital would assist with re-locating R3 to another facility. This was confirmed by V5 (Psychiatric Rehabilitation Service Director/PRSD) on 8/18/20 at 12:35 PM and V1 (Administrator) on 8/18/20 at 12:08 PM. Review of nurse's notes/social service notes (5/13/20, 5/14/20), facility's incident report (5/13/20, 5/19/20) and the facility's investigation (5/13/20) and staff and resident interviews, document that the following occurred: On 5/13/20 at 4:30 PM in the 3rd floor dining room, R3 and R2 were both in the unsupervised 3rd floor dining room. R12 was also present and witnessed the incident. On 8/18/20 at 10:20 AM in the presence of V1 (Administrator) per R12's request, R12, an oriented male, stated there were no staff supervision in the dining room and maybe 5 other residents present along with R2 and R3. R12 stated that R2 was walking and moaning to self when R3 walked past her and told her to shut the f . up. R2 was quiet momentarily but started to moan again. R3 then moved fast toward R2's backside and pushed her with incredible force landing her onto the floor. R12 stated that many of the residents are afraid of R3 because of his size and his aggression toward others. R12 stated that R2 was in pain and could not walk so she was carried back to her room by staff. On 8/18/20 at 1:34 PM, V10 (Certified Nurse Aide/CNA) stated that R2 was in so much pain R2 could not stand or walk, so she was carried back to room. V10 stated he was not in the dining room but on his way to the pantry when he saw R3 push R2 causing R2 to land on the floor. V10 stated he called for V9 (Licensed Practical Nurse/LPN) to come, assess and assist R2 off the floor. On 8/18/20 at 11:12 AM, V9 (LPN) concurred that she assisted V10 with assessing and carrying R2 back to her room. V9 stated that R2 was in pain but refused pain medication. V9 stated due to the pain and refusal of medications, V9 called the physician and received order for x-ray to the left knee which came back negative. V9 stated that R2 would walk daily throughout the day and she was not getting up but staying in the bed. V9 stated R2's left leg became swollen and another order was received to x-ray the entire left side of the body. A fractured left hip was found. R2 was sent to the hospital. V9 stated that R3 is a bully and threatens everyone on a daily basis that he was going to kill them. R3 was non-compliant with medication since day one of admission which the administrator, Director of Nursing and psychiatrist were all aware of. R3 does not interact with anyone in the facility and has no friends or family involvement. Meanwhile, R3 was being monitored 1:1 by V11 (CNA) following the altercation. On 8/18/20 at 11:04 AM, V11 stated that R3 was taken to his room immediately after the altercation with R2. V11 stated he remained with R3 for an hour and half until paramedics arrived. V11 stated R3 was highly manic, speaking very fast and saying that R2 should not have been in the way. V11 stated R3 continued to pace the room and curse, saying a lot of random stuff. V11 stated that R3 is very unpredictable and uncontrollable. V11 stated that R3 was very happy to leave the facility with the paramedics, saying finally getting out of here. V11 stated that R3 knew right from wrong. On 8/18/20 at 12:35 PM, V5 (PRSD) stated, R3 should never have been placed in this facility. From day one, R3 refused medications, denied he was mentally ill, would verbally threaten staff daily by saying 'I will kill you in 30 days,' then each day he would count down saying 'I will kill you in 29 days,' then 28 days and so on. V5 stated that R3 refused any and all counseling and re-directions. V5 stated she and others were afraid to be alone with him. V5 stated R3 was a large man, smelled terribly due to his refusal for hygiene/bathing and would say sexually explicit things to staff when they were alone with him or passing by. V5 stated that the city police came into the facility on e day and gave R3 a restraining order for a woman in the community. V5 stated he presented as a hater of women because he would refer to his ex-wife as a w***e. V5 described R3 as consistently angry and not compliant with anything in the facility. V5 stated there were so many red flags for why R3 should not have been placed in a nursing home, such as his background of murder, attempted rape and kidnapping and non-compliant with medications before entering the facility. V5 stated that R3 did know right from wrong but had poor impulse control and poor decision-making. V5 stated she was present on 5/27/20 when R3 returned to the facility and V1 (Administrator) presented R3 with involuntary discharge papers. V5 stated that R3's response was Oh, wow. I should have killed her. V1 did confirm this statement on 8/18/20 at 12:08 PM. During interview on 8/18/20 at 11:30 AM with V7 (Psychiatric Rehabilitation Service Counselor/PRSC) and at 11:45 AM with V6 (PRSC), both stated the same information as V5 stated above. Both V7 and V6 stated R3 paced a lot in the facility and would not listen to re-directions. Both stated that if they tried to talk to R3 about his non-compliance with medications and his hygiene, R3 would be verbally aggressive threatening them that he would kill them if they did not quit asking him about meds and his refusal to follow his treatment plan. R3's homicidal ideation was noted throughout R3's clinical record along with discharges to the hospital. Both V7 and V6 stated to be fearful of R3 due to his size and his sexually explicit comments to staff. V7 stated when she was conducting an interview with R3 at admission, R3 put up his middle finger, touched V7's forehead and called her b***h with no provocation. V7 stated R3 was antagonist with everyone. V6 stated that R2 was really hurt, in pain and crying after the incident. V6 stated has never seen R2 in that state after she was pushed by R3. On 8/19/20 at 8:23 AM, V8 (former PRSC) concurred with V6's and V7's statements. V8 stated V8 was afraid of R3 due to his size, unpredictability, his refusal to take any medications, no insight into his mental illness and his sexually charged statements to others. R3's social service and nurses' progress notes dated 5/13/20, 5/14/20, 5/27/20 confirm the above statements. Notes related to refusal to take

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 0600 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) medications from month to month and R3's homicidal ideation include dates of 4/15/20, 4/8/20, 3/30/20, 3/23/20, 3/21/20 and 1/5/20. R3's sexually explicit language was noted 4/14/20, his physical aggression with other residents where R3 was kicking and pushing other residents' wheelchair into each other while in the dining room were noted on 2/17/20, his attempts to elope on 2/19/20, 2/3/20 and 1/5/20. On 1/5/20, R3 was taken out of the facility by the city police due to R3's threats of harming anyone who tried to stop him from leaving the facility. R2's in-house x-rays (5/13/20 and 5/19/20) confirmed the findings of no fracture of knee and a [MEDICAL CONDITION], respectively. On 8/20/20 at 9:45 AM, V12 (R2's brother/guardian) stated that there was surgery done for the fractured left hip but there was no surgery for [REDACTED]. The facility's ABUSE PREVENTION POLICY documents residents have the right to be free from abuse. The facility prohibits abuse of its residents, including verbal, mental, sexual or physical abuse. The facility has a no tolerance philosophy.
F 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to investigate an incident of physical abuse between 2 residents (R2, R3), This failure resulted in a delay of identifying the cause of physical abuse for one resident (R2). The facility also failed to investigate an elopement of a resident (R1). The facility failed to obtain all pertinent interview statements, failed to follow their policy for investigating physical abuse, failed to investigate an elopement, and failed to take corrective action as result of their findings for 3 (R1, R2, R3) of 4 residents reviewed for abuse in a total sample of 5 residents. Findings include: 1. Review of the facility's abuse investigation dated 5/13/20 documents R3 forcibly pushed R2 from the back causing R2 to hit the floor sustaining a [MEDICAL CONDITION]. There was one interview done with R12 (an oriented male). On 8/18/20 at 10:20 AM in the presence of V1 (Administrator) per R12's request, R12 stated there were no staff in the 3rd floor dining room when the altercation happened between R2 and R3. On 8/18/20 at 1:34 PM, V10 (Certified Nurse Aide) stated he witnessed R3 push R2 onto the floor as he walked by the dining room. V10 stated no one asked him for a statement or interviewed him. On 8/18/20 at 11:12 AM, V9 (Licensed Practical Nurse) stated V10 had witnessed R3 pushing R2 onto the floor. V9 stated she was not interviewed or asked for a statement on this incident. On 8/18/20 at 12:08 PM, V1 stated there is no formal monitoring of the dining rooms and agreed that he should have done more interviewing of potential witnesses for the physical abuse by R3. V1 asked if V12's interview confirmed the physical abuse between R2 and R3, why would there be a need for more interviews? Review of the facility's incident report dated 5/19/20 documents that at 3:30 PM on 5/19/20 it was reported R2 was allegedly pushed by a co-resident causing her to fall. Left leg x-rayed and found to be fractured. The follow-up report labeled Final Incident Report dated 5/22/20 documents allegedly pushed by co-resident causing R2 to fall. Administrator notified and investigation conducted. R2 complained of left knee pain, M.D. notified, x-ray ordered and showed a fracture of femoral neck ([MEDICAL CONDITION]), no dislocation. R2 transferred to hospital for medical evaluation. This report was completed by V2 (Director of Nursing). On 8/18/20 at 10:30 AM, V2 (Director of Nursing/DON) stated she did the investigation into R2's fractured leg and it is complete. V2 was asked why she used the word allegedly pushed in her report when the push was witnessed and confirmed to have happened per the administrator's investigation from 5/13/20. V2 stated she works independently from the administrator and did not know what was found by the administrator. When asked for the interviews V2 conducted while investigating the alleged incident of R2 sustaining a [MEDICAL CONDITION], V2 stated There are none. In the incident report by V2, R3 was never mentioned or documented. 2. The facility's incident report for missing person dated 4/24/20 related to R1's elopement documents 6:05 PM, R1 was noticed missing. Staff searched a 3-mile radius of the facility and alley behind the facility. Unable to locate. Family and Police notified. Administrator and D.O.N. informed. Will place calls to area hospital to inquire. Prior to the incident, R1 was seen walking the unit with no concerns. Talking to residents and staff. No behavior issues noted. This report was completed by V2 (Director of Nursing/DON) and sent to State Regional office on 4/24/20 at 7:49 PM. The final report to this elopement was sent to the regional office on 4/28/20 at 6:38 PM which documented that R1 was brought back to the facility by the police the same evening of 4/24/20 with no apparent injury. There was no documented information on the corrective measures the facility will take to prevent this from happening again. On 8/18/20 at 3 PM in the presence of V1 (Administrator), V2 stated the incident report on R1's elopement was complete. When asked to explain the elopement of R1, V2 stated that a staff member told her of the elopement but could not recall the staff member. V2 stated the staff went running toward the patio and she went out the front of the building but R1 was not found. V2 stated she was able to give a description of what R1 was wearing that day to the police. V2 stated V2 informed the Administrator and R1's family of the elopement. V2 stated she does not know how R1 got out on the patio nor does she know of the earlier attempt in the day of R1 trying to elope. V2 was asked for statements of people she interviewed during the course of the investigation and the staff who responded to the elopement and the hospitals that were going to be called. V2 stated she did not have any statements or any other documentation to present. V2 recalled that it was V13 (Certified Nurse Aide) who informed her that R1 had eloped. V2 stated that V13 was in the facility working and could come down for interview. On 8/18/20 at 3:50 PM, V1 returned to the conference room and stated that V13 had not been the person to notify V2 of R1's elopement. On 8/18/20 at 12:35 PM, V5 (Psychiatric Rehabilitation Service Director) stated she and V8 (Psychiatric Rehabilitation Service Counselor/PRSC) were in the social service office which is located in the basement, when they looked out their window that leads to the outside patio and saw R1 coming down the outside stairwell into the patio. V5 stated she and V8 ran from their office to the outside patio to find R1 on top of the 6 foot 4 inch high fence. Both V5 and V8 tried to talk R1 off the fence and to come inside. V5 stated she told V8 to go and tell V2 what was occurring. V5 stated that R1 was wanting to elope earlier in the day but V5 was successful in deterring her. R1 refused to come back in and said Bye and jumped down on the other side of the fence. V5 stated that there was no one else on the patio. V5 stated V2 was informed. V5 stated she was on her way home immediately following the elopement and drove around the block looking for R1 but R1 was not found. V5 stated she did not see staff searching the outside perimeter of the facility. V5 stated she was not asked to write up a statement for the elopement nor was she interviewed. On 8/19/20 at 8:23 AM, V8 (PRSC) stated she was in the office with V5 when they saw R1 entering the outside patio. V8 stated they both responded. V8 stated that patio was closed at that time for residents requiring supervision and R1 was assessed to need supervision to smoke. V8 stated that she and V5 responded so quickly that there was no way to inform the other staff of what was happening. V8 stated when R1 jumped from the fence, V5 and V8 went back into the facility and told V2 that R1 just eloped from the outside patio. V8 stated that there was no code green called (which is code for elopement) but that is V2's call as to what is done. V8 stated she left the facility at 6:30 PM and stated she saw no staff wandering the streets for R1. V8 stated she and V5 went back into the facility to write up their narratives in the progress notes immediately after the elopement. V8 stated she was never asked for statements or was she interviewed about the elopement. Record review documents R1 is an alert, oriented [AGE] year old female who was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. R1 suffers from hallucinations and requires limited assistance with most activities of daily living, except eating and toilet use. R1 is ambulatory and uses a walker. R1 exhibits physical aggression with attempts to hit others with wheelchair or will hit with her fists. R1 is manipulative and has history of elopements, which is care planned. R1 is to wear a personal safety device that alerts staff she has left the facility due to R1 requiring supervision in the community due to her physical impairments and use of mobility devices. The elopement assessment dated [DATE] documents R1 not wanting to wear the personal safety device. R1 is no longer in the facility. Three days (4/27/20 at 3 PM) after the elopement, R1 ties a sheet around her neck which a nurse was able to remove. R1 continued to destroy stuff in her room. R1 remained sad and tearful and attempts to strike out at staff and eventually hitting a CNA with her closed fist. R1 was sent out for psychiatric evaluation on 4/27/20 at 6 PM and returns to the facility on [DATE] where she is placed on strict isolation due to COVID-19 precautions which makes her more depressed and suicidal. On 5/14/20 it is documented by V8 (PRSC) that R1 approached V8 and told her she is suicidal, wants to harm herself, has tears in her eyes and states she has had the suicidal thoughts for 3 days. R1 is counseled by V8 about coping skills. V8 notified Director of Nursing and the unit nurse. It was not until 5/15/20 at 3:15 PM (documented by V2) that R1 was voicing concerns with increased hallucinations and wanting to die. R1 was placed on 1:1 monitoring. R1 tried to elope again and code green was called. R1 was sent to psychiatric hospital for suicidal ideation and never returned per social service notes and the MDS. R1's care plan for elopement documents R1's attempts to elope from the facility on 1/28/20, 2/12/20 and two times on 4/24/20 related to being upset. The only intervention was R1 requires supervision and/or a personal safety device. There were no changes to the care plan since admission. The facility's INCIDENT INVESTIGATIONS policy documents The purpose of this policy is to ensure all incidents are investigated and to ensure the appropriate investigation tool is utilized when conducting an investigation. All allegation of abuse or injury of unknown origin must be investigated by administrator or designee. All incidents must be investigated using the Incident Investigation Form.

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F 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) This investigation must be completed by the Director of Nursing. The facility's PATIO HOURS policy document that the patio will be open 7 am to 10 pm unless otherwise stated on the posted schedule. If at any time the patio is opened to allow residents to smoke, a staff member must accompany the resident and upon completion of smoking, staff will ensure the patio door is locked. At no time should a resident be on the patio without staff supervision. The FACILITY POLICY REGARDING MISSING RESIDENTS AND ELOPEMENTS documents It is the policy of this facility that all residents are afforded adequate supervision to meet each resident's nursing and personal needs. All residents will be assessed for behaviors or conditions that put them at risk for elopement. Residents at risk for elopement shall be provided at least one of the safety precautions: a personal safety device that alerts staff when a resident has left the facility without supervision; and/or door alarms on exit doors; and/or staff supervision either by visual contact or by video camera of facility exits. An investigation shall be coordinated by the Administrator or designee in which both the inside and outside of the facility are thoroughly searched. Should a search of the inside and outside of the building prove unsuccessful, the immediate vicinity surrounding the facility shall be searched and all potential witnesses questioned regarding the whereabouts of the resident. The incident report shall include the steps taken to recover the resident and the steps taken to prevent the elopement in the first place. Should an elopement occur, the facility's Quality Improvement Committee or Safety Committee shall review the facility's systems, policies and procedures and responses to elopement to evaluate if all systems are working as they should or whether there are gaps that should be addressed or areas that can be improved.