

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145479	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/22/2024
NAME OF PROVIDER OR SUPPLIER  Atrium Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49666</b></p> <p>Based on observation, interview and record review the facility failed to accommodate a resident's preference to aid in providing a comfortable and homelike setting for one (R1) resident out of eight residents reviewed for resident's rights.</p> <p>Findings include:</p> <p>On 03/19/24 at 10:00 AM observed R1 sitting up on her bed, in her room, alert and responsive. Surveyor did not observe any fan in R1's room.</p> <p>R1's clinical record documents admitted [DATE]. Diagnoses included but were not limited to other specified depressive episodes, multiple sclerosis, paranoid schizophrenia, personality disorder, other muscle spasm, and diabetes.</p> <p>On 03/19/24 at 10:00 AM R1 said that last week R1 requested a fan from the social worker (identified as V7), and the social worker responded that she would check to see if she had one in her office, but she never brought a fan to her. R1 stated that she met with social worker yesterday and social worker did not mention anything about the fan. R1 said that the room feels warm and there is an air conditioner but is on the window side and R1's bed is closer to the room door.</p> <p>On 03/19/2024 10:51AM V7 (Assistant Director of Social Services/PRSD) stated that R1 did request a fan from her but V7 didn't have a fan that V7 can give her. V7 said that she did not tell anyone else about R1 requesting a fan. V7 said that she did not update R1 regarding not having an available fan to give her.</p> <p>On 03/21/24 at 2:04 PM surveyor observed R1 sitting on her bed, no fan observed in R1's room.</p> <p>Facility document dated 12/04 titled Rights and Privileges of the Resident documents in part, The Residents of Atrium Health Care Center have the right to exercise their individualities and to develop their capabilities in all facets of life. We consider it our duty and privilege to assist them in this ongoing process .29. All staff of the facility will know and understand the rights and privileges of the Resident.</p> <p>Long-Term Care Ombudsman Program Residents' Rights documents in part Your rights to safety: Your facility must provide services to keep your physical and mental health, at their highest practical levels .Your facility must be safe, clean, comfortable and homelike.</p>

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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<p>F 0567</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to manage his or her financial affairs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45000</b></p> <p>Based on observation, interview and record review, the facility failed to properly secure and protect the resident's money for six (R2, R4, R5, R6, R7, R8) out of eight residents reviewed for resident's rights.</p> <p>Findings include:</p> <p>On 03/19/2024 at 11:45AM, V4 (LPN-Licensed Practical Nurse) states the day R2 went to the hospital, V6 (CNA- Certified Nursing Assistant) came to the third floor nurses' station and showed him an envelope. V4 states the envelope was a yellow envelope. V4 states V6 took money out of the envelope and was waving the money saying, I want you to see R2's money. V4 states V6 then put R2's money back into the envelope. V4 states he and V6 did not count R2's money. V4 states the envelope was not sealed and V4 folded the envelope in half and placed it inside of the narcotic lock box located inside of the medication cart. V4 states he was not familiar with the protocol to follow for storing R2's belongings because he never had to keep money for residents at previous facilities V4 has worked for.</p> <p>On 03/19/2024 at 2:00PM, surveyor located on the 3rd floor of the facility with V4 (LPN), V5 (LPN), and V3 (Assistant Director of Nursing/ADON).</p> <p>Surveyor observes the following items inside the narcotic lock box in medication cart #1:</p> <p>1 small, white, unsealed envelope with R5's name written on it.</p> <p>1 small, white unsealed envelope with R4's name written on it.</p> <p>V4 states he is responsible for medication cart #1.</p> <p>On 03/19/2024 at 2:05PM, V3 opens the envelope with R4's name on it and observes money inside. V3 counts the money and the total amounts to \$30 in denominations of one dollar bills.</p> <p>On 03/19/2024 at 2:06PM, V3 opens the envelope with R5's name on it and observes money inside. V3 counts the money and the total amounts to \$10 in denominations of one dollar bills.</p> <p>V4 states he was aware the envelopes were located inside medication cart #1.</p> <p>Surveyor observes the following items inside the narcotic lock box in medication cart #2:</p> <p>1 small, white, unsealed envelope with R6's name written on it.</p> <p>V5 states she is responsible for medication cart #2.</p> <p>On 03/19/2024 at 2:11PM, V3 opens the envelope with R6's name on it and observes money inside. V3 counts the money and the total amounts to \$30 in denominations of one dollar bills.</p> <p>V5 states she was aware the envelope was located inside medication cart #2.</p> <p>(continued on next page)</p>		

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<p>F 0567</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 03/19/2024 at 2:23PM, surveyor located on the 2nd floor of the facility with V10 (LPN) and V3 (Assistant Director of Nursing/ADON).</p> <p>Surveyor observes the following items inside the narcotic lock box in medication cart #3:</p> <p>1 small, white, unsealed envelope with R7's name written on it.</p> <p>1 small, white unsealed envelope with R8's name written on it.</p> <p>V10 states she is responsible for medication cart #3.</p> <p>On 03/19/2024 at 2:25PM, V3 opens the envelope with R7's name on it and observes money inside. V3 counts the money and the total amounts to \$14 in denominations of one dollar bills.</p> <p>On 03/19/2024 at 2:26PM, V3 opens the envelope with R8's name on it and observes money inside. V3 counts the money and the total amounts to \$10 in denominations of one dollar bills.</p> <p>V10 states she was aware the envelopes were located inside medication cart #3.</p> <p>On 03/19/2024 at 2:05PM, V3 (ADON) states resident's money should not be stored and kept inside of the narcotic lock boxes in the medication carts. V3 states the nurses are the only staff members who have access to the keys for the medication carts. V3 states the normal protocol is for staff to give resident's money to social services or to the administrator to be securely stored in the facility safe.</p> <p>On 03/20/2024 at 1:30PM, V1 (Administrator) states she is not aware that resident's money is being kept and stored in the narcotic lock boxes inside the medication carts. V1 states she informs the residents upon admission that if they have money or other valuables, they can choose to give their money and valuables to her to place in a safe to safe guard them. V1 states there is a safe that is kept in her office and only she has the code and key to. V1 states residents should either have possession of their own money or resident money should be given to V1 for safekeeping.</p> <p>R2's MDS/Minimum Data Set, dated dated dated [DATE] documents that R2 has a BIMS/Brief Interview for Mental Status score of 15/15, indicating that R2 is cognitively intact.</p> <p>R4's MDS/Minimum Data Set, dated dated dated [DATE] documents that R4 does not score on the BIMS and has memory problems.</p> <p>R5's MDS/Minimum Data Set, dated dated dated [DATE] documents that R5 has a BIMS/Brief Interview for Mental Status of 10/15 indicating R5 is moderately cognitively impaired.</p> <p>R6's MDS/Minimum Data Set, dated dated dated [DATE] documents that R6 has a BIMS/Brief Interview for Mental Status of 10/15 indicating R6 is moderately cognitively impaired.</p> <p>R7's MDS/Minimum Data Set, dated dated dated [DATE] documents that R7 has a BIMS/Brief Interview for Mental Status of 9/15 indicating R7 is moderately cognitively impaired.</p> <p>(continued on next page)</p>		

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<p>F 0567</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R8's MDS/Minimum Data Set, dated dated dated [DATE] documents that R8 has a BIMS/Brief Interview for Mental Status of 12/15 indicating R8 is moderately cognitively impaired.</p> <p>There is no documentation to show that R2, R4, R5, R6, R7, and R8's money was inventoried in the facility.</p> <p>Ombudsman Program Residents' Rights for People in Long Term Care Facilities dated 11/2018 documents in part, Your facility must try to keep your property from being lost or stolen.</p> <p>Facility policy undated titled Rights and Privileges of the Resident documents in part, 1. Each Resident's personal property will be identified and reserved for his or her own use; there will be sufficient storage for personal clothing, and the facility will provide safekeeping for valuables.</p>

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45000</p> <p>Based on interview and record review, the facility failed to affirm the right of the resident to be free from misappropriation of resident property. This failure affects one (R2) out of three residents reviewed for misappropriation of resident property.</p> <p>Findings include:</p> <p>R2's MDS/Minimum Data Set, dated dated dated [DATE] documents that R2 has a BIMS/Brief Interview for Mental Status score of 15/15, indicating that R2 is cognitively intact.</p> <p>On 03/19/2024 at 10:06AM, R2 states she was sent out to the hospital approximately 1 month ago. R2 states her transfer to the hospital happened so quickly that R2 had to make the decision to give her money to her roommate (identified as R3) because R2 did not want to have her money stolen while R2 was hospitalized . R2 states the social worker was not in the facility during R2's transfer to the hospital and this is why R2 gave her money to R3. R2 states she gave R3 \$385 in cash and R2 was hospitalized for approximately two weeks. R2 states when she returned from the hospital, V7 (APRSD/Assistant Psychiatric Rehabilitation Service Director) only returned \$185 dollars in cash to R2. R2 states V7 returned her money in a brown paper bag that was not sealed. R2 states she has the bag in her possession and shows it to surveyor. Surveyor observes a small brown paper bag with the words Atrium 3 written on it with a black marker. R2 states the bag does not have her name written on it and was never sealed when R2's money was returned. R2 states she spoke to R3 regarding her missing money and R3 informed R2 that R3 gave R2's money to the staff. R2 states R3 did not take her money but the staff took R2's money.</p> <p>R3's MDS/Minimum Data Set, dated dated dated [DATE] documents that R3 has a BIMS/Brief Interview for Mental Status score of 15/15, indicating that R3 is cognitively intact.</p> <p>On 03/19/2024 at 10:27AM, R3 states R2 did give money to her before R2 went to the hospital. R3 states she gave R2's money to V6 (Certified Nursing Assistant/CNA). R3 states she never counted R2's money so R3 is not certain of how much money R2 gave R3. R3 states she overheard V6 counting R2's money and V6 stated R2's money amounted to three hundred something dollars R3 states she thought she was doing the right thing giving R2's money to the staff. R3 states she had no idea that the staff would cheat R2 out of R2's money.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 03/19/2024 at 11:18AM, V6 (CNA) states he usually work 7am to 3pm and is assigned to the 3rd floor of the facility. V6 states he was made aware of R2's money the next morning after R2 was sent to the hospital. V6 states he started his shift around 7am and was performing his rounds. V6 states during his rounds, R3 informed V6 that R3 would like to speak to him. V6 states he told R3 he would come back to see R3 after V6 was done performing his rounds. V6 states he returned to R3's room around 8am. V6 states R3 informed V6 that R3 wanted to give him some money and a phone to keep and R3 informed V6 that the money and phone belonged to R2. V6 states he told R3 No and informed R3 that it was a protocol to follow and the protocol was to inform the nurse. V6 states he then walked to the nurses' station on the third floor and informed the nurse (Identified as V4) about R2's money. V6 states he does not touch the resident's money and V6 insists he never touched R2's money. V6 states he informed V4 (Licensed Practical Nurse/LPN) that R3 wanted to speak to V4. V6 states he told V4 that R3 asked V6 to keep R2's money. V6 (CNA) states he did not see what V4 did with R2's money. V6 states V4 (LPN) later told V6 that V4 gave the money to social services. V6 states he did not work in the facility the day R2 returned from the facility. V6 states R3 informed him that the money R2 gave R3 was missing some of it. V6 states this is how he was made aware that some of R2's money was missing. V6 states that's when he said, Thank God I never touched R2's money so no one can accuse me of taking R2's money. V6 states R2 approached him the morning after R2 returned to the facility from the hospital. V6 states R2 asked V6 Where is my money? V6 states he told R2 What money? V6 states he informed R2 that R3 did not give him any money. V6 states he informed R2 that he told the nurse (identified as V4) about R2's money and let V4 handle it. V6 states he then went to the third floor nurses' station and asked V4, What happened to R2's money? V6 states V4 told V6 that V4 gave R2's money to social services. V6 states he then informed V4 that R2 was asking V6 about the location of R2's money. V6 states he never touched or counted R2's money. V6 states social services (identified as V7) came to the third floor nurses' station that same day and V7 (Assistant Psychiatric Rehabilitation Service Director/APSRD) was made aware of R2's missing money. V6 states V7 told him that V7 gave R2 her money and phone the night before when R2 returned from the hospital. V6 states V7 told him not to worry because V7 would go and talk to R2 about R2' missing money. V6 states R3 asked him later that day was he angry with R3 because R2 was accusing V6 of taking R2's money. V6 states his name only surfaced in R2's missing money situation because R3 told R2 that V6 informed V4 (LPN) so V4 could handle R2's money. V6 states again that he never touched R2's money.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 03/19/2024 at 11:45AM, V4 (LPN) states he has been working at the facility since 12/2023 and is assigned to the third floor of the facility. V4 states he was the nurse assigned to care for R2 the day R2 was sent to the hospital. V4 states R2 was displaying behavior issues such as yelling, using inappropriate words, and cursing. V4 states he called R2's psychiatrist and the psychiatrist gave orders to send R2 out to have a psychiatric evaluation. V4 states the day R2 went to the hospital, V6 (CNA) came to the third floor nurses' station and showed him an envelope. V4 states the envelope was a yellow envelope. V4 states V6 took money out of the envelope and was waving the money saying I want you to see R2's money. V4 states V6 then put R2's money back into the envelope. V4 states he and V6 did not count R2's money. V4 states the envelope was not sealed and V4 folded the envelope in half and placed it inside of the narcotic lock box located inside of the medication cart. V4 states he observed the yellow envelope inside of the medication cart where he left it for approximately a few days and up to a week later. V4 states R2's phone was also kept stored in the narcotic lock box inside of the medication cart. V4 states after about a week, he no longer saw the yellow envelope or phone inside of the medication cart. V4 states he figured someone had given R2 her money and phone back. V4 states he did not inform anyone that R2's money and phone was being stored in the medication cart. V4 states he never informed social services of the location of R2's money either. V4 states he never heard anything else pertaining to R2's money and surveyor interviewing him is the first time V4 is hearing of missing money for R2. V4 states he was not familiar with the protocol to follow for storing R2's belongings because he never had to keep money for residents at previous facilities V4 has worked for.</p> <p>On 03/19/2024 at 12:22PM, V7 (APRSD) states she has been working at the facility for approximately 1 year and 3 months. V7 states she works at the facility Sunday through Thursday from 830am to 5pm. V7 states she was first made aware of R2's missing money about three weeks ago when R2 informed V7 when R2 returned from the hospital. V7 states R2 gave her money to R3 and R3 gave R2's money to V6 (CNA). V7 states R2's money was put into a brown paper bag and put into the medication cart. V7 states she investigated R2's report of missing money but there was no way of V7 knowing how much money R2 actually had. V7 states V6 (CNA) informed her that V6 took whatever money was there and V6 locked it up. V7 (APRSD) states she spoke with R3 and R3 told V7 that R3 gave R2's money to V6 and V6 locked it up at the nurses' station. V7 states she also spoke with V6 and V6 told her that V6 locked R2's money up at the nurse's station. V7 states she only informed the former Social Services Director, who no longer works at the facility, about R2's missing money. V7 states she and V6 were sitting at the nurses' station and R2 came to the nurses' station inquiring about her money. V7 states V5 (LPN) looked in the medication cart and found a brown paper bag. V7 states she opened the bag and only saw cash inside. V7 states she did not count the money inside the brown paper bag, she just handed the bag to R2. V7 states about 15 minutes later, R2 called V7 to R2's room and informed V7 that R2's money was missing. V7 states V6 told her that what was given to V6 by R3 is what was inside the brown bag. V7 states she informed R2 that there was no way to verify the amount of R2's money because no one had verified it or counted it. V7 states R2 was not pleased with this outcome. V7 states R2's money has not been found. V7 states when a resident goes out to the hospital, all of their items should be packed up by the CNAs. V7 states housekeeping should take resident items to the storage room located in the basement to be locked up and stored away. V7 states resident valuables are locked in the safe that is kept in V1's (Administrator) office.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 03/20/2024 at 1:30PM, V1 (Administrator) states she has been working at the facility for five months and she is the abuse coordinator. V1 states she was not made aware that R2 had reported that she was missing money. V1 states this is the first time she is hearing of R2's missing money. V1 states the facility is frequently in-services on abuse. V1 states the facility recently had an in-service on abuse and the topics discussed included: the different types of abuse, reporting abuse, who to report abuse to, the abuse policy, the investigation process, when to contact the police, reporting to the state agency, and resident rights. V1 states staff should have reported this to her so she could have started an investigation. V1 states this should also have been reported to the state agency. V1 states she informs the residents upon admission that if they have money or other valuables, they can choose to give their money and valuables to her to place in a safe to safe guard them. V1 states there is a safe that is kept in her office and only she has the code and key to. V1 states residents do have the right to keep and manage their own money. V1 states staff should turn money in to her for safekeeping if staff is made aware of any resident's money. V1 states when a resident goes out to the hospital, their belongings should be packed and labeled and put into the storage room in the basement until the resident returns back to the facility. V1 states resident items and valuables should be inventoried.</p> <p>There is no documentation to show that R2's money was inventoried in the facility.</p> <p>Facility policy undated, titled Personal Property Policy documents in part, Valuables: .ask the nurse in charge to please record these items on an inventory sheet that can be stored in your records. Lost or Misplaced Personal Items: we make every effort to assure that your possessions are not lost, misplaced, or stolen.</p> <p>Facility policy dated 02/07/2019, titled Abuse and Neglect documents in part The facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment. This will be done by: establishing an environment that promotes resident sensitivity, resident security and prevention of mistreatment; implementing systems to promptly and aggressively investigate all reports and allegations of abuse, neglect, exploitation, misappropriation of property and mistreatment, and making the necessary changes to prevent future occurrences; filing accurate and timely investigative reports. Misappropriation of Resident Property means the deliberate misplacement, exploitation, or wrongful temporary, or permanent use of a resident's belongings or money without the resident's consent.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>45000</p> <p>Based on interview and record review, the facility failed to report and investigate misappropriation of property for one (R2) of three residents reviewed for misappropriation of resident property.</p> <p>Findings include:</p> <p>On 03/19/2024 at 10:06AM, R2 states she was sent out to the hospital approximately 1 month ago. R2 states her transfer to the hospital happened so quickly that R2 had to make the decision to give her money to her roommate (identified as R3) because R2 did not want to have her money stolen while R2 was hospitalized . R2 states the social worker was not in the facility during R2's transfer to the hospital and this is why R2 gave her money to R3. R2 states she gave R3 \$385 in cash and R2 was hospitalized for approximately two weeks. R2 states when she returned from the hospital, V7 (APRSD/Assistant Psychiatric Rehabilitation Service Director) only returned \$185 dollars in cash to R2. R2 states V7 returned her money in a brown paper bag that was not sealed. R2 states she has the bag in her possession and shows it to surveyor. Surveyor observes a small brown paper bag with the words Atrium 3 written on it with a black marker. R2 states the bag does not have her name written on it and was never sealed when R2's money was returned. R2 states she spoke to R3 regarding her missing money and R3 informed R2 that R3 gave R2's money to the staff. R2 states R3 did not take her money but the staff took R2's money.</p> <p>On 03/19/2024 at 10:27AM, R3 states R2 did give money to her before R2 went to the hospital. R3 states she gave R2's money to V6 (Certified Nursing Assistant/CNA). R3 states she never counted R2's money so R3 is not certain of how much money R2 gave R3. R3 states she overheard V6 counting R2's money and V6 stated R2's money amounted to three hundred something dollars R3 states she thought she was doing the right thing giving R2's money to the staff. R3 states she had no idea that the staff would cheat R2 out of R2's money.</p> <p>On 03/19/2024 at 11:18AM, V6 (CNA) states R3 informed him that the money R2 gave R3 was missing some of it. V6 states this is how he was made aware that some of R2's money was missing. V6 states he then informed V4 that R2 was asking V6 about the location of R2's money. V6 states social services (identified as V7) came to the third floor nurses' station that same day and V7 (Assistant Psychiatric Rehabilitation Service Director/APSRD) was made aware of R2's missing money. V6 states V7 told him not to worry because V7 would go and talk to R2 about R2' missing money.</p> <p>On 03/19/2024 at 11:45AM, V4 (LPN) states surveyor interviewing him is the first time V4 is hearing of missing money for R2.</p> <p>On 03/19/2024 at 12:22PM, V7 (APRSD) states she was first made aware of R2's missing money about three weeks ago when R2 informed V7 when R2 returned from the hospital. V7 states she investigated R2's report of missing money but there was no way of V7 knowing how much money R2 actually had. V7 states R2's money has not been found. V7 states she informed the former social services director who no longer works at the facility of R2's missing money.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145479	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/22/2024
NAME OF PROVIDER OR SUPPLIER  Atrium Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review performed by surveyor on 03/19/2024 shows there is no documentation to show that R2's missing money was reported.</p> <p>Facility Reported Incident reviewed from 01/05/2024 to 03/03/2024 and there is no documentation to show that R2's missing money was reported.</p> <p>Grievance logs reviewed from 12/22/2023 to 02/04/2024 does not document a concern for R2's missing money.</p> <p>On 03/20/2024 at 1:30PM, V1 (Administrator) states she has been working at the facility for five months and she is the abuse coordinator. V1 states she was not made aware that R2 had reported that she was missing money. V1 states this is the first time she is hearing of R2's missing money. V1 states staff should have reported this to her so she could have started an investigation. V1 states this should also have been reported to the state agency.</p> <p>There is no documentation to show that R2's money was inventoried in the facility.</p> <p>Facility policy undated, titled Personal Property Policy documents in part, Investigating Lost Personal Items: By defining an approach to investigate complaints of theft or misplaced personal property, the administration wishes not only to discover lost items, but also to gather information and determine potential patterns that may lead to the reduction and eventual prevention of lost items or theft.</p> <p>Facility policy dated 02/07/2019, titled Abuse and Neglect documents in part Any allegations of abuse or any incident that results in serious bodily injury will be reported to the Department of Public Health immediately . Any incident that does not involve abuse and does not result in serious bodily injury shall be reported within 24 hours. Internal Investigation 2. Any incident or allegation involving abuse , neglect, exploitation, mistreatment, or misappropriation of resident property will result in an investigation.</p>		

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NAME OF PROVIDER OR SUPPLIER  Atrium Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1425 West Estes Avenue Chicago, IL 60626	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49666</p> <p>Based on observation, interview and record review the facility failed to acquire a physician ordered medication and accurately document the administration of medication for one (R1) of three residents reviewed for medication administration.</p> <p>Findings include:</p> <p>R1's clinical record documents admitted [DATE]. Diagnoses included but were not limited to other specified depressive episodes, multiple sclerosis, paranoid schizophrenia, personality disorder, other muscle spasm, and diabetes.</p> <p>R1's Minimum Data Set (MDS) dated [DATE] documents that R1 has a Brief Interview for Mental Status (BIMS) of 15 out of 15, indicating that R1 is cognitively intact.</p> <p>R1's after visit hospital summary dated 03/11/24 documents in part Take these medications Venlafaxine 150mg Capsule ER 24 HR take 1 cap by mouth once per day.</p> <p>Nurse's note dated 03/11/2024 9:29 PM documents that doctor was notified of discharge orders and gave orders to continue with discharge orders.</p> <p>R1's physician order sheet/POS documents the following order:</p> <p>Venlafaxine extended-release (ER) 150 milligrams (mg) tablet, extended release 24 hr Dispensed: venlafaxine ER 150 mg tablet, extended release 24 hr SIG: give 1 tablet (150 mg) by oral route once daily with food Protocol: GIVE AT THE SAME TIME EACH DAY; DO NOT CRUSH OR CHEW; GIVE WITH FOOD</p> <p>Start date: 03/11/2024 06:08pm</p> <p>Pharmacy document dated 03/13/2024 shows Venlafaxine tab 150mg ER is not covered by the resident's insurance plan unless prior authorization is obtained.</p> <p>Nurse's note, dated 03/17/2024 11:15 am, indicated R1 was alert and oriented times three, verbally responsive, no complain voice, no apparent distress noted, R1's Venlafaxine 150mg is not covered by R1's insurance per pharmacy, doctor made aware with order to Discontinue Venlafaxine 150mg and start sertraline 50mg PO daily, order carried.</p> <p>On 03/19/24 at 10:00 AM R1 states that she has not taken Venlafaxine since she has been in this facility but was taking it at the hospital. R1 states that she has been in the facility since last Monday. R1 states that she has been taking Venlafaxine for many years and she was informed that her insurance is not covering it. R1 states that the nurse said to her that her doctor ordered Zolofit but R1 refuses to take it. R1 states that she wants to take the same medication (Venlafaxine) she was taking before coming to the facility.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Atrium Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1425 West Estes Avenue Chicago, IL 60626	

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R1's MAR (Medication Administration Review) documents the above medication order was incorrectly documented as administered on the following dates: 03/12/2024, 03/13/2024, 03/14/2024, 03/15/2024, 03/16/2024.</p> <p>On 03/19/24 at 12:05 PM V4 (Licensed Practical Nurse/LPN) states that R1 doesn't take Venlafaxine on his shift. Surveyor shows V4 R1's MAR (medication administration record) and V4 points to R1's MAR and states for dates 03/12/24 through 03/16/24, he documented incorrectly. V4 states Venlafaxine, was not given to R1 on dates 03/12/24 through 03/16/24 although V4 documented that the medication was given.</p> <p>On 03/19/2024 at approximately 1:53 PM, surveyor observed facility's emergency medication box on the third floor and the medication Venlafaxine is not in the emergency medication box. Surveyor observed R1's medications stored in the medication cart and surveyor did not observe Venlafaxine medication in R1's medications.</p> <p>On 03/21/2024 at 10:10 AM surveyor showed R1's MAR (medication administration record) to V2 (Director of Nursing/DON) and V2 states that if initials are documented without the asterisk sign, then that means that it was documented as administered. V2 states that Venlafaxine medication is not stocked in the facility's emergency medication stock box. V2 states that the facility did not pay for R1's Venlafaxine medication. V2 states that she sent the prior authorization form to R1's doctor via fax. V2 states she cannot remember the date that she sent it. V2 states that if a medication is not available, then the nurse needs to call the pharmacy immediately and if pharmacy informs the nurse that the medication is not covered, then the nurse needs to notify the provider immediately. V2 states that a resident should not wait five days to receive their medication that has been ordered for their diagnosis.</p> <p>Facility document not dated titled Medication Administration Policy documents in part, 9. Check all medications against the MAR prior to administration. 10. Sign out medications immediately after administration (include PRN's (as needed), patient refusals and other omission codes).</p>