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	03/19/2025

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 32819 Based on interview and record review the facility failed to ensure that staff are aware of the requirements for involuntary (psychiatric) admission, failed to provide resident a petition for involuntary admission and failed to explain the rights of admittee for one of four residents (R1) reviewed for transfer/discharge. Findings include: R1's (2/5/25) petition for involuntary/judicial admission states resident was in an alleged physical altercation with co-peer, both patients were separated however he continues to attempt to become physical. Resident had to be removed from the area to a lower floor but would not comply to separate from co-peer therefore MD (physician) was made aware with order to send to hospital to prevent provoking and harm to others. [Page 3 was endorsed by V7/Social Service Director]. Page 4 states Within 12 hours of admission to the facility under this status and/or completion of a new petition, I gave the respondent a copy of this petition (IL462-2005). I have explained the Rights of admitted to the respondent and have provided him or her with a copy of it. I have also provided him or her with a copy of Rights of Individuals Receiving Mental Health and Developmental Services (IL462-2001) and explained those rights to him or her (405 ILCS 5/3-609). I certify that I provided respondent with a copy of this form. Date/Time of Admission to Mental Health Facility/Psychiatric Unit: ____. Date/Time Petition Completed: ____. Signed: ____. Page 5 states I certify that I provided respondent with a copy of this form. On: ____. Time: ____. Signature: ____. On 3/13/25 at 11:30am, surveyor inquired why R1 was sent to the hospital on or about 2/5/25, V7 stated I (V7) think that's the incident between him (R1) and (R2). He (R1) was the aggressor. Surveyor inquired about the requirements for involuntary petition, V7 responded We (staff) did the petition for him to go out. I (V7) wrote a petition, they (staff) had to call the doctor to get the order for an evaluation. Once I write the petition I give it to the nurses, the nurses do the rest. Surveyor inquired who receives the petition for involuntary/judicial admission, V7 replied Usually it goes to the ambulance driver. We make 3 copies one for the hospital, one for the ambulance and the other one I'm not sure. Surveyor inquired if R1's (2/5/25) petition for involuntary psychiatric admission was signed by the Nurse to determine if R1 received a copy and/or was made aware of his rights, V7 stated No. Surveyor inquired if R1's involuntary petition was documented in the progress notes, V7 responded It should be a note. (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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's (2/5/25) progress notes state MD (Medical Doctor) gave order to transfer resident to hospital for psych (psychiatric) evaluation. Call placed to hospital, report given to intake Nurse with Petition, face sheet and POS (Physician Order Sheets) was faxed to hospital as requested. [Petition provided to R1 and/or explanation of rights were excluded]. On 3/17/25, surveyor requested the facility policy for Involuntary (Psychiatric) Admission however the involuntary discharge policy (revised 01/06) was provided which states to ensure compliance with State and Federal regulations and guidelines for involuntary discharge/transfer. A resident can only be involuntarily discharged /transferred for the following reasons: the safety of individuals would otherwise be endangered. If a 30-day notice is issued, the resident will be given a copy of the notice. [Notice requirements for Involuntary/Judicial Admission are excluded].

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32819 Based on interview and record review the facility failed to follow policy procedures, failed to ensure that osteomyelitis was included in diagnoses, failed to schedule medication as directed, and failed to administer medications as ordered for one of four residents (R3) reviewed for medication administration. Findings include: R3 was admitted to the facility on [DATE] with diagnosis of local infection (due to central venous catheter) and discharged AMA (Against Medical Advice) on 2/16/25. R3's (2/14/25) progress notes state at 3:05pm, resident was admitted into the facility with diagnosis of acute osteomyelitis (bone infection) - which was excluded from the diagnoses. Medications verified with medical doctor with order to continue with hospital medications. R3's (2/14/25) POS (Physician Order Sheets) include the following antibiotics: Cefepime 1 gram IV every 8 hours for 1 month [Start Date/Time: 2/15/25 12:00am] and Vancomycin 750 milligrams IV every 8 hours for 1 month [Start Date/Time: 2/15/25 12:00am]. R3's (February 2025) MAR (Medication Administration Record) affirms the following: Cefepime was administered on 2/15/25 at 6am (6 hours after the prescribed start time). Vancomycin was scheduled for 9am, 12pm, and 5pm administration (every 3-5 hours - not every 8 hours as directed). R3's Vancomycin was marked * (not administered) on 2/15 at 9am (awaiting delivery) and administered on 2/15/24 at 12pm (12 hours after the prescribed start time). R3's Vancomycin was also administered on 2/15/25 at 5pm (within 5 hours therefore not as directed). On 3/18/25 at 11:46am, surveyor inquired about staff requirements for new admissions, V2 (Director of Nursing) stated Call the doctor for any orders or reconcile any orders they are coming with. Surveyor inquired when R3's Vancomycin was started by the facility V2 reviewed R3's (February 2025) MAR and responded On the 15th at 12pm [roughly 21 hours after admission]. Surveyor inquired if R3's Vancomycin was scheduled for administration every 8 hours (as directed) V2 replied No. Surveyor inquired when R3's Cefepime was started by the facility, V2 stated It was started on the 15th at 6am [roughly 15 hours after admission]. The (undated) medication administration policy states complete the pass within 2 hours (1 hour before/1 hour after). Check all medications against the MAR prior to administration. Follow the medication instructions specifically.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32819 Based on interview and record review the facility failed to follow policy procedures, failed to assess/document skin integrity impairments, failed to ensure that the facility wound report was accurate, failed to obtain descriptive treatment orders (including wound locations/medication/type of dressing), and failed to follow physician orders for one of four residents (R3) reviewed for pressure ulcers. Findings include: R3 was admitted to the facility on [DATE] and discharged AMA (Against Medical Advice) on 2/16/25. R3's (2/14/25) progress note [entered 2/18/25 - 4 days later] states at 3:05pm, resident was admitted into the facility with diagnosis of acute osteomyelitis and discharge diagnosis of pressure injury of right hip (stage 4) complicated by deep penetrating ulcer on the left buttock with osteomyelitis of ischial tuberosity and inferior [NAME] of left ischium. Resident's wound was debrided on 2/3/25 and is on wound vac for the stage 4 wounds with continuous pressure of 125/125. Dressing dry and intact [R3's skin assessment is excluded]. The (February 2025) facility wound report excludes R3. R3's (2/15/25) POS (Physician Order Sheets) include wound dressing change schedule every day at 11:00pm-7:00am however wound location(s) and required medication/dressings are excluded. R3's (February 2025) TAR (Treatment Administration Record) states wound dressing change Start Date: 2/15/25 [wound locations and prescribed treatments are excluded]. On 2/15/25, * is documented (indicating not administered). (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/18/25 at 11:46am, surveyor inquired about staff requirements for new admissions V2 (Director of Nursing) replied We expect them (staff) to do a head-to-toe assessment, call the doctor for any orders or reconcile any orders they are coming with. Surveyor inquired who's responsible for obtaining wound care orders V2 stated The wound nurse. Surveyor inquired about R3's wounds V2 responded I know he came in with a wound, but I did not assess her. Surveyor inquired about R3's wound assessment (which was requested and not received) V2 replied It was done but she V11 (Prior Wound Care Nurse) didn't put a note there, I don't know why [The facility provided no evidence during this survey that R3's wound was assessed by staff]. Surveyor inquired about R3's prescribed treatment V2 reviewed R3's (February 2025) POS and stated Wound dressing change every day at 11pm-7am on the night shift. I don't see any order here; it just say wound dressing change. Surveyor inquired if R3's treatments were documented on the (February 2025) TAR V2 responded On the 15th it say wound dressing change not administered and affirmed that dressing changes were also not documented on 2/14 and 2/16. Surveyor inquired if R3's wound locations (right hip/left buttock) and/or treatments for each wound are on the on the TAR V2 replied No. Surveyor inquired if R3 received a wound vac at the facility V2 stated We ordered a wound vac that Friday (2/14/25) because at the time that he (R3) came we don't have it, but I know we ordered one. At 1:11pm, V2 affirmed that R3's wound vac was received by the facility on 2/15/25 at 1:49pm. The delivery invoice #4717645 affirms a wound vac pump, canister with tubing and large dressing kit were delivered on the stated date and time [roughly 23 hours after admission] however R3's progress notes affirm implementation and/or use of the wound vac on or about that date/time was not documented. On 3/18/25 at 12:13pm, surveyor inquired about staff requirements for residents admitted with wounds V9 (Wound Care Nurse) stated A good assessment of the patient on admission because they (staff) see the patient before me (V9). They let me know what is going on with the patient. I (V9) assess the patient myself and have a good record of assessment, know the history of the patient, have good documentation, and I need to call the wound doctor to get orders. Surveyor inquired what's required in a treatment order V9 responded I need the prescription of what should be used for the treatment of the wound and what the patient is taking to improve the wound healing. Surveyor inquired about concerns with R3's (2/15/25) treatment orders V9 reviewed R3's (February 2025) POS and replied, I can't really see the location of the wound here and I can't see a prescription for the wound. The wound assessment policy (revised 11/18) states it is the policy of this facility to do a systemic ongoing wound assessment on all wounds in order to determine the response to nursing care and treatment modalities. The presence of wounds, ulcers and/or other skin abnormalities will be indicated on the admission nursing assessment. A comprehensive wound assessment will be documented on the pressure sore log and/or other skin log will contain the following information: wound classification, wound location, pressure ulcer staging or description of the extent of tissue damage, description of wound bed, drainage, margins/surrounding skin, odor., and wound measurements.