| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145479 | A. Building<br>B. Wing | 04/11/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Atrium Health Care Center | 1425 West Estes Avenue<br>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 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow a care plan and provide a safe environment for a resident at risk for falls by failing to ensure items were away from a residents bed/space for one (R1) of three residents reviewed for falls. Findings include:R1's history includes but is not limited to heart disease, paranoid schizophrenia, hypertension, chronic pain, and history of falling.R1's Minimum Data Set (MDS), dated [DATE], documents, in part, for Section C. Brief Interview for Mental Status (BIMS) score is a 7 which indicates R1 has severe cognitive impairment. Section GG. Mobility: D. Sit to Stand is coded as a 3 which indicates partial/moderate assistance. I. Walk 10 feet is coded with a 3 which indicates partial/moderate assistance.On 4/10/26 at 12:10 pm, R1 noted in room lying in bed. R1's right upper eye lid is noted to be black with no swelling. R1's bed was noted in the lowest position with one floor mat on the right side. There was no floor mat on the left side of the floor.R1's progress notes dated 4/4/26 at 3:16 pm, documents, in part, Around 8:00 am, resident observed comfortably in bed. Alert and oriented x1, able to answer ?yes or no' questions. Scheduled medications administered as ordered and well tolerated. Around 12:00 pm, when staff went in the room to provide care, resident was observed with swelling and discoloration on her right upper eyelid. Skin remains intact. Assessed for pain, resident verbalized No.R1's progress note dated 4/4/26 at 11:46 pm, documents, in part, Resident returned from ER (Emergency Room) accompanied by two paramedics, resident is alert and oriented to self with periods of confusion. Resident noted with darkened area/discoloration over the eyebrow region. Resident returns with a diagnosis of periorbital contusion.R1's hospital visit summary dated 4/4/26 documents, in part, Reason for visit: eye trauma. Diagnosis: Periorbital contusion.R1's Fall Occurrence Report Investigation dated 4/4/26 documents, in part, Prior history of fall. Environmental Factors: Furniture, Description of Fall: fall when ambulating, Description of Fall: Resident noted with swelling to right eye. Bedside dresser noted close to right side of bed where resident hit her eye when she fell. The facility's Final Reportable Investigation form completed for R1, dated 4/4/26 documents , Investigation reveals that the resident attempted to get out of bed unassisted lost balance and fell. Hitting the right side eye on the edge of bedside dresser which results in the injuries sustained. Upon return to the facility safety measures was put in place where by the bedside dresser located close to the right side of bed was removed from the room. On 4/10/26 at 1:00 pm, V3 Certified Nursing Assistant (CNA) stated, I took care of R1 that morning. I did my morning rounds around 7:00 am, and at that time R1 was in bed sleeping. I did not see her face at that time because of her sleeping. In the afternoon I went to give her ADL (Activity of Daily Living) care, and that's when I noticed her face. Her face was swollen and reddish. I did not ask her what happened, I just called the nurse. The right eyelid was swollen and red. Her eye was not red, just her eyelid was swollen. The nurse came in, assessed her. She was the only one in the room at that time her roommates were in the day room. She does walk at times, but she needs help and will try to get up alone. I do round every 2 hours.On 4/10/26 at 1:20 pm V4 CNA stated, I tried to feed her that morning, but she did not eat. There was nothing on her face. Her eyes area was not swollen or redden.On 4/10/26 at 1:49 pm, V5 License Practical Nurse (LPN) stated, I sent R1 to the hospital. It<br>(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 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | was a Saturday I got report from the night nurse. I did not get in report of any fall or injury that R1 had gotten. I did my round I saw she was sleeping I let her sleep. I gave morning medications to R1 and there was nothing on her face. Her face was intact. It was around noon when the CNA said to come see her face. Her right eye was swollen with some discoloration. I originally thought she had an eye infection because she had that before. She is only alert and orientated x1. She only answers yes and no questions. I called the Nurse Practitioner (NP), who said to put an ice pack on it, and I did that, I told the Director of Nursing (DON), and she said to call him (NP) back to get an order to send to the hospital because we are unsure if she had fallen. I am not aware of her falling on my shift. She would have been able to get up off the floor by herself. She can walk with assistance.On 4/10/26 at 3:17 pm, V2 (DON) stated that the nurse was called by the staff around 12:30 pm on 4/4/26 while going to do ADL care that swelling and discoloration to R1's right eye lid area was noted. The nurse called the NP and got an order for an ice pack to be sent to the ER. R1 came back from the hospital, where she had an MRI (Magnetic Resonance Imaging), CT (Computed Tomography) and an X-ray that was all normal. We think that R1 had an unwitnessed fall and hit her eye on her dresser that was close to her bed. R1 is not supposed to get up by herself, but sometimes she does attempt to get up. R1 likes being in her room. I would say R1 is a risk for falling being in her room and attempting to get up. I was told R1 sometimes tries to get up. I would say it's not proper supervision to let her stay in the room. Proper supervision would be to put her in the day room to be closely monitored by staff, with frequent monitoring. I don't know how many floor mats should be on the floor. I have to consult with restorative.On 4/10/26 at 4;00 pm, V1 Administrator stated, When R1 came back from the hospital, I went to see what happened. I asked her if she did R1 fell, and she said yes. I talked to R1 that Sunday. She can answer yes or no questions. She does understand what is being asked. No staff stated that she had fallen. No staff picked her up off the floor. She can get up off the floor on her own. That day we thought it was medical with her eye because she had swelling with redness to the eye and has had an eye condition like that in the past. More interventions could be placed to prevent her from falling. Another floor mat, shifting her bed to be closer to the wall and increasing rounds.R1's Active Physician orders dated 6/13/25 documents, in part, May have floor mat to prevent fall related injuries.R1's care plan dated 4/1/26 Focus: At risk for falls related to incidence of use of psychotropic medication or new medication that may cause dizziness. Goal: Resident will be free of injury related to falls. Interventions: increased monitoring every 1-2 hours. 4/6/26 Focus: Fall with injury noted on 4/4/26. Interventions: Move dressers and other items that could cause injuries out from residents room or away from residents bed/space, Active -effective: 7/18/2022. Facility's policy titled, Resident Supervision Policy dated 7/2025, documents, in part, Policy: To ensure the facility provides an environment that is free from accident hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent a voidable accident. Procedure: 1. All residents will be supervised . 6. Nurse will round their assignment hourly unless otherwise indicated that more often is required. 7. CNA will round his/her assignment every 2 hours unless otherwise indicated more often is required.Facility's policy titled, Fall and Safety Prevention Policy date revised 10/25 documents, in part, Policy: To ensure residents are assessed for potential fall risk and for equipment to ensure safety and prevention of injury such as floor mats, low beds, helmet and other needed devices. Procedure: . 8. The frequency of safety monitoring will be determined by the resident's risk factors and care plan. |