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	05/02/2026

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 0600 Level of Harm - Minimal harm or potential for 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. Based on interview and record review the facility failed to ensure that one resident (R1) was free from physical abuse when R2 struck R1 during an altercation in their shared room. This affected two of three residents (R1/R2) reviewed for abuse. Findings include: The facility initial reportable incident to the local state agency dated 2/12/26 at 9:54 pm, documents, in part: 2/12 2026 at approximately 804 PM it was reported that R1 and R2 displayed physical aggression in their room period staff overheard yelling and responded to residents' room as they are roommates. Resident immediately separated and both residents placed on one-to-one staff monitoring. Skin assessment completed for both residents. R1 noted with bump on right side of forehead in superficial scratch. R2 noted without injury redness swelling or bruising. Police made aware positions made aware with order to send both residents to the local hospital for an evaluation. Order noted and carried out. R1 to be sent to the local hospital and R2 to be sent to the local psychiatric hospital. To both residents being sent for evaluation, safety of other residents is secured. Both residents' representatives notified of incident and investigation process is ongoing. We will follow up when completed.The facility initial reportable incident to the local state agency dated 2/12/26 at 9:54 pm, documents, in part: R2 and R1 were in their room, as they are roommates. R2 had his television on in R1 complained about noise level, R2 pushed the dresser that is between both beds more towards the side of R1. R1 walked over towards the side of R2's bed. R2 struck R1 in the forehead. Staff overheard yelling coming from R1 and R2's room and responded immediately. Both residents were separated immediately and placed on one-to-one staff intervention. Charge nurse assesses both residents. R1 noted with bump on right side of forehead and superficial scratch. R2 two noted without any injury, redness, swelling, or bruising. Police may aware with report number JK147528. Physicians made aware with orders to send both residents to the hospital for an evaluation. Both residents remain on one-to-one monitoring until transported to hospital. Order noted and carried out. R1 was sent to the local hospital with IVD (involuntary discharge) and was readmitted . Counseling conducted with resident R1 upon return to refrain from engaging in aggressive behavior and to notify staff immediately of any issues or concerns. R2 was transported to local hospital with IVD, and was admitted , facility notified that resident will {sic} accept another facility and will be transferred. Physicians and representatives notified of outcome of investigation. Documentation completed at outcome of investigation.R1 has a diagnosis which includes but is not limited to: Paranoid schizophrenia.Brief Interview for Mental Status (BIMS) dated 3/5/26 shows a score of 12 which indicates cognitively intact.R2 has a diagnosis which includes but is not limited to: Psychosis not due to a substance, and schizophrenia.BIMS dated 12/26/25 shows a score of 13 which indicates cognitively intact.On 5/1/26 at 11:07 am, R1 stated he recalls being hit by R2 at the facility a few months ago. R1 then explained that R2 hit R1 in the face and then R1 shoved R2 back. R1 then stated that he does not recall what the altercation was regarding and that he has not seen R2 since the incident.On 5/1/26 at 11:32 am, V4 (Licensed Practical Nurse, LPN) stated in February 2026 R1 and R2 had an altercation at the facility in their room. V4 explained that during the 3:00 pm-11:00 pm shift after dinner, around 7:00 pm - 8:00 pm R1 and R2 were in their room in bed. V4 then stated that he was sitting at the nurse's station with (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the other staff members when he heard a noise from R1 and R2's room. V4 then explained that he and the Certified Nursing Assistants (CNA's) went to R1 and R2's room and noted R1 and R2 physically engaging with each other. V4 further explained that the CNA's had already separated R1 and R2 when V4 entered R1 and R2's room and he observed R1 and R2 were still verbally arguing with each other regarding R2's television (TV). V4 explained that R1 and R2 were immediately separated and that staff placed R2 in the day room. Next, V4 explained that he cleaned R1's scratches and covered R1's injury, notified the administrator and called R1's physician, who gave orders to send R1 to the local hospital due to R1's face injury and bump to the head. V4 also explained that R2's psychiatrist was notified with orders for R2 to be sent to the local hospital for psychiatric evaluation. V4 also explained that the local police were informed, arrived at the facility and spoke with R2 (R1 was already sent to the local hospital), and a report number (JK147528) was given. V4 denied any knowledge of R1 and R2 with prior altercations or ever seeing R1 or R2 in alterations with other residents. V4 also denied witnessing R1 or R2 having behaviors at the facility. V4 explained that If resident hits another resident it is physical abuse. On 5/1/26 at 3:29 pm, V1 (Administrator) stated that she is the abuse coordinator at the facility. V1 stated that staff report abuse to V1 immediately and V1 sends the initial report to the local state agency within two hours of the abuse being reported. V1 also stated that on 2/12/26 she received a call that R1 and R2 got into an altercation and were physically aggressive with each other. V1 then stated that R1 had scratches and a lump to his forehead during the altercation with R2. V1 stated if a resident hits another resident it is considered abuse. V1 also stated that staff immediately separated R1 and R2, notified V1, an initial reportable to the local state agency was made, R1 and R2's family were notified as well as the police and R1 and R2's physicians are notified with orders carried out. V1 explained that R1 and R2 were sent to the local hospital, R2 for psychiatric evaluation and R1 for medical attention due to injury to R1's face. V1 denied that R1 or R2 had any altercations prior to this incident or expressed desires to change room. V1 stated that R1 did not have any incidents while V1 was at the facility and that R2 was in a previous altercation at the facility but was not the aggressor. V1 stated that no staff witnessed the incident and both residents reported hitting each however, only R1 sustained injuries.R1's progress note dated 02/12/26 at 8:01 pm authored by V4 (LPN) documents, in part: Staff heard noise coming from resident's room, staff went to checked, noted that two residents appeared engaged in aggressive behavior. Staff intervened, separated the two residents and put them on 1:1 monitoring and Administrator immediately notified. One of the residents noted with multiple nail scratches to face and slight bump to his Rt (right) forehead. On assessment, face noted with nail scratches and slight bump to his Rt fore-head, area cleanse with NNS (normal saline solution) and dry dressing applied, and Neuro (neurology) checks initiated. V/s (vital signs) taken: BP (blood pressure) 113/76, P (pulse)/79, T (temperature)/97.6, R (respirations)/17, 02 (oxygen saturation) Sat 97% RA (room air), BS (blood sugar)117mg/dl (milligrams/deciliter). On interview, resident stated, He does not want me to watch my T.V (television) by tuning it off, so I tried to turn his off too. Teaching and education given to resident to always report any incident to the staff, nodded in understanding. (local) police was invited for investigation. Officer batch {sic} # 18400 and Beat {sic} 2432 investigated the incident, case J K 147528. Physician notified with order to transfer resident to hospital for medical evaluation. Resident contact/POA (power of attorney), notified via voice. Ambulance called with ETA (estimate time of arrival) of 40 mins (minutes), resident remain calm. At 9:20pm, 2 paramedics from Ambulance arrived facility, resident transferred in-route to the hospital. Endorse to oncoming Nurse to f/u (follow up) with disposition.R1's Physician Order Sheet (POS) dated 10/16/2023 documents, in part: Monitoring: Behavior Monitoring for the following itching, picking at skin restlessness, hitting, increase in complaints, biting kicking, spitting, cursing, elopement, stealing, delusions, hallucinations, psychosis, aggression.R1's Behavior Care plan documents, in part: R1 has diagnosis of Paranoid that contributes to their behavior symptoms. R1 demonstrates behavioral distress related to: ineffective coping mechanisms, poor verbal skills, poor self-esteem and feelings of inadequacy, and challenges of (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	mental illness. The problems are manifested by attempting to become physically aggressive behavior when agitated 8/5/24. Resident has history of physical aggressive behavior necessitating his hospitalization before his transfer to this facility. Resident appears as baseline has not been physically aggressive since admission.R2's progress note dated 2/12/26 at 8:01 pm, documents, in part: Staff heard noise coming from resident's room, staff went to checked, noted that two residents appeared engaged in aggressive behavior. Staff intervened, separated the two residents and put them on 1:1 monitoring and Administrator immediately notified. On interview, resident stated, He was in my space, trying to tune off my TV. Teaching and education given to resident to always report any incident to staff, nodded in understanding. Chicago police was invited for investigation. J K 147528. Physician notified with order to transfer resident to hospital for psych (psychiatric) evaluation. All necessary documentation faxed to psych intake nurse at the hospital. Resident remain calm at this time, skin remain intact. Ambulance called with ETA of 1hr (hour). Resident's contact/sister, called on no response, message left via voice. At 9:50pm, 2 paramedics from Ambulance arrive facility, resident transferred in-route to the hospital. Endorse to oncoming Nurse to f/u.R2's POS dated 2/1/26- 2/28/26 shows orders for Monitoring Behavior: Monitoring for itching, picking at skin restlessness, agitation, hitting, kicking, spitting, cursing, elopement, stealing, delusions, hallucinations, refusing care, anxiety, insomnia, depression interventions . Every day and night shift for target behaviors document the number of episodes that the behavior occurs each shift.R2's Behavior Care plan documents in part: Focus: Alleged physical abuse/aggression 2/12/26.The facility's document dated 2/12/26 documents, in part: Number JK147528, Incident : Battery.R2's untitled document dated 2/12/26 authored by R2 documents, in part: R1 came up to me and told me that my television was his. I told him it wasn't. He (R1) started yelling at me (R2). We argued a little and he started walking towards me (R2). He (R1) pushed me (R2), and I (R2) hit him (R1).R1's untitled document dated 2/12/26 authored by R1 documents, in part: R1 asked R2 could he stop making noise. R2 got louder and pushed the dresser over towards R1. R1 got up out of bed and walked over by R2 and R2 hit R1 and R1 hit R2 back.The facility document dated 1/2026 and titled Abuse Retaliation Policy and Prevention documents, in part: This facility affirms the right of our residents to be free from abuse, neglect, exploitation, retaliation, misappropriation of property, deprivation of goods and services by staff, or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to ensure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff, and mistreatment of residents . This will be done by Establishing an environment that promotes resident sensitivity, resident security, and prevention of mistreatment . Abuse: Abuse means any physical or mental injury; retaliation or sexual assault inflicted upon a resident other than by accidental means . Physical abuse is the infliction of injury on a resident that occurs other than by accidental means, and that requires medical attention. Abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment.