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	06/22/2026

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to protect residents from physical abuse when resident-to-resident altercations occurred, resulting in R2 slapping R1 in the face; and R4 slapping R3 in the face. This failure affected four out of six residents reviewed for abuse. Findings include: 1. R3's Brief Interview for Mental Status (BIMS) dated 3/6/26 shows a score of 4 which indicated that R3 has some cognitive impaired. R3's face sheet shows that R3 has a diagnosis which includes but not limited to anxiety disorder, developmental disorder of speech and language, nicotine dependance, chronic obstructive pulmonary disease and hypertensive heart disease. R4's Brief Interview for Mental Status (BIMS) dated 3/12/26 shows a score of 15 which indicated that R3 is cognitively intact. R3's face sheet shows that R3 has a diagnosis which includes but not limited to anxiety disorder, major depressive disorder, schizoaffective disorder, bipolar type, primary insomnia, and hypertensive heart disease. The facility's initial reportable date 5/18/26 at 6:58 pm documents, in part: On 5/18/26 at approximately 6:12 pm it was reported that R4 had slapped co-resident, R3 on the right check area on first floor hallway near room114. Alleged incident occurred due to resident R4 experiencing delusions and believing that R3 was talking about him blowing his nose and making comments about his eye. Staff immediately intervened, separated residents, and both residents placed on immediate 1:1 staff monitoring. Skin assessment completed for both residents. Both residents noted with no injuries Police made aware. Physicians made aware with orders obtained to send resident R4 to the hospital for evaluation, safety of other residents is secured. Both residents and representatives called. Resident R3 representative informed of alleged incident. R4 representatives are unable to be contacted as contact number is not in service. Investigation is ongoing. Will follow up when competed. The facility's final reportable dated 5/25/26 at 5:36 pm, documents, in part: Based on further investigation interviews and statements, alleged incident was concluded to be founded. On 6/15/26 at 1:06 pm, Surveyor observed R3 sitting on the patio area, alert, nonverbal unable to answer any surveyors' questions. Surveyor did not observe R3 with any facial injuries or (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	abnormalities. On 6/15/26 at 12:42 pm, R6 stated that about a month ago while R6 and other residents were waiting in the hallway on the first floor by the patio door for smoke break he witness R4 walk up to R3 and slap R3 in the face. R6 explained that R3 does not speak and did not know why R4 slapped R3 in the face. R6 stated that the incident took place as the residents were lined up along the patio door awaiting staff to come and that no staff was present to monitor the incident. On 6/15/26 at 1:08 pm, R9 stated, I saw him (referring to R3) get hit by another resident (unable to recall the residents name). R9 then stated, I don't know why he (referring to the resident that hit R3 (R4)) did that. He (referring to R3) is quiet and does not bother anyone. R9 also stated that the incident took place as the residents were lined up along the patio door awaiting staff to come and that no staff was present to monitor the incident. On 6/15/26 at 1:09 pm, V9 (Social Service) stated that the social service department is responsible for monitoring the residents during smoke breaks at the facility. V9 explained that residents who ambulate independently will line up forming a line along the wall outside of the smoke break patio door and when no staff is present to supervise the residents. V9 stated that he was not working on 5/18/26 the day of the incident between R3 and R4. V9 further explained when he returned to work on 5/19/26 he was informed that R4 was sent to the local hospital for slapping R3. V9 denied ever witness R3 and R4 in any previous incidents at the facility or during smoke break times. On 6/16/26 at 11:14 am, V3 (Social Services Director) stated that the social service department is responsible for monitoring the smoke breaks for the residents. V3 then stated that a social service staff should always be present during the resident's smoke breaks. V3 then explained when the resident's line up along the door of the patio area prior to the smoke break time there is not a staff member present to monitor the residents until the smoke time starts. V3 explained that the social service staff are bringing in residents from the front of the building when residents who ambulate began forming a line at the patio door before the social service staff can get to the patio area. V3 explained if residents are not supervised by the patio door, V3 stated; A fight can breakout. On 6/16/26 at 11:37 am, V11 (Psychiatric Rehabilitation Coordinator, PRSC) V11 explained that the residents have designated smoke break times and areas (the front of the facility for residents in wheelchairs and the patio areas for those residents who walk). V11 then explained that the social service staff will issue the residents the cigarettes and monitor the residents for smoke breaks. V11 further explained that residents who smoke on the patio will bring themselves down independently and form a line along the wall leading to the patio door independently. V11 explained that there is no one there to monitor the residents until a social service staff comes to begin the smoke break. V11 explained that R3 and R4 had an incident about a month ago when R4 hit R3. V11 then explained that during the time of the incident he was not present and was gathering the key to turn the patio door alarm and heard a commotion and residents saying Why did you do that? Why did you hit him? (referring to R4 hitting R3). V11 explained that when he went to the patio door area he separated R4 from R3 by removing R4 to the front receptionist desk area and took R3 to the first-floor nurse to be assessed. On 6/16/26 at 6:16 pm, V12 (Licensed Practical Nurse, LPN) stated she did not witness the incident between R3 and R4 on 5/18/26. V12 then stated that on the evening of 5/18/26 she was informed by V1 (Administrator) that she needed to assess R3 because R4 hit R3 downstairs on the first floor. V12 stated that staff brought R3 upstairs on the elevator and she then assessed R3. V12 then explained (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	during her assessment of R3 she did not observe any apparent swelling or visible injuries and then informed V13 (R3's Physician) of the incident as well as her assessment. V12 stated that R3's physician ordered a facial bone Xray for R3 and when the facility received the results of R3's Xray, the results recommended that R3 go to the local hospital for further evaluation. V12 then stated that R3 was sent to the local hospital and return to the facility however she does not know what the report of the local hospital revealed. On 6/17/26 at 1:29 pm, V14 (LPN) stated he was R4's nurse on the day of the incident with R3 and R4 on 5/18/26 at the facility. V14 stated that he did not witness the incident between R3 and R4 and was informed that R4 had a physical altercation hitting R3. V14 stated that he was informed that the altercation took place on the first floor when the residents were going to smoke. V14 explained when the smoke break time is announced by social service department the residents go to the designated area to smoke, and the social service then takes the residents out to smoke. V14 stated that residents should not be lining up for smoke break until social services inform the residents it is time to smoke and is there to supervise the resident. V14 then explained that after the altercation R4 was placed on 1:1 monitoring, informed R4's physician and R4 was sent to the local hospital for psychiatric evaluation immediately following the incident and has not returned to the facility. On 6/17/26 at 1:51 pm, V2 (Director of Nursing, DON) stated she did not witness the incident between R3 and R4 on May 18, 2026. V2 stated that V1 (Administrator) informed V2 that R4 hit R3 in the face on the first floor (V2 could not recall any further details regarding where the incident occurred). V2 stated after R4 assaulted R3 he was sent local to hospital for psychiatric evaluation and has not returned to the facility. V2 explained that R3 was assessed for injuries with no injuries noted. V2 then explained that R3's physician was informed regarding the incident with orders for Xray of the facial bone. V2 then explained that initial report indicated a fracture of the facial bone and R3's physician was informed with orders to send R3 to the local hospital for further evaluation. V2 then explained that R3's local hospital Xray results were negative for facial fracture and R3 returned to the facility. V2 denied R3 having any further signs of pain or injury since the incident with R4. On 6/18/26 at 10:29 am, V1 (Administrator) stated that she is the facility's abuse coordinator. V1 stated that last month she was notified that R4 slapped R3 while the residents were in line for the smoke by the patio door. V1 explained that R4 stated that he felt that R3 was talking about him and then V1 then explained that R3 is a non-verbal resident. V1 explained that staff separate R3 and R4 and placed them on 1:1 monitoring, called R3 and R4's physician and R4 was sent to the hospital for evaluation. V1 explained that R3 had a Xray of the face and was sent to the hospital for further evaluation and returned to the facility with no finding/injuries noted. V1 explained that if a resident hit another resident that it is resident-to resident abuse. V1 also stated if staff leave residents unsupervised accidents or an incident can occur. V1 stated that staff should have needed supplies for the residents prior to the monitoring the residents for smoke break. V1 stated that residents are directed to line up for smoke break once the smoke break is announced for residents to attend and residents who line up prior to the announcement are redirected back to the unit until the smoke break begins. V1 explained that during the altercation with R3 and R4 V11 (Psychiatric Rehabilitation Service Coordinator, PRSC) was assigned to monitor the residents for the patio smoke break and left the residents who were in line to go to the nurses station to get the residents cigarettes and keys for the smoke break and did not observe the altercation with R3 and R4. R3's progress noted dated 5/18/26 at 6:41 pm, authored by V12 (LPN) documents, in part: Around 6:00 pm, staff reported to writer that co-resident hit resident on the face during smoke break (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents immediately separated Administrator notified immediately. Upon assessment, no visible redness, swelling, discoloration, or open areas noted to the face at this time. No facial grimace or guarding of any body part noted. No change in LOC (loss of consciousness) noted, neuro (neurologic) assessment completed. Vital signs checked: BP (blood pressure) 127/80, P (pulse) 80, T (temperature) 98.3* F (Fahrenheit), RR (Respiratory Rate) 18, O2 (oxygen) sat (saturation) 98% room air. MD (Medical Doctor) notified Resident's next of kin made aware via voicemail . Call placed to schedule an X-ray of the facial bone tomorrow confirmation number of 49484847. Post incident chart initiated until 5/21/2026 3-11 pm shift. Will continue monitor. R4's progress note dated 5/18/26 at 7:16 pm authored by V14 (LPN) documents, in part: The SS (social service) reported to the NOD (nurse on duty) that resident was physically aggressive toward a co-peer without provocation. Per SS, resident was deluded into thinking that co-peer was making negative remarks against him hence, he slapped him. Resident put on 1 on 1 monitoring and physician notified with order to transfer resident to the local hospital for psychiatric evaluation. The police were also called for investigation. R4's Notice of Involuntary Transfer or Discharge Opportunity for Hearing for Nursing Home Resident dated 5/18/26 reviewed. The facility document dated 5/18/26 shows a signed statement by R4 documents in part: I was walking down the hallway. He said something about me always blowing my nose and was talking about my eye, so I smacked him. I had to stop him. I don't hit it people. The facility's document dated 5/18/26 shows policy record number JK260164, Incident: Battery simple, Victim R3. The facility policy dated 2026 and titled Facility Smoking Safety documents, in part: To provide a safe and healthy living environment with respect for the health and well-being needs of each resident, staff member and visitor. It is also the objective of this policy to communicate to each resident that they are responsible for following each rule and on-going compliance with this policy, 2. The facility initial reportable incident to the local state agency dated 05/12/2026 at 10:11 am, documents, in part: On 05/12/2026 at approximately 8:12 AM it was reported that resident R2 slapped co-resident R1 on the right cheek area in the hallway near room [ROOM NUMBER]. Incident allegedly occurred due to R1 blocking the doorway and accidentally bumped R2 with her wheelchair. The facility final reportable incident to the local state agency dated 05/19/2026 at 6:16 PM, documents, in part: Based on further investigation including interviews and statements, investigation was noted to be founded. R1 was sitting in the entryway of room [ROOM NUMBER] while R2 was attempting to enter the room. R1 attempted to move her wheelchair and, per R1 and R2, accidentally tapped R2 with the wheelchair. R2 then slapped R1 on the right cheek area while no words were exchanged. R1 has a diagnosis which includes but is not limited to schizoaffective disorder. R1 Brief Interview for Mental Status (BIMS) dated 04/16/2026 shows a score of 15 which indicated that R1 is cognitively intact. R2 has a diagnosis which includes but is not limited to schizoaffective disorder, restlessness and anxiety. R2 BIMS dated 05/12/2026 shows a score of 15 which indicates R2 is cognitively intact. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/15/2026 at 1:28 pm, R1 recalled having a recent incident with her roommate R2. R1 stated the incident happened during breakfast time in the doorway of their room. R1 said she was sitting in the doorway of her room when R2 began cursing at her and then slapped her on her face. R1 stated that during the incident V5 (Certified Nursing Assistant, CNA) was present, intervened, and separated them. When asked about any injuries sustained, R1 says she had no injuries from the altercation, also stated she was in tip-top shape. On 06/15/2026 at 1:02 pm, when R2 was asked regarding the incident that occurred 05/12/2026 with R1, R2 refused to speak with the surveyor, or answer any of the surveyors' questions. R2 stated That's in the past, my family and the facility have moved on from that. On 06/15/2026 at 12:32 pm, V5 (CNA) stated he witnessed the incident between R1 and R2 on 05/12/2026. V5 stated that he saw R2 slap R1 on her face but didn't recall which side of the face. V5 stated that he attempted to de-escalate the incident and separated them both to prevent R2 from slapping R1 a second time. After the incident V5 says he reported the incident to V6 (Registered Nurse, RN), social services, and V1 (Abuse Coordinator/Administrator). On 06/15/2026 at 2:06pm, V6 (RN) stated she was notified of the incident between R1 and R2 as she was arriving on the unit. V6 says she was told by V5 that R2 had slapped R1 on the face. V6 states she reported the incident, to V1 and V2 (Director of Nursing/DON). After the incident V6 assessed R1 and did not observe any injuries, notified both resident physicians, and resident representatives. R1 was moved to the 1st floor with all her personal belongings, and prescribed medications. On 06/16/2026 at 10:33am, V2 (Director of Nursing, DON) stated she did not witness the incident, and was informed regarding the incident with R1 and R2 on 05/12/2026 by V1. She stated it was reported that R1 allegedly bumped into R2 with her wheelchair and then R2 slapped R1. V2 stated that V1 is the abuse coordinator and conducted the investigation regarding R1 and R2s incident. On 06/16/2026 at 10:22am, V1 (Administrator) stated she was informed regarding R1 and R2 incident on 05/12/2026 around 8am about the incident by a staff member (she does not recall the staff member). She states it was reported that R1 was sitting in front of a doorway and accidentally tapped R2 with her wheelchair, and then R2 slapped R1. V1 stated that R1 was assessed for injuries and mental status change by V6, and no injuries were identified. V1 says the assigned doctor was called to inform of the incident. But no orders were given to send the resident to the hospital. V1 stated she contacted the police department to file a police report, but the actual report was not completed. V1 stated R1 chose not to speak about the incident, but R2 agreed to speak with the officer. R1's progress note dated 05/12/2026 at 3:38 pm authored by V6 documents in part On 7a-3p shift. At the beginning of the shift, staff reported to writer that co-resident slapped resident on the face during an altercation. Per staff the incident occurred due to resident blocking doorway with wheelchair and accidently tapping co-resident with wheelchair. R1's Physician Order Sheet dated 07/10/2024 documents in part Monitoring for itching, picking at skin, restlessness, agitation, hitting, kicking, spitting, cursing, elopement, stealing, delusions, hallucinations, refusing care, anxiety, insomnia, and depression. Every day and night shift R1's Behavior Care plan date 11/12/2025 documents, in part: R1 Potential for to exhibit inappropriate behavioral problem as evidenced by yelling/screaming, and potential physical Behavior. The resident displays behavioral symptoms related to severe mental illness, poor and/or ineffective coping skills, a (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	history of non-compliance with recommendations from health care professionals. These behavioral symptoms are manifested by: Verbal abuse/aggression, physical abuse/aggression, socially inappropriate and/or maladaptive, disruptive behavior, refusing/resisting care, behavior that constitutes mental abuse, and a disturbed sense of entitlement. Conduct an evaluation of the behavioral symptoms to determine what strengths or abilities and needs are communicated via the behavior (e.g., verbal abuse often communicates a need to feel in control and assertive). R2's progress note dated 05/12/2026 at 4:26 pm, documents in part, It was reported by staff that this resident slapped a co-resident on the right cheek. Both residents were immediately separated and placed on 1:1 monitoring. R2's Behavior Care plan documents in part: Focus: Behavior Symptoms: Verbal/Physical Aggression dated 05/12/2026. R2 demonstrates behavioral distress r/t ineffective coping mechanisms, outward expressions of internal pain, poor verbal skills and inability to express herself in more appropriate language, poor self-esteem, feelings of helplessness and inadequacy, and being challenged by symptoms of SMI (schizoaffective disorder). Problems are manifested by verbally aggressive behavior when agitated (R2 will pace, shout, curse, and scream either at others or internal stimuli when symptomatic), use of profanity, and a history of physically aggressive behavior when agitated. She responds to staff redirection when offered most times, however, when experiencing a psychotic episode, she presents difficulty in accepting redirection and reality orientation. R2's untitled document dated 05/12/2026 signed by R2 documents, in part: The co-peer hit me with her chair, so I was going to hit her, but I told the nurse. The resident did it again, so I hit her in her face. R1's untitled document dated 05/12/2026 signed by R1 documents, in part: As I was sitting by the doorway of my room, my co-peer attempted to come out. I did not move fast enough; therefore, she slapped me in my face. The facility policy dated 1/2026 and titled Abuse and Retaliation Policy Prevention Program 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. 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. Physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment.

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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. Based on observation, interview, and record review the facility failed to ensure timely assessment, treatment, monitoring, and physician follow-up for a resident with a persistent lice infestation. This failure resulted in the resident (R5) experiencing ongoing symptoms, including scratching, and placed the resident and other residents at risk for continued infestation. This failure affected one out four residents reviewed for resident assessment, treatment, skin conditions, and infestations. Findings include:R5's Brief Interview for Mental Status (BIMS) dated 4/7/26 shows a score of 11 which indicated that R5 has some cognitive impairments. R5's face sheet shows that R5 has a diagnosis which includes but not limited to pediculosis due to pediculous humanus capitis, rash, and other nonspecific skin eruption.On 6/15/26 at 12:30 pm, Surveyor observed R5 in bed awake, alert, noted repeatedly scratching multiple areas of the body, including the chest, back bilateral arms, and legs. Multiple scabbed lesions of varying sizes were observed on the resident's skin in the locations being scratched. R5 stated that he cannot recall when he first had lice at the facility and then stated, It feels like bugs are still crawling on me. I am itching all the time. The resident continued scratching the affected area throughout the observation period while verbalizing discomfort. On 6/15/26 at 12:37 pm, V10 (Certified Nursing Assistant, CNA) stated that a few months ago (around April 2026) he observed R5's bed with multiple small insects. V10 stated that he asked a housekeeper what the insects were and the housekeeper informed V10 that the insects were lice. V10 explained that he took a picture of insects and reported the observation to the floor nurse (unsure of the nurse). V10 further stated that R5, R10, R11, and R12 clothing and room was disinfected while R5, R10, R11, and R12 were showered and treated with a medicated shampoo. V10 explained that he did not observe any insects in R5, R10, R11, and R12's room for about two weeks after the first sighting. V10 then explained two weeks after the first sighting he saw R12's bed with the same insects and reported the insects to the nurse (unsure of the nurse) and R5, R10, R11 and R12 were treated with medication/shampoo, rooms were disinfected and treated again. V10 stated the R5 continues to scratch his skin but denied currently seeing R5 with lice on his body the facility. When V10 was asked if he reports R5's itching to the nurse, V10 stated that he did not report R5's itching because he has not seen any bugs on R5. On 6/15/26 at 12:00 pm, V4 (Infection Preventionist, Registered Nurse, RN) stated that she is the facilities Infection Preventionist at the facility and then explained that she does not tract residents with parasitic infections such as lice at the facility. V4 stated that is the responsibility of the nurse and that the nurses on the unit monitor residents who contract lice. V4 also stated that she is not sure of residents with lice are placed on isolation at the facility. V4 also explained that if a resident has lice, it could be spread to other residents in the facility. V4 finally stated, I didn't know I was supposed to tract those residents (referring to residents with lice. On 6/15/26 at 2:23 pm, V6 (Register Nurse, RN) stated that she was R5's nurse at the facility and frequently cares for R5 at the facility. V6 stated that she was aware of R5 being treated for lice on 6/5/26 however have not observed R5 with lice. V6 explained that she sees R5 scratching that R5 has complained of being itchy however have not seen any bugs crawling on R5. V6 then stated that she would call R5's physician to inform him of R5's skin condition and continued itchiness. On 6/17/26 at 2:22 pm, V2 (Director of Nursing, DON) stated that she began working in the facility February 2026 and vaguely remembers R5 being discussed in the morning meeting regarding treating R5 and his roommates for lice at the facility. V2 explained on 6/5/26 R5's was treated for lice after R5 was seen by V13 (R5's Physician). V2 stated that she does not recall any reports from the nursing staff regarding R5 having lice prior to V13 visiting R5 at the facility. V2 stated that when V13 reported treating R5 on 6/5/26 for lice V2 did not assess R5's or R5'S roommates for lice due to V2 having a phobia with bugs. V2 then stated that she informed the nurses to follow R5's physician orders to treat R5 with lice treatment shampoo and to follow the facilities policy for lice (bag the residents in the room belong, shower the residents, and notified the physician), when V13 made her aware of R5 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	having lice. V2 denied any knowledge of any R5 or any other residents in the facility with concerns for lice since 6/5/26. V5 explained if a resident goes without proper treatment for lice there is a potential for the resident to spread the lice to other residents in the facility. On 6/17/26 at 1:44 pm, V14 (Licensed Practical Nurse, LPN) stated that a CNA informed V14 that he saw lice in R5's bed over a month ago. V14 stated that he assessed R5 and observed R5 scratching black dots on R5's back and abdomen area but the black dots were not moving, and he could not determine if they were insects or parasites. V14 explained that he called R5's physician and informed him of what V5 (CNA) reported regarding seeing lice on R5 and R5's physician ordered treatment for a lice killing shampoo to be applied that day as well as a cream to be applied at night that required staying on R5 for hours (unsure of how many) then for R5 to shower. V14 also explained that all the residents in R5's room were showered, R5's room was treated with a lice spray, housekeeping deep cleaned R5's room, and every resident in the room's clothing was packed up, placed in a plastic bags and sent to be washed by laundry. V14 denied knowledge of observing or staff reporting the lice appearing for R5, R10, R11 or R12 since this insistence. V14 denied seeing insects or lice crawling on R5's bed since about a month ago however he continues to observe R5 in bed itching all the time. On 6/18/26 at 9:46 am, V13 (R5's Physician) stated he is R5's physician at the facility and last saw R5 a few weeks ago. V13 explained when he saw R5 he observed R5 scratching, very itchy, with body lice on his skin, and bed. V13 explained he ordered R5 and his roommates (R10, R11, and R12)to be treated for body lice with a topical treatment order to be applied and left on for 10 minutes then for R5 and his roommates (R10, R11, and R12) to be showered. V13 stated that the facility did not notify V13 regarding R5 having body lice and that he assessed R5 with the body lice during his visit with R5 and then informed V2 (DON) of his orders. V13 explained if a resident who has body lice is not reported, the resident will continue to be uncomfortable with itching, scratching and place the risk of spreading the infection to other residents. V13 stated that he has not received any follow up from the facility regarding R5 since ordering R5 to be treated for lice a few weeks ago. V13 could not recall R5 being treated for lice in April 2026 and only recalled treating R5 on 6/5/26. On 6/18/26 at 11:01 am, V1 (Administrator) stated that she is not aware of any residents in the facility who currently have body lice. V1 then stated that she was last made aware of a resident having body lice by the nursing staff two months ago with R5. V1 stated that she was informed that R5 was observed with body lice and was unsure if it was found by the nursing staff or housekeeping department. V1 stated that if body lice are sighted on a resident or in a resident's room the residents' physician is notified for a treatment, the treatment is implemented by the nursing staff, the residents are showered with a medication to kill the lice, and the residents clothing and furniture is cleaned with a disinfecting agent by housekeeping. V1 explained that lice infections should be tracked by V4 (Infection Preventionist, Registered Nurse, RN) to prevent the lice from spreading. V1 explained if a lice infection is not monitored or tracked the infection can spread and the resident infection can become worse. R5's progress notes dated 4/20/26 at 7:20 pm, and authored by V14 (LPN) documents, in part: During ADL (Activities of Daily Living) by staff, lice were discovered on resident's bed. A thorough body assessment was done. V13 (R5's Physician) with orders to treat resident with lice killing shampoo and body wash, bed cleaned with lice killing spray. Resident and other roommates clothing packed and sent to the laundry. Room was deep cleaned by the housekeeper. Resident with other roommates were thoroughly showered with lice killing shampoo and body wash. Staff will continue to monitor.R5's progress note dated 6/5/26 at 4:35 pm, authored by V13 (R5's Physician) documents in part: Noted bugs around him and bed . itching skin. Plan: Lice treatment and clean room.R5's Physician Order Sheet (POS) dated 4/21/26 shows order for R5 to receive permethrin 5% topical cream.R5's Physician Order Sheet (POS) reviewed.The facility undated and untitled policy for Lice Infestation documents, in part: Policy and Procedure for Scabies, Lice, Ticks, Mites, and Flea Infestation: Residents suspected of infestation or infection of scabies, lice, ticks, mites, fleas, or other arthropods shall be treated immediately.1. clinical indications or symptoms: a. Pruritus' . d. rash or trach marks commonly located on arm pits, thighs, (continued on next page)

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	06/22/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wrist, hands, between fingers or toes or extremities. 2. Attending physician or designee is to be notified immediately of any suspected infection or infestation.The facility's undated policy titled Surveillance documents, in part: Assess: the data collection and investigation may require direct observations, Review of other infection reports (resident and employee health concerns), review of literature regarding cleaning agents, interviewing residents(s) and employee(s), review of policies and procedures, observation of employee performance, assessment of use and effectiveness of equipment and supplies . Plan: Analyze/Interpret resident record for documentation of: Assessment, Signs and symptoms, vital signs. Physician notification. Medication/Treatment Record. The facility's Monthly Infection Log dated April 2026, May 2026, and June 2026 reviewed shows that R5's lice infection was not monitored.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview and record review the facility failed to ensure adequate supervision and monitoring of residents during a scheduled smoking break. This failure affected one resident (R3) resulting in resident-to-resident altercation occurring (R4 slapped R3) and has the potential to affect all 37 residents who smoke on the patio area in the facility. Findings include: R3's Brief Interview for Mental Status (BIMS) dated 3/6/26 shows a score of 4 which indicated that R3 has some cognitive impaired. R3's face sheet shows that R3 has a diagnosis which includes but not limited to anxiety disorder, developmental disorder of speech and language, nicotine dependance, chronic obstructive pulmonary disease and hypertensive heart disease. R4's Brief Interview for Mental Status (BIMS) dated 3/12/26 shows a score of 15 which indicated that R3 is cognitively intact. R3's face sheet shows that R3 has a diagnosis which includes but not limited to anxiety disorder, major depressive disorder, schizoaffective disorder, bipolar type, primary insomnia, and hypertensive heart disease. On 6/15/26 at 12:42 pm, R6 stated that about a month ago while R6 and other residents were waiting in the hallway on the first floor by the patio door for smoke break he witness R4 walk up to R3 and slap R3 in the face. R6 explained that R3 does not speak and did not know why R4 slapped R3 in the face. R6 stated that the incident took place as the residents were lined up along the patio door awaiting staff to come and that no staff was present to monitor the incident. On 6/15/26 at 1:08 pm, R9 stated, I saw him (referring to R3) get hit by another resident (unable to recall the residents name). R9 then stated, I don't know why he (referring to the resident that hit R3 (R4)) did that. He (referring to R3) is quiet and does not bother anyone. R9 also stated that the incident took place as the residents were lined up along the patio door awaiting staff to come and that no staff was present to monitor the incident. On 6/15/26 at 1:09 pm, V9 (Social Service) stated that the social service department is responsible for monitoring the residents during smoke breaks at the facility. V9 explained that residents who ambulate independently will line up forming a line along the wall outside of the smoke break patio door and when no staff is present to supervise the residents. V9 stated that he was not working on 5/18/26 the day of the incident between R3 and R4. V9 further explained when he returned to work on 5/19/26 he was informed that R4 was sent to the local hospital for slapping R3. V9 denied ever witness R3 and R4 in any previous incidents at the facility or during smoke break times. On 6/16/26 at 11:14 am, V3 (Social Services Director) stated that the social service department is responsible for monitoring the smoke breaks for the residents. V3 then stated that a social service staff should always be present during the resident's smoke breaks. V3 then explained when the resident's line up along the door of the patio area prior to the smoke break time there is not a staff member present to monitor the residents until the smoke time starts. V3 explained that the social service staff are bringing in residents from the front of the building when residents who ambulate began forming a line at the patio door before the social service staff can get to the patio area. V3 explained if residents are not supervised by the patio door, V3 stated; A fight can breakout. On 6/16/26 at 11:37 am, V11 (Psychiatric Rehabilitation Coordinator, PRSC) V11 explained that the residents have designated smoke break times and areas (the front of the facility for residents in wheelchairs and the patio areas for those residents who walk). V11 then explained that the social service staff will issue the residents the cigarettes and monitor the residents for smoke breaks. V11 further explained that residents who smoke on the patio will bring themselves down independently and form a line along the wall leading to the patio door independently. V11 explained that there is no one there to monitor the residents until a social service staff comes to begin the smoke break. V11 explained that R3 and R4 had an incident about a month ago when R4 hit R3. V11 then explained that during the time of the incident he was not present and was gathering the key to turn the patio door alarm and heard a commotion and residents saying Why did you do that? Why did you hit him? (referring to R4 hitting R3). V11 explained that when he went to the patio door area he separated R4 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	from R3 by removing R4 to the front receptionist desk area and took R3 to the first-floor nurse to be assessed. On 6/17/26 at 1:29 pm, V14 (LPN) stated he was R4's nurse on the day of the incident with R3 and R4 on 5/18/26 at the facility. V14 stated that he did not witness the incident between R3 and R4 and was informed that R4 had a physical altercation hitting R3. V14 stated that he was informed that the altercation took place on the first floor when the residents were going to smoke. V14 explained when the smoke break time is announced by social service department the residents go to the designated area to smoke, and the social service then takes the residents out to smoke. V14 stated that residents should not be lining up for smoke break until social services inform the residents it is time to smoke and is there to supervise the resident. V14 then explained that after the altercation R4 was placed on 1:1 monitoring, informed R4's physician and R4 was sent to the local hospital for psychiatric evaluation immediately following the incident and has not returned to the facility. On 6/18/26 at 10:29 am, V1 (Administrator) stated that she is the facility's abuse coordinator. V1 stated that last month she was notified that R4 slapped R3 while the residents were in line for the smoke by the patio door. V1 explained that R4 stated that he felt that R3 was talking about him and then V1 then explained that R3 is a non-verbal resident. V1 explained that staff separate R3 and R4 and placed them on 1:1 monitoring, called R3 and R4's physician and R4 was sent to the hospital for evaluation. V1 explained that R3 had a Xray of the face and was sent to the hospital for further evaluation and returned to the facility with no finding/injuries noted. V1 explained that if a resident hit another resident that it is resident-to resident abuse. V1 also stated if staff leave residents unsupervised accidents or an incident can occur. V1 stated that staff should have needed supplies for the residents prior to the monitoring the residents for smoke break. V1 stated that residents are directed to line up for smoke break once the smoke break is announced for residents to attend and residents who line up prior to the announcement are redirected back to the unit until the smoke break begins. V1 explained that during the altercation with R3 and R4 V11 (Psychiatric Rehabilitation Service Coordinator, PRSC) was assigned to monitor the residents for the patio smoke break and left the residents who were in line to go to the nurses station to get the residents cigarettes and keys for the smoke break and did not observe the altercation with R3 and R4. The facility document dated 5/18/26 shows a signed statement by R4 documents in part: I was walking down the hallway. He said something about me always blowing my nose and was talking about my eye, so I smacked him. I had to stop him. I don't hit it people.The facility policy dated 2026 and titled Facility Smoking Safety documents, in part: To provide a safe and healthy living environment with respect for the health and well-being needs of each resident, staff member and visitor. It is also the objective of this policy to communicate to each resident that they are responsible for following each rule and on-going compliance with this policy.The facility policy dated 1/26 and titled Resident Supervision Policy documents, in part: 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: All residents will be supervised.