STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146169	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fargo Health Care Center	1512 West Fargo 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)
F 0600 Level of Harm - 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** 45196 Based on interview and record review, the facility failed to ensure that a resident (R3) was free from physical abuse. This failure resulted in R3 sustaining a bruise and skin tear to the left arm that required a dressing twice a day and R3 being afraid at the facility. Findings include: The facility's Preliminary Incident Investigation Report to the local state agency dated 11/22/24 completed by V1 (Administrator) shows a report of physical abuse with alleged individual V11 (CNA/Certified Nursing Assistant) and R3. The facility's Completed Incident Investigation Report to the local state agency dated 11/27/24 competed by V1 documents, in part On 11/24/24 (should be 11/22/24) at approximately 11:45 am, R3's CNA (V14) was making rounds. V14 stated, I (V14) saw bleeding on the left arm. I (V14) asked what happen and R3 said the night CNA did that to me. Based on the known facts, medical record review, and interviews, the following conclusion have (sic) been determined about the allegation: Abuse-Neglect Founded. Based on statements from R3 and staff an investigation was conducted by V1, and incident noted to be founded. R3 stated that V11 (CNA) was turning him over hard. R3's Brief Interview for Mental Status (BIMS) dated 11/22/24 shows that R3 has a BIMS of 15 which indicates that R3 is cognitively intact. On 12/16/24 at 11:52 am, V3 (Licensed Practical Nurse, LPN) stated that V3 is familiar with R3 at the facility. When V3 was asked regarding the event with R3 on 11/22/24, V3 stated that V3 recalls on 11/22/24 at around 7:15 am, V14 (Certified Nursing Assistant, CNA) informed V3 that R3 wanted to see V3 regarding R3's arm. V3 stated that when she (V3) went to R3's room, V3 observed R3's left forearm with ecchymosis (bruising), red and, bleeding. V3 then stated that V3 asked R3 what happened to R3's left arm and R3 stated that the 11:00 pm - 7:00 am, CNA (who has been identified as V11 [CNA]) pulled R3's arm roughly bruising and tearing the skin to R3's left forearm. V3 explained that V3 assessed R3's left forearm and informed V2 (Director of Nursing/DON) regarding R3's left forearm injury. V3 then stated that V2 asked R3 additional questions and V3 left R3's room to inform R3's physician and family of the event. V3 further explained that R3's physician gave treatment orders for R3's bleeding left forearm injury and for an X ray of R3's left forearm. (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 0600 Level of Harm - Actual harm Residents Affected - Few	On 12/16/24 at 12:02 pm, V5 (Certified Nursing Assistant, CNA) was asked regarding the event with R3 on 11/22/24, V5 stated that V5 recalled the event with R3 on 11/22/24. V5 explained that R3 told V5 that V11 (Certified Nursing Assistant, CNA) held R3 very hardly by R3's arm and caused bruising to R3's left arm. V5 stated that V5 observed R3's left arm with bruising. V5 stated that V5 did not recall the color of R3's left arm bruising on 11/22/24. V5 stated that V5 then reported R3's concern and injury regarding R3's left arm to V3 (Licensed Practical Nurse, LPN) (R3's nurse) on 11/22/24. On 12/17/24 at 11:04 am, V17 (Registered Nurse, RN) stated that V17 is familiar with R3 at the facility. V17 then stated that R3 is alert , oriented and able to make R3's needs known at the facility. V17 stated that V17 was R3's 11:00 pm to 7:00 am nurse on 11/22/24 and that V17 recalled being phoned and questioned by V2 (Director of Nursing, DON) and asked if V11 (CNA); (R3's CNA on 11/22/24) made any reports to V17 regarding R3 during V17 shift on 11/22/24. V17 stated that V17 informed V2 that V17 was not made aware of any incidents or reports with R3 during V17's shift on 11/22/24. V17 stated that R3 slept during V17's shift on 11/22/24 and that V17 last saw R3 in bed sleeping around 5:30 am, when V17 was administering medication to R3's roommate. V17 denied witnessing any neglect, abuse, or injury to R3 at the facility. On 12/17/24 at 11:36 am, V11 (Certified Nursing Assistant, CNA) stated that V11 has worked at the facility for over 1 year and is scheduled to work at the facility on Monday's, Tuesdays, Thursdays, and every other weekend. V11 also stated that V11 recalls R3 at the facility and that V11 hasn't worked with R3 since 11/22/24. V11 stated that on 11/22/24 V11 provided incontinence care to R3 around 6:20 am and left R3's room. V11 then explained that around 6:30 am, R3 pulled the call light for V11 to come back into R3's room. V11 further explained when V11 went back into R3's room, R3 showed V11 a skin tear to R3's left inner arm, that needed to be covered up. V11 then explained that R3 stated that the skin tear to R3's left arm happened while V11 provided care to R3 around 6:20 am on 11/22/24. V11 denied causing injury to R3's left arm. When V11 was asked to describe how V11 last saw R3's left arm, V11 described R3's left arm at 6:30 am on 11/22/24 as opened with skin pulled back that looked tender, bruise and red, but not bleeding. V11 further explained that V11 informed R3 that V11 did not see the injury to R3's left arm when V11 provided care to R3 at 6:20 am. When V11 was asked when was the last time V11 provided care to R3 prior to 6:20 am and V11 stated that V11 did not provide any incontinence care to R3 prior to 6:20 am and that V11 only completed the round book to check to make sure R3 was ok and breathing well. V11 stated that V11 did not see bruising to R3's left arm until R3 pointed out R3's injury at 6:30 am. When V11 was asked if V11 reported R3's injury to R3's nurse V11 stated that R3's nurse left the first-floor unit and went to the third-floor unit prior to V11 providing care to R3 and that V11 did not report R3's injury to R3's nurse or any other nurse at the facility. V11 further explained that around 7:00 am, V11 informed V14 (CNA) for the 7:00 am to 3:00 pm CNA, that R3 needed the nurse and to let the nurse who comes in for the morning shift know. When V11 was asked regarding when V11 was scheduled to return to work at the facility V11 stated, They have not put me on the schedule yet, I am still suspended. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 12/17/24 at 1:48 pm, V14 (Certified Nursing Assistant, CNA) stated that V14 provides care to R3 daily on the 7:00 am to 3:00 pm shift at the facility. When V14 was asked regarding R3's event on 11/22/24, V14 stated that on 11/22/24 around 7:00 am, V14 began rounding for V14's 7:00 am to 3:00 pm shift on the first-floor unit at the facility when R3 stated to V14 Look at what the night CNA (referring to V11) did to my (R3) left arm. V14 stated that V14 observed R3's left arm red, bruising and with visible red blood from R3's left lower arm extending to above R3's left elbow. V14 then explained that V11 (CNA) was still in the facility and, V14 went to V11 and asked V11 if she knew what R3 was saying about R3's left arm injury. V14 further explained that V11 stated that V11 didn't know how R3's left arm injury happen and that V11 then left the facility for the day. V14 then explained that the day shift nurse V3 (Licensed Practical Nurse, LPN) arrived at the facility around 7:15 am, and V14 reported to the day shift nurse V3 that R3 had left arm bruising that R3 stated V11 (CNA) caused. On 12/17/24 at 2:04 pm, Surveyor observed R3 in R3's room, in bed, awake, alert and oriented times four. Surveyor observed R3's left arm area with pink discoloration, and the skin intact. R3 stated that a few weeks ago around 6:15 am, a night shift CNA intentionally caused an injury to R3's left arm. R3 explained that on 11/22/24 the CNA from the night shift (referring to V11) came into to R3's room to assist R3 with changing R3's incontinent brief. R3 further explained that V11 dug V11's fingers into R3's left arm to reposition R3 onto R3's right side. R3 then stated that R3's left arm began to bleed. R3 further stated that R3 told V11 that R3's arm was bleeding and asked V11 to get the nurse. However, V11 didn't. R3 stated that R3 waited until a staff member from the morning shift placed a bandage onto R3's left arm. R3 stated that R3 felt that V11 purposely injured R3's left arm because V11 would often speak meanly to R3 at the facility. R3 finally explained that V2 (Director of Nursing, DON) questioned R3 regarding the incident with R3 and V11 and informed R3 that V11 would not be allowed to work on the first floor with R3 again. When R3 was asked if R3 felt safe at the facility R3 stated, No! I (R3) am afraid that she (V11) will come back during the night from another floor and hurt me again. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 12/18/24 at 9:46 am, V2 (Director of Nursing, DON) stated V2 is familiar with R3 and that R3 is an alert and oriented times 3-4 resident at the facility. When V2 was asked regarding R3's event on 11/22/24, V2 explained that on 11/22/24 around 9:00 am, V2 recalls V3 (Licensed Practical Nurse, LPN) informing V2 that R3 had an injury to R3's left arm that was bleeding. V2 stated that V2 then went to assess R3's left arm and observed a skin tear that was approximately 4.0 cm (centimeters) in length by 4.0 cm width, red, open skin, and slightly bleeding. V2 then stated that V2 asked R3 what happened to R3's left arm and R3 stated The nightshift CNA (referring to V11) was cleaning me (R3) up, grabbed my arm and dug into it. Then she (V11) flipped me over to change me and when I (R3) looked at my (R3) arm it was all bloody. V2 further explained that R3 stated that R3 asked V11 if she would tell the nurse and V11 said that she would. R3 then stated that V11 had been mean to R3 for a while and that R3 didn't tell anyone because R3 thought V11 was going to change. V2 then stated that V2 immediately reported R3's allegations against V11 to V1 (Administrator) and that V1 immediately started an investigation. V2 further explained that V1 and V2 phoned V11 and informed V11 of R3's statement regarding V11 injuring R3's left arm. V2 stated that when V2 initially spoke with V11, V11 stated that nothing happened to R3's left arm, then after V2 told V11 that R3 had a skin tear to R3's left arm and asked V11 if V11 knew anything regarding R3's left arm injury again, V11 was quiet and denied R3's arm was bleeding and refused to acknowledge seeing R3's left arm injury during V11's shift. V2 further explained that V11 did not acknowledge R3's left arm injury until V2 explained to V11 that V2 had spoken with V14 (CNA) who stated that he (V14) spoke with V11 regarding R3's left arm injury on 11/22/24 prior to V11 leaving the facility. V2 then stated that V11 finally acknowledged R3's left arm injury and stated I (V11) saw it, but it wasn't bleeding. I (V11) couldn't tell the nurse because the nurse was working another floor, but I told CNA (referring to V14). V2 stated after V11 changed her (V11's) story she (V11) was suspended until further investigation and then terminated by V1 (Administrator) and V2, after V1 concluded V1's investigation regarding R3's left arm injury. V2 then stated that V2 informed R3 that V11 would not be working with R3 anymore at the facility. When V2 was asked regarding what could happen if a staff grabs a residents' arm, digs into the resident's arm, and flips the resident over and V2 stated, They (referring to staff) can cause an injury, break the skin, cause a sore or an infection to the resident. Residents who have fragile skin can be harmed, possibly have psychological problems, and not feel safe. On 12/18/24 at 10:43 am, V18 (R3's physician) stated that V18 is familiar with R3. V18 explained that R3 is alert, oriented, able to make needs known, and ambulatory with the use of a cane with a history of falls. V18 explained that V18 last saw R3 a few weeks ago after R3 was sent out to the local hospital for something that happened to R3 at the facility (V18 could not recall). When V18 was asked regarding R3's incident on 11/22/24, V18 stated that V18 received a call from R3's nurse at the facility who stated that the staff was changing R3 when R3 acquired a skin tear on the arm that was superficial. V18 stated that V18 could not remember what orders were given regarding the incident. When V18 was asked regarding what could happen if a staff member digs their nail in R3's arm and flips R3 over onto R3's side and V18 stated that staff should not dig into a resident arm and flip a resident over because the staff can scratch and injure the skin. V18 then explained that R3 has fragile skin from receiving chemotherapy and staff should not be using their nails to reposition R3 or any resident because it can cause a nail mark or abrasion or injury to the resident. V18 stated, Repositioning should not be done with someone using their nails. Who is doing that? I (V18) was not informed that happened. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 12/18/24 at 11:19 am, V1 (Administrator) stated that V1 is the facility's abuse coordinator. V1 stated that V1 has been the Administrator at the facility for about one month. V1 then stated that V1 is familiar with R3 at the facility. V1 stated that V1 is alert, oriented, articulate, and able to make needs known. V1 explained on 11/22/24 V1 was called to R3's room and observed a reddish skin tear to R3's left forearm area that looked fresh and had a little blood to it. V1 explained that V1 asked R3 what happened and R3 stated that (the night shift CNA on 11/22/24) (referring to V11 (CNA)), had been treating R3 roughly for a long time and that R3 did not say anything because R3 thought It would get better. V1 further explained that R3 did not identify the CNA by name however, R3 stated that he was referring to the overnight CNA that had left the morning of 11/22/24. V1 then explained that V1 looked at the nursing schedule to identify the night shift CNA that left the morning of 11/22/24 and determine the CNA was V11. V1 further stated that V1 immediately suspended and removed V11 from schedule and notified the police. V11 then explained that the Police came to the facility, interviewed R3, observed R3's arm, gave a report number and left the facility. V1 stated that during V1's investigation, V1 found that V11 did not report R3's injury to the nurse on 11/22/24. V1 further explained that V11 stated, that V11 informed V14 (CNA) regarding R3's left arm on 11/22/24. V1 then explained that V1 suspended V11 then terminated V11 for improper reporting of abuse and resident injury. V1 stated that V11 denied ever abusing R3 and that V11 was not aware that R3 had a skin tear to R3's arm when V1 asked V11 regarding R3's left arm injury on 11/22/24. V1 stated that V11 was suspected of abusing R3 because R3 stated that V11 was the staff who injured R3's arm. When V1 was asked regarding what can happen if a staff handles a resident roughly and dig their nails into the residents skin and V1 stated, That is physical abuse. That is not tolerated by the facility. R3's progress note dated 11/22/24 at 12:59 pm, authored by V3 (Licensed Practical Nurse, LPN) documents, in part: Resident received alert and oriented at the beginning of the shift. At about 8.00 am the CNA notified the writer that the resident was found with ecchymosis in the lower left forearm. R3 said he got the bruises early in the morning when the CNA was cleaning him. The wound was cleaned with normal saline, and bacitracin was applied and properly dressed. He (R3) voiced no pain at that time and all due medication was administered and he is stable. V/S (vital signs) b/p (blood pressure) -130/69, PR (pulse rate)-75, RR (respiratory rate)-18, 02 Sat -(oxygen saturation) 97%, T (temperature)-96.9*F (Fahrenheit). R3's physician was notified with the order to carry out x-ray to rule out fracture's. The administrator and DON made aware. The resident was notified. R3's Physician Order Sheet (POS) dated 11/22/2024 shows an order for R3 to cleanse left arm with normal saline and apply bacitracin ointment and cover with dry gauze BID (twice a day) till (until) healed. R3's X-ray report dated 11/22/24 at 3:39 pm and titled Left Forearm 2V (view) documents, in part: left radius and ulna have normal ossification pattern. No fracture or dislocation reviewed. The facility's document titled Employee Report documents, in part: The above stated employee after an investigation was done allegedly caused an injury to a resident R3 and failed to report it properly as a result the employee is terminated. The facility's document dated 11/22/2024 and titled Victim Information Notice/Police Department documents, in part: Incident number JH517396: Incident: Aggravated (aff) Battery ([NAME]) Senior Citizen. Name of victim/complainant R3. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The facility document dated 18 November 16 and titled Abuse Prevention Program Facility Procedure documents, in part: Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish . III Orientation and Training of Employees: During orientation of new employees, the facility will cover at least the following topics: . Staff obligation to prevent and report abuse, neglect, exploitation, mistreatment, and misappropriation of resident property.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 45644 Based on interview, and record review the facility failed to submit the final investigation of an alleged abuse to IDPH (Illinois Department of Public Health) within 5 days of the alleged allegation. This failure affected two residents (R1 and R2) reviewed for resident-to-resident abuse. Findings Include: A facility reported incident was sent to IDPH (Illinois Department of Public Health) on 11/1/24. The reportable offenses documented on the Immediate Incident Investigation Report had check marks by physical, verbal, or mental abuse. Circumstances of alleged incident: On 11/1/24, R1 reported that earlier in the day he (R1) and co-resident (R2) allegedly engaged in a verbal and physical altercation. Both residents were separated immediately. No injuries were noted. On (11/1/24) IDPH was notified of the (11/1/24) incident involving R1 & R2 however a final report was not received. On 12/17/24 9:50 am, V1 (Administrator) stated, I do not know if the final was submitted to IDPH. I was not employed here at the time the incident occurred. I did look for the paperwork from the old administrator, but did not see it, so I can't say if it was submitted to IDPH (Illinois Department Public Health) or not. I did find a final incident Investigation Report, but do not know if it was sent. I could not find any confirmation that it was sent. Facility's documents dated 18-Nov-16 and titled Abuse policy documented in part, External Reporting: 2. Five- day Final Investigation Report. Within Five working days after the report of the occurrence, a complete written report of the conclusion of the investigation, including steps the facility has taken in response to the allegation, will be sent to the Department of Public Health .