

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146169	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER Fargo Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1512 West Fargo 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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40067</p> <p>Based on observation, interview, and record review, the facility failed to ensure that the residents' call light device was within a residents reach to call for staff assistance which affected 4 residents (R37, R54, R56, R245) in the sample of 28 residents reviewed.</p> <p>Findings include:</p> <p>1) On 5/20/24 at 11:02 am, R54 was observed in bed with R54's call light device (orange string) hanging from the switch on the wall and hanging down towards the floor behind R54's end table (small dresser with drawers). When asked what R54 does if R54 needs help from staff, R54 stated that R54 doesn't know where the call light string is and that R54 can't reach it.</p> <p>On 5/21/24 at 9:57 am, R54 was observed in bed with R54's call light string hanging from the wall switch then twisted with R54's over the bed light string (which is yellow). Both strings are hanging down towards the floor behind R54's head of bed out of R54's reach.</p> <p>On 5/21/24 at 1:31 pm, V4 (Licensed Practical Nurse/LPN) was observed administering a medication via R54's gastrostomy tube. When asked if R54's call light is within reach, V4 stated that it was, and must have been moved by the CNA (Certified Nurse Aid) staff since they just finished providing activities of daily living (ADL) care for R54. This surveyor informed V4 that with observations on 5/20/24 and this morning on 5/21/24, R54's call light string has been in the exact same place. V4 stated, It should be within reach attached on the pillow.</p> <p>R54's Face Sheet, documents, in part, diagnoses of cerebral infarction; neuroleptic induced parkinsonism; essential (primary) hypertension; extrapyramidal and movement disorder, unspecified; schizophrenia, unspecified; age-related nuclear cataract, bilateral; gastrostomy status; and chronic obstructive pulmonary disease, unspecified.</p> <p>R54's Minimum Data Set (MDS), dated [DATE], documents, in part, of a Brief Interview for Mental Status (BIMS) score of 7 which indicates that R54 has severe cognitive impairment.</p> <p>R54's Care Plan, active effective date of 5/4/24, documents, in part, a focus of falls in which R54 is at risk for falls related to cerebral vascular accident (CVA), impaired cognition, and use of psychotropic medication with an intervention of place call light within easy reach.</p> <p>(continued on next page)</p>

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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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2) On 5/20/24 at 11:08 am, R245 was observed sleeping in bed with the call light string hanging down from the wall switch towards the floor behind R245's headboard, not within R245's reach.</p> <p>On 5/21/24 at 9:59 am, R245 was observed awake in bed. R245's call light string is hanging from the wall switch towards floor, behind the head of R245's bed, not within reach. When asked if R245 can reach the call light string, R245 stated, No.</p> <p>R245's Face Sheet, documents, in part, diagnoses of schizophrenia; arthropathy; edema; scoliosis; unspecified dementia; and adult failure to thrive.</p> <p>R245's MDS, dated [DATE], documents, in part, a BIMS score of 14 which indicates that R245 is cognitively intact.</p> <p>R245's Care Plan, active effective date of 5/13/24, documents, in part, a focus of falls in which R245 is at risk related to daily use of psychotropic medication with an intervention of anticipate resident needs in relation to present ADL function.</p> <p>3) On 5/20/24 at 11:29 am, R37 was observed sleeping in bed with R37's call light string hanging down towards the floor from the wall switch. R37's call light is notably visible out of R37's reach on the opposite side of R37's end table which is next to R37's bed.</p> <p>On 5/21/24 at 9:51 am, R37 was observed awake in bed. R37's call light string observed in the same position as observed on 5/20/24 with the call light string hanging from the wall switch towards the floor far from R37's reach.</p> <p>R37's Face Sheet, documents, in part, diagnoses of unspecified dementia; essential (primary) hypertension; dysphagia; arthropathy; schizoaffective disorder; major depressive disorder; pain, unspecified; cognitive communication deficit; restlessness and agitation; and hyperlipidemia.</p> <p>R37's MDS, dated [DATE], documents, in part, a Staff Assessment for Mental Status indicates that R37's Cognitive Skills for Daily Decision Making is severely impaired.</p> <p>R37's Care Plan, active effective date of 2/3/23, documents, in part, a focus of falls for R37 being at risk for falls related to history of fall, unsteady gait, poor safety awareness, impaired judgement and daily use of psychotropic medication with an intervention of (R37) instructed to use the call light for assistance and to wait for staff to come and assist (R37) to the bathroom to prevent recurrence.</p> <p>4) On 5/20/24 at 11:32 am, R56 was observed in bed with the call light string hanging from the wall switch down towards the floor, behind the end table. When asked if R56 can reach the call light string from bed position, R56 said, No.</p> <p>On 5/21/24 at 9:50 am, R56 was observed in bed with the call light string hanging from switch on the wall towards floor and behind the end table. When asked if R56 is able to reach the call light string, R56 stated, I can't.</p> <p>R56's Face Sheet documents, in part, diagnoses of pulmonary embolism; hyperlipidemia; essential (primary) hypertension; dysphagia; pain; acute respiratory failure with hypoxia; and hypokalemia.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R56's MDS, dated [DATE], documents, in part, a BIMS score of 15 which indicates that R56 is cognitively intact.</p> <p>R56's Care Plan, active effective date of 2/21/24, documents, in part, a focus of visual function with R56 being at risk for injury with an intervention of encourage to ask for assistance as needed.</p> <p>On 5/22/24 at 11:20 am, V2 (Director of Nursing/DON) stated, Call light strings are to be positioned with residents in bed attached to the pillow so the resident can reach them. When asked the purpose of having the call light strings within a resident's reach in bed, V2 stated, If they (residents) need help, they have to let staff know to come help me (the resident). If it's not there, they can't. The call light lets the nurse or CNA know especially for those who can't verbalize or yell out. It's reassurance that the resident can expect someone will come help me (the resident).</p> <p>Facility undated policy titled Call Light Response documents, in part, Policy: It is the policy of this facility to promptly and efficiently respond to residents requests for assistance. All call lights must be within residents reach.</p> <p>Facility job description, dated May 2003 and titled Certified Nursing Assistant, documents, in part, Purpose of the Position: The primary purpose of the position is to provide your assigned residents with routine daily nursing care in accordance with our established nursing care procedures, and as may be directed by your supervisors. Duties and Responsibilities . Safety and Sanitation: . 6. Keep the nurses' call system within easy reach of the resident.</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45196</p> <p>Based on interview and record review, the facility failed to ensure that there is a code status documented under the physicians order in a resident's electronic medical record (EMR) which affected one resident (R11) in a sample of 28 residents reviewed for advance directives.</p> <p>Findings include:</p> <p>R11's face sheet shows that R11 has a diagnosis which includes but not limited to paranoid schizophrenia, epilepsy, essential hypertension, asthma, type 2 diabetes, and chronic obstructive pulmonary disease.</p> <p>R11's Minimum Data Set (MDS), dated [DATE], documents, in part, a Brief Interview of Mental Status (BIMS) score of 14 which indicates that R11 is cognitively intact.</p> <p>On 05/20/24 at 12:30 pm, R11's Physician Order (POS), dated 05/20/24, which includes all active orders, showed no code status order is noted for R11. Full code orders for R11 entered on R11's POS, 05/20/24 at 2:12 pm, after surveyor requested R11's advance directives orders.</p> <p>R11's care plan dated 04/29/24 shows that R11 has no advanced directives at this time and that R11 is a full code. This care plan for R11 was created without any orders for code status on R11's POS.</p> <p>R11's care plan dated 05/20/24 shows that R11 has no advanced directives at this time and that R11 is a full code. This care plan for R11 was created on 05/20/24 after surveyor requested R11's advanced directive care plan and was presented to surveyor on 05/21/24.</p> <p>R11's Physician Order for Life-Sustaining Treatment (POLST) shows that R11's POLST completed on 05/20/24 after surveyor requested R11's POLST.</p> <p>On 05/21/24 at 10:05 am, V16 (Social Service Director) stated that the admitting nurse on the floor enters the residents code status order upon admission to the facility. V16 explained upon admission to the facility the resident should have a code status entered on the residents POS. V16 explained that it is important that the resident has a code status order upon admission to that the facility so the facility will know how the resident would like to be treated, to address the resident in the highest dignity and to ensure the resident will have their wishes honored.</p> <p>On 05/21/24 at 1:15 pm, V2 (Director of Nursing/DON) stated that immediately upon admission the admitting nurse should enter a code status order on the residents POS. When V2 was asked about R11's code status orders on R11's POS, V2 stated, I (V2) missed putting his (R11) code status order in the computer when he (R11) was admitted to the facility. When V2 was asked about the importance of residents having advanced directives and a code status order on the residents POS, V2 stated, If they (referring to the resident) code, the nurse needs to make sure they are following the residents wishes and caring properly and adequately.</p> <p>(continued on next page)</p>

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Facility's policy dated 01/01/17 and titled Advance Directive, documents, in part, Policy: Upon admission, all residents will be provided information (in the Admission Packet) on Advanced Directives. Procedures: . If the resident does not provide an Advance Directive, the resident will be treated as a full code.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>45196</p> <p>Based on observation, interview, and record review the facility failed to provide a safe and functional environment for two residents (R9 and R13) in the sample of 28 residents reviewed for homelike environment.</p> <p>Findings include:</p> <p>R9's Brief Interview for Mental Status (BIMS) dated 05/16/24 shows that R9 has a BIMS score of 15 which indicates that R9 is cognitively intact.</p> <p>R9 has a diagnosis which includes but not limited to schizophrenia, essential hypertension, and pain.</p> <p>R13 BIMS dated 03/22/24 shows that R13 has a BIMS score of 15 which indicates that R13 is cognitively intact.</p> <p>R13 has a diagnosis which includes but not limited to schizophrenia, essential hypertension, major depression, disorder of bone and insomnia.</p> <p>On 05/20/24 at 11:06 am, R13's room privacy curtain was observed to be soiled with a brown stool like substance visibly smeared. R13 stated that R13 does not know when the privacy curtain was last cleaned. R13 stated that R13 wants the privacy curtain cleaned.</p> <p>On 05/20 /24 at 11:14 am, R9 was observed without a window screen. When R9 was asked how long R9's room window has been missing a window screen, R9 stated that R9 never had a window screen in the window. R9 stated that flies sometimes get into R9's room and that R9 wanted a window screen.</p> <p>On 05/21/24 at 11:34 am, R9's room window was still observed without a window screen.</p> <p>On 05/21/24 at 11:35 am, R13's privacy curtain was still observed soiled.</p> <p>On 05/21/24 at 1:31 pm, Surveyor brought R9's missing window screens observation to V8 (Maintenance Director) and V8 stated that V8 is responsible for checking the residents' windows for window screens. V8 stated that V8 is not sure how long R9's room window has been missing a window screen. V8 stated that V8 buys the materials to make the window screens at the facility and that V8 would provide R9's room window with a window screen. When V8 was asked regarding the importance of resident's windows to have a window screen, V8 stated, It (referring to window screens) prevents flies and mosquitoes from entering the resident's room and facility.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 05/21/24 at 1:37 pm, Surveyor brought R13's privacy curtain observation to V17 (Housekeeping Supervisor) and V17 stated that the housekeeping staff is responsible for cleaning the resident's privacy curtains. V17 stated that staff cleans the resident's privacy curtains as needed. V17 also explained that the housekeeper assigned to the resident's room should be inspecting the resident's privacy curtains daily when the resident's room is being cleaned. V17 stated that if a housekeeper observes a dirty privacy curtain upon cleaning the resident's room, the housekeeper should remove the privacy curtain and the privacy curtain should be cleaned. When V17 was asked the importance of residents having clean privacy curtains V17 stated, To prevent smells, germs, and to give the residents a clean environment.</p> <p>The facility's job description dated 01/01/2015 and titled Director of Maintenance documents in part: Purpose of your job position: The primary purpose of your job position is to plan, organize, develop, and direct the overall operation of the Maintenance Department in accordance with current federal, state, and local standards, guidelines, and regulations governing our facility, and as may be directed by the Administrator, to assure that our facility is maintained in a safe and comfortable manner . Safe and Sanitation: . Ensure that supplies, equipment, etc., are maintained to provide a safe comfortable environment.</p> <p>The facility's job description dated 01/01/2015 and titled Housekeeper documents in part: Purpose of your job position: The primary purpose of your job position is to perform the day-to-day activities of the Housekeeping Department in accordance with current federal, state, and local standards, guidelines and regulations governing our facility, and as may be directed by the Administrator, and/or Director of Housekeeping, to assure that our facility is maintained in a clean, safe, and comfortable manner . Safe and Sanitation: . Ensure that assigned work areas are maintained in a clean, safe, comfortable, and attractive manner.</p>

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p>47303</p> <p>Based on observation, interviews, and record review, the facility failed to ensure that residents receive assistance with shaving facial hair. This failure has affected one (R12) of six residents reviewed for personal hygiene and care.</p> <p>Findings include:</p> <p>R12 has diagnoses including but not limited to: Inflammatory polyneuropathy, age-related osteoporosis, essential hypertension, and Hyperlipidemia.</p> <p>R12's BIMS (Brief Interview for Mental Status) Score is 12, which indicates moderate impairment.</p> <p>On 5/20/2024 at 11:08 AM, R12 was observed walking in the hallway on the first floor.</p> <p>At that time, Surveyor noted that R12 had facial hair (both above lip and on chin).</p> <p>Surveyor inquired about R12's shaving schedule.</p> <p>On 5/20/2024 at 11:10 AM, R12 said, I was supposed to get shaved yesterday (Sunday), but I didn't have anyone to help me. I can shave myself if they just give me a razor, but they usually always shave my face for me. It's ok. I just have to wait.</p> <p>Surveyor asked if R12 wanted her face shaved now.</p> <p>At that time, R12 said, Yes, I would love to have my face shaved now. It itches and I feel much better when it's shaved.</p> <p>On 5/20/2024 at 11:20 AM, V5 (CNA/Certified Nurse Assistant) said, I usually shave R12 on the weekends, but I was off this past weekend. I'm going to shave her now.</p> <p>Surveyor inquired about R12's ability to shave herself with set-up and minimal assistance as needed.</p> <p>At that time, V5 (CNA) said, She (R12) can probably shave herself, but we just do it for her.</p> <p>Surveyor inquired about the expectations with facial hair on residents. On 5/21/2024 at 1:10 PM, V2 (DON/Director of Nursing) said, I would expect for the facial hair to be cut on a resident. It could be irritating, itchy and masculine looking for the female resident.</p> <p>R12' MDS (Minimum Data Set), Functional abilities and goals section documents, R12 requires partial/moderate assistance with personal hygiene, including shaving; Helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.</p> <p>(continued on next page)</p>

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R12's Care Plan documents, Resident is on a dressing and grooming program due to self-care deficit; resident to be provided with training in all aspects of dressing and or grooming in order to promote resident's highest level of independent performance.</p> <p>Facility policy titled, Personal Care Services documents, each resident shall receive services based on individual needs. Resident's hair shall be kept clean, neat, and well groomed.</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40067</p> <p>Based on interview and record review, the facility failed to prevent a resident's fall from the bed to the floor, who was assessed as a two person assist for bed mobility. This failure affected 1 (R44) of 28 residents reviewed for falls. R44 was emergently transferred to the hospital with increased pain and experiences psychosocial harm, feeling scared and afraid while being turned in bed by staff.</p> <p>Findings include:</p> <p>On 5/20/24 at 11:13am, R44 stated that R44 has been in the facility for almost 2 years, and I (R44) don't walk. R44 stated, I fell out of bed about 2 months ago. I had moved to (another floor) because they needed my room as an isolation room. R44 stated that in R44's current room, R44's bed is up against the wall and that the room on the other floor (where R44 had been temporarily transferred on 2/13/24) didn't have a wall next to R44's bed, so R44's bed was open on both sides. R44 stated, (V20 Certified Nursing Assistant/CNA) was on the same (one) side and pushed me over to change me. I was holding onto the end table. When (V20) pushed my (incontinence brief), (V20) pushed it under my buttock, and I fell face first on the floor. I had bruises on my right knee and feet and my toes and elbow hurt. There was no side rail. When asked if one or two CNAs assisted R44 with turning in bed for incontinence or activities of daily living (ADL) care, R44 stated that there was one CNA, but now, a majority of the time, there's 2 people. When asked if the staff move the bed away from the wall to stand on one side (with other CNA on the other side), R44 stated, No. I roll to the side and hang onto the wall. My body hits against the wall to keep me propped up. R44 said that both CNAs stay on the one side for R44's care. R44 stated, I am not over it. I still have issues of getting too close to the side. When asked how does this make R44 feel, R44 stated, I feel afraid on the inside. I talked to my psychiatrist (V24) about it. R44 said that R44 even asked V24 if it was R44's fault that R44 fell, and V24 said, You have nothing to do with it. It's not your fault. They had one aide there. It was their mistake. R44 stated that V24 said to get it out of R44's head and to not think about it. R44 stated that R44 talked to V24 shortly after the fall happened on 2/23/24 with V2 (Director of Nursing/DON).</p> <p>On 5/22/24 at 9:38 am, R44 was reinterviewed and stated that it was at 8:30pm on 2/23/24 when R44 fell from the bed to the floor. When asked if R44 has expressed R44's feelings after R44's fall, R44 stated, I told (V2), and I had talked to (V24) after I had fallen. I still have a phobia to falling off the side of my bed. R44 stated, (V2) was in the room with (V24) when I said that I am scared about rolling off the bed. I told (V2) the other day too. R44 stated that before this fall on 2/23/24, I have never fallen before. When asked about a fall mat as a fall precaution, R44 stated that there was one in the room but that there was problem with the bedside table not rolling on it. R44 stated, I rely on that table. I tried it, and it wouldn't roll at all. R44 stated, since I am larger, it's harder for me to move in bed. I can't move my legs. I have so much pain. R44 stated, I can pull with my arms. They had even talked about a trapeze, but that didn't come to be.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>R44's Face Sheet documents, in part, diagnoses of idiopathic peripheral autonomic neuropathy; chronic obstructive pulmonary disease with (acute) exacerbation; asthma, uncomplicated; acute embolism and thrombosis of other specified deep vein of right lower extremity; pain in left leg; anxiety disorder due to known physiological condition; arthropathy; obesity; essential (primary) hypertension; heart failure, unspecified; cramp and spasm; hypoparathyroidism; localized edema; major depressive disorder; hyperlipidemia; presence of left artificial knee joint; non-pressure chronic ulcer of unspecified part of left lower leg limited to breakdown of skin; body mass index [BMI] 34.0-34.9, adult; and bacterial pneumonia.</p> <p>R44's Minimum Data Set (MDS), dated [DATE], documents, in part, a Brief Interview of Mental Status (BIMS) score of 15 which indicates that R44 is cognitively intact. R44's bed mobility of rolling left and right is indicated as substantial/maximal assistance. R44's MDS, dated [DATE] and 4/17/24, indicate no side rails in use.</p> <p>R44's Care Plan, active effective date of 1/13/24, documents, in part, a focus of (R44) is at risk for falls related to impaired mobility, pain on right lower extremity, unable to stand without staff assistance, use of psychotropic medication with a goal of R44 being free from falls until next review and interventions of anticipate resident needs in relation to present ADL function and provide education on safety techniques.</p> <p>R44's Fall Risk Assessment, dated 1/12/24, documents, in part, a score of 10 which is a high fall risk.</p> <p>R44's Census Activity, documents, in part, that R44 was transferred to another room on another floor on 2/13/24.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146169	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER Fargo Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1512 West Fargo Chicago, IL 60626	
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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/22/24 at 2:43pm, V20 (CNA) stated that R44 is alert, and (R44) is bed bound. When asked about R44's fall incident on 2/23/24, V20 stated that V20 was taking care of R44 in R44's new room on the 3:00pm to 11:00pm shift, and it was about 8:30pm. V20 stated, I (V20) was changing (R44's) (incontinence brief), cleaning (R44) on the bed. There's no bed rail. (R44's) bed was not against the wall. I turned (R44) by myself. (R44) usually holds onto the side of the bed frame with (R44's) hand on that side. I was just ready to bring (R44) back to me when I realized that (R44) fell. I hollered help. No one came. I had to come out the room. I said to (V27, Security), 'Please call the nurse (V18, Registered Nurse/RN). I need help'. V20 stated that V18 then came into R44's room, assessed R44, and then 911 emergency services were called. When asking V20 about what action in R44's care was V20 performing when R44 fell off the bed, V20 stated, I was putting (incontinence brief) on (R44). I (V20) had rolled (R44) away from me. I was behind (R44), and I pull (R44) back to put clean (incontinence brief) under (R44's) hip. I just slid it (clean incontinence brief) under hips, and R44 fall out of bed. When asked how high the bed was during R44's care on 2/23/24 at 8:30pm, V20 stated that V20 had raised to the height of R44's bed to about V20's waist for V20 to provide R44's care. When asked if R44 was in the middle of the bed when turning R44, V20 said that V20 usually makes sure that residents are in the middle but didn't with R44. V20 stated that R44 landed on the floor, and I run around the bed and look at (R44) on the floor. That's the first thing I did, run around and see (R44). Then I hollered for help. No one. Then I run out by the room door and holler to (V27) to send in (V18). V20 stated that after V18 responded, V18 informed V20 that two staff members usually turn R44 in bed. V20 stated that V20 told V18, I never had a problem with (R44) before, but (R44) was in a room with bed against the wall. This bed was open on both sides. I didn't think something like this was going to happen. Can (R44) have a bed rail? I cared for (R44) before with one person. Bed was against the wall, I did it before. When asked, how does V20 know how many staff persons it takes to assist residents with bed mobility, V20 stated, I look at their size. I had been able to do (R44) with one before, but I know now that I need two. If it's a large person, common sense tells you, you need two. When asked if V20 looks in the chart for assistance level, V20 stated yes, but couldn't tell where to this surveyor. On 2/23/24, V20 was asked if R44 needed two staff persons for assistance with turning, V20 stated, At that time, no. Not need two people. (sic) When asked if R44 moves R44's legs in bed, (V20 shaking V20's head no) and stated, (R44) does not move (R44) legs.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/21/24 at 2:19pm, V18 (RN) stated that R44 is alert, oriented, stays in the bed and is almost bed bound. When asked about R44's fall incident on 2/23/24, V18 stated that V18 was made aware of R44's fall when V20 (CNA) came to V18 and said that R44's on the floor. V18 stated that V18 went to the room, and R44 was laying, face down on the floor and that R44 said R44 fell when V20 was taking care of R44. When asked if V18 had performed incontinence care with R44 prior to the fall on 2/23/24, V18 stated that V18 had an admission that day. V18 stated that when R44 fell, I (V18) called 911. (R44) is very big (weight). There was one CNA (V20) on the floor. (V20) was elderly. (R44) stayed on the floor. When asked about R44's position, V18 stated that R44's bed was open on both side with no side rails, and R44's position on floor was face first. V18 stated that R44's body on the floor was parallel with the bed and was in between the wall and nightstand (end table) where there was a wall near R44's head. V18 stated that R44 was alert and said that R44 bumped R44's head on the wall. When asked if R44 complained of pain after the fall on 2/23/24 at 8:30pm, V18 stated, Yes, (R44) had pain. I gave (R44) pain meds a few hours before the fall. I gave (R44) all (R44's) meds. When asked about where R44 was complaining of pain, V18 stated, (R44) didn't talk much due to position (laying face down on floor). I just moved (R44's) head to put pillow and and use sheet to cover (R44). (R44) was naked. V18 stated that (R44) did have redness to right side of R44's face. V18 stated that V18 did not medicate R44 with any pain medication due to already giving R44's pain medication prior to R44's fall. V18 stated that when V18 gave R44 the medications before R44's fall, R44's bed was in the low position; however, when V18 went in with V20 (CNA) after the fall, (R44's) bed was high. (V20) was taking care of (R44).</p> <p>In R44's Progress Note, dated 2/23/24 at 9:09pm, V18 (RN) documents, in part, At 8:40pm, writer was informed by (V20, CNA) that resident fell off the bed while giving care. Writer immediately went to resident room and found (R44) on the floor facing down, initials assessment done, noted with redness on right-side of the face, no bleeding noted, voiced 5/10 on pain scale, resident states 'I hit my head on the wall'.</p> <p>R44's February 2024 MAR (Medication Administration Record) shows that on 2/23/24 from 3:00pm to 11:00pm, there is no documentation of Hydrocodone 5 milligram (mg)/Acetaminophen 325 mg tablet oral every 6 hours PRN (whenever needed) was noted.</p> <p>Facility document, titled CNA Assignment Sheet and dated 2/23/24 for 3:00pm to 11:00pm shift (on R44's new floor from transfer date of 2/13/24), documents, in part, that V18 is the nurse assigned, and V20 is the one CNA assigned to the floor.</p> <p>R44's emergency hospital records, dated 2/23/24, document, in part, that R44 was being changed at the nursing home and fell off of the bed. (R44) with head strike and pain to right arm, bilateral feet, and that R44's pain to right arm and bilateral ankles is exacerbated from baseline.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/22/24 at 10:16am, V4 (Restorative Nurse, Licensed Practical Nurse/LPN) stated that R44 was receiving bed mobility for restorative therapy because R44 had reached R44's maximum potential with transfers in skilled therapy. V22 stated that with standing, (R44) could not do it. (R44) can't with left leg. When asked about bed mobility for R44, V4 stated that it's how (R44) can maneuver left to right in bed and repositioning. V4 stated that it's done with the CNA staff and also with the restorative aide (V5). When asked what R44's bed mobility staff assistance level for turning left to right in bed is, V4 stated, Substantial maximum assist with 2 persons. It needs to be 2 persons. It's for safety purposes. (R44) has no side rails. One person is on one side of the bed and the other person is on the other side of the bed to avoid falls. When asked how this is done when one side of R44's bed is up against the wall, V4 stated that the aides will move the bed from the wall, so that one person is on one side and the other person is on the opposite side. When asked about side rails as an option for R44, V4 stated that it's our facility policy of no side rails. We don't have side rails. V4 stated, That's why at all times for R44's changes (incontinence care), it has to be 2 persons. When asked about R44's fall on 2/23/24, V4 stated, (V20) tried doing (R44's) care alone. It caused the fall. There was no other CNA on the floor. That was the problem. When this surveyor informed V4 that R44 stated R44 is utilizing the end table next to R44's bed for support when there is one CNA turning R44 in bed, V4 stated, That's not acceptable. (R44) should not be holding that. There should be someone there. The nightstand is used for (R44's) personal things. V4 stated, (R44) has pain all the time with legs causing decreased mobility in bed which is why R44 is a two person assist for bed mobility.</p> <p>R44's Restorative Program Notes, dated 1/15/24, documents, in part, that R44 is receiving bed mobility restorative therapy with (R44) is working towards set bed mobility goal of turning onto left side with substantial maximal assist from staff, goal ongoing and that R44 has presence of left artificial knee joint, weakness, other lack of coordination and pain in left leg, and has decreased ROM (range of motion) to BLE (bilateral lower extremity).</p> <p>R44's Restorative Functional Assessment, dated 1/17/24, documents, in part, that R44 was noted with decreased bed mobility skills, total to substantial maximal assist from staff was provided to resident when performing bed mobility maneuvering and repositioning and that R44 is non-ambulatory/wheelchair/bedbound.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/22/24 at 11:20am, V2 (DON) stated that V2 was notified by V18 (RN) on 2/23/24 about R44's fall. When asked if V2 inquired about details of the fall incident, V2 stated, I (V2) asked what happened and (V18) said that (V2) was repositioning (R44) and (R44) fell . I (V2) asked (V18) if (V20) asked (V18) for help because (R44) is a two person assist. (V18) said no. When asked about R44's fall on 2/23/24, V2 stated that (R44) had never fallen before, and that since R44 had surgery on left leg with a pin inserted, R44 cannot bend the left knee. V2 stated that R44 has received multiple skilled therapy sessions to strengthen R44's legs, but R44 has reached the maximum potential. V2 stated that R44 sees V24 (Psychiatrist) for depression. When asked if V2 was with V24 (Psychiatrist) on 3/7/24, when V24 was talking to R44 after the fall on 2/23/24, Yes, I did rounds with (V24) after the fall. (R44) said that (R44) was scared and apprehensive with (staff) turning her. I assured (R44) that we will make sure proper staff provide R44's care. When asked if V2 has spoken to R44 about still feeling scared with receiving care in bed, V2 said that V2 hasn't and will make sure that V2 supervises R44's care. V2 stated, I understand that (R44's) kind of scared but will have to overcome that gradually. V2 stated that two persons are there during care so R44 should not have that feeling of being scared. This surveyor informed V2 that R44 said that when staff turn R44 now, R44 uses the wall as a support device, and V2 stated, That should never be. That's inappropriate. It should be two persons. V2 stated, It's never appropriate to use the wall like that. It should never happen. V2 stated, (R44's) care planned for two people to assist. When asked if using two persons for turning R44 in bed is ensuring that R44 is feeling safe and not scared, V2 stated, Yes.</p> <p>On 5/23/24 at 4:46pm, V24 (Psychiatrist) stated that V24 sees R44 in the facility for depression and anxiety. This surveyor explained to V24 about the review of R44's fall incident on 2/23/24 in the facility. When asked if R44 and V24 had a conversation about R44's fall after it occurred, Yes. V24 stated, It was the caregiver (V20) turning (R44) too fast or positioning. I provided (R44) more comfort. I told (R44) not to feel anxious about this one caregiver (V20) and try not to generalize it to all staff. When asked if R44 stated to V24 that R44 was still feeling afraid and scared after the fall when R44 is having care rendered by staff, V24 stated, Correct. V24 stated that R44 has a fear of falling from this fall incident on 2/23/24. When asked if V24 has visited R44 since having this conversation, V24 stated that V24 couldn't recall but doesn't think so.</p> <p>In R44's Progress Notes, dated 3/14/23 at 9:03pm, V24 documents, in part, that R44's last date seen was 3/7/24.</p> <p>Facility policy (undated) titled Fall Prevention Policy documents, in part, It is the policy of (Facility) to identify residents at risk for falls and to implement a fall prevention approach to reduce the risk of falls and possible injury . Every resident will be evaluated for falls upon admission and subsequently thereafter when the resident's condition changes or at least quarterly. The care plan will state the goals, interventions and approaches to every resident who was identified as being at risk for falls. Staff will be trained to be alert to risk and hazards for falls in the environment.</p> <p>Facility policy (undated) titled Facility Policy Regarding Resident Falls documents, in part, Overview: This facility is committed to minimizing resident falls so as to maximize each resident's physical, mental and psychosocial well-being. While preventing all resident falls is not possible, it is this facility's policy to act in a proactive manner to identify and assess those residents at risk for falls, plan for preventative strategies, and facilitate as safe an environment as possible.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Facility policy (undated) titled Personal Care Services documents, in part, Policy: Each resident shall receive nursing care and supervision based on individual needs. Each resident shall show evidence of good personal hygiene. A patient care plan for each resident is developed based on the nature of the illness, treatment prescribed, long and short term goals, and other pertinent information. The nursing care plan is a personalized plan of care for individual residents. It indicates what nursing care is needed, how it can be accomplished for each resident, how the resident likes things done, what methods and approaches are most Successful; and what modifications are necessary t (to) insure (ensure) best results. Nursing care plans are available to all nursing personnel assigned to a resident. Procedure: . Incontinent residents: Incontinent residents shall have partial baths and clean linen each time the bed or clothing is soiled.</p> <p>Facility job description, dated May 2003 and titled Certified Nursing Assistant, documents, in part, Purpose of the Position: The primary purpose of the position is to provide your assigned residents with routine daily nursing care in accordance with our established nursing care procedures, and as may be directed by your supervisors. Duties and Responsibilities: . Nursing Care Functions: . 25. Perform ADL programming in accordance with each resident's individual care plan goal . Safety and Sanitation: . 8. Follow established safety precautions in the performance of all duties.</p>

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<p>F 0741</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents.</p> <p>32338</p> <p>Based on observation, interview, and record review, the facility failed to have a Psychiatric Rehabilitation Services Coordinator (PRSC) to meet the individualized psychosocial and mental health needs of residents. This failure has the potential to affect all 68 residents with diagnoses of Severe Mental Illness and other residents in the facility who require psychosocial support.</p> <p>Findings include:</p> <p>On 5/20/24 at 10:15am after the entrance conference, V1 (Administrator) presented the facility census as 96 residents. On 5/21/23 at 2:20pm, V21(RN/Registered Nurse/Care Plan Nurse) presented the list of 68 residents with severe mental illness (SMI) and stated, We have a total of 68 SMI residents.</p> <p>On 5/20/24 between 10:30am and 12:00pm, several residents including R65, R79, R86, R88, and R195, were observed just sitting in the room with flat affect and low mood.</p> <p>On 5/21/24 at 10:44am, both R86 and R88 (roommates) were observed sitting in their beds doing nothing. The surveyor asked both residents about receiving the services of a counselor, PRSC, or a therapist. R88 stated I have not seen any counselor or therapist since I came here. I've been here for 4 months. R86 stated No one cares to know how you're feeling. Also, R65, R79, and R195 denied seeing or talking with a counselor/PRSC recently.</p> <p>On 5/21/24 at 11:55am, V10 (Licensed Practical Nurse/LPN) and V11 (Certified Nurse Assistant/CNA) were observed and interviewed on the nursing units regarding the availability of social service staff to speak with residents individually. V10 stated that V16 (Social Services Director/PRSD - Psychiatric Rehabilitation Services Director), is the Social Worker for all the residents. Again, on 5/21/24 between 10:20am and 12:00pm, no PRSC was observed on the nursing units to interact with the residents.</p> <p>On 5/21/24 at 10:22am, V16 (Social Services Director/PRSD - Psychiatric Rehabilitation Services Director), was asked to explain how she (V16) was able to provide individualized psychosocial and mental health services to all 96 residents in the facility and especially the 68 residents with diagnoses of SMI. V16 stated that she (V16) recently started work at the facility and she is doing her best with the residents. V16 stated a therapist comes twice a week to do groups for the residents. V16 was asked about what services the PRSC is supposed to provide for residents if a PRSC is hired. V16 stated Assessments, groups, and sometimes 1:1 as needed.</p> <p>On 5/21/24 at 11:25am, the surveyor called V1 (Administrator) to express the concern that only V16 (PRSD/Social Services Director) is responsible for providing psychosocial services for 96 residents, including those with diagnoses of severe mental illness. V1 stated that they had advertised the positions and made efforts to hire more people to meet the needs of the residents. The surveyor inquired from V1 how many PRSC's the facility is trying to hire. V1 stated that they need one full time PRSC and one part-time PRSC.</p> <p>(continued on next page)</p>		

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<p>F 0741</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Facility's document dated 1/1/2015 titled Job Description of the Psychiatric Rehabilitation Service Coordinator (PRSC) states The primary purpose of your job position is to assist in planning, developing, organizing, implementing, evaluating, and directing social service programs in accordance with current existing federal, state, and local standards, as well as our established policies and procedures, to assure that the medically related emotional and social needs of the residents are met/maintained on an individual basis.</p> <p>Facility's Policy on Psychosocial Programming, under Policy Statement states: The purpose of this Psychosocial program is to assist each resident in meeting his or her psychosocial needs and learning to cope successfully with his or her disability and adjusting to life in the facility. The program is based on the principles of sequential skill development. The program is carried out under the coordination of the PRSC. #1: Identify the resident's functional skills in the areas of self-care, social skills, community living skills, and vocational skills. In addition, identify physical, cognitive, communication, psychosocial, mood, and behavior problems that impair functioning.</p> <p>Facility's Facility-Wide Assessment document Part 2 states in part: Services and care we offer based on our resident's needs. Find below the types of care that our resident population requires and that we provide for our resident population: Mental Health and Behavior - Manage the medical conditions and medication related issues causing psychiatric symptoms and behavior. Identify and implement interventions to help support individuals with issues such as dealing with anxiety, individuals with depression, care of individuals with trauma, care of individuals with other psychiatric diagnosis etc. (etcetera)</p>

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<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder.</p> <p>32338</p> <p>Based on observation, interview, and record review, the facility failed to provide appropriate person-centered and individualized psychosocial and mental health services to meet residents' needs. This affected 5 of 5 residents (R65, R79, R86, R88, and R195) reviewed for individualized psychosocial needs and interventions from social services staff, as stated in the care plans.</p> <p>Findings include:</p> <p>On 5/20/24 at 10:15am after the entrance conference, V1 (Administrator) presented the facility census as 96 residents. On 5/21/23 at 2:20pm, V21 (RN/Registered Nurse/Care Plan Nurse) presented the list of 68 residents with severe mental illness (SMI) and stated, We have a total of 68 SMI residents.</p> <p>On 5/20/24 between 10:30am and 12pm, Several residents including R65, R79, R86, R88, and R195, were observed just sitting in the room with flat affect and low mood.</p> <p>On 5/21/24 at 10:44am, both R86 and R88 (roommates) were observed sitting in their beds doing nothing. The surveyor asked both residents about receiving the services of a counselor or PRSC (Psychiatric Rehabilitation Services Coordinator) or therapist. R88 stated I have not seen any counselor or therapist since I came here. I've been here for 4 months. R86 stated No one cares to know how you're feeling. Also, R65, R79, and R195 denied seeing or talking with a counselor/PRSC recently.</p> <p>MDS (Minimum Data Status) shows the residents' BIMS (Basic Interview for Mental Status) scores shows that all 5 residents are cognitively intact as follows:</p> <p>R65 - 14</p> <p>R79 - 15</p> <p>R86 - 15</p> <p>R88 - 15</p> <p>R195 - 15.</p> <p>On 5/21/24 at 11:55am, V10 (Licensed Practical Nurse/LPN) and V11(Certified Nurse Assistant/CNA) were observed and interviewed on the nursing units regarding the availability of social services staff to speak with residents individually. V10 stated that V16 (Social Services Director/PRSD - Psychiatric Rehabilitation Services Director), is the Social Worker for all the residents. On 5/21/24 between 10:20am and 12:00pm, no PRSC was observed on the nursing units to interact with the residents.</p> <p>(continued on next page)</p>		

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<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 5/21/24 at 10:22am, V16 (Social Services Director/PRSD - Psychiatric Rehabilitation Services Director), was asked to explain how she (V16) was able to provide individualized psychosocial and mental health services to all 96 residents in the facility and especially the 68 residents with diagnoses of SMI. V16 stated that she (V16) recently started work at the facility and she is doing her best with the residents. V16 stated a therapist comes twice a week to do groups for the residents. V16 was asked about what services the PRSC is supposed to provide for residents if a PRSC is hired. V16 stated Assessments, groups, and sometimes 1:1 as needed.</p> <p>On 5/21/24 at 11:25am, the surveyor called V1 (Administrator) to express the concern that only V16 (PRSD/Social Services Director) is responsible for providing psychosocial services for 96 residents, including those with diagnoses of severe mental illness. V1 stated that they had advertised the positions and made efforts to hire more people to meet the needs of the residents. The surveyor inquired from V1 how many PRSC's the facility is trying to hire. V1 stated that they need one full time PRSC and one part-time PRSC.</p> <p>Records reviewed show the following examples of the diagnoses and psychosocial/ mental health needs that the social services department are supposed to provide to the following residents, according to the care plans:</p> <p>R65 - Face sheet shows diagnosis of Schizophrenia. Care plan dated 3/18/24 states: To provide encouragement to verbalize thoughts and feelings; Teach stress and anxiety management techniques to help the resident cope with anger, for ability to deal with frustration, impulsive and impatient behavior.</p> <p>R79 - Face sheet shows diagnoses of Major Depression Disorder and Anxiety Disorder. Care plan dated 1/16/23 says to encourage verbalization of feelings.</p> <p>R86 - Face sheet shows diagnosis of Bipolar Disorder and Recurrent Depressive Disorders. Care plan intervention dated 10/30/23 states to provide supportive group intervention or 1:1 intervention.</p> <p>R88 - Face sheet shows diagnoses of Major Depressive Disorder and Anxiety Disorder. Individualized treatment care plan dated 2/8/24 states: Resident has a diagnosis and history of severe mental illness; Observe medical/psychiatric/cognitive conditions that may require ongoing assessment, consultation, and intervention such as personality disorder symptoms.</p> <p>R195 - Face sheet shows diagnoses of Major Depressive Disorder and Anxiety Disorder. Care Plan dated 5/20/24 states that resident has behavior symptoms of resisting care, related to demonstration of fear and paranoia. Intervention states to redirect negative behaviors.</p> <p>Facility's document dated 1/1/2015 titled Job Description of the Psychiatric Rehabilitation Service Coordinator (PRSC) states The primary purpose of your job position is to assist in planning, developing, organizing, implementing, evaluating, and directing social service programs in accordance with current existing federal, state, and local standards, as well as our established policies and procedures, to assure that the medically related emotional and social needs of the residents are met/maintained on an individual basis.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146169	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER Fargo Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1512 West Fargo Chicago, IL 60626	

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<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Facility's Policy on Psychosocial Programming, under Policy Statement states: The purpose of this Psychosocial program is to assist each resident in meeting his or her psychosocial needs and learning to cope successfully with his or her disability and adjusting to life in the facility. The program is based on the principles of sequential skill development. The program is carried out under the coordination of the PRSC. #1: Identify the resident's functional skills in the areas of self-care, social skills, community living skills, and vocational skills. In addition, identify physical, cognitive, communication, psychosocial, mood, and behavior problems that impair functioning.</p> <p>Facility's Facility-Wide Assessment document Part 2 states in part: Services and care we offer based on our resident's needs. Find below the types of care that our resident population requires and that we provide for our resident population: Mental Health and Behavior - Manage the medical conditions and medication related issues causing psychiatric symptoms and behavior. Identify and implement interventions to help support individuals with issues such as dealing with anxiety, individuals with depression, care of individuals with trauma, care of individuals with other psychiatric diagnosis etc. (etcetera)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45196</p> <p>Based on observation, interview, and record review the facility failed to ensure that residents' food items in the facility kitchen are dated when received and when opened; failed to discard expired food items; failed to follow proper food storage practices and labeling food to prevent food-borne illnesses; and failed to ensure that staff store their drinks out of the facility kitchen used for residents. These failures have the potential to affect all 94 residents receiving an oral diet in the facility.</p> <p>Findings include:</p> <p>On [DATE] at 9:27 am, this surveyor entered the facility's kitchen area.V9 (Dietary Manager) was observed at the cook station. At 9:28 am, surveyor and V9 toured the facility's kitchen with the following observations:</p> <p>In the walk-in cooler surveyor and V9 observed: Walk-in cooler temperature log sheets are complete. The walk-in cooler temperature is at 40 degrees Fahrenheit (F). 24 bowls of apple sauce are seen on the top shelf in the walk-in cooler undated; A metal cart to the left of the walk-in cooler seen with a tray of deli meat cheese sandwiches undated; A block of cheese out of the original packaging wrap in plastic wrap undated; To the right of the walk-in cooler on the middle shelf are two crates with carrots, cabbage, onion, and celery; The walk-in cooler top shelf has seven packages labeled Premium sliced ham that expired [DATE]. When V9 was asked about the importance of labeling, dating, and discarding expired foods V9 stated, To make sure the foods stay fresh, are good to use and that no one gets sick.</p> <p>In the freezer surveyor and V9 observed: Freezer temperature logs were completed and the freezer temperature is at -8 degrees F. In the deep freezer, a water bottle is seen containing a dark liquid color. V9 stated That is the staff. That should not be in there. When V9 was asked the importance of staff not storing drinks in the kitchen deep freezer, V9 stated, It can contaminate my products.</p> <p>In the dry storage area, there is a container of navy beans seen with an expiration date of [DATE].</p> <p>The facility's document dated [DATE] and titled Client List Report shows that the facility has 94 residents receiving an oral diet in the facility.</p> <p>The facility's undated document titled Storage of Refrigerated Foods documents, in part: Policy: Refrigerated food is stored in a manner that ensures food safety and preservation of nutritive value and quality. Procedure: Food in the refrigerator is covered, labeled and dated with a use by date.</p> <p>The facility's undated document titled Labeling and Dating Foods documents, in part: Policy: To decrease the risk of foodborne illness and to provide the highest quality, food is labeled with the date received, the date opened and the date by which the item should be discarded.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Fargo Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1512 West Fargo Chicago, IL 60626	
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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>The Facility's document dated [DATE] and titled Director of Food Service/Dietary manager documents, in part: Purpose: The primary purpose of your job position is to assist the Dietitian in planning, organizing, developing and directing the overall operation of the Dietary Department in accordance with current federal, state, and local standards, guidelines and regulations governing our facility and as may be directed by the Administrator, to assure the quality nutritional services are provided on a daily basis and that the dietary department is maintained in a clean, safe, and sanitary manner . Essential Job Functions and Responsibilities: . Inspect food storage rooms, utility/janitorial closets, etc. for upkeep and supply control.</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>32338</p> <p>Based on observation, interview, and record review, the facility failed to ensure that the air-conditioner in a resident's room was working, failed to repair a broken wall heat vent cover, and failed to clean and cover the air-conditioner air filter in residents' rooms. These failures have the potential to affect 7 residents (R73, R84, R81, R89, R86, R65, R82) in a total of 28 residents reviewed for environment.</p> <p>Findings include:</p> <p>On 5/20/24 between 11:00am and 11:45am, the following were observed on the third floor:</p> <p>In R65 and R82's room , the wall heat vent cover was observed hanging and almost falling off, and window shades were torn and worn out on the left side.</p> <p>In R86's room, R86 stated It's hot here. The surveyor observed the air-conditioner blowing warm air. The on/off button did not work either.</p> <p>In R73, R84, R81, and R89's room, the air-conditioner air-filter was observed without the vent cover and the filter had a thick layer of accumulated dust.</p> <p>On 5/21/24 at 10:45am V8 (Maintenance Staff) was notified and shown the Maintenance Log sheet on the third floor that did not show that staff reported the issues or that maintenance staff was in the process of repairing them. V8 stated that he (V8) will fix the issues as soon as possible.</p> <p>Facility's job description dated 01/01/2015 and titled Director of Maintenance documents in part: Purpose of your job position: The primary purpose of your job position is to plan, organize, develop, and direct the overall operation of the Maintenance Department in accordance with current federal, state, and local standards, guidelines, and regulations governing our facility, and as may be directed by the Administrator, to assure that our facility is maintained in a safe and comfortable manner . Safe and Sanitation: . Ensure that supplies, equipment, etc., are maintained to provide a safe comfortable environment. The facility did not follow these guidelines.</p>		