STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008155	A. BUILDING: _____ B. WING _____	C 08/10/2023

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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S 000	Initial Comments Facility Reported Incident of 6/11/23/IL161508	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1	S9999		

nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

These requirements were not met as evidenced by:

Based on observation, interview and record review the facility failed to ensure the resident receives adequate supervision and assistance devices to prevent accidents in 1 (R1) of three residents (R1, R3 and R4) included in the sample. This failure resulted in R1 sustaining a closed fracture of phalanx of right fourth toe with laceration requiring 3 sutures.

Findings include:

R1 is a 74-year-old male with a diagnosis including COPD, Schizophrenia, and Parkinson's Disease. R1 has a Brief Interview for Mental Status of 11/15. R1 requires 1-person physical assistance for transfer and walking in room. R1 uses a wheelchair to ambulate. R1 wanders and has an electric monitoring device on ankle to help prevent elopement.

Incident report sent to Illinois Department of Public Health shows on 6/11/23 at 6:45AM resident accidentally ran over by staff with his wheelchair, resulting in R1 sustaining a laceration to his right 4th toe, first aid rendered. Resident

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S9999	Continued From page 2	S9999		

transferred to hospital and returned the same day. Received 3 sutures to his laceration on the 4th toe.

Facility document titled Accident includes statement on 6/12/2023 6AM CNA observed bleeding from his socks and informed the nurse on duty. Nurse on duty assessed and notes with bleeding under the 4th toe, initiate first aid treatment by cleaning with saline and applied gauze and tape.
Resident went out to hospital and returned with 3 sutures. Resident has a diagnosis of Parkinson's and he became restless during the night and was attempting to get out of the bed. Night CNA assisted him out of bed and he has tremors, she mistakenly hit his foot with the wheelchair.

Hospital record dated 6/11/23 shows laceration of fourth toe of right foot, initial encounter. Closed fracture of phalanx of right fourth toe, initial encounter.

On 8/7/23 at 11:00 AM R1 was observed in his room in bed. R1 was clean, odor free and appropriately dressed. Attempt was made to interview him. R1 could only respond, "I don't know" and "I don't remember".

R1's wheelchair did not have footrests attached to wheelchair during this interview. R1's footrests were not in his room when surveyor searched.

A second attempt to interview R1 was made on 8/7/23 at 11:07 AM. R1 stated, "I don't know how I cut my toe. I may have bumped it while in my wheelchair. The nurse saw it and I had to go to hospital. I am ok now".

On 8/7/23 V4 (Physician) stated R1 could have

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S9999	Continued From page 3	S9999		

gotten the cut injury by hitting his foot while in the wheelchair. It was not by being run over by the wheelchair. R1 is very restless and resistive to care. Due to his cognition, it is hard to interview him so we could not get him to tell us what happened himself.

On 8/7/23 at 12PM R1 was observed in the dining room eating lunch. R1 was in wheelchair. R1 did not have footrest attached or in the immediate area for staff to use while transporting. R1 had on socks. R1's feet were in contact with the floor.

On 8/7/23 at 12:05PM V2 (DON) stated R1's footrest are supposed to be attached to wheel chair. V2 stated, "I don't know why they are not. I am also the restorative nurse".

The CNA involved in this incident was identified as V3 (CNA). During interview with surveyor on 8/7/23 at 10:42AM V3 denied allegation she injured R1 per following interview. V3 (CNA) stated, "That day I put (R1) in the chair. I pushed the chair to the nurse station. There was no injury at that time. I came back to (R1) ten minutes later and there was blood from his toe. I told the nurse. Nurse came and looked at it. She treated it. I had nothing to do with injury. I did not see the injury until I came back to him. He did not move from the location I pushed him to in front of the nurses station".

On 8/8/23 at 1:33PM V6 (RN) stated, "I was called to the floor at nurses station by the CNA (V3). (R1) was in his wheelchair. His foot was bleeding. There was a cut between the 4th and pinky toe. I assessed, cleaned and wrapped in gauze. I notified the physician and (R1) was sent out. That is all I remember. He did not say how he did it. The CNA did not say how it happened".

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S9999	Continued From page 4	S9999		

On 8/7/23 at 11:58AM V2 (DON) stated, "I was told that a (V3 CNA) ran over his foot during transfer. (R1) did not have any footrest on his wheelchair. I don't know why (R1) is missing footrest on his chair. I was told it was a mistake by (V3) herself. This was reported to Public Health. We re-educated (V3) on proper transfer to wheelchair and transport. I do not know why (V3) admitted to me running over (R1's) foot and then telling you she didn't. On the day he got hurt, (V3) told me he didn't have his footrest for his wheelchair".

On 8/7/23 at 12:05PM V4 (CNA/ Restorative Aid) stated R1 is supposed to have his footrest attached to his wheelchair when being transported. On the day he was injured he did not have footrest attached. V4 stated, "I do not know where his footrest are at this time. They are not on his chair or his room. He could easily hit his feet without the footrest in place on his wheelchair".

On 8/7/23 at 12:15PM V4 (CNA/ Restorative Aid) stated, "I was able to locate the footrest of (R1). Another CNA borrowed (R1's) footrest to use on another resident. The CNA never brought them back".

On 8/10/23 at 10:09 AM V2 (DON) on inquiry as to whether there is a policy for staff transporting a resident in a wheelchair and the use of footrest, stated we do not have a specific policy on the use of footrests for wheelchair transfer and transport of resident. The CNAs are taught that when in school.

Facility policy titled Lifting and Transferring Residents include statements:

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S9999	Continued From page 5 Standard: Residents are lifted and transferred safely in all instances. Policy: Residents are assessed and determinations made for lifting and transfer requirements and the procedure for each resident. All members of the nursing staff, nurses, nursing assistant are responsible for using good body mechanics, knowing the proper procedures, and properly operating assistive devices. (B)	S9999		