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 01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FARGO HEALTH CARE CENTER	1512 WEST FARGO CHICAGO, IL 60626

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint Investigation 24810414/IL182991	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.3210t) 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 and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. These regulations were not met as evidenced by: Based on observation, interviews and record review, the facility failed to ensure that one resident (R2) was free from abuse from her roommate (R3). This failure resulted in R2 being	S9999		

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struck by R3 and sustaining a broken nose.

Findings include:

R2 is an 81 year old with diagnosis including but not limited to: unspecified dementia, unspecified severe protein-calorie malnutrition, age- related osteoporosis without chronic pathological fracture, chronic pain and cognitive communication deficit.

R3 is a 66 year old with diagnosis including but not limited to: bipolar disorder, generalized anxiety disorder, major depressive disorder, type 2 diabetes mellitus, restlessness and agitation.

R7 is a 71 year old with diagnosis including but not limited to: essential hypertension, chronic obstructive pulmonary disease with acute exacerbation, pain in left leg, major depressive disorder and anxiety disorder. R7 has a BIMS (Brief Interview of Mental Status) score of 14, which indicates cognitively intact.

On 01/06/2025 at 10:15 AM, V1 (Administrator) said that R2 had been transferred out of the facility per family's wishes after R2 was hit by another resident.

On 01/06/2025 at 12:39 PM, V2 (DON/ Director of Nursing) said that R3 was no longer in the facility and that she was sent out for aggressive behavior and allegedly punching R2 in the nose.

On 01/06/2025 at 3:12 PM, R7 (R2 and R3's former roommate) was observed lying in her bed. R7 was asked about the incident involving R2 and R3.

On 01/06/2025 at 3:14 PM, R7 said, "The night

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that R2 was hit, I was asleep, but I heard her (R2) yell out and when I woke up, R3 was wide awake and walking around the room. R3 would always yell at and intimidate R2. She (R3) once told R2 that she wished that she (R2) would die. R2 would cry out a lot and the nurse would come in and check on R2 then leave. R3 was abusive to everyone and the staff knew it. She (R3) would cuss at staff and was always angry and demanding. At night, R2 would talk a lot and that would set R3 off. R3 would become very upset with R2. I didn't say anything because I was afraid of R3 retaliating against me. One night, I opened my eyes and R3 was standing near my bed. R3 was very unpredictable and always targeted R2."

On 01/06/2025 at 1:10 PM, V8 (CNA/Certified Nurse Assistant) said, "I saw R2 at around 7:30 AM during breakfast, I went in to feed her. Her face was covered with a blanket and when I removed the blanket, she was bloody and her face was bruised. R2 had told me that the little lady hit her but did not say a name. R3 had recently moved from the first floor and was one of R2's roommates. R3 does not talk but she is a mean person. When R2 yells out, R3 yells and tells her to shut her mouth. R7 had told me that R3 was standing over her two months ago in the middle of the night."

On 01/06/2025 at 1:26 PM, V9 (CNA) said that she was assigned to R2 on 12/16/24 and that the previous CNA did not mention anything about any injuries.

On 01/07/2025 at 12:15 PM, V2 (DON) said that she was not aware of R3 allegedly targeting or being mean to R2 in the past and that she (V2) would expect for any possible signs of abuse to be reported.

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Surveyor inquired about the purpose of staff members reporting possible signs of abuse.

On 01/07/2025 at 1:30 PM, V1 (Administrator) said that the purpose of the staff reporting any signs of possible abuse is to prevent the abuse from occurring.

Resident statement by R2 on 12/16/24 documents, "the little lady hit me."

Resident statement by R7 on 12/16/24 documents, "I heard her (R2) scream three times and my curtain was pulled. I did not see any individual come in my room. I didn't pull the call light because I've pulled the call light before and the nurse would come in to see and check on her (R2) and then say she's ok, so I didn't think that pulling the call light would make a difference. However last night was a different type of scream."

Employee statement by V8 (CNA/Certified Nurse Assistant) on 12/16/24 documents, V8 was preparing to feed R2 and saw R2's right eye bruised and swollen; R2 said the lady hit me.

Employee statement by V15 (Housekeeping Supervisor) on 12/18/24 documents the following: V15 was told by R7 that R3 physically abused R2 and that the CNA was notified; the CNA would come and check on R2, then would say that there are no bruises and would leave the room; R3 also verbally abused R2 and wished that she would die.

Facility document titled Preliminary Incident Investigation Report dated 12/16/24 documents, R2 was found by staff at approximately 7:50 AM

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S9999	Continued From page 4 in bed with swelling, discoloration and a laceration to her left eye. Facility document titled Final Incident Investigation Report dated 12/18/24 documents the following: R2 identified as the abused; on 12/16/24, R2 was found by V8 (CNA) with laceration and visible blood on her right eye; R2 said, "the little lady hit me"; physical abuse was founded. Facility Census report dated 01/06/2025 excludes R2 and R3 as residents in the facility. Facility Abuse policy documents the following: Staff obligations to prevent and report abuse; Employees are required to report any incident, allegation or suspicion of potential abuse; any incidents or allegation involving abuse, neglect, exploitation, mistreatment or misappropriation of resident property will result in an investigation; residents who allegedly abused another resident will be removed from contact with other residents during the course of the investigation. (B)	S9999		