

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0056861		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/26/2026	
NAME OF PROVIDER OR SUPPLIER FARGO HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1512 WEST FARGO , CHICAGO, Illinois, 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) COMPLETION DATE	
S0000	Initial Comments		S0000				
	Facility Reported Incident of 1/26/2026/2795630						
S9999	Final Observations		S9999				
	Statement of Licensure Violations:						
	300.610a)						
	300.1210a)						
	300.1210b)						
	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 300.1210 General Requirements for Nursing and Personal Care						
	a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active						

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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. 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 requirements were not met as evidenced by: Based on interviews and record review, the facility failed to ensure that a resident (R2) remains free from verbal and physical abuse/assault and free from injury (fracture) from another resident (R3) and failed to follow their abuse policy. These failures caused physical harm to R2 having a fracture and the need for emergency treatment and surgical intervention (sutures). These failures affected one resident (R2) out of three residents reviewed for verbal and physical abuse/assault. Findings include: Facility's Reported Final Incident Investigation Report (1/29/2026), showed in part that on 1/26/2026 approximately around 3:45 PM, verbal altercation occurred between R2 and R3 over a cigarette lighter when returning from independent pass and standing on the facility's smoking patio. Verbal altercation and name calling occurred between the two residents and R3 became agitated and hit R2 on the right cheek area, which resulted from R2's bleeding and needing emergency care treatment. R2 returned from hospital with diagnosis of closed fracture of right maxillary sinus and R3 was discharged to behavioral hospital with Involuntary petition. Facility's reported Final Incident Investigation based on medical records review and interview a conclusion of abuse was founded. On 3/23/2026 at 9:25 AM, observed few residents on the smoking patio, smoking without any staff supervision.		S9999				

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S9999	Continued from page 2 On 3/23/2026 at 10:40 AM facility's presented census sheet showed a census of 96 residents. On 3/23/2026 at 12:58 PM, R2 stated that on 1/26/2026 after returning from the outside pass, R2 was sitting on the smoking patio with R5 and talking when R3 came by and kept asking for a lighter. R2 said that R2 got upset and told R3 to "shut up" and "don't start with me" and that R3 and R2 were verbally arguing and were name calling each with derogatory remarks and that R2 told R3 to get a lighter from inside the facility and to leave R2 alone. R3 got upset and hit R2 several times on the right cheek, causing R2's bleeding from nose and having a laceration on the right cheek. R2 said that R2 did not return punch, because R2 was worried about R5 getting hurt. R2 said that R2 suffered a bone fracture under the right eye and had to have stitches. R2 affirmed that at the time of verbal altercation, derogatory name calling and then the actual physical abuse, there was no staff member, or other residents besides R5 present on the patio and that no staff came outside to help, R2 ran into the facility's building, called police and reported to V1 (Administrator) and V3 (Psychiatric Rehabilitation Services Director/ PRSD). R2 said that someone from staff should have been monitoring and supervising residents outside on the smoking patio and could help deescalate the situation and prevent R2's injury. R2 said that R2 spoke to police and was going to press charges but then changed R2's mind and R2 did not press charges on R3. On 3/24/2026 at 11:34 AM, R5 said that R5 was present during the incident between R2 and R3 at the smoking patio and was a witness to the physical abuse. R5 said that on 1/26/2026 in the afternoon, R5 was sitting in the chair on the smoking patio with R2 sitting next to R5, smoking and conversing. R3 approached R5 and R2 and kept asking for lighter. R5 and R2 said that they do not have a lighter and R2 suggested for R3 to use the light up cigarette bud that R5 was using. When R3 took the cigarette bud from R5, R2 said to R3 to not forget giving the cigarette bud back to R5 and R3 got upset and started calling R2 names and was threatening and verbally abusing R2. R5 said that R3 returned the cigarette bud to R5 and walked away and R2 and R5 thought that was the end of confrontation. R5 said that R3 then walked behind and to the side of R2 and all of sudden started punching R2 in the face. R5 said that R3 stroked R2 more than once and that R2 had a bloody nose and face. R5 said that there was no staff or security member present outside at the patio during the time of the verbal altercation and escalation to physical abuse. R5 also said that nobody from staff members came			S9999			

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S9999	Continued from page 3 outside and helped, that R2 and R5 returned to the facility together and that then R2 and R5 told V1 (Administrator). R5 said that R2 got sent to the hospital via ambulance and that R2 called police. On 3/24/2026 at 12:07 PM, V4 (Licensed Practical Nurse/LPN) stated that R2's incident happened at the smoking patio and that V4 found out from V3 (PRSD) what happened, because V4 was on the break. V4 said that R2 was bleeding from nose and right cheek and that V4 provided first aid and then R2 was sent to the hospital for evaluation and treatment. V4 affirmed that R2 was struck in the face by R3 but V4 did not witness the abuse. V4 said that R3 was sent to the hospital for behavior evaluation and then was discharged and did not return to the facility. V4 said that security should be monitoring residents when smoking and that usually the security is present outside on the smoking patio and was not sure why nobody was present at the time of verbal and physical altercation. V4 said that if there were an altercation on the unit between residents, the staff should try to resolve the conflict and interfere before the altercation escalates. On 3/24/2026 at 12:34 PM, V5 (Certified Nursing Assistant/CNA), stated that V5 is aware of the incident that happened between R2 and R3, but V5 did not witness the incident. V5 said that V5 is not sure if someone is supervising the smoking breaks on the smoking patio, but security is usually nearby and should be present at the patio to supervise residents to prevent incidents. On 3/25/2026 at 09:20 AM, four residents were observed smoking on the patio, and no supervision staff was present on the patio to monitor smoking residents. On 3/25/2026 at 10:26 AM, observed V11 (Security Guard), sitting at the nurse's station, on the first floor by the front entrance, looking at the camera monitors, but when a resident came to ask V11 a question, if V11 could buy some chips, V11 turned away from the cameras for few minutes to speak with resident and V11 was not looking at the camera monitors. V11 said that that V11 's role is to monitor the front door and provide security if needed. V11 stated that the smoking patio and the smoking area should be monitored and that on 1/26/2026 when R2's physical abuse occurred, V11 was on vacation and was not present in the facility and is not sure who covered V11's shift. V11 also said that the facility has two smoker's lists, unsupervised smokers and supervised smokers. V11 stated that the supervised smokers should always have a staff member present at the patio, and that they should never be alone. V11 said that unsupervised smokers are		S9999				

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S9999	Continued from page 4 independent residents with a community pass and are not always as closely supervised during their smoke breaks. V11 said that the camera monitors display video footage only and that V11 is not sure if audio function is working and that V11 could not hear what residents are saying when outside. V11 said that if a couple residents start verbally abusing each other, V11 would not be able to hear the altercation. V11 also said that if any argument or altercation were in progress during the smoke break, a resident would come inside the facility and ask V11 to come outside and interfere, but said that is not the resident's responsibility to notify staff, the staff should be supervising the residents and immediately try to de-escalate altercations. V11 also said that the residents with an independent community pass do not need to be supervised in person at all times. V11 said that if the supervised smokers have the smoking break, V11 would be outside with the residents, but V11 would not be with the unsupervised residents during their smoke break, V11 would monitor from the video cameras instead. V11 stated that V11 would not have enough time to go outside and prevent an altercation or physical abuse between residents when in progress, because the abuse could happen very quickly. V11 thinks that a smoke monitor should be present with residents during designated smoking times at all times to prevent altercations and prevent possible injury. On 3/25/2026 at 10:39 AM, V6 (LPN) said that some residents have behavioral issues and could be aggressive or noncompliant with the rules and should be supervised because of unpredictability. V6 said that residents with independent community access passes were assessed for risk and should not be causing problems, but sometimes the residents argue and have an altercation and that is when staff intervenes to prevent future escalation. V6 stated that all residents have the right for safety and that V11 (Security Guard) should be outside with the supervised smokers. V6 thinks that the facility should have a better policy and provide safe smoking arrangements for all residents. V6 said that it is possible for the unsupervised residents get in the argument and staff should ensure all resident's safety. On 3/25/2026 at 10:59 AM, V12 (CNA), said that if any residents would be getting aggressive, the staff should separate the residents before an altercation escalates, so someone should be supervising the residents at all times, but do not always. V12 said that the cameras do not have audio and the staff watching the cameras could not hear somebody arguing and that is why a staff member should be always present out on the smoking		S9999				

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S9999	Continued from page 5 patio with the residents to prevent confrontation and possible physical abuse. On 3/25/2026 at 11:44 AM, V3 (Psychiatric Rehabilitation Services Director/ PRSD) stated that on 1/26/2026, at the time when R2's incident occurred, (after 3pm), V3 was notified of an incident and V3 said that there was no supervising staff outside on the smoking patio with the residents. V3 did not witness the abuse, and no other staff witnessed the abuse happening. V3 said that after the incident, R2 came inside of the facility with R5 and V3 observed R2 having blood on the face and R2 was calling the police. V3 said that R2 was taken to the Emergency department for treatment and when R2 returned to the facility, R2 had diagnosis of fracture on the right cheek bone and had stitches. V3 understood that both residents signed out for pass and while at the smoking patio, R3 was asking R2 for a lighter and that R2 told R3 to get a lighter from inside of the facility and both residents were verbally abusive and calling each other names and R3 punched R2 in the right cheek several times. V3 said that the security should be supervising all smokers not just the ones on restrictions and the security should be periodically checking on the residents outside. V3 stated that the facility does not currently have a designated smoking monitor and that the security supervises restricted residents during smoke times. V3 affirmed that R2 and R3 were smokers with independent passes and were not on the supervised smoker's list. V3 said that to prevent future incidents, the facility should make sure that the smoking policy rules are strictly enforced and all residents are closely monitored and supervised during smoke breaks at all times. V3 said that somebody should be at the smoking patio at all times, including the managers, and step in to de-escalate potential arguments and to make sure that residents are properly monitored. V3 affirmed that R2 was physically and verbally abused on the smoking patio on 1/26/2026 and stated that the incident could have been prevented if a staff member was present out at the smoking patio with the residents. V3 stated that the facility is responsible for residents while the residents are on the facility's property such as the smoking patio. On 3/25/2026 at 1:20 PM, V2 (DON/Director of Nursing) stated that V2 was on vacation when R2's incident happened and that V2 was informed when returned. V2 stated that if there is nobody to supervise the residents, it is hard to prevent altercations and possible abuse. V2 said that the facility should provide residents' safety and that something should have been done to prevent future physical abuse.		S9999				

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S9999	Continued from page 6 On 3/25/2026 at 2:39 PM, V1 (Administrator) said that V11 (Security Guard) was on vacation when R2's incident happened and that V13 (Activity Director) was monitoring the front door and the smoking patio. V1 said that supposedly R2 and R3 were out on pass and collided at the smoking patio. V1 stated that normally V1 would schedule another security guard, but not sure why, V13 was used to monitor the cameras and front door. V1 said that R2 told V1 that R3 was asking R2 for a lighter and started to argue. R2 said to V1 that R3 then punched R2. V1 said that V1 is not sure if anybody from the staff knew that R2 and R3 were on the smoking patio since they both signed out on pass. V1 said that V1 performed the investigation. V1 said that R2 said that R2 got hit by R3 and then R2 was sent to emergency room for treatment. V1 said that R5 was also on the smoking patio during the incident. V1 stated that the smoke patio should be monitored at all times, even between the smoke break times. V1 said that the staff should be present on the patio with the residents and that the camera video monitoring does not provide audio, so the monitoring staff could not hear what was said. V1 affirmed that calling another person names, is considered verbal abuse. V1 affirmed that if staff was present at the time of the verbal abuse, the staff member could de-escalate the situation and prevent R2' physical abuse. V1 affirmed that every resident should be supervised and that during smoke breaks on the patio, staff should be physically present and supervise residents for safety. V1 affirmed that R2's incident was considered verbal and physical abuse and that the physical abuse caused harm for R2 as evidence by R2's suffering injury in the form of fracture of the maxilla bone and the need for sutures. On 3/25/2026 at 3:57 PM, V7 (Activity Director), stated that V7 was working the day of R2's incident and that V7 remembers that both residents signed out to go out on pass, but stayed at the patio to smoke. V7 stated that V7 was standing by the glass door and checked on R2 and R3 and that they appeared to be talking at the time of V7's check and that V7 returned to the nurses station by the cameras and sat down in the chair. V7 said that V7 did not witness R3 punching R2. V7 said that a staff member should be always present and supervise residents to prevent another future incident. R2's diagnosis include but is not limited to Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures, not intractable, without status epilepticus; Schizoaffective disorder, unspecified; Insomnia, unspecified; Restlessness and agitation; Anxiety		S9999				

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S9999	Continued from page 7 disorder, unspecified; Other chronic pain; Sleep apnea, unspecified; Tinea cruris; Nicotine dependence, unspecified, uncomplicated; Vitamin deficiency, unspecified; Cough, unspecified; Influenza due to identified novel influenza A virus with other manifestations; Functional dyspepsia; Urinary tract infection, site not specified. R2's Minimal Data Sheet (MDS), (2/19/2026), in section C for Cognitive patterns showed Brief Interview of Mental Status (BIMS) score of 15 which shows intact cognition. R2's Hospital Records (1/26/2026) showed in part that R2's reason for hospital visit was assault victim and loss of consciousness and that R2 had a closed fracture of right maxillary sinus and a laceration over right cheek and that the wound was repaired with stitches. Records also showed in part that R2 had a CT head without contrast and CT of Maxillofacial bone performed on 1/26/2026 and R2 should follow up in 5 days (1/31/2026) for suture removal. R2's Progress Note (1/26/2026 at 3:32 PM) documented by V4 (LPN) showed in part that at 3:10 PM, R2 while in the patio smoking, was physically punched by R3. On assessment, Right facial area was noted with laceration with minimal amount of blood. Progress note also showed that R2 called police and was taken to the emergency room by the paramedics. R2's Progress Note (1/26/2026 at 10:28 PM) showed in part that R2 returned to the facility with discharge paperwork that showed R2's diagnosis of Closed fracture of right maxillary sinus, Facial laceration, Assault and that laceration below right eye with two sutures was observed and one scratch on right eyebrow with minimal facial redness on the right side. R2's CT of Head (1/26/2026) showed in part small layering blood products in the right maxillary sinus with a background of mild scattered mucosal thickening; Polyps versus retention cysts in the left maxillary sinus; Comminuted, mildly impacted fracture involving the right anterior maxillary wall; Soft tissue swelling overlying the right maxillary sinus fracture. R2's CT Maxillofacial Bones (1/26/2026) showed in part Mildly impacted and comminuted right anterior maxillary sinus wall fracture. R2's Abuse Risk Assessment (2/19/2026) showed in part a yes answer to denial when discussing mental health issues and is minimizing significance of mental health		S9999				

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S9999	Continued from page 8 and psychosocial issues. R2's Care plan (1/27/2026) showed in part that R2 has a laceration below right eye with 2 sutures, and one scratch on right eyebrow and minimal facial redness. R2's Care plan (1/28/2026) showed in part that R2 has a diagnosis of closed fracture of right maxillary sinus. R2's handwritten statement (1/26/2026) showed in part that R3 was asking R2 and R5 for lighter and that R2 told R3 to get lighter from the facility and R3 started to curse out R2 and R2 told R3 to leave R2 alone and that it was not a good day. R2 started to talk with R5 and R3 was standing behind R2 and started to hit R2 several times and so R2 ran into the facility's building to tell the staff. R3's diagnosis include but is not limited to Schizophrenia, unspecified; Pain unspecified; Insomnia, unspecified; Gastro-esophageal reflux disease without esophagitis; Vitamin D deficiency, unspecified. R3's Minimal Data Sheet (MDS), (12/17/2025), in section C for Cognitive patterns showed Brief Interview of Mental Status (BIMS) score of 15 which shows intact cognition. R3's Progress Note (1/26/2026 at 3:31 pm) documented by V4 (LPN), showed in part that on 3/3/2026 at 3:10 PM, R3 was physically aggressive towards R2 during smoke break on the patio and that R3 was educated and counselled to report grievances. R3's progress note also showed in part that the police department was present and that neither of the two residents would be charged and that a physician ordered R3 to be transferred for behavioral evaluation. R3's Progress Note (1/27/2026 at 2:13 am) showed in part that social worker called hospital for follow up and that R3 was being admitted with diagnosis of Aggression and that resident would be discharged from the facility. R3's Care plan (12/13/2025) showed in part that R3 has potential to exhibit inappropriate behavioral problems and that R3 would be monitored for adjustment. R3's care plan also showed in part that R3 should be supervised while in the community and have restricted independent pass privileges. R3's Abuse Risk Assessment (12/17/2025) showed in part a yes answer to denial when discussing mental health issues and is minimizing significance of mental health			S9999			

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S9999	Continued from page 9 and psychosocial issues. R3's document titled " Petition for Involuntary/Judicial Admission" (1/26/2026), filled out by V3 (PRSD) showed in part emergency inpatient admission by certificate and that R3 was involved in a physical altercation with another resident and that R3 became physically aggressive and engaged in behaviors that pose immediate risk to the safety of others. R3's handwritten statement (1/26/2026) showed in part that R3 asked for a lighter and was told by R2 to get lighter from inside of the facility and R3 said that R3 is not talking to R2 and that R3 and R2 started arguing and R3 felt threatened and hit R2 because R2 was standing too close to R3's face and R3 was defending self. Facility's document titled " Security Staff Job Duty Instructions" (Undated), showed in part purpose to ensure accurate monitoring, documentation and reporting of all residents to maintain safety. Facility's document titled " Facility Smoking Safety Policy" (Revised 2026) showed in part that objection is to provide a safe and healthy living environment with respect for the health and well-being needs of each resident and that the facility recognizes potential harm that could result from careless smoking and implemented smoking policy to maintain a safe living environment. Facility's document titled " Resident's Rights Policy" (Reviewed 1/2026), showed in part that the purpose is that no resident should be deprived of any rights that are guaranteed by the law and that the residents have the right to be free of abuse. Facility's document titled " Rounds Policy" (Revised 12/2025) showed in part that daily rounds should be conducted to ensure residents are monitored every hour or as needed depending on resident's condition and that residents should be monitored hourly during rounds. Facility's document titled " Abuse Prevention Program Facility Procedures" (11/18/2016), showed in part that abuse is defined as the willful infliction of injury with resulting physical harm and includes verbal abuse and physical abuse. Policy also showed in part that the facility should prevent abuse by establishing a resident sensitive and secure environment by supervising and monitoring the ability of the staff to meet resident's needs and correcting situations involving inappropriate language or insensitive			S9999			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0056861		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/26/2026	
NAME OF PROVIDER OR SUPPLIER FARGO HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1512 WEST FARGO , CHICAGO, Illinois, 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) COMPLETION DATE
S9999	Continued from page 10 handling at the time situations occur. Facility's document titled " Abuse and Retaliation Policy Prevention Program" (1/2026), showed in part that the facility confirms the right or residents to be free from abuse and that facility prohibits abuse of residents by attempting to establish a resident-secure environment and ensuring that the facility is doing everything to prevent occurrences of abuse and should be immediately protecting residents involved in possible abuse. Policy showed in part that physical abuse is infliction of injury to a resident that occurs other than by accidental means and requires medical attention and includes but not limited to hitting and that verbal abuse is using oral or gestured language that deliberately includes derogatory term to residents and that facility should tall every step needed to ensure that residents are safe. (A)			S9999			