STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146169	A. Building B. Wing	02/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fargo Health Care Center	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)
F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that an involuntary discharge was not based on the residents' condition at the time of transfer to acute care and failed to provide physician's documentation of the reasons a resident was involuntarily discharged from the facility in the resident's medical record. These deficient practices affected two of three residents (R1 and R4) reviewed for involuntary discharge. 1. R1 was admitted to the facility on [DATE] and was discharged to the hospital on 9/28/2025 and was not allowed to return to the facility. R1 was petitioned for involuntary discharge and was also served a 30-day notice for involuntary transfer and discharge. Progress notes dated 9/28/2025 2:39 a.m. document R1 stated am depressed because my sister died and want to go to the hospital. R1 also stated that R1 cut herself with scissors and was observed with bleeding on R1's right wrist. R1 was sent to the hospital via 911 and returned the same day with stitches to her right wrist, was placed on 1:1 and was petitioned for involuntary discharge to another hospital for psychiatric evaluation. R1 was also issued an Involuntary Discharge and was not allowed to return to the facility. Minimum Data Sheet dated 8/1/2025 under Section E: Behaviors did not document any physical behavioral symptoms directed toward others such as hitting, kicking, pushing, scratching, grabbing, abusing others sexually; verbal behavioral symptoms directed toward others such as threatening others, screaming at others, cursing at others; and other behavioral symptoms not directed toward others (e.g. physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds). On 2/6/2026 at 11:23 am. V4, R1's Legal Guardian, stated the facility called her on 9/28/2025 to let her know that R1 had wanted to kill herself because she found out that R1's sister passed away untimely. They also let her know that R1 cannot return to the facility anymore because R1 needed 24-hour care because she would take scissors and stab herself. V4 stated V4 was happy with R1's stay in the facility because she had friends in the facility and that the facility takes good care of R1 and she would have liked for R1 to return to the facility instead of being transferred to a different facility. On 2/6/2026 at 1:48 p.m. V2, Director of Nursing, stated R1 has a diagnosis of depression, R1 doesn't have any behavior, R1 is not aggressive to other residents, does not engage fights with other residents. R1 is not a threat to the other residents in this facility. To my knowledge, the nurse and Certified Nursing Assistant/CNA made rounds that day on 9/28/2025, the resident pulled her call light and R1 had scissors and hurt her wrist using the scissors. R1 is not allowed to have scissors in her room. This was previously investigated already. This was more like a cry for help from R1. On 2/6/2026 at 2:12 p.m., V1, Administrator, stated R1 was served the Notice for Involuntary Transfer and Discharge because R1 harmed herself and how can I protect her if she conceals scissors and she can harm herself again. I don't feel she's a danger to other residents. I think she is a harm to herself. Facility presented a document titled (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notice of Involuntary Transfer or Discharge and Opportunity for Hearing dated 9/29/2025; addressed to R1 and V4, R1's Legal Guardian; signed by the previous social services director who is not employed by the facility anymore. The form documents that the reason for this proposed transfer or discharge is the safety of individuals in this facility is endangered, 483.15 (c)(1)(i)(C). R1's electronic health records exclude any documentation from the physician regarding the reason for involuntary discharge and how the safety of individuals in this facility is endangered because of R1. It also excludes any behavior that endangers the safety of other residents in the facility.2. R4 was admitted to the facility on [DATE] and was discharged to the hospital on 1/27/2026 and was not allowed to return to the facility. R4 was petitioned for involuntary discharge and was also served a 30-day notice for involuntary transfer and discharge.Progress notes dated 1/27/2026 4:21 p.m. document: Staff observed R4 smoking in a non-designated area. When staff addressed the behavior, he became verbally aggressive and refuse(sic) to be redirected, he presents as a threat and harmful to self and others. This behavior may be influenced by symptoms associated with her diagnosis of paranoid schizophrenia, including impaired judgment and difficulty with impulse control. Due to concerns regarding a decline in his mental and physical status, nursing staff contacted his physician, who recommended further evaluation. R4 was subsequently petitioned, with IVD (Involuntary Transfer and Discharge) initiated and bed-hold policy notification completed. He was transported to the local hospital for further assessment and treatment.Review of R4's electronic health record affirms that R4 has been observed to be smoking in non-designated areas for smoking multiple times and has a behavior contract addressing this behavior. R4 also exhibits profanity towards staff and aggressive behaviors toward staff and peers.On 2/6/2026 at 11:45 a.m., V5, Social Services Director, stated R4 was presented with the Notice of Involuntary Transfer or Discharge and Opportunity for Hearing, which V5 completed and signed, because the facility cannot accommodate the smoking times that R4 needs. R4 needs supervision when smoking because of mobility and safety and has violated the facility smoking policy at least three times during his stay. V5 stated she filled out the form and then gives it to the nursing department to notify the physician and hospital for necessary paperwork and documentation.On 2/6/2026 at 2:12 p.m. V1, Administrator, stated R4 is very non-compliant, is very bold, will tell you right in the face that he loves using marijuana and will not stop smoking. The reason he is being served the Involuntary Transfer and Discharge Notice is because R4 on multiple times has been caught smoking inside the facility and even engages other residents with him in his room to join him to smoke. V1 cannot provide physician documentation regarding reason for the proposed discharge of R4.Facility presented a document titled Notice of Involuntary Transfer or Discharge and Opportunity for Hearing dated 1/27/2026; addressed to R4 and R4's Representative; signed by V5, Social Services Director. The form documents that the reason for this proposed transfer or discharge is your welfare and needs cannot be met by the facility, as documented in your clinical record by your physician, 483.15 (c)(1)(i)(A). R4's electronic health records exclude any documentation from the physician regarding the reason for involuntary discharge, what services the facility was unable to provide to meet the needs of R4 and what the facility attempted to meet the R4's needs aside from the Smoking Behavior Contract.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement care plan for psychosocial and mental well being and failed to provide the necessary services for the behavioral health needs of a resident. This applies to one (R1) of 4 residents reviewed for behaviors. As a result, R1 harmed self requiring psychiatric hospitalization. Findings include: According to the Electronic Health Record (EHR) R1 had diagnoses including Other seizures; Bipolar disorder, current episode depressed, Gastro-esophageal reflux disease without esophagitis; Unspecified asthma, Major depressive disorder, single episode, Other chronic pain; Restlessness and agitation; Hypo-osmolality and hyponatremia; Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures, intractable, without status epilepticus; Pain in unspecified knee; Type 2 diabetes mellitus with other diabetic kidney complication; Cough, unspecified; and Tinea pedisR1 was admitted to the facility on [DATE] and was discharged to the hospital on [DATE].The Minimum Data Set (MDS) dated [DATE] showed cognition was intact with a fifteen out of fifteen points requires on the Brief Interview for Mental Status (BIMS).A care plan on Mental and Psychosocial Well being showed R1 is in need of specialized rehabilitation, support, counseling and/or psychotherapeutic services secondary to mental illness diagnosis and a need to develop community integration skills. Care Plan goals include: The resident will engage in the following service(s): Mental health (i.e., psychotherapy, life skill training, substance abuse services). Intervention include: Obtain proper consent prior to making any referrals. Assist the resident in locating an appropriate treatment provider and making the initial appointment. Arrange transportation, as necessary. R1's records indicate that client centered therapy sessions were conducted on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. No other therapy sessions were documented after the [DATE] session which documents in part: The therapist will continue meeting with the client for an individualized biweekly therapy for the next six months. On [DATE] at 11:45 a.m., V5, Social Service Director, facility has an outside provider that comes to the facility twice a week to conduct support group sessions and 1:1 sessions with the residents and another outside provider that provides Intensive Outpatient therapy that provides group therapy sessions outside of the facility to address their mental health needs. V5 stated she is not aware that R1 participates in either of these services and was not able to provide documentation that R1 had an ongoing structured group or individualized sessions to address her mental health needs. V5 also stated that the Social Services Department in the facility does not conduct any therapy group session or individualized sessions to address the mental health needs of the residents with behavioral and mental health needs of the residents in the facility. V5 confirmed that no other therapy sessions with R1 were conducted after [DATE] and confirmed that R1 did not participate in any psychosocial groups or 1:1 session for psychosocial well-being. Progress notes dated [DATE] 2:39 a.m. document R1 stated am depressed because my sister died (sic) and want to go to the hospital. R1 also stated that R1 cut herself with scissors and was observed with bleeding on R1's right wrist. R1 was sent to the hospital via 911 and returned the same day with stitches to her right wrist, was placed on 1:1 and was petitioned for involuntary discharge to another hospital for psychiatric evaluation. R1 was also issued an Involuntary Discharge and was not allowed to return to the facility. R1's Screening Assessment for Evaluating Self-Harm/Suicide dated [DATE] document under section Recommendation and Outcome (check the category corresponding with the resident's score): Expected to integreate (sic) with structure, direction and supportive counseling. Presents with a low to moderate risk for self-harmful behavior (score 6-10)Social Services policy with review date of 9/25 under Philosophy and Policy documents in part: (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	It is the philosophy of this organization to treat each resident as a unique individual with specific physical, psychological and spiritual needs. It is our policy to provide a competent variety of psychological programming and therapeutic recreation opportunities designed to meet, in accordance with the comprehensive assessment, the interests and physical, mental and psycho-social well-being needs of each individual resident.