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	03/26/2026

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 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.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 (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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