

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146169	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/15/2025
NAME OF PROVIDER OR SUPPLIER Fargo Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to a.) ensure the rights of the resident to receive effective and accessible means of communication and b.) ensure the residents were treated with respect and dignity by not passing out meals to residents sitting together at the same time. These failures affected two residents (R55 and R59) in a total sample of 19 residents reviewed for resident rights. Findings include:</p> <p>On 08/12/2025 at 12:03PM, surveyor located on the second floor of the facility located in the dining room. Surveyor observes meal trays being dispersed to residents sitting in the dining room. R72 and R55 observed seated at the same table in the dining room awaiting their lunch meal. R72 was served his lunch meal at 12:04PM and began eating his lunch meal. R55 did not have a meal tray and was not actively eating. V7 (CNA), V9 (CNA), V10 (CNA), and V11 (CNA) observed passing meal trays to other residents in the facility as they removed their tray off the meal cart. At 12:11PM, R55 still observed without a meal tray and not eating. R55 observed watching R72 eat his lunch meal and inquired to V9 (Certified Nursing Assistant/CNA) about where his lunch tray was asking Hey, what about me? V9 states to R5 that he will get him his tray momentarily. V9 continues passing meal trays to other residents and is observed serving R5's lunch meal tray to him at 12:13PM. At this time, R72 had finished eating his lunch meal.</p> <p>On 08/14/2025 at 12:14PM, V2 (Director of Nursing/DON) states the facility has an assigned seating chart for residents when they are eating their meals in the dining room. V2 states the resident's meals should be served according to the table they are sitting at. V2 states residents sitting at the same table should be served their meal tray at the approximate same time. V2 states this ensures a homelike environment and reserves the resident's dignity. V2 states the staff are aware of the dining room seating and meal tray service because there was an in-service recently conducted on the topic. V2 states if residents have to wait to be served their meals, then there is a potential for their meals to be served cold and residents can get upset. V2 states residents can become upset and not want to eat or they can develop a behavior and grab food off of other resident's meal trays. V2 states this behavior can cause resident-to-resident interactions or fights. V2 states this can be avoided if the staff follow the seating chart and serve residents their meals according to their assigned table.</p> <p>On 08/14/2025 at 12:28PM, V2 (DON) provides surveyor a list of resident dining room table seating charts. Second floor seating chart documents that R55 and R72 are assigned to sit at the same table.</p> <p>(continued on next page)</p>

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R55's Facesheet documents that R55 has diagnoses not limited to: Malignant neoplasm of unspecified part of unspecified bronchus or lung; Chronic obstructive pulmonary disease, Schizophrenia, Vitamin deficiency, Iron deficiency anemia, hyperlipidemia, Essential (primary) hypertension, Bipolar disorder, Unspecified protein-calorie malnutrition, hyposmolality and hyponatremia, and abnormal weight loss.</p> <p>R55's MDS/Minimum Data Set, dated [DATE] documents that R55 has a BIMS/Brief Interview for Mental Status of 15/15, indicating that R55 is cognitively intact.</p> <p>R55's diet order is documented as follows:</p> <p>Supplement, 8 ounces QID/4 times a day, Give Ice cream with lunch and dinner, High Fiber Diet, Regular NAS/no added salt diet with thin liquids.</p> <p>Facility In-services dated 04/04/2025 titled Dining room seating/Trays documents that V7 (CNA), V9 (CNA), and V10 (CNA) were in-serviced on seating and table arrangements when serving meal trays.</p> <p>Facility policy dated 2017, titled The Dining Experience documents in part, Policy: Meals served will respect the client's dignity as an individual. Meals are served at approximately the same time to all the clients sitting at a table.</p> <p>Facility policy dated 03/2024, titled Resident's Rights documents in part, 1. The right to live in an environment that promotes and supports each resident's dignity, individuality, independence, self-determination, privacy, and choice and to be treated with consideration and respect;</p> <p>R59's MDS (minimum data set) assessment reference date of 6/09/2025 section B documents that R59's hearing is highly impaired- absence; no speech- absence of spoken words.</p> <p>On 08/12/2025 at 11:30 AM R59 observed sitting on the chair, pointing to his ears when surveyor introduced self, observed communication board hung on the wall, unable to be detached from the wall to be utilized. No cue cards observed at the bedside or anywhere in the room. Per R59's care plan, items should be available to communicate with R59.</p> <p>On 08/12/2025 at 11: 45 AM V4 (Registered Nurse/ RN) states she has worked in this facility for 1 year. V4 states she does not know sign language, nor received training on sign language and usually communicates with gestures, or states R59 simply understands the day-to-day routine.</p> <p>On 8/13/2025 at 11:15 AM V20 (Certified Nursing Assistant/ CNA) stats he has been working at the facility for 2 years. When communicating with R59, V20 states he uses hand or facial gestures but does not know how to use sign language or received training on sign language. V20 states, he does not know what cue cards look like and has never used them since the time he started working in the facility.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/13/2025 at 11:20 AM V21 (License Practical Nurse/ LPN) sates he has been working at the facility for 6 years and regularly works on the first floor. V21 stated he communicates with R59 when caring for him using sign language, but very minimal. V21 states he can know when R59 is in pain by pointing out to the body part. V21 states, he is familiar with R59 and will usually be able to determine if he has a change of condition by facial grimace. V21 stated he does not use the communication board or any cue cards, but it would be helpful if utilized, and he did not receive training on sign language.</p> <p>On 08/14/2025 at 10:14 AM V4 affirmed cue cards and communication board are not being utilized with R59. V4 does not know sign language at all.</p> <p>On 08/14/2025 at 10:23 AM V12 (PRSD/ Psychiatric Rehabilitation Services Director) has been working in the facility since March 2025. V12 stated she completes her assessment with R59 by using hand gestures, cues or nonverbal communication, and has not received training in sign language.</p> <p>On 08/14/2025 at 10:41 AM V2 (Director of Nursing/ DON) stated she communicates with R59 by using hand gestures or using the application on her telephone. V2stated her expectations for her staff are to use the communication board, gestures, and if they are not able to understand R59, then they should let her know and she will call the case manager who is trained for signed language. V2 stated there is no one in the facility who is trained to speak sign language. V2 stated it would be helpful if there were staff members available who are trained to speak sign language.</p> <p>On 08/14/2025 at 10:49 AM V2 attempts to take out the communication board but was unable to detach it from the wall. V2 was also unable to find the cue cards in R59 room, there were not available or accessible. Using a note pad to ask R59 if he ever used the communication board, R59 stated he does not use the communication board or cue cards.</p> <p>Facility Policy titled Resident Rights with review date of 3/24 documents The right to live in an environment that promotes and supports each resident's dignity, individuality, independence, self-determination, privacy, and choice and to be treated with consideration and respect. The right to receive the services specified in the service plan, to review and renegotiate the plan at any time, and to be informed of the cost of the changes.</p> <p>Facility Policy titled Communication and Language Assistance Services Policy with review date of June 2016 documents Language assistance services are important at this healthcare organization. The facility strives to ensure access to healthcare information and serviced for limited-English- speaking or non-English-speaking resident or hearing-impaired residents. To address these responsibilities this facility emphasizes: Communication Board Cards: The organization shall make appropriate communication illustrations available to the resident for use, as appropriate depending on the resident's functional ability including the ability to point to letters, words and pictures.</p>

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>(continued on next page)</p>

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure splints were applied as ordered by physician for 2 (R6 and R78) of 3 residents reviewed for limited range of motion in a sample of 19. The findings include: On 8/12/2025 at 11:17AM Observed R6 sitting up on wheelchair in her room, alert and oriented x 3, verbally responsive with limited ROM (range of motion) on Right arm no device in place. R6 said she broke her wrist due to fall incident. She said staff used to apply splint on her right hand but lately it was not applied. R6 said unable to recall the last time it was applied. Multiple observations conducted with R6 on 8/12/25 between 11AM to 2PM and on 8/13/25 between 10AM to 11:30AM, R6 was not wearing Right hand splint. R6's face sheet showed admission date on 6/8/23 with diagnoses not limited to Paroxysmal atrial fibrillation; Unspecified fracture of upper end of right radius; Essential (primary) hypertension; Age-related osteoporosis; Bilateral primary osteoarthritis of knee.MDS ([NAME] Data Set) dated 6/10/25 showed R6's cognition was intact. She needed Substantial / maximal assistance with oral and personal hygiene, shower / bathe self, upper and lower body dressing; Partial / moderate assistance with eating and toileting hygiene. MDS showed R6 received splint or brace assistance. R6's POS (Physician Order Sheet) showed order not limited to: Apply splint to the right wrist at 7am. R arm splint due to Hx (history) distal radius fracture. Remove splint to the right wrist at 8pm. Splint may be removed for sleeping, bathing, writing. Please remove the splint daily for bathing. Splint may be removed to work with physical therapy on range of motion exercises. Splint may be removed if patient is sedentary. Please have splint in place when patient is ambulating utilizing platform weightbearing, splint in place for sleeping.R6's Care plan dated 7/23/25 showed in part: Splint or Brace Assistance. R6 has a Right arm splint due to history of distal radius fracture. Splint to be remove daily for bathing. Splint may be removed to work with physical therapy on range of motion exercises and when resident is sedentary. Splint in place when patient is ambulating utilizing platform weightbearing and when sleeping. Resident will keep splint on as scheduled. On 8/12/2025 at 11:30 AM R78 observed lying on low bed, with floor pad, alert and verbally responsive, left hand with contracture, fist closed with no device. He said not able to move left arm. Multiple observations conducted with R78 on 8/12/25 between 11:30AM to 3PM, no splint applied on R78's left arm / hand. R78's face sheet showed admission date on 05/01/2018 with diagnoses not limited to Hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left dominant side; Unspecified dementia, Essential (primary) hypertension; Chronic embolism and thrombosis of unspecified deep veins of right proximal lower extremity. MDS dated [DATE] showed R78 was never or rarely understood. He needed partial / moderate assistance with eating; Dependent with oral, toileting and personal hygiene, shower / bathe self, lower body dressing; Substantial / maximal assistance with upper body dressing. MDS showed R78 received splint or brace assistance. R78's POS showed order not limited to: Apply splint to left lower arm every day and remove at hs (bedtime), as tolerated, inspect skin for any s/s of irritation R78's Care plan dated 6/6/25 showed in part: Splint or Brace assistance. R78 uses splint on Left hand due to diagnosis of left side hemiplegia to prevent further contracture, Splint is applied in the morning and taken off in the evening, skin check is done before application. R78 will keep splint on. R78 will be placed into the Restorative Splint/Brace Assistance Program. On 8/13/25 at 3:01PM V21 (Restorative Nurse, LPN / Licensed Practical Nurse) stated R6 has an order for splint on right arm due to fracture of right wrist. He said splint should be applied everyday all the time except shower and sleeping or ADL (activities of daily living) care. V21 said R78 has left hand contracture with limited range of motion on left arm. Stated resident has an order for splint on left hand and should be applied every day all the time except for ADL care. V21 said if Splint is not applied as ordered by physician it could potentially lead to contracture or further contractures.On 8/14/25 at 11:13AM V2 (Director of Nursing / DON) said splint use is assessed to ensure it is appropriate for the resident to prevent contractures / further contractures, alleviate pain, support the limb or wrist. Stated splint is supposed to be applied by restorative aide, nurse, or CNA and should be monitored for placement. V2 said splint is applied according to doctor's order. Facility's contracture prevention policy dated 11/2024 showed in part: Resident assessed at risk for contracture will have contracture prevention appliance applied as ordered, and a PROM (passive range of motion) program implemented as per physician's orders.V1 (Administrator) said facility does not have policy for splint use.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on observation, interview, and record review the facility failed to (a) ensure cigarette was kept safely to prevent an avoidable accident from occurring in the resident's environment for one (R55) of one resident reviewed for smoking, and (b) monitor and follow-up with a resident (R102) who went out on independent community pass for one of two records reviewed for discharge in a sample of 19. The findings include:</p> <p>On 8/12/2025 at 11:33 AM R55 observed sitting on the side of the bed, alert and oriented x 3, verbally responsive. Stated has been residing in the facility for over a year. R55 said he is a smoker, and he is keeping his lighter and cigarette with him. Stated he lost his lighter and could not find it. Observed one (1) cigarette stick on top of nightstand bedside table accessible to another resident.</p> <p>On 8/12/2025 at 11:35 AM Requested V7 (Certified Nursing Assistant / CNA) in R55's room and said R55 is a smoker and saw one (1) stick of cigarette on top of nightstand bedside table.</p> <p>On 8/12/2025 at 11:48 AM V17 (Security) stated she has been working in the facility for 4 years and is supervising residents during smoking time. Stated staff is keeping smoking materials including lighter and cigarettes. She said residents are not allowed to keep lighter or cigarette with them for their safety.</p> <p>On 8/13/25 AT 3:22 PM V12 (Psychiatric Rehabilitation Services Director / PRSD) stated residents who smoke are not supposed to share smoking materials with other resident and should be put away or stored properly inside the room, not accessible to another resident. V12 said R55 is a smoker, cigarette is not supposed to be on top of the bedside table as it may go to the wrong hand like resident who are not smoking or not safe to smoke. V12 said smoking materials should be stored properly for safety of all residents in the facility.</p> <p>On 8/14/25 at 11:13AM V2 (Director of Nursing / DON) stated cigarette should not be kept on top of the night stand bedside table as someone can go and pick it up. She said there are residents in the facility who wander and can pick up the cigarette who were not assessed to safely smoke or not a smoker. She said smoking materials should be kept safely to avoid accident or hazard. V2 said smoking material / cigarette should not be accessible to other residents for their safety.</p> <p>R55's face sheet showed admission date on 11/20/23 with diagnoses not limited to Malignant neoplasm of unspecified part of unspecified bronchus or lung; Chronic obstructive pulmonary disease, unspecified; Schizophrenia; Essential (primary) hypertension; Bipolar disorder; Solitary pulmonary nodule.</p> <p>MDS (Minimum Data Set) dated 7/14/25 showed R55's cognition was intact. He needed supervision or touching assistance with eating, oral, toileting and personal hygiene, shower / bathe self, upper and lower body dressing</p> <p>Care plan dated 4/15/25 showed in part: Psychosocial history reveals that resident is a known smoker.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Facility's smoking safety policy dated 12/23 showed in part: To provide a safe and healthy living environment with respect for the health and well-being needs of each resident, staff member, and visitor. Smokers will be evaluated to determine their ability to comply with safety rules and their ability to carry smoking materials. Independent smokers who are able to hold their own smoking materials in a secure location or on their person.</p> <p>R102's 'Physician's Orders' include an order from 1/15/2025: Resident may have independent pass privileges.</p> <p>R102's 'Care Plan Activity Report' did not have a focus for R102's independent pass privileges.</p> <p>R102's 'Progress Notes' from 5/20/2025 do not document a planned out on pass. It also does not document when R102 left the facility. 5/20/2025 10:30 PM progress note documents in part that R102 remained out on pass. No progress notes from night shift staff about attempts to contact or locate R102 or whether R102 returned. Facility discharged R102 from the facility with last date of stay being 5/20/2025.</p> <p>On 8/13/2025 at 3:18 PM, V13 (Business Office Manager) stated the facility's front door is always manned by security including at nighttime. V13 stated the front door is alarmed and only security and staff know the code. V13 stated all other exits are alarmed and the residents are not supposed to use them. V13 stated residents are supposed to sign out in the book by security's post and sign back in when they return. V13 went over the facility's 'Release of Responsibility for Leave of Absence' papers from 5/20/2025 with surveyor. V13 stated they do not document a sign out or return time for R102 on 5/20/2025.</p> <p>On 8/13/2025 at 3:40 PM, V12 (Psychiatric Rehabilitation Services Director) stated [V12] did not know when R102 left the facility on 5/20/2025.</p> <p>On 8/13/2025 at 3:48 PM, V6 (Nurse) stated working the morning shift on 5/20/2025 on R102's unit. V6 stated administering R102's morning medications but R102 was not at the facility for lunch. V6 did not know when R102 left the facility. V6 stated when a resident with an independent pass wants to leave, they are to go through the front door and sign out with security. V6 stated only staff know the front door codes. V6 stated that if a resident with an independent pass does not return to the facility, the staff are to notify the on-call supervisor. V6 stated after 24-hours, the facility is to file a missing person report. R102's progress notes do not document that evening or night staff notified the on-call supervisor. No mention of a police report.</p> <p>R102's May 'Resident Medication Administration Record' documents in part that R102 received the morning medications (7:00 AM &ndash; 3:00 PM) but did not receive the evening shift (3:00 PM &ndash; 11:00 PM) or night shift (11:00 PM &ndash; 7:00 AM) medications on 5/20/2025.</p> <p>On 8/13/2025 at 3:58 PM, V26 (Security) stated working the evening shift on 5/20/2025. V26 did not recall R102 leaving on 5/20/2025. V26 stated residents are supposed to sign out when leaving the building and sign back in but don't always do that. V26 stated that sometimes the residents say they will only go for a smoke but will leave out for independent pass. When asked what the procedures are for residents who do not sign out, V26 did not have an answer.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/14/2025 at 8:54 AM, V17 (Security) stated working on 5/20/2025 morning shift. V17 did not recall when R102 left the building. V17 stated residents are supposed to sign out anytime they leave the building even for a smoke break. V17 stated no resident knows the door code so only staff can let them out. When asked what the procedures are for residents who do not sign out, V17 did not have an answer.</p> <p>During a joint interview on 8/14/2025 at 11:37 AM, V1 (Administrator) and V2 (Director of Nursing) stated they do not know when R102 left the building on 5/20/2025. V2 stated residents are supposed to sign out of the facility before leaving the building. At 11:48 AM, V12 joined the interview and stated there were house rules and behavior contracts to maintain independent pass privileges. V12 stated rules include to sign in and out with security and to follow curfew. V12 stated if a resident refuses to sign out with security, then staff should not allow resident to leave the building.</p> <p>R102 signed the facility's 'House Rules and Behavior Expectations' document on 3/13/2025. It documents in part: Residents who have been granted a pass privilege must sign in and out when leaving and returning to the facility. It does not explain staff procedures when the resident fails to do so. The form also documents in part: Evening curfew is at 9:00 p.m. 7-days a week. It does not explain staff procedures when a resident fails to return on time.</p> <p>When asked about the facility's policies and procedure for out on pass, the facility provided 'Out on Pass' and 'Out on Pass Medication' policies. On 8/14/2025 at approximately 12:15 PM, V12 stated the policies were specific to residents going out on pass with medications for prolonged community stays. The policies did not contain procedures for out on pass privileges without medications or short leaves in the community. They did not go into procedures on what staff should do when a resident does not sign out in the book or when a resident does not return before curfew. V12 stated the facility presents the residents with the 'House Rules and Behavior Expectations' form and the Behavior Contract but the facility didn't have a general out on pass guideline or procedure for short community leaves.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide restorative toileting program to maintain bladder functioning for one (R2) resident in a total sample of 19 residents reviewed for bowel and bladder continence. Findings include:R2's face sheet documents that R2 has diagnosis not limited to major depressive disorder, bipolar disorder, asthma, seizure.R2's MDS (minimum data set) section H dated 05/02/2025, documents R2 is frequently incontinent. R2's MDS assessment dated [DATE] documents that R2 is continent of bladder functions.On 08/12/2025 at 11:15 AM, V2 stated she uses pullups and gets up to use the restroom when needed and does not receive any bladder toilet restorative program.On 08/14/2025 at 11:23 AM, V23 (Minimum Data Set Nurse) states R2 is sometimes continent to bladder. V23 stated the facility does not have a bladder toilet restorative program. V23 stated the certified nursing assistants are expected to encourage R2 to use the bathroom, and to ask for help if needed.On 08/14/2025 at 2:28 PM, V21 (Licensed Practical Nurse/ Restorative Nurse) is made aware that R2 is not in any bladder toileting restorative program. Policy titled Bowel and Bladder Policy review date of June 2024 documents To help residents establish a pattern of control of bowel and bladder functioning. An initial assessment of the resident's bowel and bladder function, mental status, and physician status will be conducted. Resident demonstrating incontinence of bowel and/or bladder or exhibiting a history of constipation and fecal impaction will have a comprehensive assessment and subsequent placement into: Incontinence toileting program.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146169	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/15/2025
NAME OF PROVIDER OR SUPPLIER Fargo Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>Based on observation, interview and record review, the facility failed to ensure nebulizer mask and tubing were properly stored for one (R55) of one resident reviewed for respiratory care in a sample of 19. The findings include: On 8/12/2025 11:33 AM R55 Observed sitting on the side of the bed, alert and oriented x 3, verbally responsive. Stated has been residing in the facility for over a year. Observed nebulizer machine at bedside and R55 stated he has been using nebulization treatment periodically. Observed nebulizer mask and tubing not properly stored, dated and mixed with personal items inside the nightstand bedside drawer. On 8/12/25 at 11:38AM V5 (Licensed Practical Nurse / LPN) requested to R55's room and saw nebulizer mask and tubing inside the drawer mixed with personal items. V5 said it should be stored properly. On 8/14/25 at 11:13AM V2 (Director of Nursing / DON) stated nebulizer mask, and tubing is changed at least every 3 days and as needed, should be dated when changed to know when to discard. She said nebulizer mask and tubing should be stored properly when not in used in a clear plastic bag for infection control to prevent contamination. R55's face sheet showed admission date on 11/20/23 with diagnoses not limited to Malignant neoplasm of unspecified part of unspecified bronchus or lung; Chronic obstructive pulmonary disease; Solitary pulmonary nodule. MDS (Minimum Data Set) dated 7/14/25 showed R55's cognition was intact. He needed supervision or touching assistance with eating, oral, toileting and personal hygiene, shower / bathe self, upper and lower body dressing. R55's POS (physician order sheet) dated 8/13/25 with order not limited to: Albuterol sulfate 2.5 mg/3 mL (0.083 %) solution give 3 milliliters by nebulization route every 12 hours. Albuterol sulfate 2.5 mg/3 mL (0.083 %) solution give 3 milliliters by nebulization route every 6 hours as needed. R55's MAR (medication administration record) for the month of August 2025 showed / documented Albuterol nebulization was signed as given every 12 hours. Facility's nebulizer treatment / cleaning procedure policy dated 1/2025 showed in part: Cleaning and storage purpose to prevent contamination and / or cross contamination. Store respirator in a clean and clear storage bag.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>(continued on next page)</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on observations, interviews and record reviews, the facility failed to ensure a medication error rate of less than 5% for 4 (R2, R34, R56, R60) of 4 residents with 9 errors for 30 medication administration opportunities. This resulted in a medication error rate of 30%. The findings include: On 8/12/2025 9:31 AM Medication administration observation conducted with V4 (Registered Nurse / RN). Observed V4 prepared and administered the following medications to R2: Xcopri 50mg 1 tabletLevetiracetam 750MG 1 tabletValproic acid 250mg/5ml oral solution 10MLAptiom 400mg 1 tabletSodium chloride 1 GRAM 1 tabletFluoxetine 20 MG Oral 1 CapsuleLamotrigine 25MG 1 tablet Loratadine 10mg 1 tablet Observed R2 took prepared medications by mouth.R2's POS (Physician Order Sheet and MAR (Medication Administration Record) showed order not limited: Levetiracetam 750mg 1 tablet by mouth twice a day scheduled at 8am and 4pm. Valproic acid 250mg/5ml oral solution give 10ml (500mg) by oral route 3 times per day scheduled at 8am, 1pm and 6pm. Lamotrigine 25mg give 1 tablet by oral route 2 times per day scheduled at 8am and 4pm.Observed medication errors for the following medications Levetiracetam, Valproic acid and Lamotrigine due to wrong time. V4 administered medications at 9:31 AM to R2 not following physician's ordered time at 8AM. On 8/12/2025 9:41 AM Observed V4 (RN) prepared and administered the following medications to R60:Spiriva handihaler 18mcg 1 capsule by inhalation. Meloxicam 7.5mg 1 tablet Gabapentin 300mg give 1 capsule Folic acid 100MCG 1 tablet Ferrous Sulfate 325mg 1 tablet Pantoprazole 40mg 1 tablet Cetirizine 10mg 1 tablet PRN (as needed)Observed R60 took all prepared medications by mouth. R60's POS and MAR showed order not limited: Gabapentin 300mg give 1 capsule three times daily scheduled at 8AM, 1PM AND 6PM. Observed medication error for Gabapentin due to wrong time. V4 administered medications at 9:41 AM to R60 not following physician's ordered time at 8AM. On 8/12/2025 9:50 AM Medication administration observation conducted with V6 (Licensed Practical Nurse / LPN). Observed V6 prepared and administered the following medications to R34:Apixaban 5 MG [Eliquis] 1 tabletDiltiazem 90mg give 1 tablet OMEGA-3 1000MG 1 tabletVitamin D3 25mcg 1000 IU 1 tabletMetformin 1000mg 1 tabletAspirin 81mg 1 tabletGlipizide 5mg 1 tabletNamenda 10mg 1 tabletSeroquel 100mg 1 tablet Observed R34 took all prepared medications orally. R34's POS and MAR showed order not limited:Eliquis 5mg 1 tablet by oral route 2 times per day at 8am and 4pm.Diltiazem 90mg give 1 tablet by oral route 2 times per day at 8am and 4pmGlucophage (Metformin) 1000mg 1 tablet by oral route 2 times per day at 8am and 4pmNamenda 10mg give 1 tablet by oral route every 12 hours at 8am and 8pmObserved medication error for Eliquis, Diltiazem, Glucophage, Namenda due to wrong time. V6 administered medications to R34 at 9:50 AM not following physician's ordered time at 8AM. On 8/12/2025 10:03 AM Observed V6 prepared and administered the following medications to R56:Docusate sodium 100mg 1 tabletSenna plus 1 tabletVitamin D 25mcg 1000IU 1 tablet Lamotrigine 25mg 2 tabletsDepakote 500mg 1 tabletPolyethylene 1 capful powder mixed with water in a cup. Observed R56 took all prepared medications by mouth. R56's POS and MAR showed order not limited: Depakote 500mg delayed release give 1 tablet by oral route every 12 hours at 8AM and 8PM.Observed medication error for Depakote due to wrong time. V6 administered medications to R56 at 10:03 AM not following physician's ordered time at 8AM. On 8/14/25 at 11:13AM V2 (DIRECTOR OF NURSING / DON) stated she has been working in the facility for 3 years. Stated nurses are expected to administer medications at the correct time as ordered by physician and follow 5 rights in giving meds (right time, right resident, right medication, right route, right dose). V2 said standard nursing practice and facility protocol is to give medications one hour before and after the ordered time. Stated if medication ordered time is at 8am, medication should be given between 7am to 9am. V2 said if it was given after 9am, it is considered late and not following doctor's order. She said if medication was not given according to physician ordered time, there could be some reactions to the medications. V2 further stated, if it is blood pressure (BP) medication, BP could potentially go up, if it is for blood sugar medication, Blood sugar could spike up and time gap between medication could be shorter and could potentially harm the resident due to some reactions. Facility's medication administration policy dated January 2024 showed in part: Drugs will be administered in accordance with orders of licensed medical practitioners of the state in which the facility operates. Medications shall be administered one (1) hour before / after of the medication schedule unless specifically ordered otherwise.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to (a) properly date opened multi-dose inhaler for 2 (R18, R103) residents, (b) ensure that house stock medication (multidose Tubersol solution) was stored properly at appropriate temperature from 2 of 3 medication carts and 2 of 3 medication rooms inspected for medication storage and labeling. The findings include: On [DATE] at 10:13 AM 2nd floor medication cart inspected with V5 (LPN / LICENSED PRACTICAL NURSE) and found the following: Tubersol solution 1 vial kept in clear zip lock and showed house stock, pharmacy label indicated keep in refrigerator. Tubersol solution was found inside the medication cart not properly stored at appropriate temperature. R103's Trelegy ellipta 100mcg inhaler opened no date. 3 same inhalers were opened with no date. Pharmacy label indicated discard 42 days after opening. R18's Albuterol sulfate HFA 90mcg inhaler opened with no date. V5 said Tubersol solution is a House stock ordered from the pharmacy, not sure when it was delivered. She said Tubersol solution or TB (Tuberculosis) test is given to newly admitted resident and due for TB test. V5 said inhalers once opened should be dated to know when to discard. On [DATE] at 11:13AM V2 (DIRECTOR OF NURSING / DON) stated Nurses are expected to date and label the medication once opened so staff would be able to know when it was opened and when to discard as some medications is good for certain days only once opened. V2 said inhalers once opened should be dated. Stated if there is no label of date opened, medication could not be effective or could be expired don't know if it is effective, could be outdated. V2 said Tuberculin solution should be refrigerated to keep potency of the medication. she said tuberculin solution is a house stock delivered by pharmacy, and it is given for newly admitted resident 1st and 2nd step on admission then yearly. V2 said If tuberculin solution was not kept on appropriate temperature, potency of the medication is affected and could not be effective it could result to false positive or false negative result. R18's POS (physician order sheet) showed order not limited to: Albuterol sulfate HFA 90mcg inhaler inhale 2 puffs by inhalation route every 6 hours as needed. R103's POS showed order not limited to: Trelegy Ellipta 100mcg -62.5mcg-25mcg powder inhale 1 puff by inhalation route once daily. Facility's medication storage policy dated [DATE] showed in part: To ensure proper storage, labeling and expiration dates of medications, biologicals. Once any medication or biological package is opened, facility should follow manufacturer / supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened. Facility should ensure that medications and biologicals are stored at their appropriate temperatures according to the United States pharmacopeia guidelines for temperature ranges. Refrigeration: 36-46F. Facility's 2nd floor census dated [DATE] showed 33 residents. Facility's inhaler storage recommendations beyond use date policy dated 10/2020 showed in part: Trelege Ellipta Discard 6 weeks after opening the foil tray. Facility's medication storage information policy (undated) showed in part: PPD (Tubersol): Refrigerator (unopened / opened). Facility's medication administration and storage policy dated 7/23 showed in part: To ensure medications are administered and stored in accordance with standard of practice.</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to follow menus, spreadsheets, and recipes. These failures have the potential to affect all 93 residents receiving food prepared in the facility's kitchen. Findings Include: On 08/12/2025 at 11:52 AM, R63 said, I don't get enough to eat and I'm always hungry. On 08/12/2025 at 12:22 PM, observed R63 eating lunch in unit dining room. R63 received ground turkey with gravy, sweet potato, peas, yellow cake, and juice. R63 did not received any bread or a substitution for bread. On 08/12/2025 at 12:30 PM, observed R7's lunch tray. R7 received turkey, sweet potatoes, peas, cake, nectar thick water and juice. R7 did not received any bread or substitution for bread. On 08/12/2025 at 12:45 PM, observed R21's lunch tray. R21 received pureed turkey, pureed sweet potatoes, pureed peas, pureed cake, and honey thickened water and juice. R21 did not receive pureed bread or substitution for pureed bread. On 08/13/25 at 11:47 AM, observed lunch tray line in progress. Residents on regular and mechanical soft diet received spaghetti with sauce and meatballs, mixed vegetables, and lemon glaze cake. The resident on a pureed diet received pureed spaghetti with meatballs, pureed mixed vegetables and pureed lemon glaze cake. There was no Garlic Texas Toast or pureed bread on the tray line. On 08/13/2025 at 12:18 PM, observed R21's lunch tray. R21 was served pureed pasta with meatballs, pureed vegetables, pureed cake, honey thickened juice and milk. R21 did not receive any pureed bread or substitution for pureed bread. On 08/13/2025 at 12:36 PM, observed R7 eating lunch. R7 received spaghetti with meatballs, mixed vegetables, cake and nectar thick juice and milk. R7 did not receive Garlic Texas Toast or an equivalent bread substitution. R7 said, I'd like a piece of Texas Toast! Of course, I would! R7 stated he would like to eat Texas Toast because he bet it would taste good and give him some variety in his meals. On 08/13/2025 at 12:39 PM, observed R93 eating lunch in the dining room. R93 received spaghetti with meatballs, mixed vegetables, cake, and juice. R93 stated that he would have liked to receive Texas Toast with this meal because it would go well with the spaghetti and meatballs. R93 stated, I'd eat it! On 08/13/2025 at 12:42 PM, R63 stated he ate 100% of his lunch meal and it was tasty. R63 stated he would have eaten Texas Toast if he was given it. R63 stated he does not get enough to eat; the portions are small, and he is always hungry. R63 stated he would take any extra food he could get. On 08/13/25 at 12:18 PM, in the kitchen observed in the recipe binder a recipe for pureed bread for Tuesday and Wednesday lunch and a recipe for Garlic Texas Toast for Wednesday lunch. On 08/13/25 at 12:19 PM, V16 (Cook) stated he follows the posted menus, so he knows what food to prepare, the recipes so he knows how to prepare the menu items and the spreadsheets to tell him the items to be served, the portion sizes to be served, the consistency of the item and any special adjustments needed for the specialized diets. V16 stated if an item is not available, he would notify the dietary manager who would tell him what item to substitute the missing item with. V16 stated yesterday he did not serve bread to the regular diets and did not prepare pureed bread for the resident on a pureed diet. V16 stated today he did not serve Garlic Texas Toast to the regular and mechanical soft diets, and he did not prepare pureed bread for the resident on a pureed diet. V16 stated the menu already has a lot of starch in it. On 08/13/25 at 12:23 PM, V14 (Dietary Manager) stated the cook should be following the menus and spreadsheets to make sure the kitchen is providing the right nutrition to the residents. V14 stated if an item is not available the kitchen would look for a substitute of similar value. V14 stated it is important to serve all the items listed on the menu spreadsheet to make sure the residents are getting enough calories. V14 stated the kitchen does not serve bread or rolls or Texas Toast to the residents at lunch even if it is listed on the menu spreadsheet. V14 said, I think the bread is optional and the kitchen stopped sending bread to the residents at lunch about one year ago because the residents were collecting the bread and giving it to the birds outside the building. V14 stated it was not discussed as far as she knows at Resident Council Meeting, but she was told by the previous administrator to stop serving the bread and that the Registered Dietitian consultant is aware they are not serving bread at lunch to the residents. V14 reviewed the menu spreadsheets and stated it does not list the bread as optional so that means it is not optional and the kitchen should be serving it. V14 stated the kitchen is not providing a menu substitute for the bread, roll, Garlic Texas Toast not being served. V14 stated she did not know why the cook did not prepare pureed bread because it is listed on the menu spreadsheet and that the cook should have made it. On 08/13/25 at 1:40 PM, via telephone interview V22 (Registered Dietitian) stated the cooks should be preparing and providing all the food listed on the menu unless an item is not available in which case a substitute should be provided. V22 stated the menus have</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Based on observations, interviews, and record reviews the facility failed to a.) ensure kitchen staff wearing appropriate hair covering; b.) food items were properly labeled and dated; c.) food items stored according to manufacturer's guidelines. These failures have the potential to affect all 93 residents receiving food prepared in the facility's kitchen. Findings include: On 08/12/25 at 9:13 AM, during initial kitchen tour observed V15 (Dietary Aide) by the food prep area. V15 had a beard and mustache and was not wearing any type of covering over his beard and mustache. On 08/12/25 at 9:16 AM, V14 (Dietary Manager) observed V15 and said that his beard and mustache should be covered with a hair net and that he should have put it on as soon as he entered the kitchen. V14 stated the kitchen has an adequate supply of beard protectors and then showed surveyor a plastic bag full of beard protectors by the kitchen front door, next to a bag of hairnets. V14 stated any facial hair an employee has should be covered with a beard protector. On 08/12/25 at 9:19 AM, V14 stated any opened food item must be labeled with a use by date. V14 stated the kitchen does not label items with an open or prepared date, only a use by date. V14 stated most items need to be used within seven days of being opened however some items have longer shelf life depending on what the item is. V14 stated the kitchen follows manufacturer guidelines printed on the item for use by dates and storage directions. V14 stated it is important to use the item or discard the item by the expiration date and follow manufacturer guidelines for use by dates and storage because the facility does not want people to get sick and potentially causing them to get diarrhea and/or give them stomach problems. On 08/12/25 at 9:28 AM, observed in the walk-in refrigerator the following items: 1.) Opened 46-ounce carton Honey Thick Cranberry Juice. There was no opened date or use by date written by staff on the container. The manufacturer had printed on the carton best if used by date 12/11/25. 2.) Opened 46-ounce carton Nectar Thick Lemon-Flavored Water. There was no opened date or use by date written by staff on the container. The manufacturer had printed on the carton best if used by date 12/08/25. 3.) Opened 32-ounce carton Nectar Thick Milk. There was no opened date or use by date written by staff on the container. The manufacturer had printed on the carton best if used by date 12/17/25. 4.) Opened 32-ounce carton Honey Thick Milk. There was no opened date or use by date written by staff on the container. The manufacturer had printed on the carton best if used by date 09/04/25. 5.) Opened 46-ounce carton Nectar Thick Apple Juice. There was no opened date or use by date written by staff on the container. The manufacturer had printed on the carton best if used by date 01/12/26. 6.) Large supply of sliced loaves of bread. On 08/12/25 at 9:35 AM, V14 stated there are residents in the facility who are on nectar and honey thickened liquids, and they are served pre-thickened juice and milk which come in as a shelf stable item and are then refrigerated once they are opened. V14 stated she could not tell when the items were opened because there was no opened date written on any of the containers however, they follow the manufacturer's use by date printed on the containers. V14 stated the kitchen can use those products opened pre-thickened juice and milk until the manufacturer use by date which is printed on the containers. Surveyor pointed out to V14 that on the honey thickened cranberry juice, the nectar thickened lemon-flavored water, the nectar and honey thickened milk and nectar thickened apple juice containers the manufacturer had printed on the label After opening may be kept up to 7 days under refrigeration. V14 stated she had not noticed that before and since they do not label items with an open date there is no way of knowing how long the opened pre-thickened liquids had been in the refrigerator and based on the manufacturer instructions printed on the containers the items should be discarded or used by within seven days after they are opened. On 08/12/25 at 9:44 AM, observed opened 16-ounce plastic bottle of ground cloves labeled with a manufacturer's best by date of 07/31/24. V14 stated that means that is expired and should not be used. V14 stated she will throw it out. On 08/12/25 at 9:46 AM, observed opened 1-gallon plastic container of soy sauce 75% full. On the manufacturer's label of the soy sauce container, it read Refrigerate After Opening. V14 stated the kitchen is supposed to follow manufacturer's guidelines for storage. V14 stated based on the manufacturer's guidelines the soy sauce should have been stored in the refrigerator after opening. V14 stated, we didn't but we should have. On 08/12/25 at 9:58 AM, V14 stated the facility does not have any residents who are receiving NPO (Nothing by Mouth). On 08/12/25 at 10:46 AM, during pureed food preparation observed V15 (Dietary Aide) prepping lunch trays by putting silverware wrapped in napkins onto the tray and adding meal tickets to the lunch trays. V15 was wearing a beard protector which was pulled down, so his beard was covered but his mustache was not covered. On 08/13/25 at 1:50 PM via telephone interview V22 (Registered Dietitian) stated all items should be labeled with an</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observations, interviews, and record reviews, the facility failed to practice infection control and prevention measures to ensure staff wore appropriate personal protective equipment (PPE) for one (R5) resident on enhanced barrier precautions and appropriately handle and transport linen to prevent potential contamination. The facility also failed to track and register to report possible XDROs (Extensively Drug-Resistant Organisms) to the registry. These failures have the potential to affect all 93 residents residing in the facility. Findings include: On 8/12/2025 at 11:20 AM, surveyor did laundry service walk-through with V8 (Laundry Attendant). When asked about facility's laundry chute, V8 opened a door labeled 'Storage.' There was a large, gray bin filled with linen and resident clothing. Some of the linens and resident clothing were not contained in bags. When V8 opened the chute's door, multiple loose linen and resident clothing fell onto the bin. V8 stated staff are supposed to bag all linen and resident clothing but staff don't always do so. V8 also stated that sometimes staff don't always secure the bags so linen and clothing become loose while going down the chute.</p> <p>On 8/12/2025 at 12:21 PM, V8 was on the second floor delivering clean resident clothing and linen in an uncovered cart.</p> <p>On 8/13/2025 at 10:01 AM, V3 (Infection Preventionist / Assistant Director of Nursing) went over facility's infection control practices. V3 stated all linens are supposed to be secured in bags during transport and when sent down the chute. V3 also stated staff are supposed to deliver clean linen and resident clothing covered during transport.</p> <p>During the same interview, V3 stated facility does not track XDROs (Extremely Drug-Resistant Organisms). V3 stated [V3] been the facility's Infection Preventionist for the past three years and has not tracked XDROs. V3 stated [V3] is also not registered to report XDROs to the registry. V3 stated V2 (Director of Nursing) possibly has done it but V3 has not been doing it.</p> <p>On 8/13/2025 at 10:27 AM, V2 stated [V2] has not been tracking or reporting XDROs. V2 stated V3 should have been doing it.</p> <p>Facility's 'Handling Soiled Linen' policy documents in part that the purposes of the policy and procedures are to prevent contamination of Health Care Workers handling soiled linen and contamination of surfaces and clean linen. One of the important points listed include: Soiled laundry/linen should be bagged or contained where collected.</p> <p>Facility's 'Laundry Policy and Procedures' documents in part: Laundry is either bagged or covered during transport. Clean clothing is hung and placed into carts according to room number. Carts are to be covered on all sides during transport to rooms, clothing is transported to room by [evening] shift. Clean linens are all covered.</p> <p>Facility's 'Laundry and Linen Policies' document in part: Linens are handled, stored and processed to control the spread of infections.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146169	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/15/2025
NAME OF PROVIDER OR SUPPLIER Fargo Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Illinois Administrative Code Title 77: Public Health, Chapter I: Department of Public Health, Subchapter k: Notifiable Diseases and Conditions Control and Immunizations, Part 690 Control of Notifiable Disease and Conditions Code, Section 690.1510 Entities Required to Submit and Query Information documents in part that the Department requires long-term care facilities to report patient incident information regarding XDROs. It also requires skilled nursing and intermediate care facilities to query or implement alert notification with the XDRO Registry in order to identify new admissions with XDROs.</p> <p>On 08/12/2025 at 11:46AM, surveyor located on the second floor of the facility and observes a sign posted on R5's door that reads in part Enhanced Barrier Precautions Everyone Must: clean their hands, including before entering and when leaving the room. Providers and Staff must also: wear gloves and gown for the following High-Contact Resident Care Activities. Dressing, Bathing/Showering, Transferring, Changing Linens, Providing Hygiene, changing briefs or assisting with toileting. Do not wear the same gown and gloves for the care of more than one person.</p> <p>On 08/12/2025 at 11:47AM, V10 (Certified Nursing Assistant/CNA) and V11 (CNA) observed inside of R5's room transferring R5 from the bed to a wheelchair without wearing appropriate PPE/personal protective equipment. V10 and V11 observed not wearing a gown or gloves.</p> <p>On 08/12/2025 at 11:50AM, V10 and V11 observed exiting R5's room and transporting R5 to the dining room via wheelchair.</p> <p>On 08/12/2025 at 11:52AM, V5 (Licensed Practical Nurse/LPN) states R5 is on EBP due to R5 having an indwelling urinary catheter. V5 states all staff should don gloves and gown when providing care for R5, including when transferring R5.</p> <p>On 08/12/2025 at 11:56AM, surveyor makes V10 and V11 aware of the EBP sign posted on R5's door. V10 and V11 observed reading the EBP sign posted on R5's door and surveyor inquires to V10 and V11 about the appropriate PPE that should be worn while providing care for R5. V10 and V11 state they should have worn a gown and gloves while transferring R5 to his wheelchair because R5 is on EBP for his urinary catheter. V10 and V11 states enhance barrier precautions are put into place to minimize cross contamination and infections to the residents. V10 and V11 state there is a potential for residents to develop an infection if they do not wear the appropriate PPE and practice infection prevention protocols.</p> <p>On 08/14/2025 at 12:10PM, V3 (Infection Prevention Nurse) states all staff caring for residents on enhanced barrier precautions/EBP are supposed to wear a gown and gloves. V3 states this PPE is required for staff to wear to prevent cross contamination and prevent the spread of infection. V3 states residents who have a urinary catheter are at risk for UTIs/urinary tract infections and other bacteria entering their urinary catheter. V3 states if the proper PPE is not worn when caring for residents, then the staff can spread bacteria from one resident to another and cause an infection.</p> <p>R5's Physician order sheet/POS documents the following order: R5 placed on Enhanced Barrier Precaution due to Suprapubic Cath placement dated 03/01/2024.</p> <p>R5's care plan dated 06/30/2025 documents that R5 is on Enhanced Barrier Precautions due to the use of indwelling suprapubic catheter.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Fargo Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1512 West Fargo Chicago, IL 60626	

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of facility provided list titled Enhanced Barrier Precautions does not list R5 as a resident who is currently on enhanced barrier precautions for his urinary catheter.</p> <p>Facility policy dated 12/19/2024 titled Enhance Barrier Precautions documents in part, Procedure: 3. Gloves and gowns must be worn for the following High-Contact Resident Care Activities: Dressing, Bathing/Showering, Transferring, Changing Linens, Providing Hygiene, Changing Briefs or Assisting with Toileting. Device Care or Use: An indwelling medical device provides a direct pathway for pathogens in the environment to enter the body and cause infection.</p>