| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145881 | A. Building<br>B. Wing | 03/28/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Complete Care at Margate Park | 4920 North Kenmore<br>Chicago, IL 60640 |

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 0622<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of records and interviews the facility failed to support requirements for petition to involuntary admit 1 resident (R2) out of 4 residents reviewed for transfer and discharge. These failures affected 1 resident (R2) who was twice petitioned to be transferred to the hospital and did not meet regulatory requirement or documentation during both transfers.<br><br>Findings include:<br><br>R2 is [AGE] years old, initially admitted to the facility on [DATE]. R2 was twice transferred to hospital via petition for involuntary admission on [DATE] and 02/28/2025.<br><br>-<br><br>Per first petition for involuntary admission dated 01/27/2025, signed by V10 (Social Service Director), documents R2 demonstrates ongoing behaviors of medication refusals and non-compliance with care. R2 is also displaying increase irritability, agitation, aggression, and emotional distress coupled with manipulative behavior.<br><br>Review of R2's notes dated 01/27/2025, the day R2 was sent via petition for involuntary admission to the hospital, shows there was no documentation of R2's behavior as described on the petition. The only notes that were documented related to refusal to take medication were by V5 as an education note. It documents that R2 was educated on refusal of medication in the morning. R2 responded that he will only take stool softener. V5 explained to R2 that R2's blood pressure was high. R2 responded by typing to V5 not to make R2 upset.<br><br>On 03/26/2025 at 11:08 AM V5 (Social Worker) stated the first time R2 was sent out for involuntary petition was due to refusal of medication. R2's blood pressure was high. V5 said, He just picks and chooses whatever he wants on his medication. He only wants his stool softener. V5 stated the nurse informed her that R2's blood pressure was high.<br><br>Per nursing schedule dated 01/27/2025, V12 (Licensed Practical Nurse) was the scheduled nurse when R2 was sent to the hospital. On 03/26/2025 at 11:55 AM V12 stated R2 was always non-compliant with medication. R2 has problem with swallowing so his medicines need to be crushed with apple sauce. V12 stated R2 had a lot of behaviors in the past but on the day of R2's petition to be transferred involuntarily to the hospital there was no documentation of behavioral concerns.<br><br>(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 0622<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 03/27/2025 at 10:42 AM, V10 (Social Service Director) confirmed that V10 signed the petition for involuntary admission for R2 to go to the hospital on [DATE]. V10 read the petition which stated, R2 demonstrating medication refusal, non-compliance with care, displaying increase irritability, agitation and aggression, and emotional distress couple with manipulative behavior. V10 stated R2's behavior manifested that day and manifested over time. V10 explained that R2's behavioral problem was ongoing including non-compliance. V10 stated that refusal of medication on that basis alone does not support involuntary transfer and there needs to be documentation that supports behavioral concerns as basis of the petition. V10 said, On that day he was exhibiting noncompliance but there is no documentation as to his behavior to support involuntary transfer. There needs to be more documentation. It is not that we just transfer resident if they refuse medication. But I see your point.<br><br>-<br><br>Per second petition for involuntary admission dated 02/28/2025 signed by V5 (Social Worker) R2 was physically aggressive with the nurse (identified as V6 Registered Nurse) picking up laptop and slammed it to the wall meters away from V6's head. R2 putting his middle finger up at the V6 hitting V6 on the shoulder with the door. There were no notes documented to support that R2 slammed laptop on the wall meters away from V6.<br><br>On 03/25/2025 at 12:45 PM, V6 could not remember if R2 had laptop but stated that V6 was sure that R2 uses iPad for communication because R2 is nonverbal.<br><br>On 03/26/2025 at 11:08 AM V5 (Social Worker) stated the second time R2 was sent out for involuntary petition was when the nurse told V5 that R2 pushed the door into the nurse. V5 said, That is when the laptop broke. V5 stated that she did not witness R2 throwing the laptop on the wall. She just saw the laptop on the floor. V5 stated nobody witnessed R2 throwing the laptop. V5 was asked why that on the petition it was documented that R2 picked up laptop and slammed it to the wall meters away from V6's head if V6 does not know that R2 has a laptop, and nobody witnessed the act of throwing the laptop on the wall. What is the basis of this documentation? V5 said nobody witnessed it. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and records review the facility failed to accurately document on resident records for 2 (R1, R2) out of 4 residents reviewed. These failures affected 2 residents (R1, R2) on correct representation of their resident records. R1's physician order and medication administration have identified inconsistency. R2's petition for involuntary / judicial admission to the hospital documentation have identified inconsistency. These inconsistencies resulted to inaccurate representation of R1 and R2's records.<br><br>Findings include:<br><br>1. R1 currently [AGE] years old, initially admitted on [DATE]. R1's medical diagnosis includes alcoholic cirrhosis of liver with ascites, chronic obstructive pulmonary disease, centrilobular emphysema, malignant neoplasm of trachea, atherosclerotic heart disease of native coronary artery.<br><br>Per clinical notes dated 03/21/2025 by V3 (Licensed Practical Nurse) R1 was sent to the hospital due to altered mental status, very anxious and restless. On the same day (03/21/2025) V4 (Licensed Practical Nurse) documents she received a call from paramedics around 04:45 PM that R1 will be rerouted to a different hospital due to suspected overdose. At around 10:20 PM, V4 documented that R1 was admitted in the hospital with diagnosis of altered mental status and brought to intensive care unit (ICU).<br><br>On 03/25/2025 at 02:00 PM V3 (Licensed Practical Nurse) stated when V7 (Nurse Practitioner) was first informed about R1 V7 ordered laboratory blood work for CBC (Complete Blood Count) and CMP (Comprehensive Metabolic Profile) as soon as possible. V3 said, I didn't even enter it as an order. Because I realized I needed to take him to his room.<br><br>On 03/27/2025 at 11:21 AM, V7 (Nurse Practitioner) confirmed V3 called her regarding R1. V7 stated that V7 ordered CBC (Complete Blood Count) and CMP (Comprehensive Metabolic Profile).<br><br>On 03/26/2025 at 02:25 PM, V14 (Assistant Director of Nursing) was requested to provide controlled substance form for Methadone medication of R1. V14 provided controlled substance form that read R1's name and room number, give 5 ML PO QD, amount received 14, date received 03/19, nurse signature by V3 (Licensed Practical Nurse). V2 (Director of Nursing) was asked what medication the form was for. There was no medication provided. V2 stated it is for Methadone medication. V2 was asked why Methadone was not written a narcotic medicine. V2 said, I do not know.<br><br>On 03/27/2025 at 12:11 PM, Medication Administration Record (MAR) of R1 for March 2025 documents R1 has an order of Methadone 5 ML per 30 MG (controlled substance) to receive daily. In March up to the day when R1 was transferred to the hospital was signed as medication being administered except March 4 coded as 7 which means to see nurse's notes. Clinical notes of V3 documents R1 was out to an appointment March 4th. Controlled Substances Proof of Use form for R1 for Methadone does not reflect that the medicine was used on March 18 but MAR on March 18 was signed as medicine administered. V2 (Director of Nursing) stated that it is possible R1 took Methadone when he was in the appointment. V2 made aware that documentation needs to reflect that Methadone was not administered on March 18 due to an appointment instead of signing Methadone as administered in the facility.<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 03/27/2025 at 12:55 PM, V2 (Director of Nursing) stated the physician order should have been entered on R1's electronic record when V7 ordered for laboratory blood work (CBC and CMP). V2 stated medications that are not administered in the facility should have been documented as administered. It should have noted that resident went for an appointment.<br><br>2. R2 is [AGE] years old, initially admitted in the facility on 01/07/2025. R2 was twice transferred to hospital via petition for involuntary admission on [DATE] and 02/28/2025.<br><br>-<br><br>Per first petition for involuntary admission dated 01/27/2025, signed by V10 (Social Service Director), documents R2 demonstrates ongoing behaviors of medication refusals and non-compliance with care. R2 is also displaying increase irritability, agitation, aggression, and emotional distress coupled with manipulative behavior. Review of R2's notes dated 01/27/2025, the day R2 was sent via petition for involuntary admission to the hospital, shows there was no documentation of R2's behavior as described on the petition.<br><br>On 03/27/2025 at 10:42 AM, V10 (Social Service Director) confirmed that V10 signed the petition for involuntary admission for R2 to go to the hospital on [DATE]. V10 read the petition which stated, R2 demonstrating medication refusal, non-compliance with care, displaying increase irritability, agitation and aggression, and emotional distress couple with manipulative behavior. V10 stated R2's behavior manifested that day and manifested over time. V10 explained that R2's behavioral problem was ongoing including non-compliance. V10 stated that refusal of medication on that basis alone does not support involuntary transfer and there needs to be documentation that supports behavioral concerns as basis of the petition. V10 said, On that day he was exhibiting noncompliance but there is no documentation as to his behavior to support involuntary transfer. There needs to be more documentation. It is not that we just transfer resident if they refuse medication. But I see your point.<br><br>-<br><br>Per second petition for involuntary admission dated 02/28/2025 signed by V5 (Social Worker) R2 was physically aggressive with the nurse (identified as V6 Registered Nurse) picking up laptop and slammed it to the wall meters away from V6's head. R2 putting his middle finger up at the V6 hitting V6 on the shoulder with the door. There were no notes documented to support that R2 slammed laptop on the wall meters away from V6.<br><br>On 03/25/2025 at 12:45 PM, V6 could not remember if R2 had laptop but stated that V6 was sure that R2 uses iPad for communication because R2 is nonverbal.<br><br>On 03/26/2025 at 11:08 AM V5 (Social Worker) stated the second time R2 was sent out for involuntary petition was when the nurse told V5 that R2 pushed the door into the nurse. V5 said, That is when the laptop broke. V5 stated that she did not witness R2 throwing the laptop on the wall. She just saw the laptop on the floor. V5 stated nobody witnessed R2 throwing the laptop. V5 was asked why that on the petition it was documented that R2 picked up laptop and slammed it to the wall meters away from V6's head if V6 does not know that R2 has a laptop, and nobody witnessed the act of throwing the laptop on the wall. What is the basis of this documentation? V5 said nobody witnessed it. |