STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145881	A. Building B. Wing	06/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Margate Park	4920 North Kenmore 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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide adequate supervision and monitoring for residents. As a result of these failures, R1 fell in the facility on 06/08/2025 and sustained a temporal laceration with sutures. This failure affects one (R1) out of three residents reviewed for supervision and monitoring. Findings include: R1's Facesheet documents that R1 has diagnoses not limited to: osteophyte, vertebrae, bladder disorder, moderate protein-calorie malnutrition, obstructive and reflux uropathy, osteoarthritis, unspecified convulsions, other symptoms, and signs involving cognitive functions and awareness, unspecified fall, and laceration without foreign body of other part of head. R1's MDS/Minimum Data Set, dated [DATE], documents R1 has a BIMS/Brief Interview for Mental Status of 3/15, indicating R1 is cognitively impaired. R1 requires substantial/maximal assistance with ADL/activities of daily living care. R1 is incontinent of bowel and bladder and ambulates via wheelchair. R1's Fall Risk assessment dated [DATE] documents that R1 is at moderate risk for falls with a fall score of 40. R1's care plan documents that R1 is at risk for falls with interventions to include Anticipate and meet R1's needs and Monitor/document/report PRN s/sx of tremors, rigidity, dizziness, changes in level of consciousness, slurred speech. On 06/17/2025 at 11:47AM, V7 (Licensed Practical Nurse/LPN) stated she is the nurse responsible for caring for R1 today. V7 stated she did not witness R1 fall in the facility. V7 stated she was informed that R1 was located inside the 5th floor dining room when R1 tried to get up from his wheelchair and fell. (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/17/2025 at 12:45PM, V5 (LPN/Nurse Supervisor) stated the day R1 fell in the facility on 06/08/2025, she was working on the 5th floor of the facility but was not assigned to care for R1. V5 stated an agency nurse (identified as V12/RN) was assigned to care for R1 on 06/08/2025. V5 stated V12 was on a break when R1 fell and V5 was covering the floor during V12's break. V5 stated there was a total of four CNAs/certified nursing assistants assigned to work on the 5th floor of the facility on 06/08/2025 during the 7:00AM to 3:00PM shift. V5 stated R1's incident occurred around lunch time on 06/08/2025 while R1 was located inside the 5th floor dining room. V5 stated all four CNAs were passing meal trays and feeding other residents in their rooms when R1 fell in the dining room. V5 stated she was not located inside of the 5th floor dining room when R1 fell. V5 stated she was located inside of another resident's room flushing a gastrostomy tube/g-tube. V5 stated when she finished flushing the g-tube, she saw R1 lying on his right side inside the 5th floor dining room and R1 was bleeding from his head. V5 stated it appeared R1 was having a seizure because R1 was shaking and staring off into space. V5 stated R1 has a history of seizures, and this was her first time witnessing R1 have seizure-like symptoms. V5 stated when she discovered R1 lying on the 5th floor dining room floor, no staff members were located inside of the 5th floor dining room monitoring the residents. V5 stated R1 experienced an unwitnessed fall and there were no witnesses to the start of R1's seizure-like symptoms. V5 stated there were other residents located inside of the dining room at the time of R1's incident. V5 stated she stayed with R1 and called for help from the CNAs because she did not want to leave R1 alone. V5 stated she asked the CNAs to get her some towels so she could clean R1's blood and head wound. V5 stated there is supposed to be a staff member inside of the dining room always monitoring the residents. V5 stated she is not sure who was responsible for monitoring the dining room during the time R1 fell. V5 stated she believes the CNA responsible for monitoring the dining room left the dining room without first informing the nurse. V5 stated if the staff member monitoring the dining room must leave for any reason, they must first inform someone so they can be relieved, and another staff member can continue monitoring the dining room. V5 stated the CNA staff members are usually responsible for monitoring the dining room in 30-minute increments and their scheduled times are written on the daily CNA assignment sheet. V5 stated she called 911 and R1 was sent out to the hospital to be evaluated. V5 stated R1 returned to the facility with sutures on the right side of his head. On 06/17/2025 at 3:15PM, an attempt to contact V8 (Certified Nursing Assistant/CNA) was made, no answer, left voice message, awaiting call back. On 06/17/2025 at 3:17PM, V9 (CNA) stated she was feeding another resident inside of their room and was not located inside of the dining room when R1 fell. V9 stated she only saw V5 (LPN/Nurse Supervisor) attending to R1 in the dining room after R1 fell. V5 stated she saw that R1 had injuries to the right side of his head and R1 was bleeding. On 06/17/2025 at 3:23PM, V10 (CNA) stated R1's incident occurred at approximately 12:00PM during lunch time. V10 stated she was feeding another resident inside of their room and was not located inside of the dining room when R1 fell. V10 stated she did not witness R1 fall and only saw V5 (LPN/Nurse Supervisor) calling the ambulance for R1. V10 stated she saw V5 inside of the 5th floor dining room with R1 and R1 was bleeding from his head. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/17/2025 at 3:32PM, V11 (CNA) stated R1's incident occurred on 06/08/2025 during lunch time. V11 stated he was assigned to feed another resident and was located inside of another resident's room feeding them when R1 fell in the 5th floor dining room. V11 stated he was not located inside of the dining room and did not witness R1 fall. V11 stated once he finished feeding his assigned resident, he began retrieving resident meal trays and saw R1 inside of the dining room on the floor. V11 stated he saw V5 (LPN/Nurse Supervisor) bent over R1 attending to R1. V11 stated he immediately offered his assistance and went to retrieve towels for V5. V11 stated shortly after, the ambulance arrived and took R1 to the hospital. On 06/17/2025 at 3:42PM, V12 (Agency Registered Nurse/RN) stated she was the nurse assigned to care for R1 on 06/08/2025 and was not located on the unit when R1 fell. V12 stated she informed V5 (LPN/Nurse Supervisor) that she was going on break and took her break at approximately 12:05PM to 12:10PM. V12 stated she was on break for approximately 15-20 minutes when she was made aware of R1's incident. V12 stated V5 informed her that R1 experienced an unwitnessed fall while in the dining room. V12 stated she was informed by V5 that R1 had a head laceration and was sent to the hospital. V12 stated when she returned from her break, R1 had already left the facility and was sent to the hospital. V12 stated when she returned from her break, she spoke to the CNA who was assigned to care for R1 (identified as V8). V12 stated V8 informed V12 that he (V8) did not see R1 fall because he was feeding another resident at that time. R1's progress note dated 06/08/2025 at 1:50PM, written by V5 documents R1 was noted on the floor laying on his right side. Assessment initiated. Vital signs as follows: BP:118/110 HR:145 o2:98RA RESP:20. 911 Emergency services called. R1 was transported to ER/emergency room. ADON/assistant director of nursing and NP/nurse practitioner made aware. Family member notified of R1 transfer. Will endorse f/u to oncoming nurse. Facility Reported Incident dated 06/08/2025 documents the facility reported to the state agency that R1 was observed laying on his right lateral side in the dining room with open area to right temporal with minimal bleeding. R1's hospital records dated 06/08/2025 documents R1 was evaluated in the hospital on [DATE] and diagnosed with a right temple laceration and required sutures. Record review documents that V5 (LPN/Nurse Supervisor), V8 (CNA), V9 (CNA), V10 (CNA), V11 (CNA), and V12 (Agency Registered Nurse/RN) were all assigned to work on the 5th floor of the facility on 06/08/2025 during the 7:00AM to 3:00PM shift. CNA assignment sheet dated 06/08/2025 documents V9 was responsible for monitoring the 5th floor dining room from 11:30AM to 12:00PM. V11 was responsible for monitoring the 5th floor dining room from 12:00PM to 12:30PM. V10 was responsible for monitoring the 5th floor dining room from 12:30PM to 1:00PM. V8 was responsible for monitoring the 5th floor dining room from 1:00PM to 1:30PM. Facility policy undated titled Fall Prevention Policy documents in part, It is the policy of the facility to identify residents at risk for falls and to implement a fall prevention approach to reduce the risk of falls and possible injury. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility policy undated titled Facility Policy Regarding Resident Falls documents in part, It is this facility's policy to act in a proactive manner to identify and assess those residents at risk for falls, plan for preventative strategies, and facilitate as safe an environment as possible. Facility policy undated titled Seizure Management documents in part, 1. Resident diagnosed with seizures must be monitored for S/S of seizure activity. Facility policy dated 07/2024 titled Resident Supervision Policy documents in part, 1. All residents will be supervised. The day room will be supervised. 7. Social service staff will be scheduled on each unit during mealtime and medication to provide additional supervision.