

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145881	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2025
NAME OF PROVIDER OR SUPPLIER Complete Care at Margate Park		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0600 Level of Harm - Minimal harm or potential for 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. (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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145881	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2025
NAME OF PROVIDER OR SUPPLIER Complete Care at Margate Park		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0600</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 interview and record review, the facility failed to prevent and protect one (R4) resident from resident-to-resident abuse out of three residents reviewed for abuse. Findings include: On 07/15/2025 at 11:36AM, R4 stated R5 rammed his walker against his left leg while they were waiting on their smoke break on the first floor of the facility. R4 stated this incident happened approximately 2 to 3 weeks ago. R4 stated R6 was present and witnessed the entire incident. R4 stated he has never seen R5 with alcohol in the facility but R5 gets drunk when out on community pass. R4 stated he informed V4 (Receptionist) and V3 (LPN/Nursing Supervisor) of the altercation between himself and R5. R4 stated V3 took a picture of his leg and told him she would report the incident. R4 stated V3 informed him she reported the altercation to V1 (Administrator). R4 stated he overheard the police were called to the facility, but he did not get a chance to speak with a police officer or file a police report. R4 points to his left leg and surveyor observes a scabbed abrasion on R4's left calf measuring approximately 2 inches in length. R4 stated R5 caused this abrasion when R5 rammed his wheelchair against R4's leg. R4 stated after two days, he did not hear anything from the facility regarding the altercation between himself and R5. R4 stated he then went to talk to V1 (Administrator) to inform V1 R5 rammed his leg with a walker and inquire about what was being done about the altercation. R4 stated V1 acted like he didn't care and was not listening to him. R4 stated that's when he started cursing and became very upset during his conversation with V1. R4 stated he told V1 that V1 needed to report the incident. R4 stated he was sent out to the hospital for psychiatric evaluation instead. R4's MDS/Minimum Data Set, dated [DATE], documents R4 has a BIMS/Brief Interview for Mental Status of 15/15, indicating R4 is cognitively intact. R4's progress note dated 06/29/2025 at 9:13PM, written by V3 (LPN/Nursing Supervisor) documents, Writer was informed by staff and R4 the resident had concerns regarding him and another resident. R4 expressed he had a verbal disagreement with another resident. All of the resident concerns were addressed and both residents separated. DON and social services made aware. On 07/15/2025 at 12:13PM, R6 stated he is a witness to the altercation took place between R4 and R5. R6 stated this incident happened approximately 3 weeks ago. R6 stated he was located on the first floor awaiting his smoke break. R6 stated R5 was using his walker to block R4's path from getting past the elevators so R4 squeezed his way past R5. R6 stated R5 became upset about this and R5 used his rollator walker and rammed it into R4's leg. R6 stated this caused a scar on R4's leg. R6 stated he got in between R4 and R5 and broke them apart. R6 stated surveyor's interview is the first time anyone is inquiring to him about the incident between R4 and R5. R6's MDS/Minimum Data Set, dated [DATE], documents R6 has a BIMS/Brief Interview for Mental Status of 15/15, indicating R6 is cognitively intact. R5's progress note dated 06/29/2025 at 9:19PM, written by V3 (LPN/Nursing Supervisor) documents, Writer was informed by another resident and staff R5 was in a verbal disagreement with another resident. All of the resident concerns were addressed and both residents separated. DON and social services made aware. R5's progress note dated 07/01/2025 at 11:16AM, written by V14 (Social Services) documents, R5 was given a behavior contract and educated on appropriate and acceptable bx with peers, the consequences as well as the risks of consuming alcoholic beverages. R5 was receptive of the education, and requested if he can apologize to the peer, he had a disagreement with. R5 was informed Social Services will remain available for R5's needs or concerns. On 07/15/2025 at 1:12PM, V3 (LPN/Nursing Supervisor) stated she was made aware by V4 (Receptionist) of a verbal altercation between R4 and R5 and R5 called R4 a snitch. V3 stated this altercation occurred approximately 2.5 weeks ago. V3 stated she went to talk to R4 but R4 did not want to provide any information regarding the altercation and refused an assessment. V3 stated, the next day, as she was punching out, she overheard R4 telling a social services staff member about the altercation. V3 stated she then assessed R4's leg and observed there was a superficial scrape on R4' leg with skin intact, no bruising, no bleeding. V3 stated she took a picture of R4's leg and showed it to V2 (Director of Nursing/DON) then V3 left the facility. V3 stated she was going on vacation once she left the facility and have since deleted the picture of R4's leg. V3 stated she is unaware of what happened to R4's leg because R4 did not tell her. V3 stated she informed V2 (DON) so V2 could follow up. V3 stated she later found out R4 tried to get pass R5 but R5 did not move and R4 got a superficial scrape on his leg. On 07/15/2025 at 2:33PM, V2 (DON) stated she was made aware via telephone by V3 (LPN/Nursing Supervisor) of a verbal altercation took place between R4 and R5. V2 stated she was informed R4 and R5 were in the elevator and R4 was trying to come</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145881	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2025
NAME OF PROVIDER OR SUPPLIER Complete Care at Margate Park		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145881	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2025
NAME OF PROVIDER OR SUPPLIER Complete Care at Margate Park		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0609</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 interview and record review, the facility failed to report allegations of physical abuse for one (R4) resident out of three residents reviewed for physical abuse. Findings include: On 07/15/2025 at 11:36AM, R4 stated R5 rammed his walker against his left leg while they were waiting on their smoke break on the first floor of the facility. R4 stated this incident happened approximately 2 to 3 weeks ago. R4 stated R6 was present and witnessed the entire incident. R4 stated he has never seen R5 with alcohol in the facility but R5 gets drunk when out on community pass. R4 stated he informed V4 (Receptionist) and V3 (LPN/Nursing Supervisor) of the altercation between himself and R5. R4 stated V3 took a picture of his leg and told him she would report the incident. R4 stated V3 informed him she reported the altercation to V1 (Administrator). R4 stated he overheard the police were called to the facility, but he did not get a chance to speak with a police officer or file a police report. R4 points to his left leg and surveyor observes a scabbed abrasion on R4's left calf measuring approximately 2 inches in length. R4 stated R5 caused this abrasion when R5 rammed his wheelchair against R4's leg. R4 stated after two days, he did not hear anything from the facility regarding the altercation between himself and R5. R4 stated he then went to talk to V1 (Administrator) to inform V1 R5 rammed his leg with a walker and inquire about what was being done about the altercation. R4 stated V1 acted like he didn't care and was not listening to him. R4 stated that's when he started cursing and became very upset during his conversation with V1. R4 stated he told V1 that V1 needed to report the incident. R4 stated he was sent out to the hospital for psychiatric evaluation instead. R4's MDS/Minimum Data Set, dated [DATE], documents R4 has a BIMS/Brief Interview for Mental Status of 15/15, indicating R4 is cognitively intact. On 07/15/2025 at 12:13PM, R6 stated he is a witness to the altercation took place between R4 and R5. R6 stated this incident happened approximately 3 weeks ago. R6 stated he was located on the first floor awaiting his smoke break. R6 stated R5 was using his walker to block R4's path from getting past the elevators so R4 squeezed his way past R5. R6 stated R5 became upset about this and R5 used his rollator walker and rammed it into R4's leg. R6 stated this caused a scar on R4's leg. R6 stated he got in between R4 and R5 and broke them apart. R6 stated surveyor's interview is the first time anyone is inquiring to him about the incident between R4 and R5. R6's MDS/Minimum Data Set, dated [DATE], documents R6 has a BIMS/Brief Interview for Mental Status of 15/15, indicating R6 is cognitively intact. On 07/15/2025 at 1:12PM, V3 (LPN/Nursing Supervisor) stated she was made aware by V4 (Receptionist) of a verbal altercation between R4 and R5 and R5 called R4 a snitch. V3 stated this altercation occurred approximately 2.5 weeks ago. V3 stated she went to talk to R4 but R4 did not want to provide any information regarding the altercation and refused an assessment. V3 stated, the next day, as she was punching out, she overheard R4 telling a social services staff member about the altercation. V3 stated she then assessed R4's leg and observed there was a superficial scrape on R4's leg with skin intact, no bruising, no bleeding. V3 stated she took a picture of R4's leg and showed it to V2 (Director of Nursing/DON) then V3 left the facility. V3 stated she was going on vacation once she left the facility and have since deleted the picture of R4's leg. V3 stated she is unaware of what happened to R4's leg because R4 did not tell her. V3 stated she informed V2 (DON) so V2 could follow up. V3 stated she later found out R4 tried to get past R5 but R5 did not move and R4 got a superficial scrape on his leg. On 07/15/2025 at 2:33PM, V2 (DON) stated she was made aware via telephone by V3 (LPN/Nursing Supervisor) of a verbal altercation took place between R4 and R5. V2 stated she was informed R4 and R5 were in the elevator and R4 was trying to come off the elevator and R5 did not move and R4 pushed himself past R5. V2 stated she asked V3 if she had informed V1 (Administrator) of the incident and V3 said yes. V2 stated she then asked V3 if R4 and R5 were separated and V3 also said yes. V2 stated R4 and R5 were informed to stay away from one another. V2 stated the next day she was shown a picture of R4's leg by V3. V2 stated R4's leg appeared to be a superficial scratch with no swelling, no bruising, no bleeding, or redness. V2 stated the superficial scratch on R4's leg appeared to be an older wound and did not look fresh and was scabbed over. V2 stated a couple of hours after she saw the picture of R4's leg, she attempted to ask R4 what happened and R4 told her, Don't worry about it. V2 stated she has never heard of an altercation of R5 taking his rollator walker and ramming it into R4's leg and this would be considered abuse. V2 stated she has never had a conversation with R5 about the altercation took place between R4 and R5. V2 stated R5 has been avoiding her and doesn't come around her much. V2 stated V1 (Administrator) is the abuse coordinator and she reported to V1 a verbal altercation occurred between R4 and R5 On</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145881	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2025
NAME OF PROVIDER OR SUPPLIER Complete Care at Margate Park		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0776 Level of Harm - Actual harm Residents Affected - Few	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145881	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2025
NAME OF PROVIDER OR SUPPLIER Complete Care at Margate Park		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0776 Level of Harm - Actual harm Residents Affected - Few	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that a resident had routine preventative screening for 1 resident (R3) out of 3 residents reviewed for routine screenings. This failure resulted in R3 not receiving recommended annual breast mammograms while residing in the facility, which resulted in R3 being diagnosed with stage 4 breast cancer which metastasized to other parts of her body. Findings Include:R3's Face Sheet documents resident is a [AGE] year-old with diagnoses including but not limited to: Neutropenia, malignant neoplasm of unspecified site of right female breast, secondary and unspecified malignant neoplasm of axilla and upper limb lymph nodes, secondary malignant neoplasm of mediastinum, secondary malignant neoplasm of other specified sites. Minimum Data Set Section (MDS) section C (dated 09/26/2024) documents R3 has an Interview for Mental Status (BIMS) score of 11, indicating that R3 had moderate cognitive impairment. Care plan (dated 09/05/2023) documents that R3 has potential for pain related to Dx of left breast cellulitis, bilateral breast mass and right breast cancer with metastasis to right axilla, retro pectoral, mediastinum, spleen, left axilla and liver. Mammogram Policy (revised February 2025) documents in part: Female residents 55 and younger will have mammogram screenings conducted annually unless otherwise indicated by physician. On 07/16/2025 at 11:03AM, V2 (director of nursing) stated R3 was admitted to the facility 07/15/2004. R3 complained of breast pain on 05/30/2023. R3 was assessed due to complaining of tenderness and pain in the right breast. R3 was seen by the nurse practitioner due to pain in the right breast, on 05/30/2023, the same day she complained. Upon assessment, the nurse on the floor noted the right breast to be bigger than the left breast and hardening of the right breast. On 05/30/2023, the nurse practitioner ordered a breast ultrasound for R3 to be done in the hospital, and a consultation with the oncologist. On 06/27/2023, resident was taken to the hospital for the ultrasound appointment. That same day, the radiologist recommended a CT scan of the chest for further evaluation, which was done the same time as the ultrasound. The CT of the chest showed cancer which metastasized to the spleen, liver and axillary area. When R3's breast cancer was found, it was already spread to other parts of the body. R3 was admitted to the hospital from the appointment due to right breast cellulitis. R3 was seen by the oncologist at the hospital while she was admitted. R3 was receiving weekly chemotherapy treatments. When R3's cancer was found, it was treated right away. The breast exams are performed when a resident complains of pain or tenderness at the breast site. The facility's protocol is to perform breast exams when there is a concern voiced by the resident. According to the facility's policy, residents who are [AGE] years old and younger should have a breast mammogram every year. V2 stated, (R3) had a breast mammogram in 2017, and I don't see any mammograms for R3 after the one she had in 2017. (R3) had mental health co-morbidities and she often refused to be touched, refused examinations a lot of the time, and refused tests. (R3) was verbal and a lot of the times she would state that she was fine and refused assessments and examinations. Residents [AGE] years of age and under should have a routine mammogram every year. The only mammogram for (R3) that there is on record is from 06/07/2017, and (R3) was [AGE] years old at the time. (R3) should have had another mammogram after 2017, however, I cannot find a mammogram for (R3) from 2018. (R3) did not pass away in this facility. (R3) was sent out to the hospital on [DATE] for a mental health evaluation, and she did not return to this facility. I don't know where (R3) discharged to. She was receiving weekly chemotherapy treatments and going to see the oncologist on a regular basis while she resided here. On 07/17/2025 at 10:10AM, V12 (nurse practitioner) stated, The last time I seen R3 was on September 24, 2024. On 05/30/2023 R3 complained of breast pain, tenderness and swelling. I placed an order for antibiotic because the breast was swollen and tender and it was suspicious for mastitis. I also ordered an ultrasound of the breast and I ordered R3 an appointment with an oncologist, because I was suspecting breast cancer based on the presentation of the breast. R3's breast appeared to be tender, red, and swollen and I immediately suspected breast cancer. From then on, the oncologist picked right up, and he planned the treatments for R3, and we followed the oncologist's direction. When I see a change of status, take action right away, so I placed interventions for R3 immediately when her right breast was swollen. I do not believe that R3 had a mammogram prior to her breast being tender. The first mammogram for R3 that I know of was 06/20/2023. R3 should have had an annual breast mammogram prior to 06/20/2023. R3 was supposed to have a routine yearly mammogram. There was a breast mammogram done for R3 back in 2017, and it was negative, and it was recommended for R3 to have a repeat mammogram in 2018. From the records that I am</p>		