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	08/06/2025

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145881	A. Building B. Wing	08/06/2025

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 0600 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that residents are free from abuse for one of three residents (R1) reviewed for abuse in the sample of nine. R1 suffered a head laceration after being pushed to the floor.Findings include:R1's face sheet documents R1 is a 44 -year-old admitted to the facility on 11.3. 2023, with diagnoses including but not limited to: Chronic Obstructive Pulmonary Disease, Diabetes, Convulsions, and chronic kidney disease. R1's MDS (Minimum Data Set of 5.22.2025) documents a BIMS (Brief Interview for Mental Status) of 15 denoting R1 is cognitively intact.R2's face sheet documents R2 is a [AGE] year-old admitted to the facility on 11.15.2024 with diagnoses including but not limited to: Heart Failure, Peripheral Vascular Disease, Violent Behavior, and Non-Rheumatic Aortic Valve Disorder.R2's MDS (Minimum Data Set of 7.29.2025) documents a BIMS (Brief Interview for Mental Status) of 15 denoting R1 is cognitively intact. On 7.29.2025 at 7:27 pm, R1 said, It happened about eight days ago. I finished smoking; I went into the elevator. It wasn't working, I jumped into the other one. I was in the corner. R2 gets on the elevator as well. My rollator was facing the door. R2 was trying to get out on the 2nd floor. He got in front of me. R2 yelled at me, you a*****e get the f***out of the way. R2 pushed my rollator causing me to fall out of the elevator. I fell down. I hit my head. I hurt my head. I had a bump and a little slash on my head. I had to go to the hospital. They called 911. R2 got sent out for psych. There was resident on the elevator who saw everything, I can't remember his name. I think he's on the 4th floor. A nurse saw it too. I feel safe here. I feel staff acted appropriately.On 7.29.2025 at 8:16 PM, R2 said, I did not push R1, my wheelchair hit him. I was trying to get out of the elevator.8.3.2025 at 1:58 PM, R6 said, I was in the elevator with R1 and R2. When the door opened, R2 rammed R1 with R2's wheelchair. R1 fell out of the elevator.8.3.2025 at 3:34 PM, V4 (RN-Registered Nurse/Restorative Nurse) said, I completed a fall assessment for R1. He had a scratch to his head. R1 told me he was pushed by R2, causing R1 to fall out of the elevator onto the floor.8.4.25 at 10:48 AM, V1 (Administrator) said, No one actually saw any shoving going on. R6 said R1 was not pushed. V5 (LPN-Licensed Practical Nurse) said she couldn't say R1 was pushed but did see him fall out of elevator. R1 insisted he was pushed. R2 said he moved R1's walker. He said he told R1 to leave him alone, that R1 was bugging him.8.4.2025 at 2:09 PM, V15 (Social Service) said, R1 was reluctant to say anything. R1 said he was pushed out of the elevator, but he didn't know who did it. R2 was reluctant to say anything. R2 said he didn't do anything. R6 confirmed that R2 did push R1. R6 said R2 took R2's wheelchair and rammed it into R1.8.5.2025 at 2:50 PM via telephone, V5 (LPN-Licensed Practical Nurse) said, I was at the 2nd floor nurses station, when the elevator door opened. I saw R2 push R1 with his hands (R2 was in his wheelchair). R1 landed on the floor with force.Facility's final incident report of 7.25.2025 documents in part, reported to (V1-Administrator) on 7/21/25 at 7:45pm that (V5 LPN-Licensed Practical Nurse) stated (R2) allegedly pushed fellow resident R2 causing him to fall. (R1) was noted on the floor outside of the elevator with a small laceration on his head. Residents were immediately separated and placed on 1:1 supervision. Doctors were contacted and orders were given to send both residents to the hospital for further observation. Laceration was cleaned and covered and head to toe assessment done with no further concerns noted.R1's progress note of 7.21.2025 at 9:04 PM, documents in part, writer was informed by NOD (Nurse on Duty) that the resident was involved in a dispute with another resident on the elevator. When questioned, convicted that he was punched and pushed off the elevator by another resident. Resident refused to give any other information concerning the incident. Resident was reassessed per this nurse. Open area noted to the right side of the head, small amount of bleeding with slight swollen noted.R2's progress note of 7.21.2025 at 11:03 PM, documents in part, writer was informed by NOD (Nurse on Duty) that the resident was involved in a dispute with another resident on the elevator. When questioned, resident denies that he punched and pushed another resident off the elevator. Resident refused to give any other information concerning the incident. NP (Nurse Practitioner) gave orders to petition resident out to hospital for further evaluation.Abuse Prevention Policy (October 24, 2024) documents in part: This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents.Abuse: Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish to a resident Physical

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	08/06/2025

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 0726 Level of Harm - Actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. (continued on next page)

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	08/06/2025

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 0726 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to assess and immediately start CPR (Cardiopulmonary Resuscitation) for resident found unresponsive on the floor for one of one resident (R3) reviewed for CPR in the sample of sample of nine. This failure resulted in R3 being without vital signs and not receiving immediate CPR.Findings include:R3's face sheet documents R3 was a [AGE] year-old admitted to the facility on 9.12.2011, with diagnoses including but not limited to: Chronic Obstructive Pulmonary Disease, Asthma, Hypertension, and Hyperlipidemia. R3's Order Summary Report (active orders as of 5.28.2025) documents R3 was a full code.R3's progress note of 5.29.2025 at 7:55 AM, documents in part, at about 6:15 AM, while the writer was passing medication, one of the CNAs notified the writer that resident was on the floor in the bathroom. The writer immediately called out the resident's name but he was not responding well. A code blue was indicated through the receptionist and CPR was started. 911 was called during the CPR the vitals are B/P 113/94, pulse 126, R-22, and the blood sugar is 356mg/dl at the time resident transfer to hospital. R3's death certificate documents cause of death as asthma. The immediate cause of death is complete heart block.On 8.4.2025 at 1:10 PM, via telephone, V14 (Former LPN-Licensed Practical Nurse) said, That day I believe I gave R3 her 6:00 am med. I left the room. After a while, a CNA came to tell me R3 was on the floor. I stopped what I was doing and went to R3. She fell in the shower room. Prior to the fall, she was able to walk, she was up and about on the unit. I went there to assess her. We pulled her out of the shower room because she is a tall lady. We started CPR. We called 911. They (911) took her out. I can't remember what time the CNA came to get me; it was during my morning med pass. The first thing I did was to call her name. She did turn her head but did not talk. She looked pale. I called for help but the CNAs that are working with me were with patients. I called a code blue at the nurses' station then went back to her. I checked her. She was not responding well. I called code blue. Me and my coworker did CPR. I don't remember taking vital signs. I don't remember if my coworker did. Somebody started CPR, not me. (Local fire department) came, they took over, and they took her out. I don't remember what time the CNA got me.On 8.4.25 at 2:29 PM, V2 (DON-Director of Nursing) said, V14 (Former LPN-Licensed Practical Nurse) was terminated for not running a code properly. V14 did not bring crash cart or participate in Code Blue for her assigned resident (R3). The Code Blue was initiated, when the other nurses (V6 LPN-Licensed Practical Nurse/Nurse Supervisor and V10 LPN-Licensed Practical Nurse) came. There was no crash in the room. One of them got it. They also said V14 had not initiated CPR. V14 should have initiated CPR when she determined R3 had coded.8.5.2025 at 11:53 AM, via telephone, V2 said per V12 (HR-Human Resources) there is no CPR card in (Nurse) personnel folder.8.4.2025 at 5:54 PM, via telephone, V6 (LPN-Licensed Practical Nurse/Nurse Supervisor) said, At approximately 6:30 AM, I immediately responded to a code blue. I took the stairs; it took me a couple of minutes to get to the unit. V10 (LPN-Licensed Practical Nurse) was with me. R3 was on the ground. There were some CNAs (Certified Nursing Assistants). I didn't see the crash cart in the room. No one was doing compressions, I just wanted them to start compressions. I told them to start CPR. I never saw V14 do CPR. When someone is found unresponsive, you should assess for airway, breathing, circulation. Compressions should be started immediately to get the heart pumping, to get blood and air circulating.8.5.2025 at 2:27 PM, via telephone, V9 (R3's Physician) said, If the resident is a full code, call 911 and start CPR until 911 arrives. The purpose of starting CPR immediately is to get blood to the brain, to push blood to the brain. Compressions won't restart the heart. CPR is continued until 911 arrives and takes over, they can attempt to re-start the heart by administering medications such as epinephrine and shocking the patient. If CPR isn't started immediately severe anoxic encephalopathy (severe brain damage caused by a complete lack of oxygen) could occur.V10's Witness Statement (5.29.2025) documents, writer heard code blue 5th floor via overhead page. Writer along with housekeeping manager went to 5th floor. Writer along with other nurses assessed resident, no pulse noted, CPR initiated. 911 called by nursing staff. (Local Fire Department) on scene and noted vitals and pulse. Resident transferred to ER (Emergency Room) by (Local Fire Department). V10 (LPN-Licensed Practical Nurse) was not available for interview.V14's employee folder (Employee Action/Discipline of 5.29.2025) documents employee called a code blue on a resident but did not bring over needed materials for code and did not participate in code blue for her own assigned resident. Cardiopulmonary Resuscitation (CPR) policy (undated) documents in part, Procedure: 1. In the event a resident is identified unresponsive and upon a thorough A-B-C (Airway, Breathing, Circulation) assessment