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	09/23/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to ensure a resident's representative was notified of an injury of unknown source. This failure affected 1 (R1) resident reviewed for notification of representative in the total sample of 5 residents.Findings include:On 09/18/2025 at 3:12pm, V10 (Smoke Monitor/Receptionist) stated that on 07/29/2025, he (V10) was in the dining room, opening the door to the patio for the 3pm smoking time. When he saw R1 in the dining room, V10 said, Wow, he got some burn. V10 stated he sent him (R1) upstairs because he (R1) cannot stay in the patio with a big burn on his leg. V10 said there is no way he (R1) got the burn in the patio because it was not hot that day for him to get a huge burn mark. It was like riding a motorcycle and hit the leg on the exhaust of the motorcycle. V10 said he (R1) came in at 3pm to smoke and when he saw the burn mark, he sent him upstairs right away. V10 stated he did not know how he (R1) got the wound and that he (R1) got the wound somewhere upstairs, on the floor.On 09/18/2025 at 3:27pm, V11 (Agency Registered Nurse) stated she remembers that day. She was supposed to leave at 3pm and while she was waiting for the incoming nurse to come, the resident was brought upstairs, and she saw a skin tear behind his leg. V11 was thinking the tear happened while he (R1) was downstairs. V11 stated residents move around a lot. V11 did not know when he (R1) went downstairs and did not know where he (R1) went downstairs, and he came back through the elevator. V11 did not know what happened and he (R1) is nonverbal. V11 stated his (R1) wound did not happen while he was on the floor. V11 stated she just wrote the progress note that day and she did not call the family.On 09/18/2025 at 11:16am, V3 (R1's family member) stated the doctor (V6) who was treating his (R1) legs called her and informed her he has a burn on his legs. V3 stated she was not sure when the doctor called her.On 09/18/2025 at 12:56pm, V6 (Wound Care Doctor) stated he talked to (V3-R1's family member) about his (R1) wound, the treatment plan and to get consent for the debridement of the wound. V6 stated he did not remember if it was the first time he had seen him (R1) or when he needed the consent for the debridement of the wound. V6 stated he put a note in the wound rounds that he spoke with the family. On 09/22/2025 at 1:03pm, V2 (Director of Nursing) stated family should be notified of the injury as soon as possible or hopefully immediately, within 24 hours. On 09/22/2025 at 1:16pm, V16 (new DON) stated for any wound that the facility cannot account for, the family should be notified as soon as it is noted or within 24 hours.On 09/23/2025 at 4:04pm, V15 (Assistant Director of Nursing) stated there was no documentation on his electronic health record that his (R1) family was notified of his injury.R1's admission Record documented that R1's contact include V3 (R1's family member) as POA (power of attorney) and that R1's diagnoses (include but not limited to) type 2 diabetes mellitus, hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, chronic systolic (congestive) heart failure.R1's (08/05/2025) Minimum Data Set documented, in part Section C. Cognitive Patterns. C0500. BIMS (Brief Interview for Mental Status) Summary Score: 99. C0700. Short-Term memory Ok: 1 memory problem. C0800. Long-Term Memory Ok: 1. Memory Problem. C1000. Cognitive Skills for daily decision making: 3 severely impaired.R1's (07/29/2025) Progress note documented, in part: Resident came up with a skin tear behind his left leg at 3:10pm, wound care book filled up, pls follow up with the wound department for appropriate dressing. Authored by: V11. R1's (07/31/2025) Initial Wound Evaluation & Management Summary documented, in part Focused Wound Exam (Site 1) Burn Wound of The Left Leg Full Thickness. Wound Size (L x W x D): 18.5 x 7.4 x 0.1 cm. Surface Area: 136.90 cm^2. Pain assessment: Described as Severe. Signed by: V6 (Wound Care Doctor). No note that V3 was notified. R1's (08/11/2025) Wound Evaluation & Management Summary documented, in part Site 1: Surgical Excisional Debridement Procedure. Indication For Procedure: Remove Necrotic Tissue and Establish the Margins of Viable Tissue. Consent For Procedure: Treatment options-risks-benefits and the possible need for subsequent additional procedures on this wound were explained on 08/11/2025 to the patient and health care surrogate: (V3 - R1's family member) who indicated agreement to proceed with the procedure(s). Of note, notification of V3 was done 13 days after the injury was noted. R1's (07/28/2025 - 08/05/2025) Progress notes were reviewed, with no notes of family notification. The (09/22/2025) email correspondence with V15 (Assistant Director of Nursing) documented, in part Unable to locate SBAR for 7/29/25.The (9/1/2024) Notification of changes documented, in part Policy: The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification. Compliance Guidelines: The facility must inform

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	145881	A. Building B. Wing	09/23/2025

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Complete Care at Margate Park	4920 North Kenmore Chicago, IL 60640

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interviews and record review, the facility failed to implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act. This failure affected 1 (R1) resident out of 5 residents reviewed for reporting of injury of unknown source. Findings include:On 09/18/2025 at 3:12pm, V10 (Smoke Monitor/Receptionist) stated that on 07/29/2025, he (V10) was in the dining room, opening the door to the patio for the 3pm smoking time. When he saw R1 in the dining room, V10 said, Wow, he got some burn. V10 stated he sent him (R1) upstairs because he (R1) cannot stay in the patio with a big burn on his leg. V10 said there is no way he (R1) got the burn in the patio because it was not hot that day for him to get a huge burn mark. It was like riding a motorcycle and hit the leg on the exhaust of the motorcycle. V10 said he (R1) came in at 3pm to smoke and when he saw the burn mark, he sent him upstairs right away. V10 stated he did not know how he (R1) got the wound and that he (R1) got the wound somewhere upstairs, on the floor.On 09/18/2025 at 3:27pm, V11 (Agency Registered Nurse) stated she remembers that day. She was supposed to leave at 3pm and while she was waiting for the incoming nurse to come, the resident was brought upstairs, and she saw a skin tear behind his leg. V11 was thinking the tear happened while he (R1) was downstairs. V11 stated she cleansed the wound and informed the incoming nurse and (V2- Director of Nursing) before she left that day. V11 stated she saw the Director of Nursing called the wound department immediately that day when she told her about it. V11 said the wound department should take care of it, and they said they will check it out. V11 stated she told the DON on her way out. V11 did not know what happened; he (R1) was brought up from downstairs; his (R1) wound did not happen while he was on the floor.On 09/18/2025 at 12:56pm, V6 (Wound Care Doctor) he has been treating him (R1) for a while. V6 stated he talked to her (V3-R1's family member) about his wound and the treatment plan and to get consent for the debridement of the wound. On 09/23/2025 at 2:56pm, V6 (Wound Care Doctor) stated it is a serious injury because it is a full thickness burn, all the layers of the skin, including the epidermis, dermis, and subcutaneous tissue are damaged and because of the size of his wound.On 09/22/2025 at 1:03pm, V2 (Director of Nursing) stated she was not notified of R1's injury on 07/29/2025. V2 could not recall V11 notifying her of R1's injury. V2 said if notified, she would need to investigate it, she would need to talk to any witnesses who potentially working with him (R1) before and after the injury was observed. V2 would be auditing documentation to make sure family and doctor were notified, make sure the nurse reaches out to the doctor for a treatment plan and if in place, to make sure the facility is following the treatment plan, do an in-service with the nurses to make sure they are doing the right procedure. V2 stated, 'Yes', it is required of the facility to report to the State injury of unknown origin or a major injury. V2 said the timeframe for reporting is within 24 hours. Injury of unknown origin should be investigated as an allegation of abuse. There should be an abuse investigation. V2 stated she did not know about R1's injury of unknown origin and there was no investigation done, and it was not reported to the State.On 09/22/2025 at 3:30pm, V19 (New Administrator) stated abuse includes injury of unknown origin. The procedure is to report it immediately within 2 hours and to initiate the investigation immediately. Immediately means, as soon as the initial reportable was sent to the State, then she (V19) would start interviewing any party that is involved. Anybody who work with the resident who may have in contact with the resident. V19 said the purpose is to see the root cause of this and to rule out abuse. V19 stated she sent the reportable today (09/22/2025). V19 stated, It means his (R1) injury of unknown origin was not reported and was not investigated. Yes, it should be reported and investigated because facility didn't know how the resident got the injury, and per policy, it should be reported and investigated. A burn is a serious injury. R1's admission Record documented that R1's diagnoses (include but not limited to) type 2 diabetes mellitus, hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, chronic systolic (congestive) heart failure.R1's (08/05/2025) Minimum Data Set documented, in part Section C. Cognitive Patterns. C0500. BIMS (Brief Interview for Mental Status) Summary Score: 99. C0700. Short-Term memory Ok: 1 memory problem. C0800. Long-Term Memory Ok: 1. Memory Problem. C1000. Cognitive Skills for daily decision making: 3 severely impaired.R1's (07/29/2025) Progress note documented, in part Resident came up with a skin tear behind his left leg at 3:10pm, wound care book filled up, pls follow up with the wound department for appropriate dressing. Authored by: V11. R1's (07/31/2025) Initial Wound Evaluation & Management Summary documented, in part Focused Wound Exam (Site 1) Burn Wound of The Left Leg Full Thickness. Wound Size (L x W x D): 18.5 x 7.4 x 0.1 cm, Surface Area: 136.90 cm^2, Pain assessment: Described as

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to ensure injury of unknown source was thoroughly investigated. This failure affected 1(R1) resident out of 5 residents reviewed for allegation abuse. Findings include:On 09/18/2025 at 3:12pm, V10 (Smoke Monitor/Receptionist) stated that on 07/29/2025, he (V10) was in the dining room, opening the door to the patio for the 3pm smoking time. When V10 saw him (R1) in the dining room, he (V10) said wow, he got some burn. V10 stated he sent him (R1) upstairs because he (R1) cannot stay in the patio with a big burn on his leg. That there is no way he (R1) got the burn in the patio because it was not hot that day for him to get a huge burn mark. It was like riding a motorcycle and hit the leg on the exhaust of the motorcycle. V10 said he (R1) came in at 3pm to smoke and when he saw the burn mark, he sent him upstairs right away. V10 stated he did not know how he (R1) got the wound. (R1) got the wound somewhere upstairs, on the floor. V10 stated nobody interviewed him on the day the injury was noted. V10 stated he (V1-Administrator) texted him today (09/18/2025) to call him and he (V10) called him (V1) at 1:45pm and he (V10) told him (V1) that he (R1) did not get the wound in the patio. On 09/18/2025 at 3:27pm, V11 (Agency Registered Nurse) stated she remembers that day. She was supposed to leave at 3pm and while she was waiting for the incoming nurse to come, the resident was brought upstairs, and she saw a skin tear behind his leg. V11 was thinking the tear happened while he (R1) was downstairs. V11 stated she cleansed the wound and informed the incoming nurse and (V2- Director of Nursing) before she left that day. V11 stated she saw the Director of Nursing called the wound department immediately that day when she told her about it. V11 said the wound department should take care of it, and they said they will check it out. V11 stated she told the DON on her way out. V11 said she did not know what happened; that he (R1) was brought up from downstairs; that it did not happen on the floor. V11 stated she (V2) did not call her back and V2 did not ask her to write a statement. On 09/18/2025 at 12:56pm, V6 (Wound Care Doctor) he has been treating him (R1) for a while. V6 stated he talked to her (V3-R1's family member) about his wound and the treatment plan and to get consent for the debridement of the wound. On 09/23/2025 at 2:56pm, V6 (Wound Care Doctor) stated it is a serious injury because it is a full thickness burn, all the layers of the skin, including the epidermis, dermis, and subcutaneous tissue are damaged and because of the size of his wound. On 09/22/2025 at 1:03pm, V2 (Director of Nursing) stated she was not notified of R1's injury on 07/29/2025. V2 could not recall V11 notifying her of R1's injury. V2 said if notified, she would need to investigate it, she would need to talk to any witnesses who potentially working with him (R1) before and after the injury was observed, she would be auditing documentation to make sure family and doctor were notified, make sure the nurse reach out to the doctor for a treatment plan and if in place, to make sure the facility is following the treatment plan, do an in service with the nurses to make sure they are doing the right procedure. V2 stated 'Yes', it is required of the facility to report to the State injury of unknown origin or a major injury. V2 said the timeframe for reporting is within 24 hours. Injury of unknown origin should be investigated as an allegation of abuse. There should be an abuse investigation. V2 stated she did not know about R1's injury of unknown origin and there was no investigation done, and it was not reported to the State. On 09/22/2025 at 3:30pm, V19 (New Administrator) stated abuse include injury of unknown origin. The procedure is to report it immediately within 2 hours and to initiate the investigation immediately. Immediately means, as soon as the initial reportable was sent to the State, then she (V19) would start interviewing any party that is involved. V19 said anybody who work with the resident who may have in contact with the resident. The purpose is to see the root cause of this and to rule out abuse. V19 stated she sent the reportable today (09/22/2025). V19 said, It means his (R1) injury of unknown origin was not reported and was not investigated. Yes, it should be reported and investigated because facility didn't know how the resident got the injury, and per policy, it should be reported and investigated. R1's admission Record documented that R1's diagnoses (include but not limited to) type 2 diabetes mellitus, hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, chronic systolic (congestive) heart failure. R1's (08/05/2025) Minimum Data Set documented, in part Section C. Cognitive Patterns. C0500. BIMS (Brief Interview for Mental Status) Summary Score: 99. C0700. Short-Term memory Ok: 1 memory problem. C0800. Long-Term Memory Ok: 1. Memory Problem. C1000. Cognitive Skills for daily decision making: 3 severely impaired. R1's (07/29/2025) Progress note documented, in part Resident came up with a skin tear behind his left leg at 3:10pm, wound care book filled up, pls follow up with the wound department for appropriate dressing. Authored by: V11. R1's (07/31/2025) Initial Wound Evaluation & Management Summary documented, in part

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(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 - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Based on interview and record review, the facility failed to provide adequate supervision for a resident while at the facility. This failure affected 1(R1) resident out of 5 residents reviewed for supervision. R1 incurred a full thickness burn on his left leg with a surface area of 136.90 cm^2 .Findings include:On 09/18/2025 at 3:12pm, V10 (Smoke Monitor/Receptionist) stated that on 07/29/2025, he (V10) was in the dining room, opening the door to the patio for the 3pm smoking time. When V10 saw him (R1) in the dining room, he (V10) said, Wow, he got some burn. V10 stated he sent him (R1) upstairs because he (R1) could not stay in the patio with a big burn on his leg. V10 said there is no way he (R1) got the burn in the patio because it was not hot that day for him to get a huge burn mark. It was like riding a motorcycle and hit the leg on the exhaust of the motorcycle. V10 said he (R1) came in at 3pm to smoke and when he saw the burn mark, he sent him upstairs right away. V10 stated he did not know how he (R1) got the wound. He got the wound somewhere upstairs, on the floor.On 09/18/2025 at 3:27pm, V11 (Agency Registered Nurse) stated she remembers that day. She was supposed to leave at 3pm and while she was waiting for the incoming nurse to come, the resident was brought upstairs, and she saw a skin tear behind his leg. V11 said she was thinking the tear happened while he (R1) was downstairs. V11 stated residents move around a lot, she did not know when he (R1) went downstairs and did not know where he (R1) went downstairs, and R1 came back through the elevator. V11 said she did not know what happened and he (R1) is nonverbal. V11 stated his (R1) wound did not happen while he was on the floor. On 09/18/2025 at 12:56pm, V6 (Wound Care Doctor) stated he has been treating him (R1) for a while. V6 stated he talked to (V3-R1's family member) about his wound and the treatment plan and to get consent for the debridement of the wound. On 09/23/2025 at 2:56pm, V6 (Wound Care Doctor) stated it is a serious injury because it is a full thickness burn. All the layers of the skin, including the epidermis, dermis, and subcutaneous tissue are damaged and because of the size of his wound. On 09/22/2025 at 1:03pm, V2 (Director of Nursing) stated she was not notified of R1's injury on 07/29/2025. V2 could not recall V11 notifying her of R1's injury. V2 said if notified, she would need to investigate it, she would need to talk to any witnesses who potentially working with him (R1) before and after the injury was observed, she would be auditing documentation to make sure family and doctor were notified, make sure the nurse reach out to the doctor for a treatment plan and if in place, to make sure the facility is following the treatment plan, do an in service with the nurses to make sure they are doing the right procedure. V2 stated 'Yes', it is required of the facility to report to the State injury of unknown origin or a major injury. V2 said the timeframe for reporting is within 24 hours. Injury of unknown origin should be investigated as an allegation of abuse. There should be an abuse investigation. V2 stated she did not know about R1's injury of unknown origin and there was no investigation done, and it was not reported to the State.On 09/22/2025 at 3:30pm, V19 (New Administrator) stated abuse include injury of unknown origin. The procedure is to report it immediately within 2 hours and to initiate the investigation immediately. Immediately means, as soon as the initial reportable was sent to the State, then she (V19) would start interviewing any party that is involved. V19 said anybody who work with the resident who may have in contact with the resident. The purpose is to see the root cause of this and to rule out abuse. V19 stated she sent the reportable today (09/22/2025). V19 said, It means his (R1) injury of unknown origin was not reported and was not investigated. Yes, it should be reported and investigated because facility didn't know how the resident got the injury, and per policy, it should be reported and investigated. V19 (New Administrator) stated a burn is a serious injury. On 09/23/2025 at 4:04pm, V15 (Assistant Director of Nursing) stated she has been at the facility for 1 1/2 years and she sees him (R1) around. (R1) goes up and down the floor using the elevator and he (R1) never uses the stairs. V15 said the nurses and the CNAs are supposed to supervise R1 while he is on the floor. V15 stated she does not know how and still asking herself how the wound happened. V156 said she is not sure if he is supervised while in the elevator because he (R1) knows where he is going and when to comeback on the floor. V15 stated she wishes she could explain how it happened. V15 stated with an injury like that, somebody should know and should report it. V15 said it is not expected of a resident to be injured at the facility, and no one knew about it and somebody should know. V15 stated if no one knew how the injury happened, he (R1) was not supervised adequately. R1's admission Record documented that R1's diagnoses (include but not limited to) deaf, type 2 diabetes mellitus, hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, chronic systolic (congestive) heart failure. R1's (08/05/2025) Minimum Data Set documented, in part: Section C, Cognitive Patterns, C0500, BIMS