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	05/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one (R13) resident of three in a sample of 22 residents had sufficient representation to advocate for their needs. Findings include:R13's initial admission date to the facility is 11/18/24. R13 is a [AGE] year-old resident with diagnoses that include but are not limited to hemiplegia and hemiparesis following cerebral infarction affecting right dominant side; type 2 diabetes mellitus; depression; dementia; atherosclerotic heart disease; tachycardia; bipolar disorder.5/12/26 at 1:56 PM, V28 (Certified Nursing Assistant) stated, (R13) understands when we talk to them and follows commands. (R13) cannot respond verbally. I think it's from a stroke.5/12/26 at 2:10 PM, Surveyor called the language line to communicate with R13. The translator attempted to communicate with R13. Surveyor asked the translator to ask R13 for their name. R13 did not respond. R13 observed looking at surveyor and around the room. R13 did not verbally respond during interview attempt.5/13/26 at 10:05 AM, V1 (Administrator) stated we do not have a policy regarding guardianship, POA (Power of Attorney).5/13/26 at 12:24 PM, V2 (Director of Nursing) stated, I am familiar with (R13). He has a cousin on the face sheet. If you telephone them and leave a message they will call back. Whoever is on the face sheet is making decisions for (R13). (R13) has family, the two people listed on the face sheet. They can advocate for (R13) because they are emergency contacts. (R13) does not have a guardian. 5/13/26 at 1:20 PM, V26 (Licensed Practical Nurse) stated if a resident is nonverbal, not able to make needs known, then they should have a power of attorney or guardian. They need someone to advocate for their needs. 5/13/26 at 1:28 PM, V16 (Social Worker) stated, I am familiar with (R13). They do not have a POA or guardian. (R13) has a brother and cousin that are listed as emergency contacts. I don't know who gave consent to them being emergency contacts. It was like that when I started here. I've been here for a year. There are no documents saying that they are (R13's) POA. Being an emergency contact does not give authority to make decisions for the resident, especially taking medications. (R13) is not able to make their needs known. A resident that is non-verbal, cannot make their needs known requires a POA or guardian. (R13) cannot advocate for themselves, especially when it comes to making decisions regarding their medical needs. The Administrator (V1) is starting the paperwork for state guardianship for (R13). For as long as I have been at the facility, at least a year, (R13) has not been able to make their needs known.5/13/26 at 2:05 PM, V1 (Administrator) stated, I am familiar with (R13). (R13) is not verbal or able to make their needs known. (R13) does not have a POA or guardian. (R13) should have a POA or guardian. (R13) should have a POA or guardian because they are not able to make their needs known. For residents that cannot make their needs known, cannot talk, they need a POA or guardian to have someone to make decisions on their behalf.Psychosocial progress note, 2/3/26 16:13, reads in part: R13 presents as alert and oriented x1 with mental function fluctuating throughout the day. R13 experiences frequent episodes of confusion and forgetfulness. R13 has a communication deficit; often does not respond to staff when approached and demonstrates limited comprehension during interactions. Due to cognitive limitations, a staff assessment completed for BIMS (Brief Interview for Mental Status) which resulted in a score of 00/15 indicating severe cognitive impairment. R13's hearing is adequate however speech is unclear and ability to comprehend and express information is (continued on next page)

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

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	significantly compromised.R13 has a care plan that reads in part: R13 has a diagnosis of dementia. R13 is forgetful and requires guidance and cues, initiated 8/24/20.R13 has care plan that reads in part: R13 has a communication problem related to language barrier (primary language is *******). Require cues, initiated 4/13/2018.

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to prevent and protect resident's right to be free from misappropriation of resident property. This failure affects one (R9) resident out of five residents reviewed in a total sample of twenty-two residents. This failure places the resident at risk for more than minimal harm.Findings include:On 05/12/2026 at 12:34 PM, R5 was sitting on his bed and then ambulated to open the privacy curtains, alert, responsive, and in no apparent distress. R5 stated, I can go out on pass independently. I have all my documents; I have a bus pass.On 05/13/2026 at 1:17 PM, R9 was lying on her bed, awake, responsive, and in no apparent distress. R9 stated, They did an inventory of my (R9) belongings, and they saw items were missing, and I haven't heard anything since. I was missing hoodies (sports team), and I didn't send them to the laundry. The social worker came to do it, and she said they were going to get the things back, and they didn't get back to me, so it is unresolved as of today. When asked if R9 had any idea of what happened to R9's missing items, R9 stated. I think (R5) took them, I've (R9) caught him in my room several times trying to steal from me, I yelled out and I told them to take him out of here. R9 stated the male CNA (certified nursing assistant) during the evening shift helped R9 to have R5 get out of R9's room. R9 stated R5 was by R9's closet. R9 stated, And another time in the morning he came around 4:00am, and the CNA said I thought he was a family member. He was in the dark, I don't remember her name. event happened more than a couple of months ago. R9 stated she cannot recall the exact dates. R9 stated the last time R5 came into R9's room was recently like the beginning of this month. R9 stated the male CNA is African American and no longer works for the facility but R9 couldn't remember his name.On 05/13/2026 at 11:12 AM, V18 (Registered Nurse) stated V18 has worked for the facility as a registered nurse since October 2025 and prior to V18 worked as a certified nursing assistant for the facility for ten years. When asked V18 if there is a concern with R5 is stealing items from residents, V18 nodded yes. V18 stated she denied ever witnessing R5 taking anything or stealing from other residents. V18 stated staff must tell R5 to leave the floors R5 is not supposed to be on alone.On 05/13/2026 at 3:11 PM, V31 (former employee/Certified Nursing Assistant) stated, I (V31) worked there but I no longer work there, I stopped working for the facility in February. V31 stated V31 is familiar with R9. V31 stated, I (V31) used to deliver food to (R9) since (R9) preferred female workers to provide (R9) with care. There was one occasion when (R9) was screaming because a tall black guy went into her room, and he was not supposed to go in there. V31 stated he was a tall guy from the 6th floor, because a few residents complained he was stealing (money) and taking things from them. V31 stated V31 thinks the resident's name was R5. V31 denied witnessing R5 stealing any items. V31 stated he was not supposed to go to the residents' rooms. V31 stated, All I (V31) know she shouted so I came, and I told him she does not want you here and you need to leave the room, and he left. I (V31) looked at his hand and he didn't have anything. V31 stated he could not remember the date this happened. V31 stated V31 cannot remember if this happened this year or last year at the end of the year. V31 stated he had reported this to the nurse but could not remember who the nurse was.On 05/13/2026 at 3:27 PM, V16 (Social Worker) stated allegedly R5 is stealing residents' items. V16 stated, You just hear it around when other residents are talking about it. I've (V16) never seen him steal or witness it. V16 stated R9 did complain the last time the state surveyor was here. V16 stated is why I had taken out everything that R9 had in her closet and V16 cleaned it out personally and completed an updated inventory list. V16 stated V16 was on vacation when R9 filed a grievance dated 03/28/2026 regarding missing clothes.On 05/13/2026 at 3:34 PM, with R9's permission, V16 opened R9's closet and R9 was noted with one Chicago team's hoodie, black hoodie, [NAME] hoodie. R9 stated she is missing another Chicago team blue hoodie, blue sports team hoodie. V16 stated there was no blue Chicago team's hoodie and a blue Chicago hoodie found. This surveyor did not observe any sports team hoodies.R9's inventory list dated 03/17/2026 documents in part, R9 was noted with (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	five hoodies.On 05/13/2026 3:53 PM, V1 (Administrator) stated R9 has complained R5 stole her hoodies and coffee when the last state surveyor investigated this. V1 stated that is why there is a report regarding it. V1 stated, Only thing we can talk about is he (R5) has a behavior of wandering in between floors, but no one has come forward he has taken or stole anything.On 05/14/2026 at 1:46 PM, V30 (front desk) stated she has worked for the facility for a couple of months. V30 stated she is familiar with who R5 is and R5 normally comes to the front desk and goes through the log out book to check if R5's friend stepped out. V30 stated, For the most part, I (V30) don't know much about him. (R5) walks around here and there asking for a pop, nothing too crazy.On 05/15/2026 12:01 PM, V2 (Director of Nursing) stated, (R5) is alert and oriented and no, I (V2) would not be considering (R5) a wanderer. In general for a resident to be consider a wanderer they might be pacing on the floors. V2 stated R5 is residing on the independent floor. V2 stated she was not aware of, the R5 was observed in R9's room without R9's permission. V2 stated staff were told to redirect R5 If they saw him on another floor, they would redirect him back to his floor.A grievance form dated 03/28/2026 documents in part R9 believes men are stalking R9 and coming around to take items out of R9's room.R9's MDS/Minimum Data Set, dated [DATE] documents R9 has a BIMS/Brief Interview for Mental Status score of 15/15, indicating R9's thinking and memory are intact.R5's face sheet documents R5 is a [AGE] year-old individual admitted to the facility on [DATE] and has diagnoses not limited to nicotine dependence, cigarettes, uncomplicated, bipolar disorder, unspecified, major depressive disorder, recurrent, unspecified, generalized anxiety disorder, opioid dependence with other opioid-induced disorder, alcohol use, unspecified.R5's MDS/Minimum Data Set, dated [DATE] documents R5 has a BIMS/Brief Interview for Mental Status score of 15/15, indicating R5's thinking and memory are intact.R5's care plan documents in part, the resident has a history of criminal behavior according to the criminal history report obtained.R5's note dated 04/05/2025 at 3:48 PM documents in part, resident (R5) was present on other floors and selling items. Writer (V16) educated residents on facility policies.R5's note dated 07/20/2025 10:54 AM documents in part, writer (V16) met with R5 to address entry into another resident's room without permission. R5 was educated on the importance of respecting personal boundaries and obtaining consent before entering another resident's space was emphasized.R5's note dated 03/16/2026 1:40 PM documents in part, staff observed and received reports from peers indicating R5 has continued to request money and personal items (e.g., coffee, cigarettes) from other residents. Peers stated R5 offered to repay them, which has resulted in misunderstandings when the exchanges were not completed. Peers have expressed discomfort with these interactions.Facility document dated 09/01/2024 documents in part abuse, neglect and exploitation policy, it is the policy of this facility to provide protection for the health, welfare, and rights of each resident by developing and implementing written policies and procedures prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a resident's belongings or money without the resident's consent.On 05/13/2026 at 11:09 AM, this surveyor, via email (electronic mail) requested the facility's abuse policy and procedure.On 05/13/2026 at 11:19 AM, V1 (Administrator) communicated to this surveyor via email V1 will electronically attach the documents requested.On 05/13/2026 at 11:56 AM, V1 sent other document attachments but the abuse policy and procedure were not included.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interviews and record reviews, failed to follow their policy to ensure all special instructions and/or precautions such as treatment and devices (hospital bed, oxygen, implants, IVs, tubes/catheters) were in place prior to transfer to another facility for one (R7) out of three residents reviewed for discharge process in a sample of 22.Findings Include:On 05/12/2026 at 12:10 PM, R7 stated he transferred to a different facility. R7 stated his medications took a couple hours but was finally cleared up. R7 stated he was transferred with his CPAP (Continuous Positive Airway Pressure) machine. R7 stated he knows how to use his CPAP machine. R7 stated one of the items discussed during the meeting was that he needed a hospital bed. R7 stated his bed was never delivered. R7 stated he had to order his bed by himself. R7 stated it was very frustrating.On 05/13/2026 at 11:55 AM, V1 (Administrator) stated, As far as discharge process, we make sure medications are appropriately ordered, care plan meetings, who will be ordered and what needs to be done. We make sure all orders are in place for equipment, follow up doctor's orders and order for discharge are in place. We make sure the order is in place, and the necessary equipment is in place prior to the resident's discharge. V1 stated R7's bed was ordered. V1 stated she doesn't know if the bed was delivered. V1 stated there was no communication with outside agency whether R7's bed was delivered.On 05/12/2026 at 2:10 PM, V10 (Social Services Director) stated discharge planning is done by the interdisciplinary team. V10 stated, We make sure all the residents' medications, equipment such as bed, oxygen, and wheelchairs are ready at the new facility prior to discharge. We made sure everything was ready for (R7) prior to him leaving. V10 stated his bed was ordered and should have been delivered. V10 verified on R7's progress note it was not confirmed R7's bed was delivered at the other facility.On 05/13/2026 at 10:21 AM, V4 (Licensed Practical Nurse) stated, As a unit manager, once we get the order for a discharge order date. The doctor puts in an order for labs, workup, medical, physical. We will start the process with pharmacy. We make sure they have two weeks of medication before they leave. Bed and walker. We get the order from the doctor for discharge. The agency is an outside company we coordinate with to discharge a resident safely to the community. The outside agency and I would follow up to make sure everything is ordered. The outside agency can talk to unit manager and social services. V4 stated she did not follow up with anybody for R7 regarding R7's bed is appropriately delivered. V4 stated, I am not sure if R7's bed was delivered.On 05/13/2026 at 10:48 AM, V2 (Director of Nursing) stated, There is a discharge form they complete. We get a doctor's order. We see if they want labs, we make sure we give them a 14-day supply of medication before discharge. We encourage a follow up with their primary care provider in the community. Usually, social service works with the other facility to coordinate any equipment such as bed, oxygen tanks, etc. The accepting facility makes sure the orders, and the equipment is available at facility. The facility has to communicate with the other company to make sure the residents' equipment such as bed, wheelchair, oxygen tanks are delivered prior to discharge.R7's Minimum Data Sheet (MDS) Section C documents in part: R8 has a BIMS of 15. R7 is cognitively intact.R7's progress note on 04/14/2026 documents in part: Care plan conference done together with IDT, R7 and the outside agency team. This is a discharge planning for R7 who has a discharge date moved to 4/22/2026. The outside agency went over everything R7 will be needing for his discharge. Date and location was discussed, 14-days' worth of medication will be prepared for R7, script for the hydrocodone will be prepared by the nurse, settings for the CPAP will be noted on the discharge form and R7 will be discharging with about 2 boxes and 3 bagful of belongings. R7 will also be bringing his CPAP with him. A hospital bed will be ordered by the outside agency team for him.R7's progress note by V4 on 04/14/2026 documents in part: Resident hospital bed ordered awaiting delivery.R7's progress note by V4 on 04/14/2026 documents in part: R7 had a care plan meeting today. R7 follow up includes, medication and OTC for two weeks, hospital bed per Restorative to be ordered.Reviewed (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R7's progress note from 04/03/2026 to 04/22/2026. No documentation R7's bed was delivered.Facility's Transfer and Discharge Policy (03/10/2025) documents in part: For a transfer to another provider, the following information must be provided to the receiving provider; All special instructions and/or precautions for ongoing care such as treatments and devices (oxygen, implants, IVs, tubes/catheters). The facility will assist with transportation arrangements to the new facility and any other arrangements as needed.