STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145885	A. Building B. Wing	09/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at the Boulevard	5905 West Washington Chicago, IL 60644

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (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 0686 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 develop a plan of care and assure that one resident (R1) at high risk for skin breakdown received the treatment and services to prevent the development and worsening of a new pressure ulcer. This failure resulted in R1's development and deterioration of a unstageable pressure ulcer, requiring hospitalization and surgical intervention for Sacral ulcer with underlying destruction of the coccyx.Findings include:R1's medical diagnoses include but are not limited to chronic obstructive pulmonary disease, type 2 diabetes, cognitive communication deficit, depression, essential hypertension. R1 admitted to the facility on [DATE].R1's Minimum Data Set (MDS) dated [DATE] has a Brief Interview for Mental Status score of 12, indicating R1's cognition is moderately intact. R1's Braden scale dated 08/13/25 has a score of 12, indicating R1's risk for skin breakdown is high.R1's care plan dated 05/29/25 documents in part, The resident has potential/actual impairment to skin integrity with possible complications.I will not experience any additional skin breakdown or other complications.Assist me with my general hygiene and comfort measures. (No interventions noted after skin impairment reported on 8/3/25.)R1's orders include Turn and Reposition every 2 hours dated 5/6/25 (no change after development of new skin impairment.) R1's progress note titled Heath Status Note dated 08/03/25 documents in part, While receiving incontinence care CNA (Certified Nursing Assistant) on duty alerted writer of some discomfort the resident was having. Upon assessment writer noticed resident's sacrum has an opening and both interior thighs have MASD (moisture associated skin dermatitis). Resident stated sacrum and inner thigh were painful and burning.R1's progress noted titled Skin/Wound Note dated 08/04/25 documents in part, Writer made aware by staff of resident observed with skin integrity issue to sacrum. Upon writer assessment resident observed with unstageable pressure ulcer to sacrum.Preventive measures in place plan of care remain in place.On 09/22/25 at 11:10am V3 (Licensed Practical Nurse/LPN) stated that R1 was a total assist and could not reposition herself. V3 stated that R1's sacrum was intact on admission, but R1 developed a wound to the sacrum while in the facility. V3 stated that R1 would have to be transferred to her wheelchair via mechanical lift. V3 stated that R1 would sit in her chair for greater than 2 hours at a time. V3 stated that R1 was compliant with care and did not refuse to be cared for.0n 09/22/25 at 11:31am V4 (Certified Nursing Assistant/CNA) stated that R1 was dependent on staff to be cleaned and repositioned. V4 stated that R1 was compliant and did not refuse care. V4 stated that R1 needed two staff members for transfers and repositioning. V4 said when R1 was in the chair she was not repositioned every 2 hours. V4 stated that R1's sacrum wound was small but grew bigger. V4 stated that R1's sacrum wound had an odor for approximately a week before R1 was sent to the hospital. V4 stated that all the nurses were aware that R1 had an odor to the sacrum wound.On 09/23/25 9:40am V8 (Wound care tech) said when I come in, I make sure that the residents are being turned every two hours. V8 said even if they are up in the wheelchair, they may get put back down to be turned. V8 said we would try to have R1 get up at 11:00am and would try to put her back to bed after lunch and she would refuse.On 09/23/25 at 11:00am V9 (Wound Care Nurse) stated that R1 had no wound to her sacrum upon admission on [DATE]. V9 stated that R1 developed an unstageable pressure ulcer to her sacrum while at the facility. V9 stated that R1 was a high risk for skin breakdown due to being incontinent, immobile, and sitting up for 4 hours instead of 2 hours. V9 stated that R1's daughter informed him that she felt the R1 was not being repositioned enough. V9 stated that he began to bathe and reposition R1 himself to make sure that R1 was being cleaned and turned. V9 stated that he was on vacation from 08/06/25 through 08/18/25, and R1's sacrum wound had necrotic tissue, but was stable before his vacation. V9 said for R1 preventive measures in place for her included turn and reposition. V9 said I put an order for her to be turned and repositioned under physician orders. V9 said I informed the staff to make sure that she was not sitting up in the chair when I wasn't here. V9 said the purpose of interventions are to help and resolve any skin integrity issues. On 09/22/25 at 3:44pm V5, CNA, said sometimes R1 would be in her chair when she came on shift at 3:00PM. V5 said R1 would stay up until around 6:15PM (greater than 2 hours).On 09/24/25 at 10:43am V2 (Director of Nursing/DON) stated that it is the expectation of the facility for the nurses to follow the physician orders. V2 said it is my expectation that staff reposition the residents at least every 2 hours or more. They should clean the residents when they come in in the morning time, and at least every 2 hours they should be checking the for incontinent episodes. V2 said a care plan should be in place if a resident refuses care. If should be documented first by the nurse if a resident refuses care. V2 said for a resident with wounds