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	05/04/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to prevent neglect on a resident who required wound care treatment which was not completed and documented. This failure affected one resident (R1) out of three reviewed for neglect in the facility. Findings include: R1's admission diagnoses include but are not limited to cerebrum hemorrhage, atherosclerotic heart disease, colostomy, hypertension, COPD (chronic obstructive pulmonary disease), cocaine abuse, acute kidney failure, and depression.R1's Minimum Data Set (MDS) dated [DATE] documents, in part, Section C. Brief Interview of Mental Status (BIMS) score is 14. R1 is cognitively intact.R1's admission assessment dated [DATE] documents in part, 1. admission Details: c. Admitting Diagnosis CABG (Coronary Artery Bypass Graft) . 9. Skin Integrity: surgical scar post CABG. right lower extremity dressing.On 5/1/26 at 11:55 am, R1 stated, I would ask the nurses to change my leg wound dressing. The nurses would not change my dress so I would change it myself. The dressing would be dirty and bloody. I had some supplies I got from the hospital. I took pictures of my dirty dressing. The manager told me not to change my own wound dressing to let the nurses change it, but they would not do it.R1's (Active Orders as of 5/1/26) Order Summary Report, documents, in part, Order date 2/26/26, Wound care consult and treat as needed.R1's (Active Orders as of 5/1/26) Order Summary Report, documents, in part, Order date 4/10/26, Cleanse right medial leg with Dakin's pat dry pack with silver alginate and cover with dry dressing daily and PRN (As Needed).R1's wound care doctor visit dated 3/5/26 documents, in part, Wound location: Right medial Leg surgical incision. Wound Type: surgical. Wound Status: unknown. Exudate Amount; Low. Exudate Type: sanguinous (bloody). Odor: not malodorous. Treatment Recommendations: The plan for the surgical wound is to cleanse the area with normal saline. Primary Dressing: 1. Paint with Betadine. Secondary Dressing: 1. Bordered Gauze. This treatment will be done every other day until discontinued. Today's treatment will be done by the wound care team and other care performed by the staff of the facility.R1's wound care doctor visit dated 3/26/26 documents, in part, Wound location: Right medial Leg surgical incision. Wound Type: surgical. Wound Status: worsening. Exudate Amount; moderate. Exudate Type: sanguinous (bloody). Odor: malodorous. Treatment Recommendations: The plan for the surgical wound is to cleanse the area with Dakins (1/2 strength) solution. Primary Dressing: 1 Honey (Medial Grade) Gel. Secondary Dressing: Silver Alginate. This treatment will be done daily until discontinued. Today's treatment will be performed by the wound care team and other care performed by the staff of the facility. Will check CBC (Complete Blood Count). Add Doxycycline 100 mg (milligram) po (by mouth) BID (Twice a day) for 7 days.On 5/1/26 at 11:48 am, V6 License Practical Nurse (LPN) stated that the nurses are supposed to change R1's leg dressing when the wound nurse is not working. The dressing is to be documented when completed. On 5/2/26 at 12:26 pm, V3 Director of Nursing (DON) stated, I just started working here but if a resident needs wound care and don't have an order for treatment, they should follow standard wound care, moist to dry dressing. The nurse should follow up with the Doctor and get orders. It is not appropriate for the residents to change their own wound dressing. The nurses are here to do that for them. Doctors do give verbal orders sometimes. If a doctor has some (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	recommendations and does not write the order, the nurse should follow up and question it. Nurses are expected to carry out the Doctor's orders, and they need to verify that the orders are put into the computer (resident's electronic health record, EHR).On 5/2/26 at 2:15 pm, V4 (Wound Care Nurse) stated, I make rounds with the wound doctor. The wound doctor rounds twice a week. The wound doctor does tell me what the treatment recommendations are. The treatment recommendations on the notes are the doctor's orders; I normally put in orders from the treatment recommendations. I'm not sure why the order for March (3/5/26) is not in (R1's EHR). It was my omission. I did not do it. It was a lot going on at that time. I did not check the orders because I thought the orders already existed. He (R1) would ask the nurses to change his wound dressing, but no nurse came to me to say there were not any orders. I did see the recommendation for March 26th for daily dressing change, but I did not put that order into the computer. I was not aware of him (R1) needing any antibiotics. I only look at the measurement and the treatment recommendations from the doctor's notes. R1's Treatment Administration Record (TAR) for the month of March 2026, there were no documented wound treatments performed for R1's right medial leg surgical incision on the 7th, 11th, 14th, 18th, 22nd, 25th, 27th, 28th, 29th, 30th, 31st. R1's TAR for the month of April 2026, there were no documented wound treatments performed for R1's right medial leg surgical incision on the 1st, 3rd, 4th, 5th, 7th, 8th, and the 9th. R1's progress notes dated 4/2/26 documents, in part, Resident (R1) reported that he has been independently changing his own dressing using supplies kept in his room. Upon assessment, wound healing is not progressing appropriately at this time. Facility policy titled, Wound Treatment Management dated 2/10/26, documents in part, Policy: To promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders. Policy Explanation and Compliance Guidelines: 1. Wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequently of dressing change. 2. The absence of treatments orders, the licensed nurse will notify physician to obtain treatment orders. This may be the treatment nurse, or the assigned licensed nurse in the absence of the treatment nurse.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to a.) follow their policies and evaluate fall risk in accordance with professional standards of practice b.) provide supervision and assistive devices consistent with a resident's needs to prevent avoidable/reduce the risk of an accident for one resident (R6) out of three residents reviewed for accidents in a total sample of eight residents. This failure resulted in R6 sustaining a fall without significant injury. Findings include:On 05/03/2026 at 2:32 PM, R6 stated the CNA (certified nursing assistant) took me with my wheelchair to the shower room, and when she was assisting me to the shower chair, my foot got tangled, like I couldn't move, and I fell. R6 stated that she was sent to the hospital to get evaluated. R6 denied suffering any major injuries and denied any fractures.On 05/03/2026 at 2:25 PM, V12 (Certified Nursing Assistant) stated that R6 requires two-person assistant for transfers (when we transfer her from bed to wheelchair or to the shower chair). V12 stated that R6 is a fall risk and V12 stated that V12 was not here when R6 fell in March.On 05/04/2026 at 12:01 PM, V15 (Licensed Practical Nurse) stated that the day R6 fell (March 17th, 2026), V15 was called in by V16 (Certified Nursing Assistant) to the shower room and told V15 that R6 had a fall while V16 was trying to transfer R6 from the wheelchair onto the shower chair. V15 stated, it was just V16 and R6, no one else was in there. R6 had a skin tear on her right hand, I cleaned it with normal saline and applied a dry dressing. V15 denied that R6 had any bumps or significant injuries noted. V15 stated that after R6's fall, V16 was educated on proper transfer etiquette. V15 stated that prior to R6's fall, R6 was in stable condition and was not having any changes in condition.On 05/04/2026 at 1:11 PM, V17 (Restorative Nurse/Registered Nurse) stated that when a resident fall occurs, V17 investigates it and makes sure the care plan is updated with an intervention including reeducation to residents and staff. V17 stated that R6's post fall risk assessment was missed and V17 will need to update it. V17 stated that prior to R6's fall, R6 required maximum assistance and one personal physical assistance for transfers. V17 stated that in general, it is important for a resident's plan of care to be most up to date and accurate because staff look for types of preventions and if a situation like a fall would occur, it would allow staff to assess for the root cause and analysis. V17 denied witnessing R6's fall. With V17, R6's plan of care shower transfer in the last 30 days, and it documents R6 required dependent as well as maximum assistance. V17 stated that the CNAs shouldn't have documented dependent because R6 is maximum assistance. V17 stated that she has assessed R6 but V17 just didn't document it and V17 stated that if it was not documented, it was not done.On 05/04/2026 at 11:33 AM, this surveyor made an outbound call to V16 (Certified Nursing Assistant) and no answer, voicemail left.On 05/04/2026 at 11:43 AM, outbound call to V16 (Certified Nursing Assistant) and no answer.On 05/04/2026 at 11:59 AM, V3 (Director of Nursing) reported that she called V16 twice but there was no answer. V3 stated that she left V16 a detailed voicemail to contact this surveyor.R6's fall risk assessment dated [DATE] documents that R6 is high risk for falling.R6 does not have any fall risk assessments completed since 08/20/2025.R6's current face sheet document R6 is a [AGE] year-old individual admitted to the facility on [DATE] and current medical diagnosis are listed to include but not limited to: syncope and collapse, restlessness and agitation, hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting unspecified side, contracture, unspecified joint.R6's care plan documents in part, the resident has an ADL (activities of daily living) self-care performance deficit r/t dementia, Hemiplegia, Limited Mobility, Limited ROM (range of motion). Goal documents the resident will maintain current level of function in ADLs through the review date. Interventions document in part, transfer: The resident requires Mechanical Lift (Hoyer Lift) with two staff assistance for transfers. Date Initiated: 05/01/2018 Revision on: 08/10/2021.R6's Minimum Data Set (MDS), dated [DATE], documents R6 has a Brief Interview for Mental Status (BIMS) of 13 out of 15, indicating R6 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	is cognitively intact.Facility document documents in part, certified nursing assistant job description, assist residents with or perform activities of daily living for resident in accordance with care plans and established policies and procedures.Facility document dated 10/07/2025 documents in part, fall risk assessment, it is the policy of this facility to provide an environment that is free from accident hazards over which the facility has control, and provide supervision and assistive devices to each resident to prevent avoidable accidents. The risk assessment will be completed by the nurse or designee upon admission, quarterly or when a significant change is identified.Facility document dated 10/07/2025 documents in part, each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. Provide interventions that address unique risk factors measured by the risk assessment tool: medications, psychological, cognitive status, or recent change in functional status.a.Provide additional interventions as directed by the resident's assessment, including but not limited to:Assistive devicesWhen any resident experiences a fall, the facility will: Assess the resident.Complete a post-fall assessment.Complete an incident report.Notify physician and family.Review the resident's care plan and update as indicatedR6's documentation survey report for GG tub/shower transfer documents in part R6 required 01- Dependent -Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity on the following dates (03/06/2026, 03/07/2026, 03/08/2026, 03/12/2026, 03/15/2026).