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	05/16/2026

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that one resident (R1) received the correct prescribed medication. This failure caused R1 to experience symptoms of intoxication; (leaning over the table, weakness, inability to maintain upright sitting position or eat independently, decreased strength and limited ability to respond) and had to be sent out to the hospital for evaluation for receiving a medication used to treat opioid use disorder. This failure affected one resident R1 out of a sample of 3 residents. Findings Include:R1 has a diagnosis of but not limited to Spinal Stenosis, Spondylosis with Myelopathy, Hypertension, and Adult Failure to Thrive.R1 has a Brief Interview of Mental Status score of 13 that indicates intact cognition.Surveyor reviewed R1's Order Summary Report with Active Orders as of 5/14/2026 does not document a diagnosis of Opioid Dependence or an order for Suboxone Sublingual Film 8-2 mg (milligram) (Buprenorphine HCL{Hydrochloride}-Naloxone HCL{Hydrochloride} Dihydrate).R3 has a diagnosis of but not limited to Partial Traumatic Amputation of Left Great Toe, Hypertension, Opioid Dependence, Nicotine Dependence, Cocaine Use and Anxiety Disorder. R3 has a Brief Interview of Mental Status score of 15 that indicates intact cognition.R3's Order Summary Report with Active Orders as of 5/15/2026 does document a diagnosis of Opioid Dependence and an order for Suboxone Sublingual Film 8-2 mg (milligram) (Buprenorphine HCL{Hydrochloride}-Naloxone HCL Dihydrate) give 1 buccal system sublingually every 12 hours for Opioid Withdraw. On 5/14/2026 at 2:56pm R1 stated a nurse (V6, Registered Nurse, Former Employee) gave him a square film as his medication that V6 placed under his tongue that made me High as a [NAME], and my daughter had to make them (nurses) send me to the hospital. R1's progress note, authored by V6, dated 4/08/2026 at 11:22am, documents, in part, I (V6) went into (R1 and R3's shared room) to administer R3's medication. I walked into the room and called out for the resident in R3's bed (by room and bed number) and R1 (in the same room but a different bed) answered, and I gave the medication to R1.Surveyor tried to reach the nurse V6 (Registered Nurse) who administered the incorrect medication over several days (5/15 and 5/16) at different times with no success. Daily Census Report, dated 4/7/26, documents, in part, that R1 and R3 were residing in a shared room in the facility.Surveyor reviewed R1's local hospital record dated 4/08/2026 that documents, in part, altered mental status and ingestion of unknown medication, accidental or unintentional.R1's progress note dated 4/8/2026 at 12:25pm by V13 (Licensed Practical Nurse) documents, in part, R1 observed in bedroom leaning forward over bedside table, appearing weak and unable to maintain upright sitting position or eat independently. R1 noted to have decreased strength and limited ability to respond appropriately during assessment. Immediate evaluation performed; VS (Vital signs) BP (Blood Pressure)130/71, P (Pulse) 75, R (Respirations) 16, Temperature 98.3, O2sat (oxygen saturation) 96% RA (room air). V13 notified NP (nurse practitioner) and order received to send R1 to local emergency department for further evaluation and treatment.On 5/15/2026 at about 2:10pm V4 (Registered Nurse) and V13 (Licensed Practical Nurse) stated we are expected to identify the resident by checking the photo in facility's electronic charting system, ask the resident their name, and if the nurse is still not sure ask another staff member, who's familiar with the residents, to identify the resident. V4 stated we are to ensure the rights of medication administration are followed by making sure we have the (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
	145885	A. Building B. Wing	05/16/2026

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Complete Care at the Boulevard	5905 West Washington Chicago, IL 60644

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	right resident, right drug, right dosage, right route, and right time.On 5/15/2025 at 2:54pm V2 (DON) stated my expectations of the nurses when passing medication to prevent a medication error is to check the picture in facility's electronic charting system, check the name on the door and ask the resident, and/or ask the CNA's.On 5/16/2026 at 12:02pm via email V2 stated V6 verbally resigned on the morning of April 8, 2026, and did not return to work after that date.On 5/16/2026 at 1:27pm R3 stated V6 told R3 that R1 gets that medicine (sublingual Suboxone), and I (R3) told her, that was my (R3's) medicine, but she had given my Suboxone film 8-2mg (milligram) to R1.Medication Error report dated 4/08/2026 for R1 documents, in part, Incident Description: I (V6) went to (R1 and R3's shared room) to administer medications. I (V6) walked in the room and called out for the resident for (R3's room/bed number) and the resident in (R1's room/bed number) answered and I gave the medication to him (R1). After administering the medication, the (R3) let me know that he is the resident that I called out for and that I (V6) just gave the Resident (R1) next to him his medication.Medication Administration Policy with a revised date of 10/20/2025 documents, in part, Medications are administered by licensed nurses, as ordered by the physician and in accordance with professional standards of practice, 3. Identify resident by photo in the MAR (medication administration record) and 10. Ensure that the six rights of medication are followed: right resident, Right drug, and Right route.Undated Job description titled Registered Nurse documents, in part, may provide direct nursing care to the residents and prepares and administers medications as per physician's orders.