

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0056952		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/25/2025	
NAME OF PROVIDER OR SUPPLIER Complete Care at the Boulevard				STREET ADDRESS, CITY, STATE, ZIP CODE 5905 WEST WASHINGTON , CHICAGO, Illinois, 60644			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
S0000	Initial Comments		S0000				
	Complaint Investigation: 2588430/2606695						
S9999	Final Observations		S9999				
	Statement of Licensure Violations:						
	300.610a)						
	300.1210a)						
	300.1210b)						
	300.1210d)5)						
	Section 300.610 Resident Care Policies						
	a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.						
	Section 300.1210 General Requirements for Nursing and Personal Care						
	a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active						

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 participation of the resident and the resident's guardian or representative, as applicable. b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. These regulations were not met as evidenced by: 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 an 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 5/8/525. R1's Minimum Data Set (MDS) dated 08/15/25 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			S9999			

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S9999	Continued from page 2 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. On 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			S9999			

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S9999	Continued from page 3 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 05/08/25. 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 interventions should include repositioning and not sitting up too long on the wound. V2 said if a resident develops a new wound that means that the preventive measures are not working. V2 said when wounds are not changed as scheduled, they could deteriorate, and the nurse is not following the doctor's orders. V2 said I am not aware that R1 had no new interventions once she developed the new wound. V2 said R1's wound care plan is not complete and is the interventions are not individualized. On 09/24/25 at 11:58am V11, LPN, said for charting in the record, normally when I press 7, it's because the wound was already done by wound care nurse. I don't		S9999				

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S9999	Continued from page 4 know if that was a generated note. I do recall changing the sacrum dressing before and changing the groin one week before. V11 said R1's wound was so painful to her she used to scream when we had to try to clean it. On 09/24/25 at 08:52am, V18 (Wound care doctor) stated that if R1 would have been turning herself in bed, that would have helped the MASD and prevented the sacrum wound from worsening. On 9/24/25 at 1:05pm V12, Social Service director said I never was told that R1 refused care or had behaviors. V12 said social services is notified of resident care refusals. Review of R1's record shows no documentation of sacrum wound before 08/03/25. R1's wound assessment dated 08/08/25 documents in part, "Unstageable sacrum Full Thickness...Wound size (Length by width by dept) 2.5 by 3.5 by 0.3 cm (centimeters)." R1's wound assessment dated 08/13/25 documents in part, "Unstageable sacrum Full Thickness...Wound size (Length by width by dept) 4.1 by 4.2 by 0.7 cm (centimeters)." R1's physician order dated 08/07/25 documents in part, "Sacrum unstageable leptospermum honey apply once daily and as needed: If saturated, soiled, or dislodged." R1's treatment administration record (TAR) documents in part, "Sacrum unstageable leptospermum honey apply once daily and as needed." On 08/09/25 R1's TAR shows a code of 7, which indicates to see progress note. R1's progress note dated 08/09/25 documents in part, "No dressing change needed, dressing remain intact." R1's MDS dated 08/15/25 section GG for Functional Abilities has a score of 2 for Personal Hygiene, which indicates R1 requires substantial/maximal assistance to maintain personal hygiene, a score of 3 for rolling left and right, which indicates R1 needs partial/moderate assistance to roll from left to right and a score of 1 for chair/bed to chair transfer, which indicates R1 is totally dependent and helper does all of the effort. R1's progress noted dated 08/18/25 documents in part, "Writer alerted by CNA on duty that the resident was not as responsive as usual. Upon assessment vital signs 98/54, P (pulse) 113, t (temperature) 101.9, R (respirations) 19, SPO2 (oxygen saturation of peripheral blood) 95% on room air. Notified NP (Nurse Practitioner) new orders to send to ER (emergency		S9999				

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S9999	Continued from page 5 room)." Progress note dated 8/19/25 document R1 admitted with diagnosis of Sepsis and necrotizing fasciitis in ICU intubated. Progress notes reviewed 7/30/25 - 8/19/25, no documentation that R1 refused repositioning or lay down. Review of wound care provider notes 8/8/25 and 8/13/25 do not identify R1 refusing care. R1's hospital record dated 08/18/25 documents in part, "Patient presented to ED (Emergency Department) after being found to be febrile to 100.7, as well as hypotensive in her SNF (Skilled Nursing Facility). Upon arrival she was found to be afebrile, normotensive, although with leukocytosis to 33 and hyperglycemia to 388. Labs also significant for venous lactate to 2.2. Infectious workup showing sacral ulcer with underlying destruction of coccyx concerning for osteomyelitis with gas tracking into the R (right) gluteal musculature, R gluteal cleft, and perineum c/f (concern for) active infection.... CT abdomen and pelvis: 1. Sacral ulcer with underlying destruction of the coccyx concerning for osteomyelitis. Additionally, there is gas tracking into the right gluteal musculature, right gluteal cleft, and perineum concerning for active infection. Given the extent of gas tracking along the subcutaneous tissues and into the right gluteal musculature there is concerning for developing necrotizing fasciitis. No drainable abscess. R1's hospital surgical report dated 08/18/25 documents in part, "Findings: Stage 4 sacral decubitus ulcer with frankly necrotic surrounding tissue and malodorous murky grey output liquid output, probed to coccyx. Wide excision and debridement of wound to underlying healthy tissue. Anterior tracking along the R medial gluteal fold along anorectal junction. Wound base 14cm (centimeters) wide x 18.5 long x 3.5cm deep." R1's hospital records dated 08/19/25 documents in part, "Patient intubated and sedated s/p (status post) emergent wound debridement on 8/18/25, unable to participate in interview. Facility's policy titled "Turning and Repositioning" dated 09/01/24 documents in part, "Policy: It is our policy to implement turning and repositioning as part of our systematic approach to pressure injury prevention and management." Facility's policy titled "Wound Treatment Management" dated 09/01/24 documents in part, "Policy: To promote		S9999				

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S9999	Continued from page 6 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 frequency of dressing change...7. Treatments will be documented on the Treatment Administration Record or in the electronic health record...8. The effectiveness of treatments will be monitored through ongoing assessment of the wound. Considerations for needed modifications include: a. Lack of progression towards healing." (A)		S9999				