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	04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Margate Park	4920 North Kenmore Chicago, IL 60640

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 interview and record review, the facility failed to ensure residents were free from resident-to-resident physical and verbal abuse; and failed to implement effective interventions to prevent recurrence of abuse resulting in repeated incidents between R1 and R2 resulting in (R1 and R2) engaging in multiple altercations involving derogatory remarks (racial slurs) and physical aggression (throwing coffee and hitting). The facility also failed to prevent and protect a resident (R3) from resident-to- resident abuse. These failures affected 3 of 3 residents reviewed for abuse.Findings include:1. R1 has a diagnosis which includes but is not limited to unilateral primary bipolar disorder in full remission most recent episode depressed, and generalized anxiety disorder. R1's Brief Interview for Mental Status (BIMS) dated 3/2/26 shows a score of 15 which indicated that R1 is cognitively intact. R2's Brief Interview for Mental Status (BIMS) dated 2/20/26 shows a score of 15 which indicated that R1 is cognitively intact. R2 has a diagnosis which includes but is not limited to violent bipolar, bipolar disorder, major depressive disorder, single episode, schizophrenia, schizoaffective disorder, and major depressive disorder. The facility's initial reportable to the state agency dated 4/10/26 authored by V1 (Administrator) at 12:58 pm, documents, in part: On 4/10/26 V1 (Administrator) was made aware that R1 alleged that she was physically harmed by R2. R1's primary care physician was made aware an investigation was initiated. On 4/10/2026 at 12:53 pm, R1 stated that she has had two altercations with R2 at the facility involving R2 hitting R2 and using derogatory remarks. Staff are aware and present, and feels that nothing was done regarding R1's being abused by R2. R1 admitted to initiating a confrontation with R2 about three weeks ago, on the first floor, outside of the dining room, near the elevator at the facility on 3/16/26. R2 explained that she called R1 a derogatory name (R1 reports calling R2 a A**hole and N****). She states, He is low status, irritates me and retarded (referring to R2). R1 further explained that after she called R1 the derogatory names R2 replied to R1 saying, Say it again B**** and began to wheel his wheelchair to R1's wheelchair at the elevator. R1 explained that she turned around to R1 at the elevator, threw her coffee at R2 and R2 began hitting R1 in the chest. R1 explained after R2 punched her in the chest three times she yelled out for help for V5 (Activity Director) to stop R2 from punching R1 in the chest. R1 explained V5 was sitting in the dining room next to the elevator where the incident occurred and when R1 yelled out for help V5 came to the elevator where R1 and R2 was having the altercation and stood in between R1 and R2 and stated Stop to both residents. R1 opened (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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the elevator door and R1 got onto the elevator and R2 stayed on the first floor with V5. R1 explained when she returned to her room she looked at her chest and saw a red scratch on her chest that she contributed from the altercation with R1. R1 stated prior to the altercation with R2 at the elevator on the first floor on 3/16/26, R1 had an altercation with R2 near the bookkeeper's office and dietary door. R1 explained she was sitting adjacent to the bookkeeper's office next to the dietary door when R2 arrived and stated, Move to R1. R1 stated that she replied to R2 by saying, Say it nice and say please. R1 then explained that R2 replied back to R1 by saying, Move B*** and hit R1 across the chest. R1 then explained that V6 (Business Office Manager) came out of her office and asked R2 to stop hitting R1. R1 stated that she told V6 that R2 used a derogatory remark to R1 and hit R1 and separated R2 from R1. R1 stated that the punch from R2 on this encounter did not hurt, she did not sustain any injuries and that she is not afraid of R2 at the facility. R1 reported that she wants to stay at the facility and is not afraid to live at the facility with R2. On 4/10/26 at 1:10 pm, V4 (Psychiatric Rehabilitation Social Service Coordinator, PRSC) stated she has been R1's PRSC for the past nine months at the facility. V4 stated that a few weeks ago R1 came to V4 and asked if V7 (Social Service Manager) reported to V4 that R1 and R2 had name calling back and forth. V4 denied R1 mentioned any physical altercation and that R1 only informed V4 that R2 called R2 a B**** and that R1 responded to R2 calling R2 a N****. V4 stated she did not report R1 informing her of the derogatory language between R1 and R2 because R1 informed V4 that she (R1) made V7 aware and that V7 handled it. V4 further explained that she asked V7 regarding the incident and V7 stated that R1 and R2 had an altercation that consisted of R1 and R2 calling each other derogatory names and that the situation was handled. On 4/10/26 at 2:44 pm, V6 (Business Office Manager) stated she recalls R1 and R2 having an incident a few months ago when R1 was sitting adjacent to V6's office where the dietary door was and R2 was trying to knock on the dietary door to ask for something to eat. V6 explained that she could hear from her office the interaction with R1 and R2 and heard R2 call R1 a B**** followed by other people in the hallway (who V6 was unable to identify) say loudly Don't hit her. V6 stated she did not witness the hit but could hear several people in the hallway say, Don't hit her. V6 stated she then got up and went into the hallway where the incident was occurring and asked R2 if he hit R1 and R1 stated, Yes. V6 instructed R2 not to hit R1 again and directed R1 to move out of R2's way. V6 stated that neither resident appeared hurt nor had injuries. V6 explained that she immediately reported the incident to V7 (Social Service Manager). When V6 was asked if she reported the incident to V1 (Administrator) V6 stated that she informed V1 the next day in the morning meeting. On 4/10/26 at 2:53 pm, R2 stated that he has had several altercations with residents at the facility and recalls an incident where he hit a resident at the elevator (he did not know the residents name, however he described her as a white female) after the resident threw coffee in his face and called him a derogatory name. R2 stated he recalled an event when he was by the bookkeeper's office trying to get food from the facilities kitchen and the same resident (he described as a white female) would not let him get by and he called her a B*** and hit the other resident after she would not move out of his way. R2 explained that the same resident continues to call him a derogatory name N****. R2 explained that staff were present at both events and R1 feels that the staff did not address either incident. On 4/10/26 at 3:04 pm, V7 (Social Service Manager) stated R1 informed her that she (R1) initiated an incident with R2 by calling R2 A**hole. V7 then stated R1 explained that R1 and R2 had a back and forth with an exchange of words with derogatory remarks and had to be separated by staff (V7 is unsure of what staff separated R1 and R2) and denied being present during the incident or being (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	informed regarding any physical hitting between R1 and R2. V7 denied that V6 (Business Office Manager) ever informed V7 of R1 and R2 having an incident near the dietary office where R1 and R2 exchanged derogatory remarks and R2 hit R1. V7 stated that abuse should be reported to the administrator immediately. On 4/10/26 at 4:20 pm, V1 (Administrator) stated that she is the facility's abuse coordinator and staff should report abuse immediately to V1. V1 explained when abuse is initially reported the person causing the harm should be immediately removed, remove the individual who is being harmed, report the allegation to the administrator, and the investigation is initiated. V1 stated if a resident hits another resident or throws coffee at another resident hitting the resident in the face they are both considered acts of physical abuse. V1 explained if staff do not report abuse the facility wouldn't know how to prevent the abuse from recurring. V1 explained if the staff does not report resident to resident abuse there is a possibility the resident could continue to abuse the other resident. V1 stated if a resident makes a derogatory remark calling another resident a N** because he irritates her that is considered verbal abuse. V1 stated if a resident calls another resident a derogatory remark B** after another resident has thrown coffee on them, she is not sure if it is considered abuse. V1 denied knowledge of staff reporting R1 and R2 having any incidents of making derogatory remarks towards each other, R1 throwing coffee at R1 or R2 hitting R1 at the facility. R1's progress note dated 3/16/26 at 3:23 pm, authored by V4 (PRSC) documents in part: Resident came into office to inform me of the incident with another resident on the floor. She states name calling and it was earlier reported to another social worker. Asked the resident if she felt safe in the facility and she answered that she did. IDT (interdisciplinary team) made aware. R2's progress note dated 3/19/26 at 8:39 am authored by V5 (Activity Director) documents, in part: During mealtime, [NAME] displayed verbal antagonistic and disruptive behavior toward a peer. Without observable provocation, she approached the resident and directed multiple derogatory marks remarks towards them, including calling the peer trash, loser, a piece of S*** in stating that they need to leave the facility. She appeared to attempt to provoke the individual into an argument. Staff intervened immediately, providing calm redirection and guiding R1 away from the interaction. The targeted peer remained cooperative and did not engage or escalate. R1 initially resisted redirection verbally, stating I don't care when redirected but eventually relocated to another area with staff. No physical aggression was noted. Staff continued to monitor R1 for the remainder of the meal, and no further incidents occurred. R2's care plan documents in part R2 demonstrated recurrent aggressive behaviors including yelling, threatening language, and physical contact such as pushing or striking staff/peers . Interventions/Tasks: Document all incidents objectively and notify appropriate staff. The facility's policy dated 9//1/2024 and titled Abuse, Neglect, and Exploitation documents in part: Policy: it is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Definition: Physical Abuse: Includes, but is not limited to hitting, slapping, punching, biting, and kicking. It also includes controlling behavior through corporal punishment . Verbal Abuse: Use of oral, written or gestured communication or sounds that willfully includes disparaging and derogatory terms to resident or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	V. Investigation of Alleged Abuse, Neglect and Exploitation: A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. B. Written procedures for investigation include: 1. Identifying staff responsible for the investigation; 3. Investigating different types of alleged violations; 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; 5. Focusing the investigation on determining if abuse, neglect, exploitation, and or Mr. Treatment has occurred, the extent, and cause; and 6. Providing complete and thorough documentation of the investigation. 2. R4 is no longer in the facility and was reviewed as a closed record. An attempt to contact R4 was made on 04/11/2026 at 2:09PM, no answer, left voice message, awaiting call back. R4's Facesheet documents R4 was admitted to the facility on [DATE] and discharged on 03/23/2026. R4's progress note dated 03/23/2026 at 3:25PM written by V1 (Administrator) documents Writer spoke with Dr. regarding R4 Writer informed Dr. that R4 was being sent to the hospital for aggressive and threatening behaviors and is a danger to the residents and the facility. Writer confirmed resident was being sent to hospital. R4's progress noted dated 03/24/2026 at 4:55AM documents Writer called hospital for update of resident health status, R7 has been admitted for Aggression behavior. R4's progress noted dated 03/25/2026 at 11:53AM written by V5 (PRSC/Psychiatric Rehabilitation Service Coordinator), documents, R4 was sent out to hospital and admitted for aggressive behavior, after bullying another resident. All clothing was packed, and she did take certain item of importance to her. All other items were packed and sent to storage for save-keeping. On 04/11/2026 at 10:42AM, V5 (Psychiatric Rehabilitation Service Coordinator/PRSC) states R4 was bullying another female resident (identified as R3) and R3 and R4 were former roommates. V5 stated she heard that R4 was following R3 throughout the facility constantly bothering R3. V5 stated R3 informed her that she did not want to be roommates with R4 anymore. V5 stated R3 informed her that R3 and R4 were getting into confrontations and R4 was making it uncomfortable for R3 to be in the room any longer. V5 stated R4 was pretty much forcing R3 out of their shared room because R4 wanted the room to herself. V5 stated R3 was then moved back to her old room and R4 started following R3 back to her old room pretending to visit another resident in R3's room. V5 stated she heard that R4 made physical contact with R3 and pushed R4 in the head. V5 stated due to R4's behavior, R4 was sent out to the hospital for psychiatric evaluation. On 04/11/2026 at 10:56AM, V16 (Medical Director) stated he was made aware R4 was sent out to the hospital for aggressive behaviors. On 04/11/2026 at 11:26AM, V1 (Administrator) stated R3 came to her office and reported to her that R4 pushed R3 in the face. V1 stated R3 told her that this altercation took place in the receptionist area on the first floor of the facility. V1 stated R3 told her that the receptionist was present as well. V1 stated she then remembered that the facility has video footage of the receptionist area. V1 stated she immediately reviewed video footage and saw that R3 was telling the truth. V1 stated she observed on the video footage that R4 pushed R3 in the face. V1 stated she reported the incident to (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the state department of health on 03/23/2026. V1 stated she then tried to call R4 because R4 was OOP/out on pass. V1 stated during that same time frame, she received an email from the facility's attorney, who informed her that R4 had made allegations that R4 was just body slammed and choked in the facility. V1 stated she was able to debunk that allegation because she had already reviewed the video footage and knew that R4 was confabulating that allegation. V1 stated since R4 was the aggressor, R4 was sent out to the hospital for aggressive behaviors. V1 stated this is standard protocol when the facility has direct evidence of behaviors and other specific details of an altercation. V1 stated since R4 made physical contact with R3 and R3 was afraid for her safety, it was decided that R4 could not return back to the facility and an involuntary discharge was initiated. On 04/11/2026 at 12:34PM, V17 (Licensed Practical Nurse/LPN) stated she is familiar with R4 and her behaviors. V17 stated R3 and R4 were former roommates and had an altercation. V17 stated R3's room was changed to another room. V17 stated she remembers R4 going to R3's new room unauthorized. V17 stated she told R4 she could not be inside of R3's room. V17 stated R4 was bothering R3 so much that R3 could not even go to her own room and take a nap. V17 stated R4 insisted she could go to any room she wanted to and threatened to call her lawyer and the state health department. V17 stated she still told R4 to leave R3's room and made sure she left and did not bother R3 again. On 04/11/2026 at 12:51PM, R3 stated she and R4 were former roommates and R4 had been bullying her. R3 stated R4 was upset that she told them about smoking and drinking. R3 stated R4 told her that she ain't $h!+ and R3 keeps up a lot of $h!+ R3 stated she left her room and went down to the first floor to cool off. R3 stated R4 then came down to the first floor where she was located. R3 stated she was located in the receptionist area when R4 came down and began saying these h*e$ gonna stop playing with me. R3 stated R4 then jumped up in her face and pushed her on the left side of her face. R3 stated she was not sure of the receptionist's name, but the receptionist came and stood in between herself and R4 after R4 hit her. R3 stated she reported the incident to V5 (PRSC) and V1 (Administrator). R3 stated V1 then looked at the camera footage and confirmed that R4 had pushed her. R3 stated V1 then called the police and R3 filed a police report. R3 then showed surveyor a copy of her police report. Surveyor observed a police report dated 03/22/2026 with police report number as #JK191552. Police report documents an incident of simple battery with R3 named as the victim against R4. On 04/11/2026 at 2:11PM, abuse assessments and aggression assessments were requested from V1 (Administrator). On 04/11/2026 at 2:32PM, V1 stated the facility does not perform individual abuse and aggression assessments; V1 stated this information is already included in the resident's care plan. R3 and R4's abuse and aggression assessments were not provided to surveyor during this survey. R3's MDS/Minimum Data Set, dated [DATE] documents R3 has a BIMS/Brief Interview for Mental Status of 15/15, indicating that R3 is cognitively intact. R3's care plan dated 03/18/2026 documents in part, R3 will remain safe, will be treated with respect, dignity and reside in the facility free of mistreatment (i.e., abuse/neglect) through next review. R4's care plan documents in part, R4 will repeatedly make false claims and interject herself into others conversations in an attempt to cause negative interactions between peers and staff. R4 attempts to manipulate staff to get her way. R4 attempts to make herself or others victims when her behaviors are redirected. R4 demonstrates manipulative behaviors characterized by making threats to (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	contact or actually contacting the state Department of Public Health based on frivolous or unfounded concerns. These behaviors serve as coercive tactics to exert control, influence staff decisions, or retaliate, thereby disrupting the therapeutic environment, undermining staff authority, and compromising safety. These actions create unnecessary stress, erode trust, and destabilize the care setting. R4 demonstrates recurrent verbal aggression, including yelling, threatening language, towards staff and peers. Facility reported incident dated 03/23/2026 documents an incident involving R3 and R4. Facility policy dated 09/01/2024, titled Abuse, Neglect and Exploitation documents in part, Abuse means the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish Willful means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Facility policy dated 2026 titled Resident Rights documents in part, The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that allegations of resident-to-resident abuse were reported in accordance with facility policy and regulatory requirements. This failure affected 2 (R1, R2) out of 3 residents reviewed for abuse.Findings include:R1 has a diagnosis which includes but is not limited to unilateral primary bipolar disorder in full remission most recent episode depressed, and generalized anxiety disorder. R1's Brief Interview for Mental Status (BIMS) dated 3/2/26 shows a score of 15 which indicated that R1 is cognitively intact. R2's Brief Interview for Mental Status (BIMS) dated 2/20/26 shows a score of 15 which indicated that R1 is cognitively intact. R2 has a diagnosis which includes but is not limited to violent bipolar, bipolar disorder, major depressive disorder, single episode, schizophrenia, schizoaffective disorder, and major depressive disorder.On 4/10/26 at 12:17 pm, V1 (Administrator) stated that after the surveyor questioned staff at the facility regarding R1and R2 ever having an altercation at the facility V1 conducted an interview with R1 regarding concerns for abuse at the facility. The facility's initial reportable to the state agency dated 4/10/26 authored by V1 (Administrator) at 12:58 pm, documents, in part: On 4/10/26 V1 (Administrator) was made aware that R1 alleged that she was physically harmed by R1. R1 primary care physician was made aware an investigation was initiated. On 4/10/2026 at 12:53 pm, R1 stated that she has had two altercations with R2 at the facility involving R2 hitting R2 and using derogatory remarks. Staff are aware and present, and feels that nothing was done regarding R1's being abused by R2. R1 admitted to initiating a confrontation with R2 about three weeks ago, on the first floor, outside of the dining room, near the elevator at the facility on 3/16/26. R2 explained that she called R1 a derogatory name (R1 reports calling R2 a A**hole and N****). She states, He is low status, irritates me and retarded (referring to R2). R1 further explained that after she called R1 the derogatory names R2 replied to R1 saying, Say it again B**** and began to wheel his wheelchair to R1's wheelchair at the elevator. R1 explained that she turned around to R1 at the elevator, threw her coffee at R2 and R2 began hitting R1 in the chest. R1 explained after R2 punched her in the chest three times she yelled out for help for V5 (Activity Director) to stop R2 from punching R1 in the chest. R1 explained V5 was sitting in the dining room next to the elevator where the incident occurred and when R1 yelled out for help V5 came to the elevator where R1 and R2 was having the altercation and stood in between R1 and R2 and stated Stop to both residents. R1 opened the elevator door and R1 got onto the elevator and R2 stayed on the first floor with V5. R1 explained when she returned to her room she looked at her chest and saw a red scratch on her chest that she contributed from the altercation with R1. R1 stated prior to the altercation with R2 at the elevator on the first floor on 3/16/26, R1 had an altercation with R2 near the bookkeeper's office and dietary door. R1 explained she was sitting adjacent to the bookkeeper's office next to the dietary door when R2 arrived and stated, Move to R1. R1 stated that she replied to R2 by saying, Say it nice and say please. R1 then explained that R2 replied back to R1 by saying, Move B*** and hit R1 across the chest. R1 then explained that V6 (Business Office Manager) came out of her office and asked R2 to stop hitting R1. R1 stated that she told V6 that R2 used a derogatory remark to R1 and hit R1 and separated R2 from R1. R1 stated that the punch from R2 on this encounter did not hurt, she did not sustain any injuries and that she is not afraid of R2 at the facility. R1 reported that she wants to stay at the facility and is not afraid to live at the facility with R2.On 4/10/26 at 1:10 pm, V4 (Psychiatric Rehabilitation Social Service Coordinator, PRSC) stated she has been R1's PRSC for the past nine months at the facility. V4 stated that a few weeks ago R1 came to V4 and asked if V7 (Social Service Manager) reported to V4 that R1 and R2 had name calling back and forth. V4 denied R1 mentioned any physical altercation and that R1 only informed V4 that R2 called R2 a B**** and that R1 responded to R2 calling R2 a N****. V4 stated she did not report R1 informing her of the derogatory language between R1 and R2 because R1 informed (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	V4 that she (R1) made V7 aware and that V7 handled it. V4 further explained that she asked V7 regarding the incident and V7 stated that R1 and R2 had an altercation that consisted of R1 and R2 calling each other derogatory names and that the situation was handled. On 4/10/26 at 2:44 pm, V6 (Business Office Manager) stated she recalls R1 and R2 having an incident a few months ago when R1 was sitting adjacent to V6's office where the dietary door was and R2 was trying to knock on the dietary door to ask for something to eat. V6 explained that she could hear from her office the interaction with R1 and R2 and heard R2 call R1 a B**** followed by other people in the hallway (who V6 was unable to identify) say loudly Don't hit her. V6 stated she did not witness the hit but could hear several people in the hallway say, Don't hit her. V6 stated she then got up and went into the hallway where the incident was occurring and asked R2 if he hit R1 and R1 stated, Yes. V6 instructed R2 not to hit R1 again and directed R1 to move out of R2's way. V6 stated that neither resident appeared hurt nor had injuries. V6 explained that she immediately reported the incident to V7 (Social Service Manager). When V6 was asked if she reported the incident to V1 (Administrator) V6 stated that she informed V1 the next day in the morning meeting. On 4/10/26 at 2:53 pm, R2 stated that he has had several altercations with residents at the facility and recalls an incident where he hit a resident at the elevator (he did not know the residents name, however he described her as a white female) after the resident threw coffee in his face and called him a derogatory name. R2 stated he recalled an event when he was by the bookkeeper's office trying to get food from the facilities kitchen and the same resident (he described as a white female) would not let him get by and he called her a B*** and hit the other resident after she would not move out of his way. R2 explained that the same resident continues to call him a derogatory name N****. R2 explained that staff were present at both events and R1 feels that the staff did not address either incident. On 4/10/26 at 3:04 pm, V7 (Social Service Manager) stated that R1 informed her that she (R1) initiated an incident with R2 by calling R2 A**hole. V7 then stated that R1 explained that R1 and R2 had a back and forth with an exchange of words with derogatory remarks and had to be separated by staff (V7 is unsure of what staff separated R1 and R2) and denied being present during the incident or being informed regarding any physical hitting between R1 and R2. V7 also denied that V6 (Business Office Manager) ever informed V7 of R1 and R2 having an incident near the dietary office where R1 and R2 exchanged derogatory remarks and R2 hit R1. V7 stated that abuse should be reported to the administrator immediately. On 4/10/26 at 4:20 pm, V1 (Administrator) stated that she is the facility's abuse coordinator and that staff should report abuse immediately to V1. V1 explained when abuse is initially reported the person causing the harm should be immediately removed, remove the individual who is being harmed, report the allegation to the administrator, and the investigation is initiated. V1 stated if a resident hits another resident or throws coffee at another resident hitting the resident in the face they are both considered acts of physical abuse.V1 explained if staff do not report abuse the facility wouldn't know how to prevent the abuse from recurring. V1 explained if the staff does not report resident to resident abuse there is a possibility the resident could continue to abuse the other resident. V1 stated if a resident makes a derogatory remark calling another resident a N** because he irritates her that is considered verbal abuse. V1 stated if a resident calls another resident a derogatory remark B** after another resident has thrown coffee on them, she is not sure if it is considered abuse. V1 denied knowledge of staff reporting R1 and R2 having any incidents of making derogatory remarks towards each other, R1 throwing coffee at R1 or R2 hitting R1 at the facility. R1's progress note dated 3/16/26 at 3:23 pm, authored by V4 (PRSC) documents in part: Resident came into office to inform me of the incident with another resident on the floor. She states name calling and it was earlier reported to another social worker. Asked the resident if she felt safe in the facility and she answered that she did. IDT (interdisciplinary team) made aware.R2's progress note dated 3/19/26 at 8:39 am authored by V5 (Activity Director) documents, in part: During mealtime, [NAME] displayed verbal antagonistic and disruptive behavior toward a peer. Without observable provocation, she approached the resident and directed multiple derogatory marks remarks towards them, including (continued on next page)

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	04/13/2026

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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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	calling the peer trash, loser, a piece of S*** in stating that they need to leave the facility. She appeared to attempt to provoke the individual into an argument. Staff intervened immediately, providing calm redirection and guiding R1 away from the interaction. The targeted peer remained cooperative and did not engage or escalate. R1 initially resisted redirection verbally, stating I don't care when redirected but eventually relocated to another area with staff. No physical aggression was noted. Staff continued to monitor R1 for the remainder of the meal, and no further incidents occurred. R2's care plan documents in part, R2 demonstrated recurrent aggressive behaviors including yelling, threatening language, and physical contact such as pushing or striking staff/peers . Interventions/Tasks: Document all incidents objectively and notify appropriate staff. The facility's policy dated 9//1/2024 and titled Abuse, Neglect, and Exploitation documents in part: Policy: it is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Definition: Physical Abuse: Includes, but is not limited to hitting, slapping, punching, biting, and kicking. It also includes controlling behavior through corporal punishment . Verbal Abuse: Use of oral, written or gestured communication or sounds that willfully includes disparaging and derogatory terms to resident or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability. V. Investigation of Alleged Abuse, Neglect and Exploitation: A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. B. Written procedures for investigation include: 1. Identifying staff responsible for the investigation; 3. Investigating different types of alleged violations; 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; 5. Focusing the investigation on determining if abuse, neglect, exploitation, and or Mr. Treatment has occurred, the extent, and cause; and 6. Providing complete and thorough documentation of the investigation.