STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145244	A. Building B. Wing	03/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Lakeshore	7200 North Sheridan Road Chicago, IL 60626

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 0689 Level of Harm - Immediate jeopardy to resident health or safety 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 provide supervision to prevent elopement for one [R1] out of four [R1, R4, R5, R6] residents reviewed for elopement. This failure resulted in R1 eloping through the front entrance three times including on 10/12/26 sustaining open areas to both feet, and on 2/6/26 sustaining a fall with a close head injury and left lower lip laceration requiring sutures. Findings Include:This was identified as an Immediate Jeopardy which began on 10/12/25.On 2/27/26 at 1:52 pm, the administrator was notified of the Immediate Jeopardy. On 02/28/26 at 3:54PM, the facility abatement plan was approved.The Immediate Jeopardy was removed on 3/1/26. However, the deficiency remains at the second level of harm until the facility determine the effectiveness of the implementation of the removal plan. R1 was admitted on [DATE] with medical diagnosis of schizophrenia, depression, anxiety, lack of coordination, abnormalities of gait and mobility, obesity, and essential hypertension. R1's Minimum Data Set [MDS] Brief Interview Mental Status Score indicates R1 is cognitively intact. R1's progress nurse note, dated 4/23/25, at 11:00PM, documents R1 was seeking to exist the facility, tried to leave the building but staff was able to re-direct back to facility. On 2/24/26 at 8:20AM, V7 [R1's Family Member] stated, (R1) has eloped from the facility too many times. The last two elopements (R1) sustained injuries. When (R1) was on the locked unit, he was not able to elope. In January, (R1) went to the hospital and returned to an unlocked unit. At that time, (R1) eloped and sustained a head injury, lost some teeth, and a deep cut to his mouth that required sutures. The last elopement, I literally begged the hospital not to send (R1) back to that facility, I was afraid for (R1's) safety. 1.R1's Social Service Note, dated 6/21/25 6:45 PM, documents R1 left the facility without permission, staff redirected the resident back into the facility. Elopement care plan was created, elopement assessment updated. R1's 6/21/25 Elopement Risk/Community Survival Skills Assessment: documents R1 is at risk of eloping and should be placed on the Elopement Risk Protocol. A care plan for elopement is indicated. R1's Care plan: documentsR1 is an elopement risk related to exit seeking. Intervention: Intervene as appropriate. Date initiated: 6/21/25. On 2/26/25 at 10:40AM, V3 [Social Service Director] stated, An Elopement Risk/Community Survival Skills Assessment are completed upon admission, quarterly, any medical/behavior significant change, any elopements or attempt to elope. On 4/23/25, (R1) did leave out the front door, but staff were with (R1) and re-directed (R1) back to the facility. I did not complete an Elopement Risk/Community Survival Skills Assessment and did not update the care plan, because I thought it was a minor incident. On 6/21/25, (R1) left out the front lobby door, and staff went outside directly after (R1) and re-directed (R1) back into the facility. I completed (R1's) Elopement Risk/Community Survival Skills Assessment, and (R1) was now an elopement risk, and (R1's) care plan was updated. On 6/25/25, a (electronic monitoring device) was placed on (R1). I went to (V1, Administrator) to receive the (electronic monitoring device). The nurse and I went together and placed the device on (R1), and he did not refuse the device. It is the nurse's responsibility to place the (electronic monitoring device) to monitor placement and functionality. Unless I am told by nursing staff, I assume the (electronic monitoring device) is still in place. If a resident goes to the hospital, it is not my responsibility to (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
	145244	A. Building B. Wing	03/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Lakeshore	7200 North Sheridan Road Chicago, IL 60626

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	ensure the (electronic monitoring device) was still in place; nursing is responsible. (R1) was admitted to the fourth floor. After 4/23/25 and 6/21/25, (R1) remained on the fourth floor. On the fourth floor all residents can leave on the elevator at free will, there's no keypad nor any code required to exit the fourth floor. R1?s Elopement Risk and Community Survival Skills Assessment, dated 6/23/25, indicated R1 was not at risk to elope, the Elopement Risk Protocol is not indicated. Completed by V21 [Social Worker]. R1?s Elopement Risk and Community Survival Skills Assessment, dated 9/25/25, indicated R1 was not at risk to elope, the Elopement Risk Protocol is not indicated. Completed by V21 [Social Worker]. On 2/26/26 at 10:58 AM, V21 [Social Worker] stated, An Elopement Risk/Community Survival Skills Assessment are completed upon admission, quarterly, any medical/behavior significant change, any elopements or attempt to elope. I do not remember why I completed another Elopement Risk/Community Survival Skills Assessment. I don't know why I indicated (R1) was not an elopement risk two days after (R1) eloped. That was a clinical error. I do not remember the reason why I completed another Elopement Risk/Community Survival Skills Assessment for (R1) on 9/25/25. I indicated (R1) was not an elopement risk, again, it was a clinical error. On 2/24/26 at 3:25 PM, V1 [Administrator] stated, On 6/21/25 was the first time (R1) left the facility with staff present. (R1) was re-directed back into the facility and placed one to one from 6/21/25 to 6/27/25, and (R1's) (electronic monitoring device) was placed on 6/25/25. (R1) remained on the fourth floor. The fourth floor is not a locked unit. There is no code needed for elevator use. (R1's) elopement dated 6/21/25, the police were not called, there was no incident report completed, and I did not report the incident to IDPH (Illinois Department of Public Health), because there was no injury to (R1). R1's Social Service Progress, dated 09/28/2025 at 7:45PM, documented R1 attempted exit seeking behavior, redirected aggrieved to PRN, placed on 1:1 monitoring, care plan and assessments reviewed. On 2/26/25 at 10:40AM, V3 [Social Service Director] stated, (R1) was noted with exit seeking behaviors on 9/28/25. The nurse gave (R1) medication to assist with agitation. There were no Elopement Risk and Community Survival Skills Assessment complete. (R1's) care plan was not updated for 9/28/25. (R1) remained on the fourth floor, which is not a secure nursing floor. 2.R1's Social Service Note, dated 10/12/2025 at 1:45PM, documents, (R1) left the facility unauthorized. Staff conducted immediate searches in the community. 911 was called and filed was reported. Staff will continue to follow up. Care plans and assessments updated. R1's Social Service Note, dated 10/12/2025 at 5:52PM, documents it was reported that R1 took himself to the hospital because he was hearing voices. Will follow up as needed. R1's Nurse Note, dated 10/12/2025 at 6:05PM, authored by V18, Licensed Practical Nurse, documents, About 5:45PM, I received call from the nurse at hospital saying that (R1) checked himself into the hospital saying that he was hearing voices and fax medication and face sheet, administrator, on call supervisor, DON (Director of Nursing) and supervisor on duty notified. R1's Nurse Notes, dated 10/12/2025 at 8:32PM, authored by V18, Licensed Practical Nurse, documents, (R1) is back to facility per stretcher by ambulance, alert, oriented and verbally responsive upon skin assessment noted with an open area on the sole of both feet, area cleaned and apply dry dressing, physician notified and endorsed to monitor, (R1) remain 1:1 monitoring, Administrator and DON [Director of Nursing] made aware. R1's Elopement Risk and Community Survival Skills Assessment, dated 10/12/25, documents R1 is at risk of eloping and should be placed on the Elopement Risk Protocol. A care plan for elopement is indicated. R1's Care plan, updated on 10/29/25, documents Social Service Director will refer R1 to Activity Department as well as one-to-one psychotherapy. When R1 returns, R1 will be placed on one to one or every thirty minutes for 24-hours or until further notice. R1's Hospital documents, dated 10/12/25, indicates the following:Time of service: 5:25 PM.Upon R1's arrival he explained he left the nursing home today because he was hearing voices and came straight to the hospital. I hear voices like the devil.R1 was drowsy, appeared sedated.Emergency note: R1 states he lives at the nursing facility and provided the name. Phoned nursing facility and spoke to V18 [R1's Licensed Practical Nurse]. V18 stated that R1 tried to elope earlier but was stopped and given Haldol 5mg orally around 12:23PM, but she [V18] (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145244	A. Building B. Wing	03/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Lakeshore	7200 North Sheridan Road Chicago, IL 60626

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	could not locate R1 a few hours later. R1's Skin Report, dated, 10/13/25, documents R1 has open areas to the sole of both feet. R1's physician orders document: (electronic monitoring device)-Check Placement/Functionality q shift (every shift), start 6/25/26 and end 10/31/25. On 2/25/26 at 1:49 PM, V18 [Licensed Practical Nurse] stated, On 10/12/25, I worked a double shift on the fourth floor, 7AM to 3PM and 3PM to 11PM. I was (R1's) nurse. I was not aware that (R1) was an elopement risk. All the residents on the fourth floor are able to go on the elevator as they please. Earlier that morning (R1) tried to leave out the front door, but he was stopped by staff, and I was notified. I do not remember who notified me. I re-directed (R1) to come back to the fourth floor. (R1) was agitated. I gave him Haldol 5mg, and I continued to work. I did not report his exit seeking because (R1) did not get out of the facility. I kept close watch on (R1) the best I could, I had to take care of other residents. Around 1:00PM, I could not locate (R1). (V12, Weekend Nurse Supervisor) and I went outside looking for (R1), but we did not see (R1). I went back to the fourth floor and continued to work. Later around 5:45PM, I received a phone call from the hospital nurse saying that (R1) checked himself into the hospital saying that he was hearing voices. I notified the administrator, on call supervisor, and DON. (R1) returned back to the facility around 8:30 PM, per body assessment, noted (R1) with new open areas on the bottom of his feet. (R1) absolutely had a (electronic monitoring device) on his arm. A (electronic monitoring device) helps prevent a resident from eloping.R1's medication administration record documents on 10/11/25, 10/12/25, 10/13/25, 10/14/25, and 10/15 ?N' (No). R1's physician order read: (electronic monitoring device) placement and functionality every shift for monitoring. Start date of 6/25/25. V18 stated, The initials documented for 10/11/25, 10/12/25, 10/13/25, 10/14/25, and 10/15 that documented ?N' were mine. I documented ?N' for No. There was no (electronic monitoring device) in place on (R1). Now I remember (R1) did not have a (electronic monitoring device) in place. After I noted (R1) did not have a (electronic monitoring device) in place, I did not report the findings to anyone. I don't remember why I did not report (R1's) (electronic monitoring device) was not in place to administration or nursing supervisor. After (R1) eloped on 10/12/25, I still did not report to nursing administration or supervisor that R1's (electronic monitoring device) still was not in place. On 2/27/26 at 3:55 PM, V12 [Weekend Nurse Supervisor] stated, On 10/12/25, around 12:30PM, (V18, Licensed Practical Nurse) made me aware she could not locate (R1). (V18) and I searched for the facility and outside. Code pink was called. (R1) was not located. The police were notified. I did not receive a police report, I did not collect nor document the police officer badge number, and I did not request the police report number. I did not document the incident in (R1's) chart; his nurse documented. I did not know how (R1) got out the front doors. I do not remember. I do not know if (R1) had a (electronic monitoring device), I cannot remember. On 2/28/25 at 11:56AM, V1 [Administrator] stated, On 10/12/25, (R1) left the facility and took himself to the hospital. (R1) was placed one-to-one for a week, and (R1) was moved to the third-floor, locked memory care unit. (R1's) (electronic monitoring device) has always been in place since 6/25/25.I completed a past non-compliance for 10/12/25 incident. The failure was identified: (R1) exited the front door.Actions: (R1) was assessed for injuries, none was noted. Family and MD (Medical Director) were made aware. New order received from MD. Resident was placed on one-to-one supervision for a week. A Quality Assurance [QA] tool has been implemented to monitor compliance of door alarms and to monitor residents displaying new signs of elopement behavior. Administrator or designee will conduct daily audits of five residents a week for two months, then two residents a week for four months or as needed to monitor for compliance. All Resident's and care plan updated, all resident's elopement assessment has been updated. All exit doors were checked and found in compliance with functionality. Facility has implemented daily door checks of the exit doors. All staff have been in serviced on elopement policy and procedure. QAPI (Quality Assurance Performance Improvement) meeting was held to review events and action plan. Reviewed with medical director. Agency staff will be educated before the start of their first shift. Code pink drills have been conducted on all three shifts. With the past non-compliance in place (R1) eloped out the facility on 2/6/25 because he got on the elevator, and the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145244	A. Building B. Wing	03/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Lakeshore	7200 North Sheridan Road Chicago, IL 60626

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	front desk staff buzzed (R1) out the facility.V1 failed to identify R1 had an order to monitor the (electronic monitoring device) placement and functionality every shift and staff were documenting as no post his elopement. V1 also failed to recognize R1 had injury to his feet. 3.R1's progress notes, dated 02/06/2026 at 1:10PM, authored by V16, Licensed Practical Nurse, documents, (R1) was seen around 7am this morning during rounds by the elevator. When asked where he was going to, he stated he was heading to the vending machine to get a coke. Later, when I attempted to administer his medications, I noticed the resident was missing. I contacted the receptionist to page him to his room but was still unable to locate (R1). I checked the first floor and other areas but (R1) could not be found. Social services and DON [Director of Nursing, V2] were notified, and all necessary steps were taken. (R1) was later found at the hospital, Nurse practitioner and family (V7) made aware. R1's Social Service Note, dated 02/06/2026 at 1:28PM, documents R1 left facility. family notified. Care plan and assessment reviewed and updated; IDT made aware; will continue to follow up as needed. R1's Elopement Risk/Community Survival Skills Assessment, dated 2/6/26, documents R1 is at risk of eloping and should be placed on the Elopement Risk Protocol. A care plan for elopement is indicated. R1's care plan was reviewed. The care plan was not updated related to 2/6/26 elopement. R1's Hospital documents, dated 2/6/26, indicate:R1 said he was running and tripped and fell and struck his mouth and face.CT (Computed tomography) Maxillofacial - Chipped tooth at the left maxillary medial incisor. Missing right mandibular medial incisor tooth.Repaired lower lip laceration with sutures. On 2/25/25 at 1:05 PM, V16 [Licensed Practical Nurse] stated, I was (R1's) nurse on 2/6/26, on the third floor south unit. At the start of my shift at 7:00 AM, I saw (R1) standing at the elevator waiting for its arrival. I asked (R1) where he was going. (R1) said he was going down to the first-floor vending machine for a soda. (R1) knew the elevator code; I saw him place in the code numerous times. Since (R1) has been on the third floor south unit, he always goes down to the first floor to get snacks and soda out the vending machines and comes back to the floor. Around 9:30AM, I was looking for (R1) to administer his morning medications, but I could not locate (R1). Then I called the receptionist and asked her to overhead page (R1) back to his room. After a while (R1) did not return, I went to the first floor, and I did not see (R1). I notified (V1, Administrator) that (R1) could not be located. Staff and I went outside and did not see (R1). I did not work with (R1) until (R1) was re-admitted to the third floor south unit on 1/16/26. I did not know (R1) was an elopement risk resident. There is no list of elopement risk residents at the nursing station. (R1) did not have a (electronic monitoring device) since he was on this unit. There was no physician order to check for (electronic monitoring device) placement. I have never seen any (electronic monitoring device) on (R1's) wrist or ankles. There was no way for me to know (R1) was an elopement risk resident. On the third floor south unit, we have an elevator that requires a code to retrieve the elevator. The majority of the third floor south unit residents know the elevator code including (R1). The code was in place for the third floor north residents that live on the locked secure unit. Just in case the resident from the third floor north locked unit gets out, they would not be able to leave the third floor, because they don't know the code to the elevator. The code to the elevator was not kept from the third floor south residents. Later, around 10:45 AM, (V1, Administrator) told me (R1) was located at the hospital. On 2/25/25 at 1:05 PM, V17, Registered Nurse, stated, The residents and (R1) on 3South unit knew the code to the elevator. The code was put in place for the 3North residents. On 2/24/26 at 8:15 AM, V6 [Former Receptionist] stated, On 2/6/26 the start of my shift 7AM, I was at the front desk getting organized with staff standing around blocking my view. A man stood at the front door, looked like a staff member, so I pressed the door release button for the front door to open, and (R1) walked out, not knowing he was a resident. Around 9:30 AM, (V16, Licensed Practical Nurse) asked me to overhead page for (R1), because she could not find him. (R1's) name was not familiar. Later, around 10:30AM, the hospital called the facility. I heard (R1) had fallen and hit his head while lost outside. (V1) called me in his office, and he showed me the video surveillance. The time (R1) left the facility was 7:04 AM on the video. (V1) said it was all my fault, and (R1) got hurt because of me. Then (V1) fired me. (R1) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145244	A. Building B. Wing	03/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Lakeshore	7200 North Sheridan Road Chicago, IL 60626

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	was not on the elopement risk list, neither was his picture. (V3, Social Service Director) asked if the (electronic monitoring device) alarm sounded. I told them the alarm did not sound. (R1) did not have a (electronic monitoring device) in place. If (R1) had had on a (electronic monitoring device), the front door alarm would have sounded. (V1) blamed me for the whole incident and did not hold the nursing staff accountable for (R1's) elopement. There are a lot of staff that look like residents and it's hard to tell the difference. There was no way for me to know that (R1) was an elopement risk resident. On 2/27/26, V6 phoned surveyor and stated, (V14, Certified Nurse Assistant/Nurse Scheduler) called me and told me to tell the state surveyor that (R1) left the facility at 8:45AM not 7:04AM. I will not lie to the state surveyor. I saw the video, and (R1) left out the front door at 7:04AM. I do not want to be harassed to tell the state surveyor lies. On 2/27/26 at 1:15 PM, V19 [Licensed Practical Nurse] stated, (R1) was an elopement risk resident that was on this unit 3North. This is a secure locked unit. There is no elevator access to this unit. To get on or off this until you must place in a code which is the same as the elevator code. None of the residents on this unit knows the code. (R1) was on this secure unit from 10/15/26 to 1/8/26. During that time frame, (R1) did not have any elopements. (R1) went to the hospital due to behaviors on 1/8/26 and was re-admitted back to the facility on 3South unit. That unit is on the same floor, but it is not a secure lock unit. There is a keypad on the elevator, that's extra security for the 3North residents just in case they leave the secure locked unit. On 2/28/26 at 11:17AM, V13 [Maintenance Director] stated, I been working here for five years. The (electronic monitoring device) alarm is only on the front lobby door. If a resident with a (electronic monitoring device) in place and come within five feet of the front door, the alarm will sound and stay on until front desk staff enters the code. The (electronic monitoring device) alarm system is checked every day by the maintenance staff. The alarm system has been functioning properly. From 10/1/25 to present day 2/28/26, the alarm has been working. On 2/27/26 at 4:00 PM, V2 [Director of Nursing] stated, I have been the Director of Nursing since November 2025. I don't have prior information regarding (R1's) elopements. The facility has one secure unit, 3North. On 2/6/25, during my investigation, (V16, Licensed Practical Nurse), the nurse that worked with (R1) when he eloped on 2/6/26, told me she did not know that (R1) was an elopement risk resident. (V16) said (R1) knew the third-floor elevator code and saw (R1) place in the code. Other residents knew the code as well. I have seen residents put in the elevator code on the third floor. On (R1's) medication administration record for October 2025, (V18, Licensed Practical Nurse) documented 'N' for (electronic monitoring device) placement and functionality, means the (electronic monitoring device) was not in place. N means NO. If a nurse notes a (electronic monitoring device) is not in place, and there is an order for the (electronic monitoring device), the nurse was to contact the Administrator, Director of Nursing or Nurse Manager to receive a (electronic monitoring device) to place on the resident immediately. The purpose of the (electronic monitoring device) is to prevent elopement. (R1) eloped on 2/6/25 because (V16) did not know he was an elopement risk resident. (R1) had eloped in the past, (R1) knew the code to the elevator, (R1) did not have his (electronic monitoring device) on, the receptionist was not paying attention, and just buzzed (R1) right out the door. It is nursing staff responsible to ensure the orders are placed in the medication administration record to check for (electronic monitoring device) placement every shift and functionality. Upon admission or re-admission, it is the whole team to work together to ensure the elopement resident (electronic monitoring device) is back on. (R1) was on the secured locked unit from 10/15/25 until 1/8/26, with no elopement incidents. Upon (R1's) re-admission, (R1) was placed on the 3South unit. It was not my decision to move (R1) off the secure locked unit. When (R1) was sent to the hospital on 1/8/26, I was under the impression that (R1) would not be returning to the facility. Upon (R1's) re-admission, the (electronic monitoring device) was not placed on (R1), I do not know why. If (R1's) (electronic monitoring device) was placed on (R1) upon re-admission, if the receptionist (V6) and (V16) knew who the elopement residents were, and if (R1) did not know the code to the elevator, (R1's) elopement may have been potentially prevented on 2/6/26. On 3/1/26 at 11:00 AM, V20 [R1's Physician] stated, ?I take care of a lot of residents it hard (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145244	A. Building B. Wing	03/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Lakeshore	7200 North Sheridan Road Chicago, IL 60626

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	to remember all of them. I reviewed (R1's) chart prior to this interview. I don't remember if I was made aware of (R1's) elopements. The chart documented I was made aware, so I was made aware. I do not recall if (R1) had a (electronic monitoring device) in place. I don't know why the (electronic monitoring device) order dated 6/25/25 was discontinued on 10/31/25 and not reordered. There must have been a good reason why, but I do not remember. I do not see any reason documented in (R1's) medical record. According to (R1's) medical chart, he sustained bilateral foot injuries on 10/12/25. On 2/6/26, I don't know if (R1) had injuries. On 2/28/26 at 1:35 PM V1 [Administrator] stated, (R1) did not have any elopements from 10/15/25 to 1/8/26. (R1) was residing on 3North secure unit. (R1's) room was across from the nursing station. On 1/8/26, (R1) was admitted to the hospital. Upon (R1's) return back to the facility on 1/16/26, (R1) was in a room on the 3South unit. That unit is secure; the elevator has a key code in order to get on the elevator. (R1) got on the elevator with someone and went to the first floor and the front desk staff buzzed (R1) out the door. I moved (R1) off the locked unit because he was young and needed a better quality of life. I completed a past non-compliance for 2/6/26 incident. The failure was identified: (R1) exited the front door.Actions: (R1) was assessed for injuries, none was noted. Family and MD were made aware. New order received from MD. Resident was placed on one-to-one supervision for a week. A Quality Assurance [QA] tool has been implemented to monitor compliance of door alarms and to monitor residents displaying new signs of elopement behavior. Administrator or designee will conduct daily audits of five residents a week for two months, then two residents a week for four months or as needed to monitor for compliance. All Resident's and care plan updated, all resident's elopement assessment has been updated. All exit doors were checked and found in compliance with functionality. Facility has implemented daily door checks of the exit doors. All staff have been in service on elopement policy and procedure. QAPI meeting was held to review events and action plan. Reviewed with medical director. Agency staff will be educated before the start of their first shift. Code pink drills have been conducted on all three shifts. Based on interviews and record reviews, the past noncompliance dated 10/12/26, the facility failed to recognize, and correct the noncompliance related to R1's elopement on 10/12/26 and failed to prevent R1's elopement on 2/6/26 due to the following:Staff do not know who the elopement risk residents were. V6 [Former Receptionist] and V16 [Licensed Practical Nurse] did not know R1 was elopement risk. V16 allowed R1 to leave the third floor unsupervised. V6 allowed R1 to leave out the front door. V21 [Social Service] completed R1's elopement assessments and documented R1 was not an elopement risk.Nursing staff did not ensure R1's wander guard was in place and checked every shift.Elopement residents knew the elevator code.R1's care plan was not updated per all exit seeking behaviors.The facility did not review and update Elopement Risk binder for nursing stations and front desk. Facility's Elopement Device policy, dated 8/23/2017, documents:Elopement alert devices will be used as an intervention tool to prevent resident elopements.At the time of application, the approved form is kept at the front desk.The wander guard device will be inspected by nursing personnel once each day by inspecting the location of the device on the arm or leg. Placing the transmitter tester near the anklet or bracelet to test the battery for proper working order.The functionality of the device on resident will be checked daily by social services and manger on duty. Facility's Code Pink-Missing Resident/Elopement policy, dated 11/15/2017, documents:All personnel are responsible for reporting a cognitively resident attempting to leave the premises to charge nurses soon as practical.Should an employee discover that a resident is missing from facility, he or she should:Immediately report to charge nurse or supervisorReview Physician order to see if resident have an authorized pass to leaveAlert staff announcing code pinkInform staff of the name of missing resident and a pictureNotification administrator, Director of Nursing immediatelyNurse should notify the physician, resident's family, responsible party.Notify police, file a missing report.Remain in contact with hospitals, nursing facilities, and family members.Complete incident report and notify state agency according to reporting guidelines.Document notations in the medical record.Upon return to facility:Examine resident for injuriesContact physician, responsible partyComplete incident (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145244	A. Building B. Wing	03/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Lakeshore	7200 North Sheridan Road Chicago, IL 60626

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	reportDocument finds in medical recordReview Resident's out on passComplete a new Elopement Risk Assessment and update plan of careReview and update Elopement Risk binder. The immediate Jeopardy that began on 10/12/25 and was removed on 3/1/26 when the facility took the following actions to remove the immediacy: 1. All residents in the facility have been reassessed for elopement risk. The facility will monitor elopement risk assessments to ensure residents have not had a change in status to warrant a reassessment. Monitoring will be completed by Social Service Director with oversight by Administrator. A new QA tool will be put in place to monitor 10 residents a week x 12 weeks to ensure assessments are accurate. 2.All resident care plans have been reviewed with revisions made as needed. Care plans will be reviewed with each change to the elopement assessment. A new QA tool has been put in place to monitor 10 residents per week x 12 weeks to ensure compliance3.The elopement binder at the front desk and on the units has been reviewed and updated to assure that all residents that are elopement risk with wander guard are on the list including and new admissions and/or re-admissions. It will be reviewed weekly and updated with changes of resident status to ensure it is accurate.4.All staff have been newly retrained on elopement including code pink procedure, signs of elopement, elopement policy, and how to identify a resident at risk for elopement in the facility. Education has been completed by social service, administration, and nursing leadership. Any staff on FMLA or vacation will be retrained prior returning to work. The facility does not use agency for staffing.5. The facility has conducted a code pink drill on all shifts to monitor staff response and identify opportunities for additional training. Code pink drills will continue weekly x 12 weeks. This was completed by the facility administrator and the maintenance director on three shifts (1st, 2nd, and 3rd shift) - 02/27/26 and during the early morning hours on 02/28/26.6. An ad hoc QAPI meeting has been conducted with the medical director to discuss the elopement events and facility follow up7. The elopement policy has been reviewed with no required changes by the IDT team8. The facility has updated the key code to the elevators by a contracted vendor with a new key pad installed. The staff that work on the unit are to know the key code to the elevators and the staff are not to disclose the key code to residents. The code for the elevators will be changed once a month and staff will be reminded weekly not to tell the code to the residents. 9. 9. The facility has conducted a house wide audit of residents who utilize wander guard. Residents who utilize wander guard have a new corresponding order to check them each shift on the MAR and a new additional reminder on the special instruction tab on the electronic medical record. A new functionality log has been implemented to monitor function. The log will be kept on the 3rd floor nursing station and the DON and/or nursing designee will be monitoring to assure compliance.