STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145679	A. Building B. Wing	09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carlton at the Lake, The	725 West Montrose Avenue Chicago, IL 60613

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 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. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow their abuse policy and procedure to ensure that abuse allegation was reported no later than two hours to the State Agency (SA) for one (R1) out of three residents reviewed for abuse. Findings Include:R1's clinical records revealed an admission date of [DATE] with included diagnoses but not limited to major depressive disorder, epilepsy, bipolar disorder, anxiety disorder, and dissociative and conversion disorder. R1's admission minimum data set (MDS) assessment dated [DATE] shows R1 is cognitively intact with BIMS (Brief interview for Mental Status) score of 15 and requires supervision with activities of daily living.On [DATE] at 9:42 AM, interviewed R1 regarding his out on pass incident on [DATE]. R1 stated, I had a pass with an escort. That day somebody signed me out. It was my cousin [V3 (R1's Cousin)]. It was Friday he [V3] signed me out around 4:30 PM. We went out to dinner with family. We went down past Diversey. There were so many people outside. It was Labor Day weekend. After dinner we were separated. My phone kept dying. I ran out of battery. It was too crowded. My phone died. Eventually I got on the train to come back here. I ended up going South. I got surrounded by 4 colored men. I remembered 2 people raped me. I can't remember exact details. I was drugged. I got back in the facility Saturday night. What I remember is being under a Metra. Two people were doing it. I can't remember. I can't remember the full details. The next morning, I got on a bus. Still no power on my phone. I went to my old apartment complex. Charged my phone. Got back on the train. I got a hold of [V11 (Assistant Director of Nursing)] around 4:00 PM. Told her [V11] I'm on my way back to the facility. At 4:47 PM I texted [V11] I said I'm going to be back soon. Not thinking correctly, I took the wrong train. [V11] told me to get back to the facility. I told [V11] that I was sexually assaulted. I texted her [V11] at 6:02 PM that I was sexually assaulted. I think I got back here in the facility around 7:30 PM. I came back on my own. They allowed me upstairs and changed my clothes and washed my face. They let me eat. They gave me my medications which include Xanax, Briviat, and Olanzapine. The ambulance came within 45 minutes to an hour. No police came. I get to the hospital I don't remember anything that was said and done in the ER [Emergency Room]. I remember I had discharged in my pants. They did not report the sexual assault in the hospital. The rape kit was not done. Then the next morning [V16 (Registered Nurse Supervisor)] says okay we need to call the police. After the police report was done [V16] had to do a body assessment. I consented for the body check, but I felt humiliated. After that they told me to go back to the hospital. I said no. I told them that I want my outside social worker with me. Monday, I went back to [hospital]. They did the rape kit. The result of the rape kit is still pending. It will take a couple of months. Right now, I can't go out on pass anymore.On [DATE] at 11:38 AM, V11 (Assistant Director of Nursing) stated that on [DATE] at around 6:00 PM, R1 texted V11 informing her that R1 got sexually assaulted while out on pass. V11 stated R1 went out on pass with a family member. V11 stated that she informed V1 (Administrator) right after (no more than an hour) R1 told her about the sexual assault allegation. On [DATE] at 2:02 PM, V1 (Administrator) stated that she is the abuse coordinator and the facility's abuse policy is to report any abuse allegation to IDPH (Illinois Department of Public Health) no later than 2 hours. V1 stated that V11 reported to her that R1 had texted V11 that he was sexually assaulted in the community. V1 stated that V11 called her over the weekend on a Saturday ([DATE]), but V1 does not remember the exact time. V1 stated she did not do the initial reporting to IDPH within two hours and did it the next day because there were conflicting stories. V1 stated that R1 refused to tell V23 (Registered Nurse/Nursing Supervisor) anything when R1 came back in the facility. V1 stated R1 did not disclose the sexual assault to the hospital. V1 stated the next day ([DATE]), V16 questioned R1 specifically. R1 did tell V16 that he was sexually assaulted and that's when V1 did the initial report to IDPH. The facility's Abuse Report Initial Form for R1's sexual allegation shows date and time the report was sent to IDPH: [DATE] at 4:00 PM. Date and time the alleged incident occurred: [DATE] at 7:30 PM. Allegation details documents in part: [R1] stated that when he went out on independent pass yesterday with his cousin [V3] he was drugged and sexually assaulted in the community on the south side of Chicago on the street at a bus stop by 2 individuals unknown to him [R1]. A nursing assessment was done with no new injury noted, no swelling, bruising noted. [R1] complains of pain on bilateral upper extremities and dorsal aspect of the toes of both feet. The police were called, an officer came to interview [R1] and a police report was filed with report number JJ396568. [R1] is being sent to the ER [Emergency Room] for evaluation. A final report will be sent to the state within 5 working days The facility's Abuse and Neglect policy dated [DATE] documents in part:

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to follow their policies and procedures to ensure (a) the police were contacted to assist with finding a resident who was on supervised community pass and did not return as indicated on the sign out sheet, (b) a resident was reviewed for risk for elopement concerns upon admission, and (c) a person-centered care plan was initiated timely to address community pass privilege. These failures affected one (R1) out of three residents reviewed for community pass privileges.Findings Include:R1's clinical records revealed an admission date of 7/24/25 with included diagnoses but not limited to major depressive disorder, epilepsy, bipolar disorder, anxiety disorder, and dissociative and conversion disorder. R1's admission minimum data set (MDS) assessment dated [DATE] shows R1 is cognitively intact with BIMS (Brief interview for Mental Status) score of 15 and requires supervision with activities of daily living. R1's electronic health records (EHR) revealed no risk for elopement was completed upon admission. R1's physician order shows R1 may go out on pass with his family ordered on 8/26/25. R1's outside pass privilege care plan was initiated on 9/3/25.R1's RELEASE OF RESPONSIBILITY FOR LEAVE OF ABSENSE (OUT ON PASS) signed by V3 (R1's Cousin) on 8/29/25 at 4:30 PM reads in part: I, [V3], here to accept complete responsibility for [R1] while away from [The facility], and absolve the management of said nursing home, its personnel and the attending physician of responsibility for deterioration in condition, or accident that may happen while the patient is away. I understand that a bed will be reserved for the above - named patient when he/she returns on or before 8:00 PM.R1's progress notes dated 8/30/25 at 7:40 PM revealed R1 came back in the facility on 8/30/25 at 7:35 PM.On 9/7/25 at 9:42 AM, R1 stated he went out on pass on 8/29/25 at around 4:30 PM with V3. R1 stated V3 signed him out. R1 stated they went out for a family dinner. R1 stated after dinner, he got separated from V3 and that his phone ran out of battery. R1 got back at the facility on his own on 8/30/25 at 7:30 PM.On 9/7/25 at 11:38 AM, V11 (Assistant Director of Nursing) stated that R1 can go out on pass with escort. Family member or facility staff. They just have to sign [R1] out. V11 stated residents can go out on pass from 10:00 AM to 8:00 PM. V11 stated that if a resident does not return the facility by 8:00 PM, the nursing supervisor on duty informs administration and they contact whoever was listed as emergency or whoever sign them out. V11 stated that administration will make determination when to call 911 if resident does not return in the facility by a certain period. V11 stated that on 8/30/25, around 4:00 PM, [R1] called [V11] that his phone was about to die and that [R1] was on his way back to the facility.On 9/7/25 at 11:58 AM, V18 (Social Service Designee) stated that the risk for elopement assessment was not completed for R1 on admission. It was completed on 9/1/25.On 9/7/25 at 12:48 PM, a phone interview was conducted with V19 (Registered Nurse). V19 stated that on 8/29/25, R1 went out on pass and did not return. V19 stated he contacted R1 but did not pick up. V19 stated he called V15 (R1's Brother) but does not know R1's whereabouts. V19 stated he did not call the police, but he informed V20 (Evening Registered Nurse Supervisor).On 9/7/25 at 12:54 PM, a phone interview was conducted with V20 and stated that on 8/29/25, V20 called R1 after 11:00 PM but was not picking up the phone. V20 stated he left around midnight and R1 was still not back in the facility. V20 stated he is not sure what is the facility's policy when to call the police if resident does not come back within the curfew. V20 stated that he posted to the facility's communication platform to notify management that R1 was out on pass with family and has not returned in the facility.On 9/7/25 at 1:38 PM, a phone interview was conducted with V23 (Registered Nurse/Nursing Supervisor) and stated that she was the nursing supervisor on 8/30/25 from 7:00 AM until 11:00 PM. V23 stated, I was notified that [R1] did not return the facility. At 8:00 AM, I started calling his [R1] cell phone multiple times. [R1] did not answer. I also tried calling [V3] he was the one signed him [R1] out but it was not connecting. I called [V3] multiple times. I informed [V2 (Director of Nursing)] and [V11] that [R1] has not returned. I also contacted his [R1] other responsible party they said that [R1] did not contact them. V23 stated that R1 returned in the facility on 8/30/25 at around 7:30 PM.On 9/7/25 at 3:04 PM, a phone interview was conducted with V25 (Receptionist) and stated that she worked on 8/29/25 PM shift. V25 stated, [R1] told me that he was going to head out. [R1] was waiting in the lobby area. [R1's] cousin [V3] came with another friend. They left the building around 4:30 PM. [V3] signed [R1] out. [V3] put his information on the sign out sheet. All three of them left the facility together at around 4:30 PM. When [R1] did not return at 8:00 PM, I called [R1] three times, and I called [V3] three times. [V3's] number went straight to voicemail. [R1] did not answer.On 9/7/25 at 2:45 PM, V1 (Administrator) stated that the facility calls the