STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510368	A. BUILDING: _____ B. WING _____	C 09/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE OAKS ASSISTED LIVING	1055 SILVER LAKE RD CARY, IL 60013

(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) COMPLETE DATE
A 000	Initial Comment Original investigation of FRI IL 197102. VIOLATION - 295.4060 h) 3) A)	A 000		
A4060	Seciton 295.4060 Alzheimer's and Demential Programs This Regulation is not met as evidenced by: Tytpe 2 Violation Section 295.4060 Alzheimer's and Dementia Programs h) An establishment that offers to provide a special program for persons with Alzheimer's disease and related disorders shall: 3) Develop and implement policies and procedures that ensure the continued safety of all residents in the establishment including, but not limited to, those who: A) May wander; and These requirements were not met as evidenced by: Based on observation, record review and interviews, the establishment failed to prevent the elopement of one of one sampled memory care residents. (R1) This failure creates a substantial probability of harm to a resident or residents. Findings include: R1's progress notes note that R1 was admitted to the establishment memory care unit on 8/19/25	A4060		

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A4060	Continued From page 1 the same day the elopement occurred. Establishment incident report dated 8/19/25 reads, "On 8/19/25 at approximately 6:00 P.M., Executive Director (E1) observed resident (R1) outside of the facility walking without a walker. (E1) immediately escorted the resident back to the Memory Care unit and notified the nursing staff of the elopement. Nursing staff performed an assessment upon the resident's return. Vital signs were stable, and no new skin issues or injuries were noted. The resident (R1) stated she had been 'looking for someone'. The gate was found open when the resident (R1) was discovered. A full resident count was conducted to ensure the safety of all the other residents, and the gate was secured to prevent further risk of elopement. At the time of the incident, the resident had been in the secured Memory Care courtyard. Due to the design of the courtyard access system, either the interior doors or the exterior gates can be locked and alarmed - but not both simultaneously. A scheduled system switch occurs at 6:00 P.M. daily. At that time, the interior doors automatically lock and become alarmed, while the exterior gates become disalarmed. The resident (R1) was outside during this transition, and once the courtyard gate became unalarmed, she (R1) was able to open it and exit the secured area undetected. At 6:10 P.M., the residents Power of Attorney was contacted and informed of the incident. She was advised that the resident (R1) had been found outside the facility, was uninjured, and had stated she was looking for someone. (POA) acknowledged that the resident (R1) had previously eloped from another facility. All other her questions were addressed. In response to the incident, the facility will conduct elopement drills multiple times daily for the next three days and	A4060		

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A4060	Continued From page 2	A4060		

review elopement procedures with all staff to reinforce safety protocols."

On 9/28/25 at 11:00 A.M., E1 stated that on 8/19/25 just after 6:00 P.M., she happened to be driving by the facility when she noticed R1 walking on the public sidewalk next to the roadway. E1 said that she immediately parked her car and escorted R1 back onto the Memory Care unit. E1 stated that R1 had been out on the patio at 6:00 P.M. when the doors and gates locked and unlocked. E1 stated that staff are supposed to check patio every evening at that time to make sure no residents are out on the patio at that time to prevent elopements like this from occurring but staff failed to do the check that evening. E1 stated that it was lucky she happened to be driving by the facility at that time and see R1 on the sidewalk. E1 stated that they do not have a policy or procedure that provides direction on what is to happen as far as door and resident checks at 6:00 P.M. every night when this door situation occurs. E1 stated that they will now specifically assign a staff member every evening to do that check, document that the check was done and residents are safe. E1 stated that R1 is very confused and would not be able to answer any questions appropriately due to her level of Dementia.

On 9/28/25 at 10:40 A.M., this surveyor walked from the Memory Care unit patio gate to the public sidewalk where E1 found R1 the day of the elopement. The distance was approximately 450 feet. The sidewalk is next to a busy four lane road.