| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | ASL510149 | A. BUILDING: _____ B. WING _____ | C 10/08/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EVERGREEN SENIOR LIVING - CHILLICOTHE | 404 S STILLWATER DRIVE CHILLICOTHE, IL 61523 |

| (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<br><br>Original investigation of FRI IL 197837 and FRI IL 197936.<br><br>FRI IL 193837 - TYPE 1 - 295.6000 a) 13)<br><br>FRI IL 197936 - No violations cited. | A 000 | | |
| A6000 | Section 295.6000 Resident Rights<br><br>This Regulation is not met as evidenced by:<br>Section 295.6000 Resident Rights<br><br>a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of his or her status as a resident of an establishment, nor shall a resident forfeit any of the following rights:<br><br>13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor;<br><br>TYPE 1 VIOLATION<br><br>Based on record review and interviews, the establishment neglected to prevent one of three sampled residents from eloping from the establishment. (R1) This failure had a substantial probability of causing severe harm.<br><br>Findings include:<br><br>R1's Admission Record and Service Plan notes that R1 was admitted to the establishment Memory Care unit on 9/29/25. Records note that R1 has Diagnosis including Alzheimer's Disease, | A6000 | | |

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| A6000 | Continued From page 1<br>Hypertension, and Bilateral Hearing Loss.<br><br>On 10/7/25 at 11:25 A.M., E1 (Executive Director) stated that on 10/1/25 R1 eloped from the Memory Care unit without staff's knowledge sometime after 11:00 A.M.. E1 said that a staff member had last seen R1 on the Memory Care unit at approximately 11:00 A.M.. It was at approximately 11:20 A.M. when staff realized that R1 was missing. They then began a search of the establishment and the surrounding neighborhood. E3 (Activity Director) found R1 a couple blocks away walking in a local physician's office parking lot. E1 stated that R1 is very confused. E1 stated that when they informed Z1 (R1's wife and POA), she was very upset. E1 stated that they cannot say for sure how he was able to exit the locked Memory Care unit undetected. E1 stated that R1 was not injured as a result of the elopement.<br><br>R1's Progress Notes dated 10/21/25 at 11:21 A.M., read, "Was reported to this nurse by the Wellness Director that one of the Legacy residents (R1) was missing. Staff initiated the elopement protocol. Staff did room checks on the unit while other staff performed an exterior check. Resident (R1) was last seen at 11:00 sitting in the common area across from L-17. Resident (R1) was found in the (Local Physician's Office) parking lot by a staff member and was escorted back to the facility. Resident was fully dressed with a fall jacket on. Resident was offered a snack and water. Per protocol resident was sent out to (Hospital) ER for evaluation."<br><br>On 10/9/25 at 9:45 A.M., Z1 stated that facility staff had called her on the afternoon of 10/1/25 and informed her that R1 had gotten out of the locked Memory Care unit unbeknownst to staff. Z1 stated that they told her that R1 was found a | A6000 | | |

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| A6000 | Continued From page 2<br>couple blocks away walking in a physician's office parking lot. Z1 stated she admits she was very upset because R1 is very confused and does not have any safety awareness. Z1 stated she had admitted R1 there for his safety and hopefully this does not happen again to another resident. | A6000 | | |