STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510575	A. BUILDING: _____ B. WING _____	C 10/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRULEE EVANSTON	1815 RIDGE AVENUE EVANSTON, IL 60201

(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 Facility Reported Incident 9/27/25 - IL197877 - Substantiated 295.4010d)e)	A 000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Type 2 Violation Section 295.4010 Service Plan d) The service plan, which shall be reviewed annually, or more often as the resident's condition, preferences, or service needs change, shall serve as a basis for the service delivery contract between the provider and the resident (see Section 295.2030). (Section 15 of the Act) e) The service plan shall be reviewed and revised if necessary immediately after a significant change in the resident's physical, cognitive, or functional condition (see Section 295.4000). This requirement was not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure a residents service plan was followed and was updated after a significant event for 1 of 3 residents (R1) reviewed for service plans in the sample of 3. This failure has the substantial probability to cause harm to residents. The findings include:	A4010		

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A4010	Continued From page 1 On 10/2/25 at 11:15 AM, R1 was in bed in her room with a rolling walker at her bedside. R1 had a private caregiver in the room with her. R1 said she went outside herself and "got in trouble," by everyone but didn't remember much about the event. R1's Nurse's Note dated 7/20/25 shows "At approximately 3:00 AM, the nurse on duty was notified by the Certified Nursing Assistant that R1 was found wandering in the basement, appearing exhausted and confused. Upon assessment, R1 was observed wearing only a T-shirt, without pants or underwear, and without her wrist monitoring band. When asked by the nurse on duty what she was doing in the basement, R1 stated "I am looking for my friend's puppy". This behavior is not unusual for R1 and constant with her dementia diagnosis." R1's Nurse's Note dated 9/27/25 at 9:43 AM shows "At approximately 8:15 AM, R1 was noted to be missing form the community. Staff and the manager on duty immediately initiated a search of the premises and surrounding community; however the resident was unable to be located." R1's Nurse's Note dated 9/27/25 at 3:45 PM, R1 returned to the community at approximately 10:00 AM accompanied by staff. R1 was picked up from local police station. Upon return, R1 noted safe." R1's most recent Service Plan dated 5/9/25 and shows "Resident will remain safe while moving throughout the community. One staff will escort resident throughout the community." There were no updated to this Service Plan after R1's incident on 9/27/25.	A4010		

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A4010	Continued From page 2 R1's Service Plan prior to 5/9/25 was dated 10/2/24 and shows ""Resident will remain safe while moving throughout the community. One staff will escort resident throughout the community." There were no updates to this Service Plan after R1's incident on 7/20/25. On 10/20/25 at 10:10 AM, E2 Director of Nursing (Health Care Professional) said on 9/27/25, E7 saw R1 outside and stepped away from the front desk and when she returned, noticed R1 was not sitting there anymore. E2 said E7 called the nurse at that time and a search began. E2 said after R1 was unable to be found, 911 was called. E2 said the police called the facility a short time later and said R1 was at the police station. On 10/20/25 at 10:44 AM, E3 Licensed Practical Nurse said she was the nurse on duty on 9/27/25 and she was not aware that R1 was outside by herself. On 10/20/25 at 11:05 AM, E4 Caregiver said she was assigned to R1 on 9/27/25 and was not aware R1 was outside by herself. On 10/20/25 at 12:36 AM, E2 said R1 should have not been outside without an escort as per her Service Plan. E2 said Service Plans are updated after a significant event or change in condition and should have been updated after the incident on 7/20/25 and 9/27/25.	A4010		