STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510479	A. BUILDING: _____ B. WING _____	C 10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON AT LINCOLNWOOD	3501 NORTHEAST PARKWAY LINCOLNWOOD, IL 60712

(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 Investigation of Facility Reported Incident of 10/8/25/IL198048-substantiated. 295.4010 cited	A 000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Type 2 Violation This Regulation was not met as evidenced by: 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) This Requirement was not met as evidenced by: Based on observation, interview, and record review the establishment failed to follow a residents service who requires to be escorted by staff and failed to ensure his monitoring device was in place for resident at risk for elopement. This applies to 1 of 3 (R1) residents reviewed for elopement in the sample of 3. This failure creates a substantial probability of harm to a resident or residents. The findings include: R1's Final Incident Report dated 10/15/25 shows on 10/8/25 approximately between 3:30 PM to	A4010		

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A4010	Continued From page 1 4:00 PM, (R1) was found outside walking in the middle of the street ...R1 was escorted to the establishment by E7 (Transporter), R1 was found not wearing his wanderguard (montioring device) at the time of the incident ...the video footage shows (R1) exited through the entrance door at approximately 3:07 PM. The same incident report shows on 10/11/25 at 6:34 AM, (R1) was found sitting outside on a bench outside of the community near Assisted Living Entrance ...at 5:00 AM, during wellness rounds R1 was found sleeping in his apartment ...At 6:30 PM, (R1 's) door was propped open and was not in his room. The staff notified the supervisor at 6:30 AM, and R1 was located on the premises. R1's Service Plan shows he has moderate disorientation and difficulty recalling information. R1 requires escort to and from activities and the dining room and staff are to make sure he has his wanderguard to help ensure his safety. R1's service plan shows he is an elopement risk with interventions to ensure he wears his monitoring device and observe his location. On 10/22/25 at 10:05 AM, R1 was residing on the transitional unit for residents with cognitive impairments. R1's wanderguard was located in his vest. On 10/22/25 at 10:18 AM, E5 (Care Associate) said on 10/8/25, he was escorting R1 and another resident off the unit to attend happy hour. E5 said they got on the elevator and off the 1st floor. One of the residents became short of breath and he stopped at the wellness center with the other resident. R1 continued walking and he was out of his supervision. E5 said he let R1 walk without being escorted and assumed staff would stop R1. E5 said he did not report to any staff R1	A4010		

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A4010	Continued From page 2 continued to walk without being escorted. E5 said R1 has cognitive impairments and does not know what he is doing, he requires supervision and has history of wandering. E5 said he should have reported to the nurse right away R1 was walking without supervision. On 10/22/25 at 11:34 AM, E2 (Wellness Director) said R1 had a wanderguard placed months ago because he was at risk for wandering. R1 resides on the 3rd floor it ' s a transitional unit from assisted living to memory care. Residents have cognitive impairments and require supervision. On 10/8/25, E5 was escorting two residents to activites when one of the residents became short of breath. E5 let R1 walk without notifying staff he needed assistance for R1. She would expect her staff to call for help in this situation and not let the resident continue to walk without being escorted. R1 was found wandering outside in the street. On 10/11/25, R1 eloped for the 2nd time form the 3rd floor. R1 was not found in his room and was located within 5 minutes. The wandergaurd should alarm when residents attempt to get near the elevator. V2 said R1 did not have his wanderguard on when he eloped on 10/8/25 and 10/11/25. The facility's Elopement Policy dated 2024 states, " Elopement precautions will be carried out for residents who have demonstrated previous attempts or have a history of elopement ..."	A4010		