STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510228	A. BUILDING: _____ B. WING _____	C 11/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLNSHIRE PLACE - DECATUR	1215 W ARBOR DRIVE DECATUR, IL 62526

(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 198260. Type 1 Violations: Section 295.4060 h) 3) A)	A 000		
A4060	Seciton 295.4060 Alzheimer's and Demential Programs This Regulation is not met as evidenced by: 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 TYPE 1 VIOLATION Based on record review and interviews, the establishment failed to have an elopement prevention policy in place and implemented in order to prevent one of one sampled memory care residents (R1) from eloping from the establishment. This failure had the probability to cause significant harm. Findings include:	A4060		

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A4060	Continued From page 1 R1's face sheet and service plan notes that R1 was admitted to the establishment on 10/16/25 with diagnosis including Dementia, Depression, and Glaucoma. R1's service plan notes that R1 is not capable of independent and safe decision making. R1's progress notes on 10/24/25 read, "Writer entered pod between 0645 and 0700, (R1) was sitting in a chair next to the nurses station and med cart, (R1) was fully dressed and had a bag with her, writer said good morning to (R1) and (R1) was in a good mood and calm, (R1) then went to her room, at approximately 0730 the RA asked if (R1) was in dining room, writer looked and did not see her, RA went to (R1's) room and she was not there, her window was open about 2 inches and no screen noted in window, writer and RA then began searching the pod and each room for (R1), alerted staff on other pod (R1) was missing and conducted search and did head count to ensure other residents were accounted for, writer and other staff searched perimeter of the building, with staff driving around area to look in neighborhoods. Administrator and DON notified, resident's son / POA notified as he came into the building. 911 called and resident reported missing, police arrived, and were able to locate (R1), (R1) stated she fell outside, assessment completed no injuries noted, (R1) alert at baseline no complaints of pain, one on one sitting initiated, (R1) currently in activities with family and activity staff." On 11/2/25 at 11:15 A.M., E2 (Director of Nursing) stated that on the morning of 10/24/25 she received a call from staff letting her know that R1 was missing. E2 stated that she arrived, reviewed security footage noting R1 going in her	A4060		

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A4060	Continued From page 2	A4060		

room and never coming out. Police were notified and assisted in the search with a drone. The police found R1 in a field approximately a half mile from the establishment at approximately 8:50 A.M.. R1 told the police she had fallen a couple times outside but was not injured. E2 stated that R1 was placed on one to one observations and R1's window was made so it would not open far enough to crawl out.

Establishment incident report dated 10/24/25 reads, "Dear Compliance Officer, this letter serves as a formal incident report regarding the elopement of resident (R1) from Lincolnshire Place, which occurred on the morning of 10/24/25. At approximately 7:00 A.M., Certified Nurse's Assistant (CNA) discovered that (R1) was not in her room during morning rounds, the CNA had last seen (R1) walking within the pod around 6:45 AM. Upon discovering (R1's) absence, the facility staff immediately initiated a comprehensive search of the entire premises, both inside and outside. After the search proved unsuccessful, the Administrator, House Doctor, Family Power of Attorney (POA), and the Director of Nursing (DON) were notified at 7:29 AM. Upon our arrival at 7:45 AM, a review of security camera footage showed (R1) entering her room at approximately 6:50 AM but not exiting thereafter. Based on this information, it was concluded that (R1) likely exited the facility through her room window. The Decatur Police Department was contacted at 8:05 AM to report (R1) as a missing person, and officers arrived on-site at 8:33 AM to begin an external investigation. The Decatur Police Department conducted a thorough search of the neighborhood, surrounding fields, and wooded areas, utilizing a drone to aid in the search efforts. (R1) was located in a wooded area less

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A4060	Continued From page 3 than one mile from the facility. Paramedics were called to the scene to assess (R1) condition. (R1) was found to be in stable condition and when evaluated, stated she was very warm and sorry it's her birthday and she didn't want to be in the newspaper." On 11/2/25 at 11:40 A.M. E1 (Executive Director) stated that they did not complete an "Elopement Risk Assessment" on R1 when she was admitted. Elopement policy provided by E1 did not address precautions that would prevent residents from possible elopements. E1 stated that they are having all the windows made so they will not open far enough to allow a resident to crawl out of.	A4060		