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	5108250	A. BUILDING: _____ B. WING _____	C 01/06/2026

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AMERICAN HOUSE OAK PARK	703 MADISON STREET OAK PARK, IL 60302

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A 000	Initial Comment Complaint investigation 25912789/IL199308 295.2050 a)b) Facility Reported Incident of 12/26/25 IL199347 295.6000 a) 13) 295.2050 a)b)	A 000		
A2050	Section 295.2050 Incident and Accident Reporting This Regulation is not met as evidenced by: Type 3 Violation Section 295.2050 Incident and Accident Reporting a) An establishment shall report to the Department any serious incident or accident. For the purposes of this Section, "serious" means any incident or accident that causes physical or emotional harm or injury to a resident. A change in an individual's (resident's) condition that is due to health or medical decline is not a reportable incident or accident. b) The report shall be made by contacting the Department of Public Health Division of Assisted Living via email at DPH.LTCAL@illinois.gov or as requested by the Department within 24 hours after the occurrence of the incident or accident. These Requirements are not met as evidenced by: Based on interview and record review, the facility failed to forward 2 reportable incidents involving an allegation of abuse (R1) and an incident	A2050		

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involving an elopement to the Illinois Department of Public Health for one resident (R2) within 24 hours as required out of 3 reviewed for compliance with reporting requirements in a total sample of 3.

Findings include:

1. Facility investigation report summary documents an allegation on 12/29/25 at 1:30 pm "that CNA (Certified Nursing Assistant) (E9) hit (R1) on the head in the sensory room after (R1) refused toileting assistance. No witnesses were present ..."

Copy of email from E2(Director of Health) documents the 1st and final report to the Illinois Department of Public Health as on "Tuesday 12/30/25 at 6:46 pm."

Based on review, the facility sent the initial and final report for R1's allegation of abuse more than 29 hours after the facility became aware of the allegation.

2. R2 resides in Assisted Living has diagnoses not limited to but including Dementia, Cardiomyopathy, and chronic kidney disease stage 3. Date of admission to assisted living in profile is documented as 10/31/25 however, 1st nursing note describing admission date is 12/2/25. This note reads "85 year old while male arrived to community via personal vehicle ...alert and oriented x 3 - 4 ...able to ambulate with study gait ..."

Based on review of clinical nursing notes starting on 12/5/25 - 12/21/25 R2's orientation is markedly confused with documentation consistently showing R2 having confusion requiring staff

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assistance.

Despite the confused behavior with aimless wandering and notification to administration, R2 is allowed to leave the facility unaccompanied on 12/26/25. R2 is found in an alley by a bystander who then visits the facility in the late evening to report R2's whereabouts. Based on weather map the outside temperature on 12/26/25 at 6:00 pm was between 43 and 39 degrees.

E2 (Director of Nursing) was asked 2 times for R2's elopement incident report sent to the Illinois Department of Public Health. In response to this request, E2 forwarded Quality Assurance documents outlining results of the investigation into events of 12/26/25.

The incident created by E2(Director of Health) that was required to be sent to the Illinois Department of Public Health was not forwarded to the surveyor as requested. A copy of what was sent to the Illinois Department of Public Health was forwarded by Z6 (Division Chief of Assisted Living).

The forwarded document sent by Z6 has an official date sent by facility of 12/30/25 at 10:18 pm or 4 days after the elopement occurred which is outside the required timeframe for reporting of an incident for a cognitively impaired resident who is allowed to leave the facility unaccompanied and subsequently is found on the ground in an alley 2 blocks away from the facility

On 1/6/25 at 4:15 pm, E2(Director of Health) stated, "I didn't know the timeframe for reporting. I started in June of 2025 as Director of Health.

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A6000	Section 295.6000 Resident Rights	A6000		

This Regulation is not met as evidenced by:
Type 1 Violation

Section 295.6000 Resident Rights

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:

13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor;

These Requirements are not met as evidenced by:

Based on observation, interview and clinical record review, facility failed to:

1) Provide adequate supervision for resident (R1) given cognitive impairment and wandering behavior;
2) Create and Implement service plans which address supervisory needs for resident (R1) with both cognitive impairment and wandering behaviors and prevent elopements;
3) Create and implement a facility system which includes the participation of the front desk concierge to address residents who have cognitive impairment coupled with wandering behavior to address elopement risk (R2, R4, R5, and R6); and

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A6000	Continued From page 4 4) At a management level in a timely manner respond to and address communication from staff of significant changes involving resident(R1) confusion and wandering behaviors. This deficient practice placed R2 at risk of severe harm and affected 1 resident (R2) out of 3 reviewed for elopement in a total sample of 6. Findings include: Based on observation, clinical record review and interviews, R2 resides in Assisted Living and has diagnoses not limited to but including Dementia, Cardiomyopathy, and chronic kidney disease stage 3. Date of admission to assisted living in profile is documented as 10/31/25 however, 1st nursing note describing admission date is 12/2/25. This note reads "85 year old white male arrived to community via personal vehicle ...alert and oriented x 3 - 4 ...able to ambulate with study gait ..." Based on review of clinical nursing notes starting on 12/5/25 R2's orientation is markedly confused with additional documentation consistently showing R2 having confusion requiring staff assistance due to confusion and wandering. Nursing note on 12/5/25 at 2:00 pm describes R2 as "alert and oriented x 1 - 2 ..." and by 12/14/25 at 6:56 pm nursing is writing, "(R2) requiring frequent assistance with short term memory needs such as (R2) apartment location, use of tv remote and mealtime and location of dining room ..." On 12/18/25 at 7:21 pm R2 required redirection and assistance with location, time and situation throughout the shift and was observed walking	A6000		

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barefoot and disoriented on the 1st floor. Both the Director of Nursing (E2) and "assisted living director" are notified of R2's confused and wandering behavior

On 12/21/25 at 4:10 pm another resident complains to the nurse, R2 has gone into other resident's room 3 times today and required redirection while wandering down the hall pulling at apartment door handles. R2 requires "continuous monitoring" according to this nursing note.

On 12/26/25, R2 who has significant cognitive impairment and wandering behavior walked out the front door sometime between 7:30 pm and 8:00 pm. Front desk concierge witnessed R2 leave through the front door. Facility staff in charge of R2 were not aware R2 had left the building. A bystander found R2 in an alley behind a local business 2 blocks away. R2 was found on the ground with skin tears.

Despite the confused behavior with aimless wandering and notification to nursing administration, R2 is allowed to leave the facility unaccompanied on 12/26/25. R2 is found in an alley by a bystander who then visits the facility in the late evening to report R2's whereabouts.

Based on weather map the outside temperature on 12/26/25 at 6:00 pm was between 43 and 39 degrees.

Despite staff advising Administration of R2's confusion and wandering, interventions to protect R2 and address supervisory needs were not implemented placing R2 in danger.

Facility front desk identified as E3 (concierge) by

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E5(concierge) allowed R2 to leave the building. E3 could not be reached for interview however, on 12/31/25 at 3:00 pm E5 stated she would not have let R2 leave the building and identified other residents who also should not be allowed to leave the building based on her encounters with them. E5 was asked what system was in place to identify residents who should not leave the building unaccompanied and stated in part, "no list for elopement. Just know who can't go out ..."

At 3:00 pm additional concierge arrived and self-identified as E4(pm concierge). E4 reported there was a binder with the pictures of residents who are elopement risk. A white binder was pulled from inside administration offices and was shown to E5 who stated those are pictures of all the residents and not of elopement risk. Based on interview and review of presented documentation, facility does not have a system in place to identify elopement risks or those residents who should not exit the building unaccompanied.

Timeline of investigation and documents reviewed follows:

On 12/31/25 in the late morning this facility reported incident was assigned for review. Requested incident report with investigation for facility reported incident of 12/26/25 from E2(Director of Health). A second request for the incident report was made on 1/6/25 at approximately 2:00 pm of E2(Director of Health). E2 did not forward the requested incident report which was sent to the Illinois Department of Public Health. E2 forwarded the following documents in response to request:

1. A copy of an email document labeled as "Fwd:

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Incident Report (12/26/25) and dated Tuesday 12/30/25 at 6:32 pm from E3(facility front desk receptionist) to E2(Director of Health) and then forwarded to unidentifiable email address associated with facility.

The email message reads:

"On December 26th at approximately 7:30 pm, (R2) left out of the building - exiting on (Location) Avenue.
Shortly after around 9:00 pm, a pedestrian from the street came in asking if we have a resident by the name of (R2). I confirmed the colored flannel that I (E3) seen (R2) in and upon confirming, the pedestrian informed me that the resident was found near (business) on (streets) in the back alleyway sitting on the ground.
Assisted Living nurses were notified immediately."

2. Document titled, "Investigation Statement" with date of incident as 12/26/25 with time of incident between "7:30 - 9:30 pm." E2's (Director of Health) signature with date of 12/30/25 is at the bottom of the page.
Reader is referred to "please see attachment" for " ...facts regarding the incident."

3. Third document dated 12/26/25 is titled, "Quality Assessment Performance Improvement Program Post Elopement Huddle Form." R2's living venue is documented as Assisted Living. This document includes some of the following information:

Elopement risk 7;
No history of elopement;
Last rounded by the CNA at 6:40 pm by the 3rd floor hallway;

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Location of elopement - 2 corners away from facility at the alley behind business;
When was it determined the resident was missing? Not determined
How did the employee become aware the resident was missing? Bystander
When was the resident last seen? Left the facility between 7:30 - 8:00 pm
Not in a secure unit (AL)
Who located the resident? Bystanders
What time was the resident located? 9:00 pm
Was the resident injured? How? Yes, acquired 3 small skin tears to right wrist; undetermined.
Could the resident state where they were going? Resident could not remember or provide details about the events leading to the elopement.
Are there any cameras recording exits? Where they reviewed? Yes

The incident created by E2(Director of Health) was not forwarded by E2(Director of Health) to the surveyor as requested. A copy of what was sent to the Illinois Department of Public Health was sent by Z6 (Division Chief of Assisted Living) for review.

According to 11/22/25 Service plan, R2 has "moderate impairment of both Short and Long Term Memory with staff needed to provide direction and reminding when (R2) appears frustrated, lost, or anxious. Staff to report to nurse if resident is observed to have a change in long-term memory abilities and short-term memory. Under short term memory this service plan describes R2 as needing staff to provide direction and reminding to support resident safety.

The reportable incident dated 12/20/25 at 10:18 pm forwarded to the Illinois Department of Public

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A6000	Continued From page 9 Health document includes statements not limited to: The concierge observed the resident leave the facility. A bystander reported the resident "sitting on the ground near (local pharmacy) approximately 2 blocks away from the community." Nursing staff responded and returned (R2) to the facility at approximately 9:30 pm. 3 small skin tears were noted to the right wrist. A "change in condition assessment" following the incident is completed with R2 assessment findings showing "increased risk related to cognitive impairment and wandering behavior. It was determined that the resident requires increased supervision beyond Assisted Living capabilities to ensure safety." Facility implemented a 24-hour private caregiver 7 days a week for R2. On 1/6/26 at 10:55 am, a private caregiver was present in R2's room. R2 could not answer any questions responding, "I don't know." Additional forwarded material by E2 (Director of Health) included an untitled and undated In-service record with staff signatures along with a 27-page copy of an in-service titled, "Missing Resident Elopement Procedures." The in-service record does not include any signatures from the concierge (E3, E4, E5, E10, E11, E12, E13, E14) and does not address how the facility will prevent an elopement from occurring in the future when both cognitive impairment and wandering behaviors are present and given that the facility accepts Dementia diagnosed residents into Assisted Living. On 12/31/25 at 4:00 pm E2(Director of Health)	A6000		

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was asked when R2 was admitted to the facility, what R2's cognition/mental status assessment showed and whether R2 should have been allowed to exit the building unsupervised. E2(Director of Health) responded, "(R2) wasn't here yet ...did virtual assessment on 11/10/25, me (E2) and (E1) Executive Director but (R2) was not admitted yet. Not sure why didn't move in. Completed 11/22/25 assessment should be within 2 weeks (of admission). Still at home. Has not wandered or attempted to leave home. Mental status, orientation not determined or disoriented at (that) time. Didn't do (mental status assessment) on 11/22/25. Not required in assisted living to do (mental status assessment). (R2) should not go out by self. Moderate short term and moderate long term mean danger if goes out by self. Yes, because new environment ...Assessment before admitted shows moderate short term and moderate long term. Shouldn't go out and get lost. Could get hit by car. Temperature, got out between 7:30 pm - 9:30 pm, Dec 26. Last seen at 7:30 pm. Came here at 9:00 pm bystander. (What was temperature outside on December 26th in the evening?) (Was 39 degrees on Dec 26) (E3) at front desk saw (R2) leave. After happened called POA (power of attorney) ...I didn't do a (mental status assessment) ..."

E2 was asked to identify confused and wandering residents in the facility living in assisted living and place a "w" next to their name on the roster. E2 identified R2, R4, R5 and R6 as confused and wandering. Given the facility's current practices and E2's statements R4, R5 and R6 are at risk for an elopement.