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DISCOVERY COMMONS ORLAND PARK	7420 W 159TH STREET ORLAND PARK, IL 60462

(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 Annual Licensure Survey Violations cited: 295.4010 a) b) 1) c) d) e) g) 1) C) Complaint Investigation IL199858 Violations cited: 295.2000 a) c)1) 3) 295.4010 a) b) 1) c) d) e) g) 1) C) 295.6000 a) 1) 13)	A 000		
A2000	Section 295.2000 Residency Requirements This Regulation is not met as evidenced by: GENERAL VIOLATION Section 295.2000 Residency Requirements a) No individual shall be accepted for residency or remain in residence if the establishment cannot provide or secure appropriate services, if the individual requires a level of service or type of service for which the establishment is not licensed or which the establishment does not provide, or if the establishment does not have the staff appropriate in numbers and with appropriate skill to provide such services. (Section 75(a) of the Act) c) A person shall not be accepted for residency if: 1) The person poses a serious threat to themselves or to others; 2) The person is not able to communicate	A2000		

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A2000	Continued From page 1 their needs in any manner and no resident representative residing in the establishment, and with a prior relationship to the person, has been appointed to direct the provision of services; 3) The person requires total assistance with 2 or more activities of daily living; 4) The person requires the assistance of more than one paid caregiver at any given time with an activity of daily living; These requirements were not met as evidenced by: Based on observation, record review and interview the establishment failed to assess a change in mental condition for 1 of 2 residents (R1) identified as having wandering behavior and a elopement risk. This failure resulted in R1 wandering out of the front door of the establishment without her walker one frigid morning, fell and was found lying on the ground by administrative staff. R1 expired hours later at a local hospital. These failures have a probability to affect all residents in the establishment. Findings include: R1 was a 86 year old resident who moved into the establishment on 10/29/22. R1 had diagnoses including depression, anxiety disorder, Type 2 diabetes mellitus, COPD, (chronic obstructive pulmonary disease) and acute myocardial infarction, R1 was also assessed as a fall risk.	A2000		

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A2000	Continued From page 2	A2000		

The progress note dated 1/25/26 shows at 9:45pm: R1 was confused, wandering around 1st floor this evening stating she was going to her house on the corner outside the facility. R1 redirected by nurse (E5), R1 went back to her apartment accompanied by staff.

The progress note dated 1/26/26 at 6:15am E3 (LPN) wrote: while making rounds, noted R1 was not in her apartment. Informed E2 (director of wellness) and proceeded to search for R1. While initial search, was informed by E1 (executive director) that R1 was outside in side lying position. E1 and E2 stayed with R1 and blankets placed on R1 for warmth. 911 called. R1 taken to ED (emergency department).

The Incident & Accident report dated 1/26/26 at 6:28am, shows as E1 (executive director) arrived at the community, Upon walking towards the assisted living entry way, E1 observed R1 lying on the sidewalk. R1 was fully clothed with shoes however her rolling walker was not with her. R1 was alert and responsive via squeezing of her hand. E1 immediately called 911 and remained with R1. E1 alerted for additional staff assistance and responded with blankets while awaiting EMS (emergency medical service). 911 transported R1 to the ER (emergency room).

The Weather Channel website shows that the outside overnight weather temperature from 1/25/26 to 1/26/26 was 21 degrees Farenheit with a wind chill (real feel) of 9 degrees Farenheit.

On 1/26/26 at approximately 9:36am, the local hospital called the community to advise that R1 had expired.

On 1/28/26 at 2:30pm E1 stated: "I parked on the

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A2000	Continued From page 3	A2000		

southwest corner of the parking lot. She was lying right outside of this window. It was still dark outside. I walked up to her, based on the time on my phone was 6:28am. I called 911. The dog walked in front of me. He stopped right by her. I realized it was a person. I took my coat off to cover her. R1 was alert but mumbling. I called E2 (health and wellness director) and staff came with blankets. The paramedics came to take R1 to the hospital. R1 was a AL (assisted living) resident. From what we surmise, R1 may have exited thru the front door because R1 wasn't that far from the front door. R1 ambulated with a walker but didn't have her walker with her. R1 didn't have exit seeking behavior. Nothing like that. No, there aren't any cameras at the front door. The front door is locked from 8pm to 8am. The door isn't secure from the inside but once outside you can't get back in without a fob or someone letting you in."

On 1/29/26 at 12:45pm (E2) stated, I had just arrived but I usually come through the kitchen. I received a call from E1 who said R1 was outside on the ground. I put my stuff down, grabbed some blankets and went out the front door. R1 was lying on the ground. We covered R1with our coats and the blankets. I was calling her name, R1 only responded with a moan. The paramedics came and took R1 to the hospital. This incident was a surprise. R1 lived on the first floor. R1 didn't try to elope before.

On 2/3/26 at 1:45pm via telephone, E3 (LPN) stated, "I actually was passing meds. I checked in R1's room and thought it odd that R1 wasn't in there but R1's walker was still in the room. I called E2 (health & wellness director) and told her what happened. We did a head count and started searching for R1. E2 is the one who told me the

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A2000	Continued From page 4	A2000		

R1 was outside on the ground. E2 is the one who covered R1 with blankets. E1 and E2 stayed with R1 until the first responders arrived. R1 wasn't talking but was mumbling. I've taken care of this resident for the last 2 years on all 3 shifts. R1 wasn't an elopement risk, at least not for me."

On 2/4/26 at 11:33am via telephone E4 (LPN) stated, "I work on 3rd floor. I took care of R1 a lot. R1 had a history of not wanting to take a shower. Sometimes I could get her to take one and sometimes not. R1 was starting to become confused more often, Staff would escort R1 to and from dinner. R1 would wander on the floor. Sometimes R1 would go to the 2nd floor and think it was the 3rd floor. We could easily redirect R1 to her room. I wasn't there the day the incident happened."

The local hospital ED (emergency department) notes show in part the following:

Arrival Date/Time: 01/26/2026 at 0700 (7:00am)

Chief Complaint: Cardiac Arrest, CPR (cardiopulmonary resuscitation) IN PROGRESS FROM EMS

Visit Diagnosis: Cardiopulmonary arrest

Discharge Date/time: 01/26/2026, 11:10am

HPI (History of Present Illness)
Patient is a 86-year-old female with a history of COPD, myocardial infarction was found outside, unknown amount of time, unknown downtime at her facility, unresponsive, was brought in with cardiopulmonary arrest. EMS (emergency medical service) and CPR in progress, they did not have any line, they did not notice any trauma,

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A2000	Continued From page 5	A2000		

they said it was PEA (Pulseless Electrical Activity) in route on the monitor. EMS (emergency medical service) states they found the patient pulseless and apneic, they could not intubate due to the patient's jaw being stiff, when patient arrived, CPR was in progress, patient's rhythm showed asystole with artifact or possible fine vfib (ventricular fibrillation) there was no pulse, she had no spontaneous respirations, pupils were nonreactive upon a Physical Exam.

Constitutional:
Comments: Patient had no spontaneous respirations no response to deep pain, pale, cold. After intubation the patient started to have bleeding from the mouth, reevaluated with the Gllde Scope ET (endotracheal) was in proper position. Could not see any active bleeding in the mouth, may have been esophageal origin

Head: Normocephalic.
Comments: Some bruising to the right forehead arrival attempted intubation with glide scope unsuccessful the first 2 attempts, was successful in the third attempt on the patient's head and neck were very stiff. In between attempts patient was bagged with 100% oxygen.

Comments:
Pupils are nonreactive
Cardiovascular: There are no heart tones, no pulse
Pulmonary: No spontaneous respirations

Unable to obtain temperature reading on the rectal probe during resuscitation at the bedside

ED Notes, 1/26/26 at 7:00am:
Patient arrives to ED (emergency department) via EMS, CPR in progress, BVM (Bag-Valve-Mask),

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A2000	Continued From page 6 warm fluids infusing 20g PIV (peripheral intravenous). Per EMS, patient lives in a assisted living facility, was found outside unresponsive, unknown mechanism, unknown down time. Patient very cold to touch, unable to attempt a core temp, reading low. BG (blood glucose) reading 319 per EMS. No obvious trauma noted to patient. Pt transferred immediately to ED stretcher, ED MD (medical doctor) at bedside for immediate assessment, CPR continued, preparing patient for emergency intubation. On 1/29/26 at 1:45pm, E1 presented the Elopement policy and procedure which shows in part: Policy: Elopement precautions will be carried out for residents who have demonstrated previous attempts to elope or have a history of elopement.	A2000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: GENERAL VIOLATION Section 295.4010 Service Plan a) b) 1) c) d) e) g) 1) C) a) Based on the physician's assessment and establishment evaluation (see Section 295.4000), a written service plan shall be developed and mutually agreed upon by the establishment and the resident. (Section 15 of the	A4010		

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A4010	Continued From page 7 Act) The establishment shall respect and accept the resident's choices regarding the service plan. b) The service plan shall be developed by: 1) The resident, resident's representative or any individual requested by the resident; c) The service plan shall be signed and dated by all individuals involved in its development. 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). g) Service plans shall address: 1) The level of service the resident is receiving, including: C) special accommodations for the resident. These requirements were not met as evidenced by: Based on record review and interview, the establishment failed to: 1) ensure the service plan for 2 out of 5 residents	A4010		

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A4010	Continued From page 8 (R2, R3) were signed and dated by all individuals involved in its development; 2) immediately revise the service plan to include interventions to address a significant change in one of five residents (R1) cognitive conditon and wandering behavior. This failure resulted in R1 eloping from the establishment during the night shift, was found lying outside on the ground. R1was not appropriately dressed for the frigid outside temperatures. These failures have the probability to affect all residents who reside in the facility. Findings include: 1. R1 was a 86 year old resident who moved into the establishment on 10/29/22. R1 had diagnoses including depression, anxiety disorder, Type 2 diabetes mellitus, COPD, (chronic obstructive pulmonary disease) and acute myocardial infarction, R1 was also assessed as a fall risk. The progress note dated 1/25/26 shows at 9:45pm: R1 was confused, wandering around 1st floor this evening stating she was going to her house on the corner outside the facility. R1 redirected by nurse (E5), R1 went back to her apartment accompanied by staff. The progress note dated 1/26/26 at 6:15am E3 (LPN) wrote while making rounds, noted R1 was not in her apartment. Informed E2 (director of wellness) and proceeded to search for R1. While initial search, was informed by E1 (executive director) that R1 was outside in side lying	A4010		

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A4010	Continued From page 9	A4010		

position. E1 and E2 stayed with R1 and blankets placed on R1 for warmth. 911 called. R1 taken to ED (emergency department).

The Incident & Accident report dated 1/26/26 at 6:28am, shows as E1 (executive director) arrived at the community, Upon walking towards the assisted living entry way, E1 observed R1 lying on the sidewalk. R1 was fully clothed with shoes however her rolling walker was not with her. R1 was alert and responsive via squeezing of her hand. E1 immediately called 911 and remained with R1. E1 alerted for additional staff assistance and responded with blankets while awaiting EMS (emergency medical service). 911 transported R1 to the ER (emergency room).

The service plan dated 11/16/25 shows R1 has occasional confusion & difficulty recalling details. Needs occasional prompting or orientation. Under chronic illness & disorders: Confusion, Psychological & Anxiety disorder, Depression

On 1/28/26 at 2:30pm E1 stated: "I parked on the southwest corner of the parking lot. She was lying right outside of this window. It was still dark outside. I walked up to her, based on the time on my phone was 6:28am. I called 911. The dog walked in front of me. He stopped right by her. I realized it was a person. I took my coat off to cover her. R1 was alert but mumbling. I called E2 (health and wellness director) and staff came with blankets. The paramedics came to take R1 to the hospital. R1 was a AL (assisted living) resident. From what we surmise, R1 may have exited thru the front door because R1 wasn't that far from the front door. R1 ambulated with a walker but didn't have her walker with her. R1 didn't have exit seeking behavior. Nothing like that. No, there aren't any cameras at the front door. The front

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A4010	Continued From page 10 door is locked from 8pm to 8am. The door isn't secure from the inside but once outside you can't get back in without a fob or someone letting you in." On 2/4/26 at 11:33am via telephone E4 (LPN) stated, "I work on 3rd floor. I took care of R1 a lot. R1 was starting to become confused more often, Staff would escort R1 to and from dinner. R1 would wander on the floor. Sometimes R1 would go to the 2nd floor and think it was the 3rd floor. We could easily redirect R1 to her room. I wasn't there the day the incident happened." 2. During the annual survey the service plans for R1 through R5 were reviewed. The service plan for R2 and R3 did not include the signature and dates of all individuals involved in its development. The service plan for R3 was not signed and dated. R4's service plan only had E2's (health and wellness director) signature and date.	A4010		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: GENERAL VIOLATION Section 295.6000 Resident Rights Level 3 Violation 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:	A6000		

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A6000	Continued From page 11 1) The right to live in an environment that promotes and supports each resident's dignity, individuality, independence, self-determination, privacy, and choice and to be treated with consideration and respect; 13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor. These requirements were not met as evidenced by: Based on observation, record review and interview the establishment failed to ensure that a resident was free from abuse. This failure involves 1 of 2 residents (R1) identified as having wandering behavior and at risk for elopement . This failure resulted in R1 being neglected, resulting in R1 wandering out of the front door of the establishment without her walker one frigid morning, fell and was found lying on the ground by administrative staff. R1 expired hours later at a local hospital. These failures have a probability to affect all residents who reside in the establishment. Findings include: R1 was a 86 year old resident who moved into the establishment on 10/29/22. R1 had diagnoses including depression, anxiety disorder, Type 2 diabetes mellitus, COPD, (chronic obstructive	A6000		

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A6000	Continued From page 12	A6000		

pulmonary disease) and acute myocardial infarction, R1 was also assessed as a fall risk.

The progress note dated 1/25/26 shows at 9:45pm: R1 was confused, wandering around 1st floor this evening stating she was going to her house on the corner outside the facility. R1 redirected by nurse (E5) R1 went back to her apartment accompanied by staff.

The progress note dated 1/26/26 at 6:15am E3 (LPN) wrote: while making rounds, noted R1 was not in her apartment. Informed E2 (director of wellness) and proceeded to search for R1. While initial search, was informed by E1 (executive director) that R1 was outside in side lying position. E1 and E2 stayed with R1 and blankets placed on R1 for warmth. 911 called. R1 taken to ED (emergency department).

There was no progress note for the night shift (1/25/26 through 1/26/26) to indicate R1 was checked on during the shift prior to discovering R1 was not in her room.

The Incident & Accident report dated 1/26/26 at 6:28am, shows as E1 (executive director) arrived at the community, Upon walking towards the assisted living entry way, E1 observed R1 laying on the sidewalk. R1 was fully clothed with shoes however her rolling walker was not with her. R1 was alert and responsive via squeezing of her hand. E1 immediately called 911 and remained with R1. E1 alerted for additional staff assistance and responded with blankets while awaiting EMS (emergency medical service). 911 transported R1 to the ER (emergency room).

The Weather Channel website shows that the outside overnight weather temperature from

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A6000	Continued From page 13 1/25/26 to 1/26/26 was 21 degrees Farenheit with a wind chill (real feel) of 9 degrees Farenheit. On 1/26/26 at approximately 9:36am, the local hospital called the community to advise that R1 had expired. On 1/28/26 at 2:30pm E1 stated: "I parked on the southwest corner of the parking lot. She was laying right outside of this window. It was still dark outside. I walked up to her, based on the time on my phone was 6:28am. I called 911. The dog walked in front of me. He stopped right by her. I realized it was a person. I took my coat off to cover her. R1 was alert but mumbling. I called E2 (health and wellness director) and staff came with blankets. The paramedics came to take R1 to the hospital. R1 was a AL (assisted living) resident. From what we surmise, R1 may have exited thru the front door because R1 wasn't that far from the front door. R1 ambulated with a walker but didn't have her walker with her. R1 didn't have exit seeking behavior. Nothing like that. No, there aren't any cameras at the front door. The front door is locked from 8pm to 8am. The door isn't secure from the inside but once outside you can't get back in without a fob or someone letting you in." On 1/29/26 at 12:45pm (E2) stated, I had just arrived but I usually come through the kitchen. I received a call from E1 who said R1 was outside on the ground. I put my stuff down, grabbed some blankets and went out the front door. R1 was lying on the ground. We covered R1with our coats and the blankets. I was calling her name, R1 only responded with a moan. The paramedics came and took R1 to the hospital. This incident was a surprise. R1 lived on the first floor. R1 didn't try to elope before.	A6000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510473	A. BUILDING: _____ B. WING _____	02/20/2026

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A6000	Continued From page 14 On 2/3/26 at 1:45pm via telephone, E3 (LPN) stated, "I actually was passing meds. I checked in R1's room and thought it odd that R1 wasn't in there but R1's walker was still in the room. I called E2 (health & wellness director) and told her what happened. We did a head count and started searching for R1. E2 is the one who told me the R1 was outside on the ground. E2 is the one who covered R1 with blankets. E1 and E2 stayed with R1 until the first responders arrived. R1 wasn't talking but was mumbling. I've taken care of this resident for the last 2 years on all 3 shifts. R1 wasn't an elopement risk, at least not for me." On 2/4/26 at 11:33am via telephone E4 (LPN) stated, "I work on 3rd floor. I took care of R1 a lot. R1 had a history of not wanting to take a shower. Sometimes I could get her to take one and sometimes not. R1 was starting to become confused more often, Staff would escort R1 to and from dinner. R1 would wander on the floor. Sometimes R1 would go to the 2nd floor and think it was the 3rd floor. We could easily redirect R1 to her room. I wasn't there the day the incident happened." The local hospital ED (emergency department) notes show in part the following: Arrival Date/Time: 01/26/2026 at 0700 Chief Complaint: Cardiac Arrest, CPR (cardiopulmonary resuscitation) IN PROGRESS FROM EMS Visit Diagnosis: Cardiopulmonary arrest Discharge Date/time: 01/26/2026, 11:10am	A6000		

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A6000	Continued From page 15 HPI (History of Present Illness) Patient is a 86-year-old female with a history of COPD, myocardial infarction was found outside, unknown amount of time, unknown downtime at her facility, unresponsive, was brought in with cardiopulmonary arrest. EMS (emergency medical service) and CPR in progress, they did not have any line, they did not notice any trauma, they said it was PEA (Pulseless Electrical Activity) in route on the monitor. EMS (emergency medical service) states they found the patient pulseless and apneic, they could not intubate due to the patient's jaw being stiff, when patient arrived, CPR was in progress, patient's rhythm showed asystole with artifact or possible fine vfib (ventricular fibrillation) there was no pulse, she had no spontaneous respirations, pupils were nonreactive upon a Physical Exam. Constitutional: Comments: Patient had no spontaneous respirations no response to deep pain, pale, cold. After intubation the patient started to have bleeding from the mouth, reevaluated with the Gllde Scope ET (endotracheal) was in proper position. Could not see any active bleeding in the mouth, may have been esophageal origin Head: Normocephalic. Comments: Some bruising to the right forehead, attempted intubation with glide scope unsuccessful the first 2 attempts, was successful in the third attempt, the patient's head and neck were very stiff. In between attempts patient was bagged with 100% oxygen. Comments: Pupils are nonreactive Cardiovascular: There are no heart tones, no pulse	A6000		

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A6000	Continued From page 16 Pulmonary: No spontaneous respirations Unable to obtain temperature reading on the rectal probe during resuscitation at the bedside ED Notes, 1/26/26 at 7:00am: Patient arrives to ED (emergency department) via EMS, CPR in progress, BVM (Bag-Valve-Mask), warm fluids infusing 20g PIV (peripheral intravenous). Per EMS, patient lives in a assisted living facility, was found outside unresponsive, unknown mechanism, unknown down time. Patient very cold to touch, unable to attempt a core temp, reading low. BG (blood glucose) reading 319 per EMS. No obvious trauma noted to patient. Pt transferred immediately to ED stretcher, ED MD (medical doctor) at bedside for immediate assessment, CPR continued, preparing patient for emergency intubation	A6000		