STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510538	A. BUILDING: _____ B. WING _____	C 05/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALOS HEIGHTS SENIOR LIVING	7100 WEST COLLEGE DRIVE PALOS HEIGHTS, IL 60463

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A 000	Initial Comment Entity Reported Incident Investigation IL00191810- Substantiated, 295.2050, 295.4060 cited.	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. c) A copy of the report shall be maintained by the establishment for one year after the date of the incident or accident. (Source: Amended at 47 Ill. Reg. 13264, effective August 30, 2023) These requirements are not met as evidenced by:	A2050		

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A2050	Continued From page 1 Based on interview and record review, the establishment failed to notify the Department within 24 hours of residents' elopement. This deficient practice affected two (R1, R2) residents and have the probability to affect all Memory care residents. Findings include: According to R1's Incident report submitted by establishment to State Agency with incident date 4/29/25, R1 eloped from a scheduled activity taking place in the building on the second floor community room while under the supervision of the activity therapist (E3- Terminated Activity Therapy) ...it is unclear how or when she exited the room, as therapist was assisting another resident ....Resident was safely escorted back to the secured Memory Care (MC) unit without incident or injury ... According to R2's Incident report submitted by establishment to State Agency with incident date 4/29/25, R2 eloped from a scheduled activity taking place in the building on the second floor community room while under the supervision of the activity therapist (E3) ...A Caregiver on the AL second floor found the resident ambulating in the hallway and she was safely escorted to the secured MC ... R1 and R2 are Memory Care residents with Dementia diagnosis according to the resident face sheets. The second floor Activity area is unsecured room. R1's and R2's emails indicated, the Department was notified of these incidents on 5/6/25. There was also no written summary of the	A2050		

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A2050	Continued From page 2 investigation conducted. On 5/12/25 at 10:54am, E4 (Health and Wellness Director) confirmed the incident reports were sent couple of days later, and no summary of the investigation.	A2050		
A4060	Seciton 295.4060 Alzheimer's and Demential Programs This Regulation is not met as evidenced by: Type 3 Violation Section 295.4060 Alzheimer's and Dementia Programs a) In addition to this Section, Alzheimer and dementia programs shall comply with all of the other provisions of the Act. (Section 150(a) of the Act) 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; and B) May need supervision and assistance when evacuating the building in an emergency; 6) Provide an appropriate number of staff for its resident population. The establishment shall provide staff sufficient in number, with qualifications, adequate skills, education, and experience to meet the 24-hour scheduled and unscheduled needs of the residents and who	A4060		

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A4060	Continued From page 3	A4060		

participate in ongoing training, to serve the resident population. At a minimum, at least one staff member shall be awake and on duty at all times;

9) Develop emergency procedures and staffing patterns to respond to the needs of residents; (Section 150(f) of the Act)

These requirements are not met as evidenced by:

Based on interview and record review the establishment failed to provide supervision to two Memory care residents (R1, R2), resulting to residents' wandering in unsecured areas of the establishment.

Findings include:

R1's face sheet indicated, R1 is 79 years old. R1 moved into the Memory Care (MC) unit on 3/5/25. R1's diagnoses include but not limited to Unspecified Dementia, mild with Agitation. R1's St Louis University Mental Status (SLUMS) Examination score dated 4/7/25 was 6 indicating Dementia.

According to R1's Incident report submitted by establishment to State Agency with incident date 4/29/25, R1 eloped from a scheduled activity taking place in the building on the second floor community room while under the supervision of the activity therapist (E3- Activity Therapy-Terminated) ...it is unclear how or when she exited the room, as therapist was assisting another resident. The concierge on the first floor identified the resident in the lobby area ...safely escorted back to the secured MC unit without

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A4060	Continued From page 4 incident or injury ... On 5/12/25 at 11:39am, E5 (Concierge) said, she found R1 seated on the bench near the Independent Living elevator, unknown how long R1 has been there. E5 said, R1 was alone unmonitored when found. E5 said, she recognized R1, a MC resident. E5 confirmed, memory care residents should be in memory care unit unless they were under supervision. According to R2's face sheet, R2 is 82 years old. R2's diagnoses include but not limited to Dementia. R2 moved into the MC unit on 12/28/21. R2's St Louis University Mental Status (SLUMS) Examination score dated 12/9/2021 was 15, indicating Dementia. On 5/12/25 at 9:56am, E2 (Memory Care Manager) said, R2's cognitive functions have deteriorated since assessment. No current cognitive assessment has been conducted. According to R2's Incident report submitted by establishment to State Agency with incident date 4/29/25, R2 eloped from a scheduled activity taking place in the building on the second floor community room while under the supervision of the activity therapist (E3) ...A Caregiver on the AL second floor found the resident ambulating in the hallway and she was safely escorted to the secured MC ... On 5/12/25 at 11:45am, E6 (Resident Assistant) said she was coming out of the bathroom when she saw R2 in front of the elevator, R2 was alone, without supervision. R2 told E6, "I am going home, where is my home?" E6 recognized R2, a MC resident. E6 escorted R2 to the MC unit. Once there, one of the MC staff was looking for R2's walker, because according to staff, R2 was	A4060		

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A4060	Continued From page 5	A4060		

a fall risk and required walker to ambulate. E6 said, she did not know R2 was a fall risk when she escorted her (without the walker) back to the Memory care unit. After going back to the second floor, E6 saw E3 looking for R2. E6 informed E3, she returned R2 to the MC unit.

On 5/12/25 at 9:26am, E2 (Memory Care Manager) said, E3 took a group of MC residents to Assisted Living activity area. E2 said at times, MC residents would be escorted out from the MC unit to the AL activity room, or theater by Activity staff. The activity staff are responsible for the MC residents. During this particular incident, E3 was responsible for these MC residents, while they were in the activity.

On 5/12/25 at 10:54am, E4 (Health and Wellness Director) confirmed incidents involving R1 and R2. E4 indicated she was not present at the time of incident, but she investigated the incident. E4 said, the activity therapist turned her back, helping an Assisted Living resident, she was alone with 6 memory care residents, they were on the second floor activity room, the doors were open, they were all sitting at a table. "The Receptionist alerted staff a resident (R1) was found in the lobby, that's the time (E3) realized two residents from her group were gone. E4 said, E3 admitted, she should have not turned her back, which caused her to get distracted. E4 said moving forward, "Another person will be present as a backup. The doors should have been shut and not left wide open; she did not notice that these people were gone from the group."