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	ASL510348	A. BUILDING: _____ B. WING _____	C 03/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF GURNEE	500 N HUNT CLUB RD GURNEE, IL 60031

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A 000	Initial Comment Facility Reported Incident Survey IL00200919- Unsubstantiated IL00200382- Substantiated. 295.4010 a) e) 295.6000 a) 13)	A 000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Type 1 Violation Section 295.4010 Service Plan 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 Act) The establishment shall respect and accept the resident's choices regarding the service plan. 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). These requirements were not met as evidenced by Based on interview and record review, the establishment failed to implement interventions to ensure safety for one (R3) cognitively impaired resident resulting in elopement.	A4010		

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A4010	Continued From page 1 This failure creates substantial probability of severe harm or death to R3 and other residents. Findings include: R3's medical record showed R3 moved into the establishment on 7/14/2025, resided in the Assisted Living unit, and had multiple diagnoses, including Alzheimer's Disease with Late Onset. R3's Service Plan, dated 1/17/2026, showed R3 was independent with transfers and mobility. R3's Focus: Elopement and Safety-initiated on 7/9/2025. Interventions initiated 7/21/2025: My triggers for wandering/elopement are due to my anxiety and new environment from my home to Sunrise, observe my location in the community and direct me to an activity, sit with me, hold my hand to comfort and/or find out what I want to do. Observe my choices throughout the day to ensure safety of self and others. R3's progress Notes indicated the following: 2/19/2026- R3 continues to show a decline in judgement and memory. R3 was seen by Z1 (neurologist) who recommends memory care to best meet R3's needs. Staff continue to support R3 in making appropriate choices and meeting R3's needs at this time. E1 (Executive Director/ ED) will contact R3's POA (Power of Attorney) to explore memory care options. 2/21/2026- R3 put keys on the concierge desk and started to walk to the door. Concierge asked R3 where she was going and told R3 it was very cold outside - R3 not wearing a coat. R3 responded that she was leaving. Concierge R3 asked if she was ok and R3 responded "No. I'm very angry. I feel like I'm trapped here and I'm	A4010		

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A4010	Continued From page 2	A4010		

leaving." R3 then went upstairs to her room.

2/23/2026- "This writer was informed by the care manager that R3 was not found in her room at approximately 6:20 PM. R3 was also not observed in the dining room or activity room. An elopement search was initiated by this writer immediately, beginning at 6:30 PM. Care managers and additional management staff assisted in searching the building and the surrounding exterior areas."

2/23/2026- On 2/26/26 at approximately 6:20 PM, staff reported resident R3 missing from the community. Missing Resident Protocol initiated; internal search and camera review began. ED contacted POA, who confirmed R3 was not with family. R3's cell phone was found in her suite. At approximately 6:40 PM, ED contacted 911. Police later confirmed R3 was located about 2.5 miles from the establishment (38-60 minutes' walk) after sustaining a fall with facial lacerations; R3 was transported to Local Hospital. R3 reportedly stated intention to "walk back to Arlington Heights." Camera review showed that R3 exited at 4:19 PM, returned, ate dinner at ~5:00 PM, and exited again at 5:41PM.

R3's Functional Assessment Staging of Alzheimer's Disease (FAST) dated 7/23/2025 Score: Stage 4, which indicates Stage 4 (mild dementia): difficulty with complex tasks, such as managing finances, planning, or traveling. Require intermediate assistance.

On 3/26/2026 at 11:52AM, E3(Wellness Nurse Supervisor) said that R3 lived in assisted living but they were talking about moving to Memory Care either here in this community or family was looking for another place. R3 was very impulsive,

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A4010	Continued From page 3	A4010		

R3 would sign out to walk around the building, R3 was able to walk outside and was able to come back. E3 said that R3 scored very high on BIMS 15/15. R3 was seen by Psychiatrist and had her own outside neurologist. E3 said that the day R3 eloped R3 fell when she was out, R3 was taken to local hospital as someone called 911, R3 fractured her ankle. R3 never came back to this community.

On 3/26/2026 at 12:48PM, E4 (Lead Care Manager) said "I was serving dinner that day, R3 ate dinner, after dinner I came upstairs and one of the care managers said she couldn't find R3, we started searching for her. I went to E1 (ED) to tell her R3 can't be found. The building was searched. E1 call police, Police found R3. R3 never came back. R3 was able to make sense when talking to her and was able to go outside for walks. R3 lived in Assisted Living.

On 3/26/2026 at 1:50PM, E5 (Lead Care Manager) said that R3 was on two hours checks, R3 was fine, R3 used to go for walks and R3 knew she couldn't leave the facility.

On 3/26/2026 at 4:01PM, E6 (Licensed Practical Nurse) said "I really didn't work with R3, R3 was declining cognitively and there were talks with her POA about her cognition, this is all I know about her."

On 3/30/2026 at 11:44AM, E2 (Resident Care Director) said that R3 was not declining cognitively, R3 was still able to sign out to go for walks around the building. R3 was getting forgetful, R3 would come in the morning to have breakfast, have some bites, go to her apartment and come back again, R3 participated in activities, but then R3 will go to the bathroom in

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A4010	Continued From page 4 her apartment because R3 had a phobia to use the bathroom in the community. R3 was overeating. On 3/30/2026 at 1:01PM, Z1 (Psychiatrist) said that After R3 left the facility Z1 thought that R3 needed a more structured environment, R3 was confused. Z1 said that "I was surprised when R3 left the facility, R3 hasn't done anything like this before." On 3/30/2026 at 1:41PM, Z2 (Neurologist) said that R3 has Frontal dementia, possible Alzheimer's, R3 had poor judgment, R3 would take money out, R3 needed a supervise typed environment. Z2 said that one-time R3 went out to the movie, and while at the movie theater, R3 went to the bathroom, R3 didn't come back, R3 was walking around until she returned to the community after walking for about 2 hours. R3 was getting confused; had safety issues, that's why R3 needed a supervised environment. R3 was trying to get into other people's cars in the parking lot.	A4010		
A6000	Section 295.6000 Resident Rights 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	A6000		

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A6000	Continued From page 5 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 interview and record review, the establishment failed to prevent elopement by one (R3) resident out of 3 residents reviewed for elopement. This failure creates substantial probability of severe harm or death to R3 and other residents. Findings include: R3's medical record showed R3 moved into the establishment on 7/14/2025, resided in the Assisted Living unit, and had multiple diagnoses, including Alzheimer's Disease with Late Onset. R3's Service Plan, dated 1/17/2026, showed R3 was independent with transfers and mobility. R3's Focus: Elopement and Safety-initiated on 7/9/2025. Interventions initiated 7/21/2025: My triggers for wandering/elopement are due to my anxiety and new environment from my home to Establishment, observe my location in the community and direct me to an activity, sit with me, hold my hand to comfort and/or find out what I want to do. Observe my choices throughout the day to ensure safety of self and others. R3's progress Notes indicated the following: 2/19/2026- R3 continues to show a decline in judgement and memory. R3 was seen by Z1 (neurologist) who recommends memory care to best meet R3's needs. Staff continue to support	A6000		

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A6000	Continued From page 6 R3 in making appropriate choices and meeting R3's needs at this time. E1 (Executive Director/ ED) will contact R3's POA (Power of Attorney) to explore memory care options. 2/21/2026- R3 put keys on the concierge desk and started to walk to the door. Concierge asked R3 where she was going and told R3 it was very cold outside - R3 not wearing a coat. R3 responded that she was leaving. Concierge R3 asked if she was ok and R3 responded "No. I'm very angry. I feel like I'm trapped here and I'm leaving." R3 then went upstairs to her room. 2/23/2026- "This writer was informed by the care manager that R3 was not found in her room at approximately 6:20 PM. R3 was also not observed in the dining room or activity room. An elopement search was initiated by this writer immediately, beginning at 6:30 PM. Care managers and additional management staff assisted in searching the building and the surrounding exterior areas." 2/23/2026- On 2/26/26 at approximately 6:20 PM, staff reported resident R3 missing from the community. Missing Resident Protocol initiated; internal search and camera review began. ED contacted POA, who confirmed R3 was not with family. R3's cell phone was found in her suite. At approximately 6:40 PM, ED contacted 911. Police later confirmed R3 was located about 2.5 miles from the establishment (38-60 minutes' walk) after sustaining a fall with facial lacerations; R3 was transported to Local Hospital. R3 reportedly stated intention to "walk back to Arlington Heights." Camera review showed that R3 exited at 4:19 PM, returned, ate dinner at ~5:00 PM, and exited again at 5:41PM.	A6000		

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A6000	Continued From page 8	A6000		

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