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A 000	Initial Comment Change of Ownership (CHOW) --295.3000 a) h) 3) --295.4010 a) e) --295.6000 a) 13) FRI # 200952 Incident of 3/21/26 --295.3000 a) h) 3) --295.4010 a) e) --295.6000 a) 13)	A 000		
A3000	Section 295.3000 Personnel Requirmts, Qualifns, and Trng This Regulation is not met as evidenced by: TYPE 1 VIOLATION Section 295.3000 Personnel Requirements, Qualifications and Training a) The establishment shall have staff sufficient in number with qualifications, adequate skills, education and experience to meet the 24 hour scheduled and unscheduled needs of residents and who participate in ongoing training to serve the resident population. (Section 35(a)(3) of the Act) h) The establishment shall have sufficient personnel to provide the following for its current resident population: 3) Service to meet the needs of each resident, including 24 hour scheduled and unscheduled needs, general supervision, and the ability to intervene in a crisis; This requirement is not met as evidenced by:	A3000		

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A3000	Continued From page 1	A3000		

Based on staff interviews, record review and review of video the
establishment failed to adequately supervise 1 of 7 sampled residents
(R7) reviewed for elopement risk .
This failure resulted in R7 leaving the establishment unsupervised .
This failure creates a substantial probability of severe harm or death to a resident or residents.

Findings include:

R7 was admitted to the establishment 11/21/25 with a diagnosis of Unspecified Dementia.
R7's cognitive assessment assessed the resident as having significant cognitive impairment. The 11/18/25 Physician Assessment and Medical Evaluation documented R7 was confused, was a fall risk and required supervision due to her dementia.

R7's Progress Notes documented R7's exit seeking behavior on 12/2/25, 12/14/25 (two separate occasions),12/31/25 (wandering and voicing desire to leave),1/13/26, 2/8/26 (exited into courtyard after setting off door alarm).

R7's Progress Note dated 3/21/26 documented the resident's actual elopement from the establishment as well as the establishment's being unaware until 4;00PM when they were notified by police that the resident had left the establishment and was being returned. The occurrence was verified by video surveillance which showed R7 exited through the front lobby door at approximately 2:00PM.

R7's service plan (SP) dated 3/7/26 assessed the resident as having memory impairment, a history of wandering and exit seeking and requiring

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A3000	Continued From page 2	A3000		

protection and supervision due to making unsafe or inappropriate decisions, as occasionally disoriented and in need of directions and reminders by staff. One intervention listed was closely supervising and redirecting when she showed exit seeking behaviors. The SP wasn't revised when R7 continued exit seeking behaviors and actually managed to open one door (that lead into a courtyard) on 2/8/26 and when the resident actually managed to elope into the community through the front door lobby on 3/21/26. The SP was not revised with new goals and interventions implemented when it was apparent those interventions in place weren't effective which resulted in R7's ability to actually elope.

The establishment's policy: "Safety and Security of Residents" instructs staff to monitor residents on each shift on an every two hour basis by visually locating the resident and confirming their location". Documentation could be in the electronic record (EHR)or on paper.

Staff interviewed stated they don't document verification of rounds/monitoring having been done.

On 10/30/26 at 10:30AM E1(Executive Director) admitted R7 eloped 3/21/26 at about 2:00PM when a delivery of medical equipment was brought in through the front lobby doors and R7 exited through the lobby doors. E1 stated the resident wanders through out the establishment. E1 stated R7 would previously try to leave through exit doors but was redirected by staff. The resident was monitored every two hours. On 3/21/26 R7 was returned to the establishment at 4:00PM by the police . After the elopement R7 was monitored every 30 minutes and as of

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A3000	Continued From page 3	A3000		

3/30/26 is still on every 30 minute monitoring. E1 stated none of the residents wear electronic monitoring devices.

On 3/30/26 at 11:30AM E11 (caregiver) stated the day R7 had eloped, Saturday 3/21/26, E11 had brought the resident to the Bistro in the front lobby for bingo then went on her break. She learned R7 was missing at about 4:00PM. Neither she nor any resident wears any type of monitoring device to prevent them leaving the establishment. Residents are checked every two hours, but they don't document the checks.

E11 went on to say R7 was returned to the establishment on 3/21/26 at about 4:00PM by the family of another resident who recognized her. R7 was checked after returning then kept in the Bistro on the 300 wing afterwards and then was checked every half hour which isn't documented. The resident hasn't tried to leave since then until yesterday (3/29/26) when she tried to sneak out with visitors during the Easter Brunch festivity. E11 stated R7 is confused, knows her name but not where she is and often asks why she is here.

On 3/30/26 at 3:40PM E15 (Nurse) stated R7 is alert and oriented X 1-2 (person, place) and wouldn't be able to know where she is. There have been times when R7 has tried to leave. Staff uses activities to keep her busy. R7 walks around the establishment. All doors are alarmed. E15 wasn't aware that the resident is an elopement risk and had previously eloped from the establishment. She'd see R7 in the morning and during 2 hour checks. Staff doesn't document the checks.

E15 worked 3/21/26 and last saw R7 about "1 ish" in the dining room on the 300 wing but didn't

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A3000	Continued From page 4 know she was trying to leave and didn't know R7 was missing before E15 left at the end of her shift at 3:00PM. On 3/30/26 this surveyor observed R7 in the dining room on the 300 wing. The resident was alert but confused and unable to remember having left the establishment and didn't know the name of the establishment. At 4:40PM E1 showed the video of R7 eloping from the establishment. The video was dated and time stamped 3/21/26 at 2:08PM and showed R7 leaving the lobby's front door after the delivery person brought equipment through the doors. The concierge (E16) was sitting at the front desk and was seen looking at the delivery person. The video showed R7 glancing in the direction of the front desk and concierge and delivery person, pushing on the door's bar and leaving. On 3/30/26 at 3:10PM E2 (Health Services Director) presented an Elopement Assessment dated 3/21/26 for R7 that indicated the resident was an elopement risk and admitted there had not been an elopement assessment done when R7 was initially admitted.	A3000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Type 1 Violation Section 295.4010 Service Plan	A4010		

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A4010	Continued From page 5 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). This requirement is not met as evidenced by: Based on record review, interview and observation the establishment failed to revise service plans to develop and implement interventions to address one resident's exit seeking behavior (R7) who repeatedly tried to elope from the establishment and did actually elope from the establishment on 3/21/26 and the establishment failed to revise service plans to develop and implement interventions for residents' falls and care needs for 7 of 7 sampled residents (R1, R2, R3,R4, R5,R6 and R7). These failures create a substantial probability of severe harm or death to a resident or residents. Findings include: 1). R7 was admitted to the establishment 11/21/25 with a diagnosis of Unspecified Dementia. R7's Progress Notes documented R7's exit seeking behavior on 12/2/25, 12/14/25 (two separate occasions),12/31/25 (wandering and	A4010		

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A4010	Continued From page 6 voicing desire to leave),1/13/26, 2/8/26 (exited into courtyard after setting off door alarm). R7's Progress Note dated 3/21/26 documented the resident's actual elopement from the establishment as well as the establishment's being unaware until 4;00PM when they were notified by police that the resident had left the establishment and was being returned. The occurrence was verified by video surveillance which showed R7 exited through the front lobby door at approximately 2:00PM. R7's service plan (SP) dated 3/7/26 assessed the resident as having memory impairment, a history of wandering and exit seeking and requiring protection and supervision due to making unsafe or inappropriate decisions, as occasionally disoriented and in need of directions and reminders by staff. One intervention listed was closely supervising and redirectingR7 when she showed exit seeking behaviors. The SP wasn't revised when R7 continued exit seeking behaviors and actually managed to open one door (that lead into a courtyard) on 2/8/26 and when the resident actually managed to elope into the community through the front door lobby on 3/21/26. The SP was not revised with new goals and interventions implemented when it was apparent those interventions in place weren't effective which resulted in R7's ability to actually elope. On 4/13/26 during exiting with E1 stated interventions had been documented inR7's progress note. 2). R1 was admitted to the establishment 8/31/24 with diagnoses including Unspecified Dementia. The resident is also on hospice.	A4010		

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A4010	Continued From page 7 Progress Note 3/10/26 document staff hearing screaming and found R1 laying on the floor in the 100 Wing Bistro. R1 was yelling and anxious and the nurse documented there wasn't any visible injury. Progress Note 3/11/26 documented R1 complained of right leg and hip pain and had difficulty standing. The appropriate people were notified and ordered a Xray which showed R7 had a right femur fracture. E1(Executive Director) and E2 (Health Service Director) were asked to provide R1's current Service Plan (SP). The SP provided was dated 4/3/25 as was the two signatures on the SP. R1's SP wasn't revised with new goals and interventions developed and implemented to address the residents' fractured femur, the use of oxygen and failed to address R1's use of hospice and the services hospice provided. The only fall assessment provided was dated 3/13/26 after R1's fall and fracture. R1was assessed as high risk for falls. Their Fall Assessment Policy discussed the identification of residents at risk or predisposed to fall, listed fall prevention guidelines for staff, ongoing follow up, barriers to fall prevention and the types of falls. 3). R2 was admitted to the establishment 6/14/23 with diagnoses including History of Falls, Muscle Weakness and Unspecified Dementia. The resident is on hospice. The incident for R2 dated the resident fell out of her bed on 11/11/25.	A4010		

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A4010	Continued From page 8 R2's Fall Assessment provided was dated 11/12/25 (the day after the resident's fall) and assessed the resident's fall potential at "24" (high risk). R2's SP dated 11/5/25 wasn't revised with new goals and interventions implemented to address the residents' fall potential nor the actual fall when it became apparent those interventions in place to try to prevent falls weren't effective. The SP also failed to address R2's use of oxygen and failed to identify the exact services hospice provided, failed to address the fact R2's wound had progressed to a stage 4 and didn't identify who was responsible for dressing changes to R2's pressure ulcer if needed when hospice staff weren't available. 4). R3 was admitted to the establishment 12/31/25 with diagnoses including Unspecified Dementia, Abnormality of gait and mobility. Fall Risk Results dated 1/21/26 and 3/14/26 assessed R3 as a high fall risk. R3's Progress Notes mention the resident's left abdominal colostomy. The resident is documented as having fallen 1/14/26 and 3/12/26. R3's current SP wasn't revised with new goals and interventions dated 2/5/26 failed to address the resident's colostomy and falls. 5). R4 was admitted to the establishment 12/12/23 with diagnoses including Dementia, Unspecified Fall, Anxiety and Depression. The establishment failed to provide an elopement	A4010		

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A4010	Continued From page 9	A4010		

assessment upon several verbal and email requests. The Fall Risk Results dated 11/5/25 scored the resident as high risk.

Progress Notes for R4 documented the resident was observed "The resident continues to push exit doors daily".

R4's SP dated 9/26/25 provided by the establishment contained written documentation of the resident having fallen on10/18/25 and 11/4/25 was not revised with new goals and interventions implemented to address the residents' falls in an attempt to try to prevent further falls and failed to develop goals and interventions to address R4's repeated exit seeking behaviors.

6). R5 was admitted to the establishment on 1/29/25 with a diagnosis of Dementia.

R5's Fall Assessment 2/9/26 assessed the resident as 8 (cognitively impaired).

Progress Notes document R5 has a coccyx wound being treated by hospice.

R5's SP dated 3/18/26 the establish failed to revise and develop goals and interventions and implement them to address the falls to attempt to prevent future falls when it was obvious those interventions in place for the falls were not effective. The SP failed to address, develop, intervention and implement those interventions regarding R5's coccyx wound. The establishment failed to address the hospice's treatment of R5's wound.

7). R6 was admitted to the establishment 10/31/23 with diagnoses including Dementia.

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A4010	Continued From page 10 R6's cognitive assessment assessed the resident as cognitively impaired. The Fall Risk 2/9/26 assessed the resident as a high fall risk. R6's SP 3/17/26 documented the resident had a potential for falls and mentioned the resident had fallen 1/25/26 and 1/29/26. The SP wasn't revised with new goals and interventions implemented in an attempt to prevent further falls.	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 the following rights: 13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor This requirement is not met as evidenced by: Based on record review, interviews and review of the establishment's video the establishment failed to follow It's elopement policy and failed to initiate effective interventions to prevent the elopement by 1 of 7 sampled residents (R7) who frequently attempted to exit the establishment resulting in	A6000		

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A6000	Continued From page 11	A6000		

R7 actually eloping and the establishment not being aware R7 was missing for 2 hours. This failure creates a substantial probability of severe harm or death to a resident or residents.

Findings include:

R7 was admitted to the establishment 11/21/25 with a diagnosis of Unspecified Dementia. The Saint Louis University Mental Status Examination (a cognitive assessment) dated 1/14/26 assessed R7 as scoring 10 (dementia or significant cognitive impairment). The Physician Assessment and Medical Evaluation, both dated 11/18/25 documented the resident was confused, was a fall risk and required supervision for dementia.

R7's Progress Notes documented R7's exit seeking behavior on 12/2/25, 12/14/25 (two separate occasions),12/31/25 (wandering and voicing desire to leave),1/13/26, 2/8/26 (exited into courtyard after setting off door alarm).

R7's Progress Note dated 3/21/26 documented the resident's actual elopement from the establishment as well as the establishment's being unaware until notified by police that the resident had left the establishment and was being returned. The occurrence was verified by video surveillance.

R7's service plan (SP) dated 3/7/26 assessed the resident as having long and short-term memory impairment with a history of occasional disorientation to place, time or situation that requires some directions and reminding from others. The SP also identified R7 as having a history of wandering and exit seeking, especially in the afternoon and evening with an occasional

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A6000	Continued From page 12	A6000		

inability to recognize unsafe situations, poor judgement and requiring protection and supervision due to making unsafe or inappropriate decisions. Interventions included closely supervising R7 and redirecting the resident when she showed exit seeking behaviors. The SP was not revised with new goals and interventions implemented when it was apparent those interventions weren't effective which resulted in R7 actually eloping.
The establishment's policy: Safety and Security of Residents instructs staff to monitor residents on each shift on an every two hour basis by visually locating the resident and confirming their location". Documentation can be in the electronic record (EHR)or on paper.
Staff interviewed stated they don't document verification of rounds/monitoring having been done.
On 10/30/26 at 10:30AM E1(Executive Director) admitted R7 eloped 3/21/26 at about 2:00PM when a delivery of medical equipment was brought in through the front lobby doors and R7 exited through the lobby doors. The resident wanders through out the establishment. E1 stated R7 would previously try to leave through exit doors but was redirected by staff. The resident was monitored every two hours. R7 was returned to the establishment at 4:00PM by the police .
After the elopement R7 was monitored every two hours and as of 3/30/26 is still on every 30 minute monitoring. E1 stated none of the residents wear a electronic monitoring device.
On 3/30/26 at 11:30AM E11 (caregiver) stated the day R7 had eloped, Saturday 3/21/26, E11 had brought the resident to the Bistro in the front lobby for bingo then went on her break. She learned R7 was missing at about 4:00PM. Neither she nor any resident wears any type of monitoring device to prevent them leaving the establishment.

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A6000	Continued From page 13 Residents are checked every two hours, but they don't document the checks. E11 went on to say R7 was returned to the establishment on 3/21/26 at about 4:00PM by the family of another resident who recognized her. R7 was checked after returning then kept in the Bistro on the 300 wing afterwards and then was checked every half hour which isn't documented. R7's family visits and takes her out of the establishment weekly. The resident hasn't tried to leave since then until yesterday (3/29/26) when she tried to sneak out with visitors during the Easter Brunch festivity. E11 stated R7 is more confused knows her name but not where she is and often asks why she is here. After the interview E11 approached this surveyor and informed this surveyor the establishment had a video of the elopement. On 3/30/26 at 3:40PM E15 (Nurse) stated R7 is alert and oriented X 1-2 (person, place) and wouldn't be able to know where she is. There have been times when R7 has tried to leave. Staff uses activities to keep her busy. R7 walks around the establishment All doors are alarmed. E15 wasn't aware that the resident is an elopement risk and had previously eloped from the establishment. She'd see R7 in the morning and during 2 hour checks. Staff doesn't document the checks. E15 worked 3/21/26 and last saw R7 about "fish" in the dining room on the 300 wing but didn't know she was trying to leave and didn't know R7 was missing before E15 left at the end of her shift at 3:00PM. On 3/30/26 this surveyor observed R7 in the dining room on the 300 wing. The resident was alert but confused and unable to remember having left the establishment and didn't know the name of the establishment.	A6000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510324	A. BUILDING: _____ B. WING _____	04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBERGE AT NAPERVILLE A MEMORY CARE COMM	1936 BROOKDALE ROAD NAPERVILLE, IL 60563

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A6000	Continued From page 14 At 4:40PM E1 showed the video of R7 eloping from the establishment. The video was dated and time stamped 3/21/26 at 2:08PM and showed R7 leaving the lobby's front door after the delivery person brought equipment through the doors. The concierge (E16) was sitting at the front desk and was seen looking at the delivery person. The video showed R7 glancing in the direction of the front desk and concierge and delivery person, pushing on the door's bar and leaving. On 3/30/26 at 3:10PM E2 (Health Services Director) presented an Elopement Assessment dated 3/21/26 for R7 that indicated the resident was an elopement risk and admitted there had not been an elopement assessment done when R7 was initially admitted.	A6000		