

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ASL510184	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/24/2026
NAME OF PROVIDER OR SUPPLIER HARBOR CHASE OF NAPERVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 1619 N MILL STREET NAPERVILLE, IL 60540		
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A 000	Initial Comment Complaint Investigation: 2675587/IL201721 - 295.4000a)b) 295.4010a)b)1)c)g)1)C) 295.2050a)b)c) 2675579/IL201724 - No Deficiency	A 000		
A2050	Section 295.2050 Incident and Accident Reporting This Regulation is not met as evidenced by: Type 1 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.	A2050		

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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A2050	Continued From page 1 This REQUIREMENT was not met as evidenced by: Based on interview and record review the facility failed to report to Illinois Department of Public one resident (R2) that eloped from the memory care secure unit and failed to report an accident of one resident (R1) that fell twice and sustained a large bump on the head and a bruise beneath the left eye for two of three residents reviewed for reporting. These failures resulted in one resident (R2) eloping from the secured memory care unit and being found wandering on the second floor of the assisted living residence for an unknown amount of time and R1 falling twice and sustaining a large bump on the head and bruise beneath the eye. This failure creates a substantial probability of severe harm to a resident or residents. Findings include: R2 is a 79-year-old male admitted to facility on 9/30/2021 with diagnosis not limited to: PTSD and Dementia R2's nursing note dated 4/22/2026 9:02 PM documents in part: Other-Elopement Resident was found outside memory care unit by first floor nurse station wondering. Resident redirected by one of our staff. Resident is on Alert charting, staff will continue monitor. Endorsed to oncoming nurse to follow up E6 (Licensed Practical Nurse) On 5/22/2026 at 4:31pm E6, LPN stated she was familiar with R2 and on 4/22/2026 R2 pushed the door back by the kitchen and the alarms should have gone off. We did not hear an alarm and E10, Care Partner who works in AL found R2 by	A2050			

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A2050	Continued From page 2 the first-floor nurses' station and the first floor nurse brought him back. E6 stated, the residents do not wear monitoring device. From what I was told, R2 walked out of the memory care door walked out 2nd door to the 1st floor nurses station and E10 the care partner found him and the nurse in AL brought him back to the unit. An incident report was not done; I documented in the progress note. The nurses and care givers monitor them. Alarm was not working and did not sound. He should not be outside of memory care walking by himself. I did not know he was gone. No one knew he was gone until we got the call from the 1st floor. The care givers do their rounds every 2 hours. He will ask about going home and wanders around the unit. We try to redirect him more often. They do head count to make sure everyone is there. When this happened, E6 stated, she was on break. On 5/22/2026 at 5:12pm E2, Director of Resident care, stated, she was not made aware that R2 eloped out of the memory care unit, because she would have to do a reportable. E2 stated, she should have been alerted, but she was not notified. E2 stated, she does not know how it happened and is not good because she should be aware of things that happened. E2 stated she relies on people letting her know. There is a progress note, but there is not an incident report for the elopement. There should be an incident report for the elopement. R1 had a fall on 4/23/2026 and she was not sent out to the hospital. It was an unwitnessed fall. E2 stated she believed she was sent right back. She had two falls that day found sitting down in bedroom 4/23/2026 at 5:00am sitting by her bed was verbal and again on 4/23/26 at 9:45pm. POA was notified. She could not say what happened. R1 sustained a bruise under right eye. A reportable	A2050		

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A2050	Continued From page 3 was not done. Normally reportable if there is broken bone, laceration, it sounded like she was just sitting on the floor. I did not see any mention of a black eye. I noticed it a couple of days later. Reportables are done when a resident is injured even if they do not go out to the hospital. R1 is a 66-year-old female admitted to facility on 12/18/2024 with diagnosis not limited to: Seizure Disorder, Depressive Disorder, Anxiety, Memory loss, Behavioral Disorders Associated with Dementia, Dementia, unspecified, moderate w/ psychotic disturbance & agitation, Alzheimer's Disease R1's nursing note dated 04/23/26 at 7:14am documents by E11 in part: Fall This writer received a report from the caregiver that the resident was on the floor, upon checking, observed resident in a sitting position nearby her bed, alert and verbally responsive, ROM WNL, noted a bumped on her left forehead, ROM WNL, no c/o pain and discomfort, resident assisted back to bed, vital signs taken R1's nursing note dated 04/23/26 at 2:55PM documents in part: Alert Charting - Fall With Injury, OTHER-Neuro check for 72 hours Resident observed alert and verbally responsive speech clear coherent with no signs of acute distress, able to follow commands, both eyes pupil reactive to light and accommodation, bilateral upper extremities and lower extremities strong able to move, bilateral hand strong hand grasp. left forehead hematoma applied ice pack compression. E12 (Licensd Practical Nurse) R1's nursing note dated 04/23/26 at 9:27pm documents in part: Alert Charting - Fall With Injury, New/Changed Medication, OTHER-Neuro	A2050		

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A2050	Continued From page 4 check for 72 hours Resident alert and oriented to self, resident denies pain or discomfort, no new physical injuries reported post fall, purplish discoloration to left temple still present, skin intact. E15 (Licensed Practical Nurse) On 5/23/2026 at 10:24am E8, Care Partner in Memory Care, I am familiar with R1. I was working the night R1 fell. It was about 4:30 in the am and doing out last rounds and E9 asked me if I could help get R1 up because she fell. R1 stumbled into the care partner and hit left forehead on the floor. We do not fill out an incident report. Nurse came into room and we told her she hit her head and she had a big goose egg on her head, she did not have a bruise under her eye. On 5/23/2026 at 11:26am E9, Care Partner stated, she was familiar with R1. E9 was assigned to care for R1 that day and it was between 4:00am and 4:30am on 4/23/2026 and she (E9) went in R1's room to change R1. E9 stated, she will usually take R1 to bathroom and have her stand up and change her clothes. E9 had her stand up while E9 was fixing her bed and taking off wet chucks, my back was facing R1 and E9 heard her say something she stumbled back, E9 fell onto R1's bed and R1 fell on the floor. E9 called E8, CP and she came. We cannot touch resident until nurse gets there. R1 was trying to sit up. E11, LPN came and checked her out and saw the obvious bump on her head and said she was gonna check on her meds maybe to see if on blood thinners. R1 was not sent out. We thought she would be sent out because of the obvious bump on her head. E11 did not send her out. We thought it was head trauma. R1 hit her head, and you could see the big bump on her head right away. E9 stayed in the room for a little	A2050		

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A2050	Continued From page 5 bit because E9 thought E11 was gonna tell me she was going to send her out but that never happened. E9 stated she did not do an incident report that is usually the nurse that does that. R1 did not have a bruise under her eye with first fall just bump on her head. On 5/23/2026 at 5:34pm E11, LPN stated, she was familiar with R1, she is a memory care patient. She fell in her bedroom early in the morning on 4/23/2026 in the morning. The caregiver was calling me that morning. They take her to the bathroom in the morning. E11 forgot how she fell. It was in the morning, and the caregiver called me to check on her. R1 was okay and kind of weak that morning. She can ambulate independently. When she fell, we helped her back to bed. She could not really tell me how she fell. I know the next day she got a bruise, but the bruise came late. I think I told the family about it. We usually text the doctor to inform them. E11 stated, as far as she knew if taking a blood thinner will send out unless the family or doctor says no, but we usually send out. R1 was not sent out. It was endorsed that R1 fell, and the doctor was coming in to see her that day. Our DON will send reportable to the state. I did an incident report and progress note and monitor for 3 days, R1 did have a bump on her head. On 5/24/202 at 3:57pm E1, Executive Director stated she was familiar with R1. E1 stated she does not know if incident reports were done because E2 always handles that. The incident reports E1 gets do not get reported to the state. E1 further stated, she thought if resident went to hospital, it as a reportable but she does not send it, but she looks it over. E1 stated, this was a one-time thing, and we are we gonna make sure it does not happen again. If there is an injury and	A2050		

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A2050	Continued From page 6 resident remains in the facility, I would say that it is a reportable. Yes, any kind of injury I would report it. E1 stated she was familiar with R2, and she received a phone call from E10 after 10:00pm on 4/22/2026 and E10 said she found R2 by the front elevator. Before E1 could get up and call nurse E17, Licensed Practical Nurse (LPN) the nurse was mad that E1 was called and E17 told me not to worry about it and E10 was new and he was not sure why she called me. E1 stated if R2 is out of the memory care unit he got out and she would consider that an elopement if that was reported. E1 did not investigate it no more than what the staff was telling me. E1 stated she was in a dead sleep and did not think anything was wrong, E17 told me nothing was wrong. E1 was assured R2 was not out the unit. R2 got out of the unit that is an elopement. E1 stated, she listened to the nurse who she trusts, it was not told to me. If it was reported to me, she would have done an investigation. We have done some elopement drills since that time. Facility Reporting policy not provided during the course of the survey.	A2050		
A4000	Section 295.4000 Physician/s Assessment This Regulation is not met as evidenced by: Violation Section 295.4000 Physician's Assessment a) No more than 120 days prior to admission of a resident to any establishment, a comprehensive assessment that includes an	A4000		

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A4000	Continued From page 7 evaluation of the prospective resident's physical, cognitive, and psychosocial condition shall be completed by a physician. The physician's assessment shall include documentation of the presence or the absence of tuberculosis infection in accordance with the Control of Tuberculosis Code. At the time of admission, the physician's assessment must reflect the resident's current condition. b) At least annually, once a resident has moved into the establishment, a comprehensive assessment shall be completed by a physician. This REQUIREMENT was not met as evidenced by: Based on interview and record review, the facility failed to ensure resident physical assessments and reassessments were signed and completed by a medical doctor annually for one (R2) of three residents reviewed for physician assessment. Findings include: R2 is a 79-year-old male admitted to facility on 9/30/2021 with diagnosis not limited to: PTSD and Dementia R2's Physician Plan of Care dated 02/27/2026, does not address residents' condition, does not incorporate the physician assessment to develop an accurate service plan, and physician signature omitted. On 5/23/2026 at 11:53am E2 stated, medical certification is done yearly and if there is any change of condition. They have to sign that the resident is appropriate for Assisted Living facility.	A4000		

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A4000	Continued From page 8 During course of investigation, facility did not provide requested policies.	A4000		
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. 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. g) Service plans shall address: 1) The level of service the resident is receiving, including: C) special accommodations for the resident; This REQUIREMENT was not met as evidenced by:	A4010		

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A4010	Continued From page 9 Based on interview and record review, the facility failed to follow a resident's service plan to keep one (R2) of three residents in a safe supervised environment while residing in the secured memory care unit and failed to ensure three residents (R1, R2, R3) of three residents service plan were signed and dated. This failure resulted in R2 eloping from the secured memory care unit and found wandering in the assisted living residence building for an unknown amount of time. This failure creates a substantial probability of severe harm to a resident or residents. Findings include, R2 is a 79-year-old male admitted to facility on 9/30/2021 with diagnosis not limited to: PTSD and Dementia R2's nursing note dated 4/22/2026 9:02 PM documents in part: Other-Elopement Resident was found outside memory care unit by first floor nurse station wandering. Resident redirected by one of our staff. Resident is on Alert charting, staff will continue monitor. Endorsed to oncoming nurse to follow up E6 (Licensed Practical Nurse) R2's Service Plan dated 4/21/2026 documents in part: Ned: Psychosocial Goal: Resident will maintain and/or maximize current level of functioning with wandering Action: Wandering, Exit Seeking, or Pacing Issues Resident has current or history of wandering, exit seeking, or pacing. Resident may require supervision, resident centered programing, or other interventions. Encourage resident to participate in programming/activities of choice.	A4010		

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A4010	Continued From page 10 R2's Individualized Service Plan dated 4/21/2026 no signature of E1, E2, or R2's POA (Power of Attorney) On 5/22/2026 at 4:31pm E6, LPN stated she was familiar with R2 and on 4/22/2026 R2 pushed the door back by the kitchen and the alarms should have gone off. We did not hear an alarm and E10, Care Partner who works in AL found R2 by the first-floor nurses' station and the first floor nurse brought him back. E6 stated, the residents do not wear monitoring device. From what I was told, R2 walked out of the memory care door walked out 2nd door to the 1st floor nurses station and E10 the care partner found him and the nurse in AL brought him back to the unit. An incident report was not done; I documented in the progress note. The nurses and care givers monitor them. Alarm was not working and did not sound. He should not be outside of memory care walking by himself. I did not know he was gone. No one knew he was gone until we got the call from the 1st floor. The care givers do their rounds every 2 hours. He will ask about going home and he wanders around the unit. We try to redirect him more often. They do head count to make sure everyone is there. When this happened, E6 stated, she was on break. On 5/22/2026 at 4:46pm E4, Director of Memory Care stated R2 eloped, E4 got a call on the pm shift we have two entrances. The first floor Assisted Living nurse (E17) called me and told me they found R2 by the first-floor nurses' station. He went out the back door of the MC (Memory Care) unit. The door is alarmed and as soon as you push the door the alarm will sound off. The opposite door will light up blue showing a door has been opened and will go off on our radios that MC door alarmed. The MC staff radios will	A4010			

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A4010	Continued From page 11 go off and say memory care alarm memory care alarm and will not turn off unless someone resets it. We must lock the alarm to shut off. As soon as she tried to open the door and fob in and out R2 and the care partner in AL were walking in. Head counts are done in MC to make sure everyone is there. R2 will walk around and has moments when he thinks he is on the battlefield, and it causes anxiety; this comes in waves. R2 sees the door and knows not to go. E5, Care Partner was assigned to him. The nurse was on break. E5 said she was with another resident. They all said they were all with other residents. Care partners were E5, E18 and E7. AL nurse (E17) said it was so quick. The staff did not know R2 was gone until AL staff brought him back. Walkie will go to all staff in AL and MC. R2's room is right by the door, but he never goes through it although he talks about his kids and going all the time. I do not think a reportable was done but an incident report was done. I am not sure of the requirement that is sent to the state. That incident triggered us to do more elopement drills with the team. E4 stated, she was not sure if the E2 was notified. The AL nurse was E17, LPN he does not work her anymore and is out of the country. Care partners and nurses have to count their group. On 5/22/2026 at 5:12pm E2, Director of Resident care, stated, she was not made aware that R2 eloped out of the memory care unit, because she would have to do a reportable. E2 stated, she should have been alerted, but she was not notified. E2 stated, she does not know how it happened and is not good because she should be aware of things that happened. E2 stated she relies on people letting her know. There is a progress note, but there is not an incident report for the elopement. There should be an incident report for the elopement. R1 had a fall on	A4010		

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A4010	Continued From page 12 4/23/2026 and she was not sent out to the hospital. It was an unwitnessed fall. E2 stated she believed she was sent right back. She had two falls that day found sitting down in bedroom 4/23/2026 at 5:00am sitting by her bed was verbal and again on 4/23/26 at 9:45pm. POA was notified. She could not say what happened. R1 sustained a bruise under right eye. A reportable was not done. Normally reportable if there is broken bone, laceration, it sounded like she was just sitting on the floor. I did not see any mention of a black eye. I noticed it a couple of days later. Reportables are done when a resident is injured even if they do not go out to the hospital. On 5/22/2026 at 5:47pm E5, Care Partner stated R2 eloped, and she was working that night. E5 stated she could not remember if she was his caregiver. It was past 8:00pm, close to 9:00pm and we were putting our residents to bed and heard alarm go off by the dining room. E5 state, "I went there, and no one was there so I thought it was nothing and someone was trying to come in. Sometime when they use the key fob the alarm will go off". Then they (staff from AL) were calling on the radio and asked if someone could come to AL first floor. E5 stated she went out the door and me and the nurse met and E5 took R2 back inside. He was confused at the time, and I redirected him. When we do our rounds, we make sure resident are ok and ready for bed. E5 stated R2 was in bed, and he got up maybe we just missed him, and she was doing something and the other caregivers were taking care of other residents. If the alarm goes off it comes on the walkie and intercom. E5 stated she heard the alarm go off. R2 said he went out through the door and educated him not to do that. She (E5) redirected him and took him back to his room. She (E5) did not do a report. E5 stated she was	A4010		

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NAME OF PROVIDER OR SUPPLIER HARBOR CHASE OF NAPERVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 1619 N MILL STREET NAPERVILLE, IL 60540		
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A4010	Continued From page 13 not sure where the nurse was, but she was pretty sure she was on break. When the alarms went off, E5 had to go get keys to turn off the alarm and only the nurses had them. She was notified that R2 had left. E5 stated she was not sure if you could hear alarm in the break room or she had her walkie on. On 5/23/2026 at 10:11am E7, Care Partner I do not remember when R2 eloped. R2 was very anxious all week and E7 told the nurses. E7 stated, she did not consider what he did elopement. E7 heard the alarms go off and went to the door by the main entrance and did not see anyone go out. E7 stated, she was changing residence because it was time for bed. R2 was in the common area when she went to change another resident. E7 stated, she was R2's caretaker that day. R2 was not pacing and was not saying anything. On the walkie talkie E7 heard someone say why is R2 in AL. I think one of my co-workers went to go get him. We are supposed to check to see if anyone left or visitor did not open door right. If a resident is not in the common area check room and around the kitchen and nurses' station and if not there considered missing. The nurse was on break but was aware she heard it on the walkie. E7 stated she was in another room for about 10 minutes with the other resident. I did an incident report; I believe the nurse did it. E4 was made aware. The director talked to us and told us we had to be in the common area, and someone always had to be there. E7 believe there was an elopement drill because of R2 but she was not scheduled that day. On 5/23/2026 at 11:40am E10, care partner stated, she works in AL and remembers incident that happened on 4/22/2026 with R2. E10 stated	A4010		

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A4010	Continued From page 14 she was on the second floor and pushed the elevator to go down and when the door opened R2 came out of the elevator. E10 grabbed his hand, and he did not know where he was. We went to the first floor, and I radioed for a nurse to come. R2 was confused. E10 stated, she does not remember who came to get him. E10 waited at the nurses' station on the first floor for someone to come and get R2. Someone from MC came to get him. E10 stated, "I radioed for nurse and did not get an answer and did not get any answer after a few times calling so I ended up call our boss E1 to let her know what happened. I did not feel comfortable letting R2 go back without telling somebody". E1 immediately got in contact with the nurse and said she would figure out what happened. I just told her, I do not remember if a report was done. On 5/22/2026 at 5:12pm E2, Director of Resident care, stated, she was not made aware that R2 eloped out of the memory care unit, because she would have to do a reportable. E2 stated, she should have been alerted, but she was not notified. E2 stated, she does not know how it happened and is not good because she should be aware of things that happened On 5/24/202 at 3:57pm E1, Executive Director stated she was familiar with R1. E1 stated she does not know if incident reports were done because E2 always handles that. The incident reports E1 gets do not get reported to the state. E1 further stated, she thought if resident went to hospital, it as a reportable but she does not send it, but she looks it over. E1 stated, this was a one-time thing, and we are we gonna make sure it does not happen again. If there is an injury and resident remains in the facility, I would say that it is reportable. Yes, any kind of injury I would	A4010		

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A4010	Continued From page 15 report it. E1 stated she was familiar with R2, and she received a phone call from E10 after 10:00pm on 4/22/2026 and E10 said she found R2 by the front elevator. Before E1 could get up and call nurse E17, Licensed Practical Nurse (LPN) the nurse was mad that E1 was called and E17 told me not to worry about it and E10 was new, and he was not sure why she called me. E1 stated if R2 is out of the memory care unit he got out and she would consider that an elopement if that was reported. E1 did not investigate it any more than what the staff was telling me. E1 stated she was in a dead sleep and did not think anything was wrong, E17 told me nothing was wrong. E1 was assured that R2 was not out the unit. R2 got out of the unit that is an elopement. E1 stated, she listened to the nurse who she trusts, it was not told to me. If it had been reported to me, she would have done an investigation. We have done some elopement drills since that time. R1 is a 66-year-old female admitted to facility on 12/18/2024 with diagnosis not limited to: Seizure Disorder, Depressive Disorder, Anxiety, Memory loss, Behavioral Disorders Associated with Dementia, Dementia, unspecified, moderate w/ psychotic disturbance & agitation, Alzheimer's Disease R1's Individualized Service Plan dated 5/22/2026 no signature of E1, E2, or R1's POA (Power of Attorney) R3 is an 86-year-old female admitted to facility on 4/29/2025 with diagnosis not limited to: Alzheimer's Disease, CVA, CAD, Hyperlipidemia, Essential Hypertension, benign, Dementia, Glaucoma, Muscle weakness (generalized), Osteoarthritis, Anemia, Orthostatic Hypotension,	A4010		

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A4010	Continued From page 16 Fracture of Unspecified part of Neck of Left Femur R3's Individualized Service Plan dated 4/13/2026 no signature of E1, E2, or R3's POA (Power of Attorney) During course of the investigation, facility did not provide requested policy regarding supervision nor service plan. Illinois Long-Term Care OMBUDSMAN PROGRAM RESIDENTS' RIGHTS LONG-TERM CARE dated (Rev. 11/18) documents (in part): Your rights to safety Your facility must be safe, clean, comfortable and homelike. Illinois Department of Public Health Assisted Living in Illinois documents (in part) In Illinois, assisted living facilities are required to provide a safe environment for residents. This includes adherence to building codes related to accessibility, fire safety, and sanitation, such as adequate lighting, ventilation, and emergency exits, including smoke detectors and fire extinguishers. Facilities must also ensure that the environment is safe, clean, comfortable, and homelike, with reasonable arrangements to meet residents' needs and choices.	A4010			