STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510018	A. BUILDING: _____ B. WING _____	C 05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBORS AT ADAMS POINTE, THE	201 NORTH 48TH STREET QUINCY, IL 62305

(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 Original investigation of Facility Reported Incident IL 201961. 295.4060 h)3)a) Cited.	A 000		
A4060	Seciton 295.4060 Alzheimer's and Demential Programs This Regulation is not met as evidenced by: TYPE 1 VIOLATION Section 295.4060 Alzheimer's and Dementia Programs h) An establishment that offers to provide a special program for persons with Alzheimer's disease and related disorders shall: 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 This requirement was not met as evidenced by: Based on record review and interviews, the establishment failed to prevent one of three sampled residents from eloping from the facility unsupervised. (R1) This failure creates a substantial probability of severe harm (or death) to a resident. Findings include: R1's current face sheet and service plan notes	A4060		

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A4060	Continued From page 1 that R1 has Diagnosis including but not limited to Cognitive Impairment and Memory Changes. Service Plan notes that R1 is at high risk for elopement. R1's "Assisted Living and Shared Housing Incident and Accident Report" form reads, "Date 5/14/26, Time 10:15 A.M., Resident (R1) observed by Nurse (E2 Health and Wellness Director), seated unattended on the front patio, while sitting in office. Floor staff notified, resident (R1) along with her walker escorted back into building." E2's Witness Statement dated 5/14/26 reads, "At approximately 10:10 AM today, writer observed resident (R1) seated unattended on the front patio while sitting in my office with window open. Writer monitored briefly for staff presence and noting none. Alerted staff members assigned for that shift (1 LPN & 3 Caregivers). Resident (R1) was escorted back inside with her walker. She (R1) was unable to stated how she got outside or who assisted her to exit the key pad secured gate. Resident (R1) only alert to self, and repeatedly verbalized that she was waiting her daughter. Resident (R1) denied pain, no injuries noted." On 5/28/26 at 11:25 A.M. E2 stated that R1 did elope from facility unsupervised on 5/14/26. E2 stated that she happened to see R1 out on the patio by herself. E2 stated that staff were able to get R1 back inside without any issues. E2 stated that they are unaware of how R1 was able to get out of the facility without an alarm going off.	A4060		