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	ASL510324	A. BUILDING: _____ B. WING _____	C 07/27/2026

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AUBERGE AT NAPERVILLE A MEMORY CARE COMM	1936 BROOKDALE ROAD NAPERVILLE, IL 60563

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A 000	Initial Comment Entity Reported Incident Survey Conducted. # IL202940 - Substantiated Violations: 295.6000 a) 13 295.6010 a) 1) 2) 295.4060 a) b)	A 000		
A4060	Seciton 295.4060 Alzheimer's and Demential Programs This Regulation is not met as evidenced by: . Type 1 violation REPEAT 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) b) No person shall be admitted or retained in an assisted living or shared housing establishment if the establishment cannot provide or secure appropriate care, if the resident requires a level of service or type of service for which the establishment is not licensed or which	A4060		

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A4060	Continued From page 1	A4060		

the establishment does not provide, or if the establishment does not have the staff appropriate in numbers and with appropriate skill to provide such services. (Section 150(b) of the Act)

This requirement is not met as evidenced by:

Based on interviews and record reviews, establishment failed to provide appropriate care and safety for the residents.
This applies to 2 of 3 residents (R1 and R2) reviewed for care and safety in a sample of 3
This failure creates a substantial probability of severe harm to residents.

Findings include:

1) R1's face-sheet showed R1 was an 83 years old male admitted with Alzheimer's disease, Epilepsy, Glaucoma and Anxiety disorder.

R1's service plan dated 7/20/26 showed wandering precaution including location checks every 30 minutes and spot checks every two hours. R1's service plan also showed he attempted to elope on 5/16/26, 5/24/26 and 5/27/26.

R1's Progress notes dated 7/17/26 at 10:06 PM showed R1 eloped from the establishment through the front door without staff knowledge. Staff began search when door alarm went off. Head count showed R1 was missing and later was found walking down the street.

R1's Progress notes dated 6/2/26 at 3:03 PM showed R1 activated the northeast exit door around 2:40 PM.

2) R2's face-sheet showed that R2 was an 84

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A4060	Continued From page 2	A4060		

year old female admitted on 11/21/25 with a diagnosis to include dementia.

R2's service plan dated 3/19/26 showed wandering interventions as structured routines and supervised activities.

Incident report on R2 showed R2 eloped on 3/21/26. R2 was observed wandering by a couple who happened to be outside of their house tending their yard. They called the Police Department. The resident safely returned to the community accompanied by the policeman and the couple who found her.

On 7/25/26 at 11:50 AM E3 (LPN-Licensed Practical Nurse) stated R1 left the building on two occasions because there was no one to watch him as all the caregivers were busy caring for other residents and there was no activities to engage him.

On 7/25/27 at 12:30 PM E4 (CG-Caregiver) stated, "our staffing is poor. Need to get more staff. We are short mostly. Just 4-5 caregivers on day shift. Today from 6-8:30 AM, there was only 4 cg for 65 res. The 5th came at 8:30 AM. That's the time when we have more work. Mondays and Thursdays we have a lot of showers. We are not able to finish our showers by 8:30 AM. On a daily basis just having 5 cg is not enough to finish our work. Most of them need extensive assist for ADLs.

On 7/25/27 at 1:30 PM E7 (RCC-Resident Care Coordinator) stated usually there are 5 caregivers in day shift. If someone calls off and whoever is coming in or filling the gap is not always on time. And during that busy time there is not much people who are free. E7 stated the caregivers are

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AUBERGE AT NAPERVILLE A MEMORY CARE COMM	1936 BROOKDALE ROAD NAPERVILLE, IL 60563

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A4060	Continued From page 3 not able to watch the residents who are at risk for elopement and finish their work as the acuity is high. Staffing is an issue in this establishment. More caregiving staff and more activities are needed. On 7/25/26 at 12:45 PM E5 (CG) and E6 (CG) stated current staffing is not adequate to provide adequate care and safety due to the high acuity of the residents. On 7/25/26 at E2 (HSD-Health Service Director) stated R1 eloped because there was no one to watch him. There is activity only upto 4:00 PM and nothing after that. When this happened, there was no activity to keep him engaged. E2 (HSD), E3 (LPN), E4 (CG), E5 (CG), E6 (CG) and E7 (RCC) stated the acuity of the residents is too high for current staffing. Also that the staff is not able to work comfortably and keep an eye on the residents at risk for elopement.	A4060		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: . Type 1 Violation REPEAT 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	A6000		

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A6000	Continued From page 4 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 Observation, interviews and record reviews, establishment failed to provide a safe environment for residents with dementia and neglected to protect them from elopement. This applies to 2 of 3 residents (R1 and R2) reviewed for neglect. This failure creates a substantial probability of severe harm to residents. Findings include: 1) On 7/25/26 at 10:30 AM observed R1 walking down the hallway. R1 alert, oriented to self, forgetful, confused, talking irrelevantly. Looks clean and well groomed. 2) On 7/25/26 at 10:45 AM observed R2 sitting on her bed in her room. Alert, oriented to self and her immediate surrounding. Clean, well groomed. Observed she was able to wear her shoes and tie the lace. Confused, forgetful. Can hold a simple conversation in simple words. 3) On 7/25/26 at 11:00 AM observed R3 standing in the hallway. Alert, oriented to self, confused, forgetful, talks irrelevantly. Clean, moderately groomed.	A6000		

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A6000	Continued From page 5 On 7/25/26 at 11:18 AM, E4 (CG-Caregiver) stated R1 has sun-downing syndrome. He is more agitated after dinner and wants to go home. E4 stated from 5:00 PM till 8:30 AM the following day, there is no-one at the reception desk. E4 stated on 7/17/26 a little after 6:00 PM, he just walked out of the front door and nobody noticed. One of the nurses went looking for him in her car and found him down the street on the sidewalk, walking aimlessly. She brought him home. E4 stated staffing in the establishment is poor and not enough because of the acuity of the residents. On 7/25/26 at 12:30 PM, E4 (CG) stated the day R1 left the building, nobody was watching him. All the staff were in dining room or putting residents to bed. E4 stated R1 attempted elopement twice. The first time, he pushed open the side door and jumped over the fence. It was at noon. One of the cg was on break outside who saw him and brought him back inside. On 7/25/26 at 11:50 AM, E3 (LPN-Licensed Practical Nurse) stated on 7/17/26 at 7:55 PM, the front door alarm went off. E3 went outside the main door to look if any resident left the building. She did not see anyone. When the head count was done, R1 was missing. Then E3 went searching in her car and found R1 walking on the sidewalk about 20 minutes down the street. E3 stated she called 911 and informed them as to what happened. E3 stated when the cameras were reviewed, it showed that R1 followed the pharmacy delivery personnel to exit the building. After R1 was brought back into the facility he was on 1:1 supervision for 24 hours. On 7/25/26 at 1:30 PM E7 (RCC-Resident Care Coordinator) stated R1 left behind a person	A6000		

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A6000	Continued From page 6	A6000		

through the main door. If the staff is busy taking care of other residents given the acuity of our staff, there is nobody to watch him.

On 7/25/26 at 1:03 PM, E2 (HSD-Health Services Director) stated on the evening of 7/17/26, R1 followed the pharmacist out of the door. He did not attempt to push the door. At the time the staff was spread out, checking on their people. So, nobody was watching. E2 stated at that time, there was no activity to keep him engaged. E2 stated the risks of elopement are dangerous including automobile accidents, falls, temperature hazards etc.

E2 (HSD) stated R1 had attempted to elope once before also. E2 stated on 6/2/26 R1 got out of the side door and jumped over the fence. One of the caregivers was on break and was parking her car and she saw him. If she was not there he wouldd have gone out into the streets.

R1's Progress notes dated 7/17/26 at 10:06 PM showed R1 eloped from the establishment through the front door without staff knowledge. Staff began search when door alarm went off. Head count showed R1 was missing and later was found walking down the street.

R1's Progress notes dated 6/2/26 at 3:03 PM showed R1 activated the northeast exit door around 2:40 PM.

R1's face-sheet showed R1 was an 83 years old male admitted with Alzheimer's disease, Epilepsy, Glaucoma and Anxiety disorder.

R1's service plan dated 7/20/26 showed wandering precaution including location checks every 30 minutes and spot checks every two

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A6000	Continued From page 7 hours. R1's service plan also showed he attempted to elope on 5/16/26, 5/24/26 and 5/27/26. R2's face-sheet showed that R2 was an 84 year old female admitted on 11/21/25 with a diagnosis to include dementia. R2's service plan dated 3/19/26 showed wandering interventions as structured routines and supervised activities. Incident report on R2 showed R2 eloped on 3/21/26. R2 was observed wandering by a couple who happened to be outside of their house tending their yard. They called the Police Department. The resident safely returned to the community accompanied by the policeman and the couple who found her.	A6000		
A6010	Section 295.6010 Abuse, Neglect, and Financial Exploitation Pr This Regulation is not met as evidenced by: . Type 2 Violation Section 295.6010 Abuse, Neglect, and Financial Exploitation Prevention and Reporting a) When the establishment has a reasonable belief that a resident has been the victim of abuse, neglect, or financial exploitation, the establishment shall: 1) Notify the Department within 24 hours	A6010		

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A6010	Continued From page 8	A6010		

after receiving the allegation, by contacting the Assisted Living Complaint Registry by telephone, fax, or other electronic means. The establishment shall document this report and maintain documentation on the premises for 12 months after the date of the report.

2) Investigate and develop a written report within 14 days after the initial report. The establishment shall send the written report to the Department within 24 hours after it is completed and shall maintain a copy of the written report on the premises for 12 months after the date of the report.

This requirement is not met as evidenced by:

Based on interviews and record reviews, establishment failed to report to the Department resident eloped the establishment unnoticed. This applies to 1 of 3 residents (R1) reviewed for neglect.

This failure creates a substantial probability of harm to residents.

Findings include:

R1's face-sheet showed R1 was an 83 years old male admitted with Alzheimer's disease, Epilepsy, Glaucoma and Anxiety disorder.

R1's service plan dated 7/20/26 showed wandering precaution including location checks every 30 minutes and spot checks every two hours. R1's service plan also showed he attempted to elope on 5/16/26, 5/24/26 and 5/27/26.

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A6010	Continued From page 9 R1's Progress notes dated 7/17/26 at 10:06 PM showed R1 eloped from the establishment through the front door without staff knowledge. Staff began search when door alarm went off. Head count showed R1 was missing and later was found walking down the street. R1's Progress notes dated 6/2/26 at 3:03 PM showed R1 activated the northeast exit door around 2:40 PM. On 7/25/26 at 12:30 PM E4 (CG-Caregiver) stated R1 attempted elopement twice. The first time, he pushed open the side door and jumped over the fence. It was at noon. One of the CG was on break in the parking lot, who saw him and brought him back inside. On 7/25/27 at 1:03 PM E2 (HSD-Health Services Director) stated R1 had attempted to elope on 6/2/26. E2 stated R1 got out of the side door and jumped the fence. One of the caregivers was on break and was parking her car. She saw him and brought him back into the building. If she was not there he would have gone out into the streets. On 7/25/26 at 2:00 PM E1 (ED-Executive Director) stated this incident was not reported because R1 was located without much delay and he did not go out into the streets.	A6010		