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	ASL510124	A. BUILDING: _____ B. WING _____	C 08/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTAGES OF NEW LENOX, COTTAGE #4	1029 S CEDAR RD NEW LENOX, IL 60451

(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 Facility Reported Incident of 7/26/26 IL203054 295.4010 d) 295.4060 h)3)A)	A 000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Type 1 Violation Section 295.4010 Service Plan d) The service plan, which shall be reviewed annually, or more often as the resident's condition, preferences, or service needs change, shall serve as a basis for the service delivery contract between the provider and the resident (see Section 295.2030). (Section 15 of the Act) This requirement was not met as evidenced by: Based on interview and record review, the facility failed to update a resident's (R1) service plan timely to include a resident's attempts of elopement. This failure resulted in R1 eloping from the facility and exiting the enclosed courtyard. This failure creates a substantial probability of severe harm to a resident or residents. Findings include: R1 was admitted to the facility on 6/23/26 with a diagnosis of Alzheimers. R1 sent to the hospital	A4010		

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A4010	Continued From page 1 on 8/1/26 and did not return. R1's progress notes documents the following: 6/23/26 - Resident is newly admitted to the community. During the shift, the resident exhibited some exit-seeking behaviors. Care staff encouraged the resident to participate in activities; however, the resident declined. The POA called to check on the resident. This writer updated the POA regarding the resident's behaviors. The POA stated that they would allow the resident time to settle into the community and would not be visiting tomorrow but planned to visit on Thursday. The pharmacy delivered the resident's medications. Medications were received, reviewed, and placed in the medication drawer. At the time of this note, the resident is in the common area watching television and is not exhibiting any exit-seeking behaviors. Resident appears calm and comfortable. Continued monitoring will be provided. 6/24/26 - Resident is having exit seeking behaviors and resident is difficult to direct at times, resident has no PRN medications, resident's POA was informed and POA stated she would prefer if resident has orders for PRN medications when resident is exit seeking. NP was notified, awaiting possible new orders. 6/25/26 - Resident is up during most of the night only laying in bed for less than an hour. Resident offered snacks, and other activities such as folding laundry. Resident does attempt to get out of exit doors during the night multiple times, resident redirected all night. 7/26/26 - Caregiver notified this nurse that the resident could not be located. A Code Alert was	A4010		

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A4010	Continued From page 2	A4010		

initiated, and this writer and care staff immediately began searching for the resident. The resident was observed outside near the parking lot and was safely redirected back to the cottage without incident. Vital signs obtained upon return were as follows: BP 132/80 mmHg, pulse 80 bpm, respirations 18/min, temperature 98.6°F, oxygen saturation 98% on room air. The NP, POA, ED, and HWD were notified of the incident. The resident was sitting in the living room watching television with peers. No signs of distress were noted at that time. At 8:04 PM, care staff notified this writer that the resident had gone to her room. When staff went to check on the resident, they noted the resident's window was approximately one-quarter open with the window screen popped off. Staff looked outside and observed the resident climbing out of the Room 15 window. Care staff immediately responded to Room 15 and observed the resident as she was exiting through the window. When care staff went outside to assist the resident, the resident removed one of her shoes and began swinging it toward the caregiver in an aggressive manner. Care staff was able to calmly redirect the resident. The resident sat down on the grass with staff assistance, and staff assisted the resident with putting her shoe back on. Care staff immediately notified this writer. Upon this writer's arrival, the Room 15 window screen was observed on the ground outside, along with two bedside drawers on the grass that the resident had apparently used as steps to climb out of the window. The resident denied pain and stated, "I have to leave to catch the train to go home." The resident was redirected back toward the cottage but became aggressive, yelling that she would not return inside. The resident refused to allow this writer to obtain vital signs. 911 was called due to the resident's elopement

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A4010	Continued From page 3	A4010		

attempt, escalating behaviors, aggressive behavior toward staff, and refusal of assessment. The NP, POA, ED, and HWD were notified. The resident was transported by EMS to (Local Hosptal) for further evaluation. Location: Outside (On Premise) Day & Time: 07/26/2026 8:04 PM.

R1's service plan dated 7/22/26, does not contain a section "Elopment Risk Evaluation" and nor address R1's attempts to open exit doors and documents R1 was independent with transfers and ambulatoin.

R1's service plan dated 7/27/26 documents: Elopement Risk Evaluation:
Wandering/Elopement Risk - (R1) is a high elopement risk. 7/26/26 (R1) was displaying exit seeking behaviors and was able to get out of the door behind a visitor. She got outside of the gate and was redirected back into the building. Resident was then seen crawling out of a window in the next door room. Resident stated she needed to catch a train. Resident refused to come inside with care staff. 911 was contacted and paramedics arrived to transport resident to (Hospital) for further evaluation/treatment. She returned the same evening with NNO. Resident had a telehealth visit on 7/27/26 with psych NP and resident's aripiprazole was increased, and PRN medication was added. Safety stops will be installed on all windows. If resident is displaying exit seeking behaviors nurse on duty will be notified immediately and staff will attempt to redirect resident with an activity, snack, or walk outside if possible.

On 8/21/26 at 8:15 am, E7, Caregiver, was asked about R1's elopement and if R1 had eloped prior to her 7/26/26 elopement. E7 stated "I wasn't here when she eloped and she's never gotten out

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A4010	Continued From page 4	A4010		

when I was working. She (R1) would push on the doors to try and get them open. We had to re-direct her and she would get aggressive." E7 was asked how long R1 had been trying to physically open the doors. E7 stated "Pretty much since she got here. She was always wandering and pushing on the doors."

On 8/21/26 at 8:19 am E3 LPN stated "(R1) had a lot of exit seeking behaviors. She would constantly push on the doors to try and open them. We have signs on the door that say hold the bar for 15 seconds and then open. She knew how to read and follow directions, so she held the bar down and opened the door. We've had to redirect her inside a few times. (While walking through facility courtyard , E3 LPN pointed to the Gazebo and stated) she came out here one time when it was raining and I couldn't get her to go back inside. She would get combative and start swinging at you." E3 was asked if R1 had ever eloped from the facility prior to her 7/26 elopement. E3 stated "No, she would just push on them to try to get them open." E3 was asked how long R1 had been doing that. E3 stated "Since she got here. The family said she tried climbing out of the windows at home."

On 8/21/26 at 10:06 AM, E6, Caregiver, was asked about R1's elopement and if R1 had eloped prior to her 7/26/26 elopement. E6 stated "Not that I know of." E6 was asked if R1 ever tried to open the exit doors. E6 stated "She would always try to open the doors, but they're locked. You have to hold the bar down to open them. When she tried to open the doors, we had to re-direct her." E6 was asked about R1's ability to read and follow the directions on the door to hold the bar down for 15 seconds to open the door. E6 stated "Yeah, she (R1) could do that." E6 was

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A4010	Continued From page 5 asked how long R1 had been attempting to open the doors. E6 stated "Since she got here." On 8/21/26 at 11:11 AM, E2, HWD, was asked if the family had mentioned R1 being an elopement risk and trying to climb out windows at home. E2 stated "Not that I can remember, I can always look at the pre-admission assessment and see what's documented." This surveyor pulled up R1's EMR (Electronic Medical Record) and E2 pointed at a service plan and evaluation tab and directed this surveyor to open the pre-admission evaluation. While opening the document, it was noted that there is a 30 day evaluation and service plan dated 7/22/26. The pre-admission assessment was opened. It does not document any elopement risks. This surveyor then opened the 30 day assessment and service plan dated 7/22/26. R1's evaluation documents no/low risk for elopement and the service plan does not address R1's elopement attempts. E2 was asked to look at R1's service plan dated 7/22/26 for where it's addressed. E2 looked at the service plan and confirmed they were not added until the 7/27/26 service plan. This was after R1 had eloped from the facility.	A4010		
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	A4060		

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A4060	Continued From page 6 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; This requirement was not met as evidenced by: Based on observation, interview and record review, the facility failed to implement procedures to prevent a resident (R1), with known elopement attempts, from eloping from the facility. This failure resulted in R1 eloping twice in one day and getting outside of the facility's enclosed courtyard to the parking lot. This failure creates a substantial probability of severe harm of death to a resident or residents. Findings include: R1 was admitted to the facility on 6/23/26 with a diagnosis of Alzheimers. R1 sent to the hospital on 8/1/26 and did not return. R1's incident investigation dated 7/26/26 documents: On July 26, 2026, at approximately 6:00 PM, resident (R1) was observed walking throughout Cottage 4 and repeatedly attempting to open both the front and back exit doors by pushing on them, activating the door alarms. Care staff redirected R1 several times and offered activities to engage and redirect her. Although she initially participated in activities, she would leave the activity shortly afterward and resume walking throughout the	A4060		

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A4060	Continued From page 7	A4060		

cottage and attempting to open the exit doors.

At approximately 6:10 PM, another resident's visitor exited Cottage 4. At that time, (R1) was observed standing near the common television area. At approximately 6:11 PM (R1) activated her call pendant. At approximately 6:14 PM, care staff notified the nurse on duty that (R1) could not be located within Cottage 4 and that her pendant was activating. Staff had already initiated a Code Silver over the walkie-talkie while another caregiver notified the nurse on duty by telephone.

At approximately 6:15 PM, Cottage 4 staff conducted another search of all resident rooms bathrooms, and common areas. Staff from the other cottage responded to assist with the search.

During the investigation, an additional witness statement was obtained. At approximately 6:20 PM, while cleaning the dining room area in Cottage 2 a staff member observed a visitor approaching Cottage 2 and knocking on the window. As the staff member approached the door, they observed (R1) walking outside from the direction of the corridor leading from Cottage 4.
The visitor reported that (R1) had exited quickly behind her as she was leaving Cottage 4 and that she was unable to redirect (R1) back into Cottage 4. The visitor stated that (R1) agreed to walk with her toward another cottage.

The Cottage 2 staff member attempted to redirect (R1) into Cottage 2· however, (R1) refused to enter and continued walking throughout the secured courtyard. At approximately 6:22 PM, the staff member notified the nurse on duty that (R1) had been observed outside in the courtyard. At approximately 6:25 PM, a caregiver from

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another cottage approached (R1) near the rear of Cottage 2 and assisted with redirecting her.

(R1) was located approximately eight minutes after staff determined she was not inside Cottage 4. Staff maintained supervision of (R1) once she was located and initiated appropriate response procedures, including Code Silver, staff notification, community search procedures, and clinical follow-up.

At approximately 6:45 PM, (R1) was observed watching television in the common TV area. At approximately 7:15 PM, (R1) was observed eating a snack and walking throughout the cottage.

At approximately 7:53 PM, during routine rounds, care staff observed that (R1)'s bedroom window in Room 15 was open and the window screen had been removed. Staff looked outside and observed (R1) climbing out of the bedroom window. Care staff immediately responded and observed (R1) exiting through the window.

When staff attempted to assist (R1), she removed one of her shoes and swung it toward the caregiver. Staff maintained a calm approach and were able to redirect (R1). (R1) sat on the grass with staff assistance, and staff assisted her with putting her shoe back on.

The nurse was immediately notified. At approximately 8:00 PM, upon the nurse's arrival, the window screen was observed on the ground outside the window. Inside the room. both window stoppers were observed on the floor next to the window. Two bedside drawers were also observed outside on the grass below the window. The Maintenance Director was notified and stated

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A4060	Continued From page 9	A4060		

he would replace the window stoppers throughout Cottage 4 to ensure resident safety.

(R1) denied pain and stated, "I have to leave to catch the train to go home." Staff attempted to redirect (R1) back into the cottage; however, (R1) became increasingly agitated yelling that she would not return inside. (R1) refused to allow the nurse to obtain vital signs or complete a nursing assessment.

Due to (R1)'s continued exit-seeking behaviors increased agitation. aggressive behavior toward staff, and refusal of nursing assessment, 911 was contacted for assistance and further evaluation. The Nurse Practitioner, Power of Attorney, Executive Director, and Health and Wellness Director were notified. (R1) was transported by EMS to Hospital Emergency Department for further evaluation.

R1's progress notes documents the following:

6/23/26 - Resident is newly admitted to the community. During the shift, the resident exhibited some exit-seeking behaviors. Care staff encouraged the resident to participate in activities; however, the resident declined. The POA called to check on the resident. This writer updated the POA regarding the resident's behaviors. The POA stated that they would allow the resident time to settle into the community and would not be visiting tomorrow but planned to visit on Thursday. The pharmacy delivered the resident's medications. Medications were received, reviewed, and placed in the medication drawer. At the time of this note, the resident is in the common area watching television and is not exhibiting any exit-seeking behaviors. Resident

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A4060	Continued From page 10	A4060		

appears calm and comfortable. Continued monitoring will be provided.

6/24/26 - Resident is having exit seeking behaviors and resident is difficult to direct at times, resident has no PRN medications, resident's POA was informed and POA stated she would prefer if resident has orders for PRN medications when resident is exit seeking. NP was notified, awaiting possible new orders.

6/25/26 - Resident is up during most of the night only laying in bed for less than an hour. Resident offered snacks, and other activities such as folding laundry. Resident does attempt to get out of exit doors during the night multiple times, resident redirected all night.

7/26/26 - Caregiver notified this nurse that the resident could not be located. A Code Alert was initiated, and this writer and care staff immediately began searching for the resident. The resident was observed outside near the parking lot and was safely redirected back to the cottage without incident. Vital signs obtained upon return were as follows: BP 132/80 mmHg, pulse 80 bpm, respirations 18/min, temperature 98.6°F, oxygen saturation 98% on room air. The NP, POA, ED, and HWD were notified of the incident. The resident was sitting in the living room watching television with peers. No signs of distress were noted at that time. At 8:04 PM, care staff notified this writer that the resident had gone to her room. When staff went to check on the resident, they noted the resident's window was approximately one-quarter open with the window screen popped off. Staff looked outside and observed the resident climbing out of the Room 15 window. Care staff immediately responded to Room 15 and observed the resident as she was

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A4060	Continued From page 11	A4060		

exiting through the window. When care staff went outside to assist the resident, the resident removed one of her shoes and began swinging it toward the caregiver in an aggressive manner. Care staff was able to calmly redirect the resident. The resident sat down on the grass with staff assistance, and staff assisted the resident with putting her shoe back on. Care staff immediately notified this writer. Upon this writer's arrival, the Room 15 window screen was observed on the ground outside, along with two bedside drawers on the grass that the resident had apparently used as steps to climb out of the window. The resident denied pain and stated, "I have to leave to catch the train to go home." The resident was redirected back toward the cottage but became aggressive, yelling that she would not return inside. The resident refused to allow this writer to obtain vital signs. 911 was called due to the resident's elopement
attempt, escalating behaviors, aggressive behavior toward staff, and refusal of assessment. The NP, POA, ED, and HWD were notified. The resident was transported by EMS to (Local Hospital) for further evaluation. Location: Outside (On Premise) Day & Time: 07/26/2026 8:04 PM.

8/1/26 - Care staff notified this nurse that resident was pushing on backdoor and door was opened due to resident pushing on it for a long period of time. Care staff quickly went to get resident and resident refused to walk back inside the building. This nurse came in front of Cottage Four and tried to get resident inside of building with care staff, after many attempts and different ways of persuasion, resident refused to come back into community and would begin yelling and attempting to hit care staff and this nurse. POA was notified and asked if she could come help bring resident inside, POA stated she is an hour

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A4060	Continued From page 12 away and would not be here in a timely matter, POA stated we can call 911 to have an officer assist staff and escort resident back inside. 911 was called and Officer arrived on scene, after 20 minutes of Officer talking with resident, resident finally came back inside. Resident then sat down with other residents for dinner, and no other behaviors were noted the rest of shift. POA arrived and 7PM and stayed for approximately an hour. All parties notified. Vitals unable to be obtained at this time. Location: Outside (On Premise) Day & Time: 07/31/2026 5:00 PM R1's service plan dated 7/22/26, does not contain a section "Elopment Risk Evaluation" nor address R1's attempts to open exit doors and documents R1 was independent with transfers and ambulatoin. R1's service plan dated 7/27/26 documents: Elopement Risk Evaluation: Wandering/Elopement Risk - (R1) is a high elopement risk. 7/26/26 (R1) was displaying exit seeking behaviors and was able to get out of the door behind a visitor. She got outside of the gate and was redirected back into the building. Resident was then seen crawling out of a window in the next door room. Resident stated she needed to catch a train. Resident refused to come inside with care staff. 911 was contacted and paramedics arrived to transport resident to (Hospital) for further evaluation/treatment. She returned the same evening with NNO. Resident had a telehealth visit on 7/27/26 with psych NP and resident's aripiprazole was increased, and PRN medication was added. Safety stops will be installed on all windows. If resident is displaying exit seeking behaviors nurse on duty will be notified immediately and staff will attempt to redirect resident with an activity, snack, or walk	A4060		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510124	A. BUILDING: _____ B. WING _____	C 08/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTAGES OF NEW LENOX, COTTAGE #4	1029 S CEDAR RD NEW LENOX, IL 60451

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A4060	Continued From page 13 outside if possible. On 8/21/26 at 8:15 am, E7, Caregiver, was asked about R1's elopement and if R1 had eloped prior to her 7/26/26 elopement. E7 stated "I wasn't here when she eloped and she's never gotten out when I was working. She (R1) would push on the doors to try and get them open. We had to re-direct her and she would get aggressive." E7 was asked how long R1 had been trying to physically open the doors. E7 stated "Pretty much since she got here. She was always wandering and pushing on the doors." E7 added that R1 was able to get out the window in room #15. On 8/21/26 at 8:19 am E3 LPN stated "(R1) had a lot of exit seeking behaviors. She would constantly push on the doors to try and open them. We have signs on the door that say hold the bar for 15 seconds and then open. She knew how to read and follow directions, so she held the bar down and opened the door. We've had to redirect her inside a few times. (While walking through facility courtyard , E3 LPN pointed to the Gazebo and stated) she came out here one time when it was raining and I couldn't get her to go back inside. She would get combative and start swinging at you." E3 was asked if R1 had ever eloped from the facility prior to her 7/26 elopement. E3 stated "No, she would just push on them to try to get them open." E3 was asked how long R1 had been doing that. E3 stated "Since she got here. The family said she tried climbing out of the windows at home." E3 was asked which window R1 climbed out of. E3 stated "Room #15." On 8/21/26 at 8:25 am, observation of room #7 window shows a 2 metal L brackes screwed into each side of the window frame preventing the	A4060		

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A4060	Continued From page 14 window from being opened more than approximatley 6 inches. On 8/21/26 at 8:48 am, E4 was asked about R1's elopement. E4 was asked how R1 was able to get the window open if they were secured with stops. E4 stated "These stops (pointing to the metal L bracket stops on the window in room #7) weren't installed in room 15. That's why she was able to get it open." E4 was asked why room #15 didn't have any window stops installed. E4 stated "They were supposed to, but it didn't get installed." E4 was asked at the time of the elopement, how many windows didn't have stops. E4 stated "There were 5 windows that still needed to be completed, but I went around and installed these brackets on all 5 windows. Now all the windows have stops." E4 was asked why the windows never had the window stops installed prior to R1's elopement. E4 stated "Back in 2025, I was supposed to install window stops on all the windows here (Cottage #4), but other things came up and I got busy and didn't get them all done. That's why those 5 didn't get completed." On 8/21/26 at 9:20 am, E1, ED, was asked to see room #15. Upon entry of the room, 2 metal L brackets were installed on each side of the window frame. E1 stated "(R1) was able to break the window stops and get out this window." The conversation with E4 was mentioned to E1 about the window not having stops. E1 stated "These (pointing to the metal brackets) were installed after (R1)'s elopement. The day she eloped, the windows had a plastic stop. I'm not sure how they were mounted. We found the plastic piece she broke on the floor when we started the investigation the same day." On 8/21/26 at 9:45 AM, E5, Maintenance	A4060		

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A4060	Continued From page 15 Director, was asked about the plastic stops on the window prior to the metal L brackets being installed. E5 stated "We had these plastic stick on stops. We replaced them because over time, the heat and sun made them weak and they would come off easily. So we installed the metal brackets with screws. These won't come off. Some of the windows didn't get the metal brackets installed and still had the old plastic stops." On 8/21/26 at 10:06 AM, E6, Caregiver, was asked about R1's elopement and if R1 had eloped prior to her 7/26/26 elopement. E6 stated "Not that I know of." E6 was asked if R1 ever tried to open the exit doors. E6 stated "She would always try to open the doors, but they're locked. You have to hold the bar down to open them. When she tried to open the doors, we had to re-direct her." E6 was asked about R1's ability to read and follow the directions on the door to hold the bar down for 15 seconds to open the door. E6 stated "Yeah, she (R1) could do that." E6 was asked how long R1 had been attempting to open the doors. E6 stated "Since she got here." On 8/21/26 at 11:11 AM, E2, HWD, was asked if the family had mentioned R1 being an elopement risk and trying to climb out windows at home. E2 stated "Not that I can remember, I can always look at the pre-admission assessment and see what's documented." This surveyor pulled up R1's EMR (Electronic Medical Record) and E2 pointed at a service plan and evaluation tab and directed this surveyor to open the pre-admission evaluation. While opening the document, it was noted that there is a 30 day evaluation and service plan dated 7/22/26. The pre-admission assessment was opened. It does not document any elopement risks. This surveyor then opened	A4060		

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A4060	Continued From page 16 the 30 day assessment and service plan dated 7/22/26. R1's evaluation documents no/low risk for elopement and the service plan does not address R1's elopement attempts. E2 was asked to look at R1's service plan dated 7/22/26 for where it's addressed. E2 looked at the service plan and confirmed they were not added until the 7/27/26 service plan. This was after R1 had eloped from the facility. E2 was also asked about the service plan documenting R1 getting outside the gate. E2 confirmed E2 got outside the gate and started there is a sign on the gate directing individuals to push a button to open the gate and that R1 was able to read and follow the directions and opened the gate.	A4060		