STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146159	A. Building B. Wing	04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Terrace	1615 Sunset Avenue Waukegan, IL 60087

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to supervise a resident with dementia, poor safety awareness, and known exit seeking behaviors resulting in the resident eloping from the second floor of the facility through an alarmed door, walking down 14 interior steps, and going out a second alarmed door that led outside. R1 proceeded down 4 concrete steps, onto a wooden deck, turned right, and went down a wooden ramp, across the facility's parking lot, then crossed a busy 4 lane street. R1 then walked through another parking lot of an apartment complex and was found unresponsive (deceased) near the back of the apartment building approximately 125 yards from the facility's emergency exit door on 4/8/26. This applies to 1 of 6 residents (R1) reviewed for safety and supervision in the sample of 12. The Immediate Jeopardy began on 4/8/26 when R1 eloped from the facility. V1 (Administrator) and V2 (Director of Nursing) were notified of the Immediate Jeopardy on 4/10/26 at 4:24PM. The surveyor confirmed by observation, interview and record review, that the Immediate Jeopardy was removed on 4/10/26, but noncompliance remains at a Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training. The findings include: R1's Physician's Order Sheet shows that R1 was admitted to the facility on [DATE] with diagnoses including Parkinsonism, Chronic Obstructive Pulmonary Disease, Dementia, Unsteadiness on Feet, Combined Systolic and Diastolic Heart Failure, Atrial Fibrillation and Cognitive Communication Deficit. On 4/10/26 at 11:49 AM, V1 (Administrator) and V2 (DON-Director of Nursing) were interviewed together and stated, (V2) found him across the street, to the left of the apartment building where the blacktop ends, (R1) was on the ground. He was not breathing. I (V2) started compressions. It was me and (V6-CNA-Certified Nursing Assistant) and (V4-RN-Registered Nurse) doing CPR (Cardiopulmonary Resuscitation) and (V3-LPN Licensed Practical Nurse) called 911. Probably took them (Emergency Medical Services) 2-3 minutes to arrive. At the same time, I (V1) was in the building calling 911 to give a description of (R1) and let them know about the missing resident and believe it or not, they put me on hold because they said they think a colleague was also calling 911. (V2) said he had a history of elopement in December when he first got here but we got him right back in the building and that is why we moved him to the second floor. We had him on increased monitoring. He has not had any incidents since. The staff have to have face checks on him every hour. The nurse (V3) had him in her line of vision most of the day. Then she went in to do wound care. (V7-Activity Aide) was supposed to be watching him. The staff all were running around when they noticed the alarm going off. Both doors are alarmed and were going off.On 4/10/26 at 12:15PM V3(LPN) stated, (V8-CNA) told me when I came in that (R1) was very agitated and wanted to go home. I talked to (R1) and was able to calm him down some. He had breakfast but then he got agitated again. He kept going to the elevator. I notified the DON and the NP (Nurse Practitioner) was here, so I talked to the NP, and he ordered blood work and a UA/C&S (Urinalysis/Culture and Sensitivity). I talked to (R1) and he agreed to give me a urine sample, and I got a little bit in the cup. I put it in the refrigerator and scheduled the lab work for the next day. He kept needing to be redirected. I tried to reach out to social service and (V9- Social Service Assistant) came up and spoke to him. I called the Administrator and (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the DON. He kept going to the elevator. We were taking turns watching him. We had lunch and I spoke to (R1's) son and had him speak to his son. I don't know what his son said to him, but he was not happy about it. Then they sent (V7-Activity Assistant) up and told me she was assigned to take care of him. Me and (V8-CNA) went in to do wound care on another resident and when I was done, I said, Where is (R1)? (V7) said, He went down the hall. I thought (R1) went to his room - he was in (room number) so I checked his room and he was not there, so I started checking some of the other rooms and I called down to the other nurse who was at the nurse's station in the middle of the hall and she said he was not there. I came back and found (V4-RN- Registered Nurse) coming out of the bathroom and told her I could not find (R1) and she said she had just seen him at the nurse's station, so I went back up there. Then I turned around and saw everyone running towards the other end of the hall so I started running down there too. As I got closer, I could hear the door alarm going off and then I could see his wheelchair sitting outside the stairwell door. Then I could hear the door alarm at the bottom of the stairs ringing too and I said, oh, he went out the door. I called the DON, the MD, and the Administrator and the Administrator called a Code Green. We all started looking inside and outside the building for (R1). It was a very nice day, warm outside. I was running outside; we went to the (Fast Food Restaurant), (Fast Food Restaurant), the apartments next door. Then they said that the cameras showed that (R1) crossed the street and we ran over there. (V2-DON) was in her car and she was there first and then several of us were right behind her. I called 911. V4, V6 (CNA) and (V2) did CPR and I switched out with them as they got tired. The Paramedics arrived in about 5 min. The paramedics took over and they put the machine on him and transported him to the hospital.On 4/10/26 at 1:22PM V4 (RN) stated, I had just come upstairs, and I saw (R1) in the wheelchair at the nurse's station. Then I went to the bathroom. As I was coming out (V3) said she couldn't find (R1). I looked towards the nurse's station, and I didn't see him and then under the sound of the call light I could hear this very faint dinging sound. The call light system is old so it is very loud, but I could hear another ding, ding, ding under that sound. So, I ran towards the door at the end of the hall, and I saw (R1's) wheelchair outside the door, so I booked it down the stairs and out the door. I called the Administrator at 2:26PM and she called the code green. The camera shows (R1) coming out the door at 2:24 PM. I went towards the apartments next door because there are always people outside. I don't know the exact time he was found. I ran back upstairs and got my keys and went down and got in my car and started driving around. I went to the parking lot across the street, but I went to the right because I thought it went all the way around and then I came back here. As I was getting out of my car, I saw people running across the street, so I got back into my car and drove back over there and assisted with CPR. When the paramedics got there, they took over. There were no signs of life. He was fully dressed with shoes on. It was a beautiful day, probably 70 degrees outside. I had seen him earlier in the day talking to his son, he wanted to go home.On 4/10/26 at 12:35PM Surveyor reviewed R1's exit path with V3 (LPN), V1 (Administrator) and V2 (Director of Nursing). R1 went down the hall, turned down the narrow hallway with the stairwell door at the end. R1 went out the stairwell door, setting off the alarm, went down 14 interior stairs and out the exterior door, setting off the second alarm. R1 proceeded down 4 concrete steps and onto a wooden deck. R1 turned right onto a wooden ramp that led to the side of the facility's parking lot. R1 walked across the parking lot, across a 4-lane busy street, and into the parking lot of an apartment complex. R1 turned left and followed that parking lot around to the back where he was found unresponsive on the ground near the building. On 4/10/26 at 12:45PM Surveyor assessed door alarms on the second floor. As Surveyor and V3 (LPN) were walking towards the stairwell door someone stated that the alarm was going off right now. Surveyor was unable to distinguish the door alarm over the call light system. After assessing the doors and the alarms and the areas that R1 exited the building, surveyor asked V5 (Maintenance) to trigger the alarm on the stairwell door. Surveyor walked down the hall towards the center nurse's station. About halfway down the hall, at about room [ROOM NUMBER] (before the main nurse's station, dining room and elevator) the door alarm was no longer audible to Surveyor. As Surveyor walked back towards the (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	stairwell door, a call light came on and the door alarm was not audible to Surveyor at all, even at room [ROOM NUMBER], closer to the door alarm. On 4/10/26 at 2:35PM V9 (Social Service Assistant) stated, I went to the second floor because the nurse (V3) said (R1) was anxious. He was very anxious, worried. The nurse wanted me to talk to him. He calmed down a little bit, and I went back downstairs to do other work. I called his son and the son said he had already talked to his dad. I went back upstairs to talk to him, and he was calm, so I came back down to do other work and talk to other residents. I had worked with him a few times before. He was not trying to get on the elevator when I saw him. He didn't have any complaints. He was just anxious but did not give me any reason for his anxiety. He was just sitting in the dining room.On 4/13/26 at 9:20AM V8 (CNA) stated, I saw (R1) before (V3) and I went in to do the wound care (down the same hall as the elevator) V7(Activity Aide) was sitting by the elevator and (R1) was moving down the hallway. He was in his wheelchair. There were a few other residents in the hallway, and this was not really unusual. I think (V7) thought she was just supposed to be guarding the elevator. I told her she didn't have to stay in front of the elevator if (R1) is down the hall. After the wound care I went into (Room number) to change another resident. I heard the code green and it took me a minute to respond because I had to finish up and put the bed back in the low position and give the resident her call light. I could not hear the door alarm going off. I couldn't differentiate that from the call light bells going off since the call lights are so loud. Then I heard (R1) was missing. I ran downstairs and then I remembered seeing him in the hallway and V5 (Maintenance) and I ran back up thinking that maybe he couldn't get out of the stairwell. He wasn't there so I got in my car and started driving around and kept thinking, (R1) couldn't have gotten this far. (R1) walked pretty good. He kept saying he wanted to walk home, he wanted to walk to (his hometown) and I showed him on my phone that it would take him 15 hours to walk there (42miles from facility) and (R1) said if you people wouldn't keep stopping me. I know (R1) talked to his son, and I don't know what was said but I know it was an argument because I could hear them both yelling on the phone. (V3) calmed (R1) down quite a few times that day but he still wanted to go home.On 4/13/26 V7(Activity Aide) stated, At 1:35PM my boss (V10- Activity Director) told me to go upstairs and do the activity on the second floor. When I got up there, (V8-CNA) told me I needed to watch after (R1). I went closer to the nurse's station, and I asked the nurse with the red hair (V3) if I could sit at the nurse's station and she said it was only for the nurses. So, I sat in front of the nurse's station and (V8) and (V3) walked away. Then I went and sat in front of the elevator and (R1) went down the short hall and I brought him back and he got a cup of water and then he went down the long hallway and there were a couple other residents and another CNA and a nurse in the hallway too. Then (V9- Social Service Assistant) came up on the elevator and she asked me if I knew how to work a (Virtual Assistant Device) because (R1's) family wanted to be able to call him on it and I told her I really didn't know how. Then I saw (V8) and he told me I really didn't have to sit in front of the elevator if (R1) was down the hall so I went and sat at the long table in front of the TV and I was working on a flowerpot with one of the other residents. Then a few minutes later (V3) came and asked me if I knew where (R1) was and I told her he was in the hallway and then a few minutes after that (V4- RN Infection Preventionist) came and asked me if I knew where (R1) was and I told her the same thing. I could not hear the door alarm- but the dining room is usually pretty loud. Then everyone started running and I was left alone on the floor with all the residents in the dining room.On 4/13/26 at 2:30PM V10 (Activity Director) stated, I told (V7) to go upstairs and run the activity and watch (R1) so he doesn't get on the elevator- while she does the activity. A lot of times while we are in the dining room we are also monitoring the dining room and the elevator because we are right there. I knew (R1) was trying to elope so I thought she could do the activity and also just kind of watch the elevator to make sure he doesn't get on it. She didn't really have to guard the elevator- just watch (R1) while she was in the dining room. I don't know what she was told when she got up there.R1's EMS Report shows that the EMS call came in at 2:54PM. The report states, (City) Rescue 4 and Engine 4 called to noted location for an unresponsive/person down. Upon arrival crew waved down by a civilian and directed crew to (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	patient. Pt was supine on the parking lot floor with a significant amount of Vomit. CPR was in progress. Crew took over checked for pulse and breathing. Crew determined that patient was pulseless and not breathing. Pt presented with Asystole on the cardiac monitor. Crew initiated CPR and began to bag patient with a BVM (Bag-Valve-Mask) supplied with oxygen. Pt suctioned and OPA (Oropharyngeal Airway) placed, attempted placement of NPA (Nasopharyngeal Airway) no success no visual signs of trauma noted. LUCAS ([NAME] University Cardiopulmonary Assist System) device place for continuous CPR. IO (Intraosseous) established in the Left Tibia. Fluids and EPI 1:10 administered per protocol. It was determined that patient is a resident of (Facility) and he had absconded from the facility. Multiple staff members on scene, it was determined that the person left the facility approximately 14:15 (2:15 pm) and they have been looking for him since. When staff found him he was unresponsive and initiated CPR and called 911. Crew continued to work patient Pt was in Asystole with no changes. Pt intubated and obtained a brief spiked reading of ETCO2.(End-Tidal Carbon Dioxide) Pt prepped for transport. ET (Endotracheal) tube checked after pt moved, still in place. Pt suctioned once again as tube became filled with frothy sputum. Unable to get a adequate ETCO2 reading. Contacted (Local Hospital) with a full report, no orders given. Continued CPR and EPI 1:10 during transport no changes noted pt remained in asystole during the entirety of the incident. Upon arrival to (Local Hospital) pt was taken to ED room report was given to RN pt care was transferred without incident. Pt remained in asystole.R1's Elopement Risk assessment dated [DATE] states, Resident at risk for elopement. IDT reported resident for an attempt to leave unattended and paces on the unit.R1's Care Plan dated 12/22/25 states, The resident is an elopement risk/wandered related to History of attempts to leave facility unattended, impaired safety awareness. New to facility. Worsening confusion during evening hours. One of the Interventions states, Provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures and memory boxes.The facility presented an abatement plan to remove the immediacy on 4/10/26. The survey team reviewed the abatement plan and was unable to accept the plan to remove the immediacy. The abatement plan was returned to the facility for revisions. The facility presented a revised abatement plan on 4/13/26, and the survey team accepted the abatement plan on 4/13/26.The Immediate Jeopardy that began on 4/8/26 was removed on 4/10/26 when the facility took the following actions to remove the Immediacy:1.The facility has taken the following actions concerning the IJ complaint:a. The identified exit door was monitored by staff 24/7 beginning on 4/10/2026.b. Second floor and first floor middle of the hallways alarm bells were delivered and installed on 4/11/26. An additional alarm bell was placed by the second floor nursing station/elevator area on 4/12/26. In addition to being alarmed, first and second floor middle of the hallway stairwell doors were added to the existing bells on 4/13/26.c. An emergency QAPI meeting was held with the medical director on 4/8 to review the incident and for any additional input.d. Inservices was done by administrator and/or designee to staff prior to the start of their shift regarding: code green (missing resident), what to do if a resident is exit seeking and anxious, and residents that are identified as elopement risk and placed on 1:1 care, what to do if they walk away.2.Measures the facility will take to ensure the problem will be corrected and not recur.a. The maintenance director or designee will monitor and test the alarm bells. The bells will be tested weekly on various shifts for three months.b. The maintenance director or designee will perform code green (missing resident) mock drills monthly for three months on various shifts.c. Social services will identify residents that are at risk for elopement. These assessments will be completed for current residents on 4/13/26. All new residents will be assessed for elopement risk. Interventions for elopement will be put in the residents' care plan.3.The administrator will monitor continued compliance via the following Quality Improvement programs:a. A QA tool was developed to review the alarm bells weekly and ensure they are audible for 3 months.b. A QA tool was developed to review any attempted or actual cases of elopement weekly for 3 months.c. Outcomes of bell testing and code green (missing resident) drills will be discussed at monthly QAPI. These reviews will be ongoing for 3 months and may continue based on outcome of the (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	findings.d. Interventions for identified residents that are an elopement risk will be discussed at monthly QAPI meetings. These reviews will be ongoing for 3 months and may continue based on outcome of the findings.e. The results of the monitoring completed under this plan are submitted to the QA/QAPI committee for review and follow-up and reviewed with the Medical Director. Next QAPI meeting scheduled for April 30th, 2026.Date Removal Plan Will Be Completed: 4/10/2026