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S 000	Initial Comments Complaint Investigation # 2276978/IL150762	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210c) 300.1210d)6) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with	S9999	Attachment A Statement of Licensure Violations	

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each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These Requirements were not met evidenced by:

Based on observation, interview and record review, the facility failed to ensure that a resident identified with exit seeking behavior, was provided adequate supervision to prevent elopement from the facility. The facility also failed to ensure that the main entrance sliding door

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alarm was working to alert facility staff to a resident's attempt to elope.

This failure resulted in R1 eloping from the facility without being witnessed by the staff on August 31, 2022. R1 was found walking on the street by the local police department approximately 338 feet from the facility, on a six-lane road. This applies to 1 of 5 residents (R1) reviewed for elopement risk in the sample of 5.

The findings include:

R1 is 101 years old, admitted to the facility on July 25, 2022. R1 has multiple diagnoses which included, acute respiratory failure with hypoxia, chronic diastolic (congestive) heart failure, atrial fibrillation, congenital heart block and generalized muscle weakness, based on the face sheet.

R1's admission MDS (minimum data set) dated August 1, 2022 shows R1 has severe cognitive impairment. R1 requires extensive assistance from the staff with most of her ADLs (activities of daily living) including transfer, walking in the room and locomotion on the unit. The same MDS shows that R1 has no functional limitation in range of motion on both upper and lower extremities and uses a walker or wheelchair for mobility.

R1's exit seeking/wandering/elopement risk assessment, dated August 1, 2022 shows that the resident scored "1" which meant that R1 is not at risk. Under the evaluation section of the assessment, it asks if "the resident have the physical ability to leave the building on their own?" This was answered "yes." The second question in the evaluation asks if the "resident is

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cognitively impaired with deficits in orientation, decision making related to diagnosis of dementia, DD/ID (developmentally disabled/intellectually disabled), or severe mental illness and/or have an active decision maker (guardian, POA (Power of Attorney), healthcare surrogate?" This was answered "no." Under the same evaluation, there was no documentation that R1 had history or current behavior of elopement attempts, exit seeking behavior, wandering behavior or any factors which may contribute to R1's risk for elopement.

R1's progress notes from admission (July 25, 2022) through August 31, 2022 shows multiple documentation regarding wandering/exit seeking behaviors, including, August 27, 2022 (12:30 PM) created by V5 (Nurse), "resident was trying to go out with exit alarm door, resident reeducated not to use exit alarm door" and on August 30, 2022 (10:50 PM) created by V3 (Nurse), "Resident has been exhibiting wandering behavior the entire evening shift. She is constantly redirected by staff. Will continue to monitor."

Further review of R1's progress notes dated August 31, 2022 (1:05 AM) created by V3 (Nurse) shows in-part, "Resident was able to get out of building but was brought back in. Patient was then brought to room and being supervised every 30 minutes. Daughter was informed about the incident. Nurse Practitioner made aware of incident."

Review of the facility's investigation of R1's elopement incident shows that V3 and V4 (CNA/Certified Nursing Assistant) were interviewed by V1 (Administrator). The facility documented time of events according to V3 shows, "[R1] was at nursing station with nurse.

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New admission arrived just after 12:30 am. [V3] stated that at this time, he believes [R1] left through the front door of the building and headed toward the sidewalk. [V3] stated at some point during this time, Police found [R1] and brought her back to the facility at approximately 1:30 am. [V3] completed head-to-toe assessment noting no injuries to the resident, and resident returned to her room. DON (Director of Nursing) notified who was in the building on the third floor. Then, Administrator notified via phone call from nurse at approximately 1:50 am. Administrator called [V3] for statement on [August 31] at approximately 2 am. [V3] stated that [R1] was gone between 12:30 am - 1:50 am. [V3] stated "I only remember her gone for 10-30 minutes." [V3] stated that the Police caught her at the side walk and brought her back to the facility." The facility documented time of events according to V4 shows, "Upon interview, [V4] stated that she was assigned to first floor. She did try to exit but I caught her the first time and she went back to her room. Around 1:30 am, I saw her prior to going into the room to care for another resident and saw her again and redirected her back to her room. I then provided care to another resident. Police refused to speak to me and only spoke to [V3]. I am not sure of the conversation that happened. Later, I asked the nurse and they saw her on the sidewalk, near Army Trail Road by the building prior to being returned to us. [V4] stated that the resident was wandering more than usual this night and was getting up more than normal."

On September 1, 2022 at 12:17 PM, V2 (Director of Nursing) stated that R1 was admitted to the facility for therapy services with the goal of going back to the assisted living after therapy. V2 stated that based on R1's MDS dated August 1, 2022, the resident has a BIMS (Brief Interview for

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S9999	Continued From page 5 Mental Status) score of "04" which meant that the resident is severely impaired with cognition. According to V2, R1's exit seeking/wandering/elopement risk assessment dated August 1, 2022 should reflect that the resident is cognitively impaired and the answer to the second evaluation question should be "yes" instead of "no" which puts R1 at risk for elopement. V2 added that based on the exit/seeking/wandering/ elopement risk assessment instructions, two or more "yes" responses to the questions place the resident at risk for elopement. According to V2 she was informed by V8 (manager on duty) on August 27, 2022 that R1 wanted to go down to the basement, but she was not aware that R1 had exit seeking behavior. V2 stated that when R1 manifested exit seeking and wandering behavior on August 27, 2022, as documented on the progress notes, a new exit/seeking/wandering/elopement risk assessment should have been completed because "there was no doubt that (R1) was an elopement risk." V2 stated that any resident from the first floor identified as at risk for elopement like R1 will be moved to the 3rd floor for close monitoring because the 3rd floor is a "locked unit" that requires a code to leave. V2 added that if R1's family does not want R1 to be moved to the locked unit, the resident could stay on the first floor, but the staff should always have visual control of R1 when the resident is awake while ambulating and/or sitting on her wheelchair, and if R1 is sleeping the staff should check on the resident every hour to ensure safety and accountability of the resident. During this interview, V2 stated that the facility does not know how R1 got out of the facility unwitnessed during the early hours on August 31, 2022.	S9999		

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S9999	Continued From page 6 On September 1, 2022 at 2:06 PM, V10 (Receptionist) stated that she normally works at the facility from 6:00 AM through 2:00 PM and at times would work from 2:00 PM through 8:00 PM as needed. V10 stated that when the receptionist leaves the building at 8:00 PM, the main entrance sliding door would automatically lock, not allowing anyone from the outside to come inside the facility. For the staff to come in after 8:00 PM, they have to use their swipe card for the main entrance sliding door to open. Visitors have to ring the door bell and the first floor staff would come to the main entrance sliding door to open. According to V10 since the main entrance sliding door automatically locks at 8:00 PM, the receptionist does not do any other procedure such as turning on the switch that is located on the upper right side of the door. V10 added that after 8:00 PM, from the inside of the facility, anyone can go outside including residents because the main entrance sliding door would automatically open and no alarm could be heard coming from the door. However, V10 does not know if there is an alarm going off on the first floor nursing station when someone leaves the building through the main entrance sliding door. On September 1, 2022 at 2:10 PM, V11 (Receptionist) stated that she regularly works at the facility from 2:00 PM through 8:00 PM. V11 stated that she was the receptionist who worked on August 30, 2022 from 2:00 PM through 8:00 PM. According to V11, when she left at 8:00 PM on August 30, 2022, it was just like all the other days that she worked. By 8:00 PM the main entrance sliding door would automatically lock from the outside, which meant that anyone coming in the facility cannot enter unless they have a swipe card (for staff), and if they are visitors, they need to ring the door bell and the	S9999		

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first floor staff would come to the main entrance sliding door to open. Per V11 she does not touch the switch that is located on the upper right side of the door to lock the sliding door. According to V11, anyone can come out of the building (resident, visitor, or staff) through the main entrance sliding door because the door would open automatically without any alarm sounding on the door. V11 stated that she does not know if an alarm will go off at the first floor nursing station if someone leaves the building through the main entrance sliding door.

On September 1, 2022 at 2:16 PM, R1 was residing at the locked unit of the facility, were in a code is needed to use the elevator to leave the unit. R1 was sitting in her wheelchair in front of the nursing station asking assistance to use the toilet. On September 1, 2022 at 2:22 PM, R1 was sitting in her wheelchair inside the locked unit dining room. R1 was alert, verbally responsive but confusion. V2 asked R1 if she remembered walking out of the facility and being taken back by the police. R1 responded incoherently and could not provide information why and how she left the facility during the early hours on August 31, 2022.

On September 1, 2022 at 4:27 PM, V3 (Nurse) stated that on August 30, 2022 he was the assigned nurse for R1 during the afternoon shift (3:00 PM - 11:00 PM) and night shift (11:00 PM - 7:00 AM). V3 stated that during the night shift on August 30, 2022, he was working with V4 (CNA/Certified Nursing Assistant) on the first floor where R1 resides. V3 confirmed that he was the nurse who documented on August 30, 2022 at 10:50 PM, about R1 exhibiting wandering behavior of going into other residents rooms, the entire shift which required constant redirection from the staff. According to V3, on August 31,

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2022 around 1:30 AM, R1 had opened the west side exit door on the first floor that triggered the alarm. V3 stated that they (V3 and V4 (CNA/Certified Nursing Assistant)) responded to the west side exit door alarm and saw R1 standing behind her wheelchair in front of the alarming exit door. V3 stated that they assisted R1 to sit in her wheelchair, placed R1 and her wheelchair between room 107 and 109 and instructed R1 to go to the nursing station, while they (V3 and V4) went inside room 109 to change a resident with the door closed for privacy. According to V3 that was the last time he saw R1 because he got busy attending to other residents, until a Police officer rang the facility doorbell between 1:50 AM and 1:55 AM asking him if R1 is one of the facility resident. V3 stated that the Police officer walked with him from the facility to the sidewalk of the Army Trail Road. It was there that he identified R1 as a facility resident. V3 was informed by the Police officer that they saw R1 pushing her wheelchair to walk on the Army Trail Road sidewalk. According to the Police officer, they asked R1 to sit on her wheelchair while one Police officer watched R1, and the other Police officer went to the facility to inquire. According to V3, the location where R1 was with the Police officer was on the sidewalk of the Army Trail Road outside of the facility parking lot, near the intersection stop light. V3 stated that he wheeled R1 back to the facility with the Police officers. When R1 was inside the facility he assessed the resident. R1 had no visible injury but appeared nervous. R1 was wearing a white shirt, gray pants, and a slip on shoes. V3 stated that on the night of August 30, 2022, R1's behavior of wandering to other resident's rooms and attempting to exit the facility was increased and he was aware that the resident had wandering behavior even prior to August 30, 2022. V3 was

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asked why he did not document on R1's progress notes about the resident triggering the west side exit door on August 31, 2022 at 1:30 AM. V3 responded, "I forgot because I was busy attending to other residents." During the same interview V3 stated that after 8:00 PM, when the receptionist left the building, the facility's main entrance sliding door would automatically lock and when a visitor wants to come in the building, the visitor needs to ring the doorbell and the staff on the first floor would open the door to gain access. V3 stated that for staff, a swipe card is used to enter the building after 8:00 PM through the main entrance sliding door. According to V3, after 8:00 PM when someone (either staff or resident) wants to leave the building, the main entrance sliding door would automatically slide open when the person is in-front of the sliding door sensor, allowing the person to leave. V3 was asked if an alarm wound sound when someone leaves the building through the main entrance sliding door after 8:00 PM. V3 responded, "there is no alarm on the main entrance, the sliding door just slides open, then they can go out. The only alarm are on the west, east and patio exit doors." V3 was asked if he heard any door alarm coming from the west, east, patio or main entrance door on August 31, 2022 after 1:30 AM, after R1 triggered the west exit door. V3 responded, "no door alarms went off on the west, east or patio exit doors." V3 added, "there was no door alarm on the main entrance door, it just slides open, and anyone can go out." V3 was asked how R1 could go out of the facility without any staff witnessing? V3 responded, "I believe she got out through the main entrance sliding door because it would slide open automatically and then she can walk through the parking lot to the Army Trail side walk." V3 added that he does not believe R1 got out through the

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other exit doors because the west and east exit doors had alarm and it is heavy to push for the resident, while the patio exit door also has an alarm but is enclosed without access to leave. According to V3, R1 has short term memory problem with on and off confusion, a wanderer, able to ambulate by pushing her wheelchair using it like a walker and was capable of going out of the facility. V3 stated that because R1 had increased wandering and exiting behavior, the resident got out of the facility unwitnessed.

On September 1, 2022 at 6:02 PM, V3 was asked about the electronic progress notes he created on August 31, 2022 at 1:05 AM, regarding R1 getting out of the building and was brought back. V3, responded that the electronic documentation was the elopement of R1 on August 31, 2022, however, V3 admitted that he changed the electronic documentation entry time to 1:05 AM, instead of documenting the time the Police officer came in the facility to inform him that R1 was found walking on the side walk. During the same interview, V3 verbalized that since he changed the documentation entry time on the electronic record, he had approximated the time of the elopement incident.

On September 1, 2022 at 6:30 PM with V1 (Administrator), V2 (Director of Nursing) and V3 (Nurse), the distance from the facility entrance to the side walk where R1 was found by the Police officer was measured using the facility's digital measure wheel. The distance was approximately 338 feet. The side walk was located on the East Army Trail Road, a six-lane street, with three lanes going east and three lanes going west with a raised median in between.

On September 1, 2022 at 8:12 PM, no reception

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personnel was observed by the front lobby. The State Agency personnel was able to swing open the front center swing (double) door by either pushing one of the door or by pressing the push pad/button on the wall which causes both of the doors to swing open. Upon reaching the main entrance sliding door, the said door slide open, as well as the second sliding door from the inside which was leading to the parking lot. An alarm was sounding on the panel inside the first floor nursing station when the main entrance sliding door was opened from the inside of the building. When outside of the facility, the State Agency personnel cannot gain access to the facility until a staff member opened the sliding door. During this observation V3 was at the first floor nursing station. V3 stated that he had been working at the facility for a while on a needed basis as a floater (first, second or third floor) at least two-three times per week. In front of V1 (Administrator) and V2 (Director of Nursing), V3 stated that after the elopement incident of R1 on August 31, 2022, he was informed by V7 (Nurse) that the first floor nurse is responsible for making sure that the main entrance sliding door alarm is working after 8:00 PM, by checking the door alarm panel on the back wall of the first floor nursing station. V3 stated that according to V7 the alarm should go off on the first floor nursing station door alarm panel every time someone leaves the building through the main entrance sliding door. V3 stated that he was never aware of this procedure before, until he was told by V7. In the presence of V1 and V2, V3 stated that on August 31, 2022 when R1 had eloped the facility, he did not hear an alarm after 1:30 AM to indicate that someone went out of the building from the main entrance sliding door or on any side exit doors. At 8:36 PM, the State Agency personnel again attempted to leave the facility using the

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main entrance sliding door. An alarm was sounding on the panel inside the first floor nursing station when the main entrance sliding door was opened from the inside of the building. With V2 it was observed that from the hallway outside of room 109 (located towards the end of the west side wing) the door alarm could barely be heard and when inside room 109 with the door closed, the alarm cannot be heard.

During separate interviews held on September 2, 2022 at 2:45 PM and 3:15 PM respectively, V12 (CNA, who regularly works 10:00 PM - 6:00 AM) and V13 (CNA, who regularly works 2:00 PM - 10:00 PM) stated that they have taken care of R1 prior to the resident's elopement incident, while resident was resident at the first floor. V12 and V13 stated that R1 had wandering behavior, going in and out of other resident's rooms. According to V12, there are times that the first floor staff are busy taking care of other residents and no one is available at the nursing station to check the alarms. V12 and V13 stated that when the staff is inside a resident's room providing care with the door closed, the door alarms cannot be heard at times, especially if the room is towards the end of the hallway, away from the first floor nursing station alarm panel. V14 (Nurse) who was also interviewed on September 2, 2022 at 3:45 PM, stated that she regularly works the first floor from 3:00 PM through 11:00 PM. V14 stated that she has not taken care of R1 because she is assigned on the other hall but has heard from V5 (Nurse) that R1 would wander to other residents room. According to V14 there are times when there is no staff at the nursing station because they are attending to other residents. V14 stated that when the staff is inside the resident's room providing care with the door closed. The exit door alarms cannot be heard, especially if the

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S9999	Continued From page 13 room is located at the end of the hall, away from the nursing station alarm panel. On September 6, 2022 at 11:00 AM, V5 (Nurse) stated that she was the nurse who documented on R1's progress notes dated August 27, 2022 (12:30 PM). V5 stated that she documented that R1 was trying to go out of the building using the exit door. According to V5, on August 27, 2022, R1 had increased confusion, wandering from room to room, and attempting to open the first floor exit side doors on the east and west side which triggered the alarm. V5 stated that because the side exit doors are heavy to fully open and with the alarm sounding, R1 was not able to get out of the building. V5 added that because of R1's increased confusion and wandering behavior the physician was notified with order to check for UTI (urinary tract infection). According to V5 she informed the manager on duty (V8) about R1's exit seeking behavior and V8 stated that she will inform the Director of Nursing. On September 6, 2022 at 11:30 AM, V4 (CNA/Certified Nursing Assistant) stated that she works at the facility on a needed basis at least once or twice per week as a floater, which meant she can be assigned to any of the floors (first, second or third). V4 stated that she was assigned to R1 on August 30, 2022 during the night shift (10:00 PM - 6:00 AM) on the first floor. V4 stated that on August 31, 2022 at approximately 1:30 AM, R1 attempted to open the west exit door that triggered the door alarm. According to V4, she and the nurse (V3) went to check on the west exit door and found R1 standing at the back of her wheelchair, pushing the west exit door but was not successful in going out. V4 stated that they (V3 and V4) assisted R1	S9999		

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to sit on her wheelchair and they (V3 and V4) went inside room 109-2 to change a resident with the door closed for privacy. According to V4, when she got out of room 109-2, R1 was still sitting in her wheelchair, so she assisted R1 to bed. However, she does not know what happen after she assisted R1 to bed because she got busy providing care to other residents. V4 stated that the next thing she knew, the Police was inside the facility with R1. During the same interview, V4 stated that during her shift on August 30, 2022 prior to R1 leaving the facility unsupervised, she observed R1 multiple times wandering to other resident rooms, and then at approximately 1:30 AM on August 31, 2022 the resident had exit seeking behavior when she triggered the west exit door. Per V4, most of the time R1 uses her wheelchair to ambulate by pushing the back of the wheelchair or at times uses a walker to ambulate. V4 stated that after 8:00 PM, prior to R1's elopement incident, the main entrance sliding door does not open from the outside unless the staff uses their swipe card to enter and for visitors, they have to ring the door bell and the staff would go to the main entrance sliding door to let them in. V4 added that to go out of the facility, anyone (a staff or resident) could walk or wheel out of the facility unnoticed, because the main entrance sliding door would automatically slide open and no alarm would go off. According to V4, she believes that R1 walked out of the main entrance sliding door while pushing the back of her wheelchair to ambulate. V4 stated that because the door would slide open automatically, R1 could easily go out of the facility to the parking lot, then walk to the side walk of Army Trail Road without being noticed by the staff. V4 added that there was no alarm sounding on the main entrance sliding door to indicate that someone used the said door to go out of the

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building, from the start of her shift on August 30, 2022 until the elopement incident of R1. According to V4, R1 can push open the other exit doors but she does not believe that R1 got out through those exit doors because the west and east exit doors had alarm and the doors are heavy to push, and the patio exit door also has an alarm but is enclosed.

On September 7, 2022 at 11:40 AM, V7 (Nurse) stated that on August 31, 2022 at approximately 1:49 AM, she saw two Police officers coming out of the facility. When she reached the first floor unit, she saw V4 (CNA) sitting by the nursing station with R1. V4 informed her (V7) that R1 was found by the Police outside of the facility and was brought in. According to V7 at approximately 1:50 AM, the Police officers came back and was looking for V3 (Nurse) and was asking for R1's name. V7 stated that after the Police officers had left, she told V3 and V4 that the first floor staff should make sure that after 8:00 PM when the receptionist is no longer in the building and until the receptionist comes back in the morning, the alarm panel on the back wall of the first floor nursing station should have "no red light on" to ensure that the alarms on all exit doors including the east and west side exit doors, patio door and main entrance sliding door is activated. V7 stated that if all the door alarms are activated with "no red light on," the alarm would sound off when any of the said exit doors are opened from the inside of the building, to ensure that first floor staff checks the sounding alarm to prevent any resident from getting out of the facility unnoticed. During the same interview, V7 stated that while she was explaining this procedure to V3 and V4, she noticed that a red light was on, on the alarm panel which she pointed to V3 and V4 stating, "this light should be off, so the alarm would

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S9999	Continued From page 16 sound" and she turned off the red light. However, V7 does not remember which exit door had a red light on to determine which exit door alarm was not activated at that time. Review of the facility's door alarm check verification from May 2022 through September 5, 2022 shows that the main entrance sliding door was not included in the checklist. There was no documentation that the main entrance sliding door was being checked to ensure functionality. Review of the facility's policy and procedure regarding door alarm function test dated March 2014 shows under policy, "Exterior and Interior door alarms will be tested daily to ensure proper functioning." Under the procedure it shows, "1. All exterior door alarms will be tested twice a day by the Building Manager, House Supervisor or Designee at the beginning of his/her shift in the morning and at the end of the shift in the afternoon. 2. All interior door alarms will be tested once per shift (3 times daily), by the Building Manager, House Supervisor, or designee. 3. Testing will be performed by opening the door to verify that the alarm is functioning as designed (local alarm, alarm at nursing station or both). 4. Facility will develop a door alarm verification checklist that lists in logical order all exterior doors with alarms and all interior door alarms with spaces for testing individuals initials. 5. Every alarm tested will be initialed on the door alarm verification checklist. 6. Nonfunctioning alarms will be reported to the Administrator and Building Manager for repair or referral to contractor. Until repair is made the door must be made secure by placement of an additional temporary alarm or added supervision." Review of the invoice/service report created by an outside door company dated September 7, 2022	S9999		

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S9999	Continued From page 17 shows in-part, "Reported Problem - Interior slide sensor" "Description of work completed - Inspection revealed loose wires at the switch for Interior sensor control during after-hours. Rewired switch with new wires. Reset slide door control program - completed." On September 8, 2022 at 2:06 PM, V9 (Building Manager) stated that according to the outside door company the loose wires at the switch affected the main entrance sliding door from the inside going out of the facility. However, according to the outside door company, the same switch which is located on the upper right side of the door should be switched on after 8:00 PM, to ensure that the sliding door does not open automatically until the staff deactivate/turn off the switch to allow passage. On September 8, 2022 at 2:18 PM, V2 (Director of Nursing) stated that the switch which is located on the upper right side of the sliding door was never switched on after 8:00 PM prior to September 7, 2022. V2 stated that prior to September 7, 2022 the sliding door of the main entrance door would automatically lock from the outside to ensure that only staff with swipe card can come in the building. The visitors who wants to come in the building after 8:00 PM needs to ring the door bell for the staff to open the sliding door from the lobby. Prior to September 7, 2022, after 8:00 PM, the main entrance sliding door would slide open when someone wants to leave the building and it should alarm on the first floor nursing station panel to alert first floor staff that someone left the building. The first floor staff should check if it was a staff, visitor or resident who left the building. On September 12, 2022 at 11:22 AM, V16	S9999		

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(Physician) stated that prior to admission to the facility, R1 was residing at the supportive living place. While at the supportive living, R1 was alert and oriented x 3 and would walk using her walker. R1 was admitted to the facility for therapy services. V16 stated that on August 27, 2022 while R1 was at the facility, she was informed by the staff that R1 was having confusion. According to V16 she ordered for R1 to be checked for UTI (urinary tract infection) which turned out to be positive. V16 stated that it was possible that on the early morning of August 31, 2022, R1 was sleeping and woke up confused with sundowning and left the facility without being witnessed by the staff.

On September 12, 2022 at 12:01 PM, V17 (Police Officer) stated that on August 31, 2022 at 1:30 AM, he saw R1 pushing behind her wheelchair, walking on the Army Trail Road going west bound coming towards the intersection of Glen Ellyn Road. V17 verified that R1 was walking on the street and not on the sidewalk. V17 described the Army Trail Road as a six-lane street with three lanes going east and three lanes going west with a raised median in between. V17 stated that he assisted R1 to the sidewalk and requested the Police department dispatch to call the facility to inquire if they have a missing resident, to which the facility responded that they do not have any missing resident at that time. V17 stated that since the facility was the closest place for possible resident to have eloped, another officer went to the facility to inquire aboutmissing resident and had the nurse walk with the officer to the sidewalk where R1 was safely placed. According to V17, it was only then that the nurse identified R1 as their resident. R1 was then brought back to the facility by the nurse while being followed by the police officers. V17 added

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S9999	Continued From page 19 that when they found R1 walking on the street, there was a communication barrier, R1 was confused, does not know her name and without any identification with her. (A)	S9999		