STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0032896	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN POPLAR CREEK REHAB & HCC	1545 BARRINGTON ROAD , HOFFMAN ESTATES, Illinois, 60169

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S0000	Initial Comments Facility Reported Incident of July 1, 2025 IL196001	S0000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 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. 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 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. These requirements are not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a resident with severe	S9999		

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

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S9999	Continued from page 1 cognitive impairment and a history of wandering was supervised to prevent elopement. This failure resulted in R1 eloping from a secured memory care unit, exiting the building without staff identifying and preventing R1 from eloping. R1 exited the building and ambulated without her walker crossing a six-lane busy intersection and was found approximately 0.8 miles away from the facility wandering outside of the local grocery store. This applies to 1 of 6 residents (R1) reviewed for safety in the sample of 6. The findings include: R1's face sheet shows she is an 82-year-old female, with diagnoses including vascular dementia, moderate without behavioral disturbance, hypertension, history of falling, ataxia, primary osteoarthritis, and hyperlipidemia. R1's Exit Seeking/Wandering/Elopement Risk Assessment, dated 6/9/25, shows she is at risk for elopement. R1's Fall Risk Assessment, dated 4/8/25, shows her mobility is unsteady and or/use of ambulatory aide, impaired memory and incontinent. R1's current care plan shows she has short term and memory impairment…she needs supervision and support throughout the day to maintain independence with activities of daily functioning (ADL). R1 has an ADL self-care deficit due to poor safety awareness, poor judgment, impaired balance, unsteadiness on feet and history of falling. R1 has a history of being at risk for elopement related to cognitive impairment. History of exit seeking behavior and physical ability to ambulate with walker. She continues to have compromised safety awareness. Interventions include frequent checks and supervision, monitor behaviors, staff/family escort when off secured unit. R1's facility EHR does not show documentation of R1 eloping from the facility in the medical record. R1's Final Incident Report, dated 7/7/25, shows on 7/1/25, R1 eloped from the facility, facility responded appropriately. R1 was taken to the local hospital for evaluation and returned. R1's Hospital Records, dated 7/1/25 at 8:31 PM, shows, "(R1) arrives via EMS (Emergency Medical Services). EMS states someone called police, (R1) wandering around the streets to the grocery store with known baseline of dementia…brought in for evaluation for possible	S9999		

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S9999	Continued from page 2 elopement. Family at bedside and they are upset that (R1) was not guarded appropriately and left the facility and found wandering…family and staff confirm (R1) has chronic cognitive impairment with occasional wandering behavior." On 7/8/25 at 11:38 AM, V1 (Administrator) and V2 (Director of Nursing) confirmed R1 eloped from the secured memory unit on 7/1/25. After the dinner meal around 6:30 PM, staff could not locate R1. V9 (Receptionist) said he saw someone who looked like R1 walk out of the building with family. V9 did not recognize R1 was leaving the building without her family. Both said family members had the access code to get on the elevators leaving the secured unit, and there is no alarm that alerts the staff a resident is attempting to exit the secured unit. On 7/8/25 at 9:41 AM, R1 was on the secured memory care unit, sitting in the dining room with her walker next to her. R1 was alert to self only. R1 could not recall the date, time, or where she was. This surveyor asked about the incident on 7/1/25. R1 could not recall the incident and stated, “I did that, Oh my God. Did I get hurt? Oh my God, I must be losing my mind. I did not know I did that.” On 7/8/25 at 11:52 AM, V7 (Certified Nursing Assistant) said on 7/1/25, she was R1’s CNA. R1 was in the dining room at 5:00 PM for the dinner meal. At 5:40 PM, she left the dining room to assist other residents back to their rooms. At 6:30 PM, she could not locate R1. She asked V11 (Activity Aide), who was in the dining room supervising the residents, about R1. V11 said she did not know where R1 was. V7 said she notified V3 (R1’s nurse) R1 was missing. "(R1) is alert to self; she had a history of wandering when she first came to the facility. (R1) likes to lay down after meals and requires staff assistance to get back to her room. She uses a walker, and she is definitely not safe to leave the facility on her own. (R1) probably got on the elevator with someone else’s family. (R1) should have been supervised to prevent her from leaving the unit attended." On 7/8/25 at 1:09 PM, V11 (Activity Aide) said on 7/1/25, she was supervising the dining room. She saw R1 leave the dining room about 5:40 PM. "About 6:40 -7:00 PM, staff asked me if (R1) was in the dining room; she told them (R1) left the dining room by herself when she was done eating." V11 said R1 was not on the wandering list, and she did not report to staff when R1 left the dining room.	S9999		

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S9999	Continued from page 3 On 7/8/25 at 12:09 PM, V3 (Registered Nurse/RN) said on 7/1/25, she was R1's nurse. R1 was in the dining room during dinner at 5:00 PM, she gave R1 medications after dinner. At about 6:30 PM, she was finished passing her evening medications, and V11 (CNA) reported they could not locate R1. "We called a code a green to search for (R1), but we could not locate her." She called V9 (Receptionist) and asked if he had seen R1. V9 said there was someone who fits the description of R1 who left the facility with family. V9 said he was not 100 percent sure if that was R1 because he was not familiar who R1 was. V3 said R1 got on the elevator, and she was busy passing medications. She was not paying attention who was getting on the elevator. R1 looks like a resident, and she is not safe leaving the building unsupervised. Increased supervision should have happened, those are the busiest times of the night, after the dinner meal. On 7/8/25 at 12:30 PM, V9 (Receptionist) said on 7/1/25, he was working at the front desk, he heard a code green overhead, and he received a call from V3 (RN) asking if he saw R1. V9 said he did recognize R1 by name, then looked her up in electronic health records and said he saw R1 leave the building with family. "I assumed they were family because they were walking together." V9 said, "(R1) looked normal to me." V9 said he could not recall about what time this occurred. He said there is an elopement binder at the front desk, with each resident's name and picture, but he had not seen R1 before and did not review the binder every shift. On 7/8/25 at 12:09 PM, V8 (CNA) said R1 was in the dining room during the dinner meal at 5:00 PM. About 5:45 PM, she left the dining room to assist other residents, R1 was still in the dining room sitting at her table. At 6:00 PM, she was in another resident room assisting with cares. About 6:30 PM, staff were looking for R1 and could not locate her. "(R1) usually needs direction to get back to her room when leaving the dining room. There is usually someone supervising her to her to room. The activity aide should report to staff when a resident is leaving the dining room, so we are aware. I'm guessing she got on the elevator with another resident's family because you need a code to get on the elevator and visitors are given the code." On 7/10/25 at 8:34 AM, V12 (RN) said on 7/2/25, he was R1's nurse after she returned back to the hospital. "There was a concern she had fallen when she was found outside of the facility. They did x-rays and scans with no injury. (R1) is alert to self, she has a history of wandering into other resident rooms, and she needs to	S9999		

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S9999	Continued from page 4 be directed and supervised. There is a reason why she is on a secured memory care unit, because she is ambulatory, she is at risk of eloping. You never know what's on her mind or what she is thinking." On 7/8/26 at 2:13 PM, V13 (R1's Power Of Attorney/POA) said she was out of the country when all this happened, but she received a call from the facility at 7:18 PM. "They said they saw her last after dinner and thought she was with me. (R1) got on the elevator with another resident's family member." She called her other sisters to inform them of the incident. Her sister arrived in the facility about 7:45 PM, and the police had not been notified yet. Someone called the police and reported R1 was found wandering at the outside of the grocery store without her walker. They reported she fell because there was grass found in her hair. When R1 was living with her, she had an episode of eloping from her home, and that's when she was sent to the facility. She was no longer safe to be home because she needed more supervision. On 7/9/25 at 9:04 AM, V14 (R1's daughter) said, "On 7/1/25 about 8:00 PM, I received a call from the facility asking me if my mom (R1) was with me. They said my mom (R1) had been missing since 7:30 PM. I was going to call my siblings to ask if they were with mom. My other sister arrived at the facility and asked if they had called the police yet. The facility had not notified law enforcement, which is a big problem, because my mom (R1) has dementia. My sister called the police and reported her missing, and they told her someone reported a wandering person at the local grocery store. My mom was sent to the local hospital for evaluation. When she arrived to the hospital, (R1) had grass clippings in her hair, and I was told (R1) was found on the floor by the paramedics. This was scary and nerve wracking. She got on the elevator and out the front door without anything alarming or anybody noticing she was a resident. They don't have a monitoring device to alert them someone is leaving their building; that should not be. I was concerned about her safety. She is not safe to be crossing that busy intersection. That's crazy she made it to the local grocery store in one piece she had to cross a busy intersection." The facility's Elopement and Management of Missing Resident Policy, dated 2023, states, "Elopement is defined as a dependent (cognitively impaired, non-decisional) resident leaving a facility without staff awareness and under circumstances that place the resident's health, safety, or welfare at risk….	S9999		

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S9999	Continued from page 5 Suspected Missing Resident…. if a resident are unaccounted for, notify the Administrator and Director of Nursing. Direct all staff to make a thorough search of the building and external premises. In unable to locate the resident, call 911 to report the resident missing. Notify resident's legal representative/responsible party…complete incident report. Document accordingly in the medical record." (A)	S9999		