STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6015507	A. BUILDING: _____ B. WING _____	C 09/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN COURTS OF WATERFORD	1991 RANDI DRIVE AURORA, IL 60504

(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
S 000	Initial Comments Facility Reported Incident of September 5, 2021/IL138222	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 a) 300.1210 b) 300.1210 d)3) 300.1210 d)6) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which	S9999	Attachment A Statement of Licensure Violations	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6015507	A. BUILDING: _____ B. WING _____	C 09/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN COURTS OF WATERFORD	1991 RANDI DRIVE AURORA, IL 60504

(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
S9999	Continued From page 1 allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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. 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6015507	A. BUILDING: _____ B. WING _____	C 09/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN COURTS OF WATERFORD	1991 RANDI DRIVE AURORA, IL 60504

(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
S9999	Continued From page 2 review, the facility failed to identify the root cause of a resident elopement and identify interventions to prevent further resident elopements. The facility failed to provide adequate staffing and supervision for residents at risk for elopement. The facility also failed to assess newly admitted residents ' risk for elopement and provide for accurate and ongoing elopement risk assessments by a trained and qualified individual. The facility also failed to provide staff training on resident elopement and missing resident procedures. These failures resulted in the potential to affect all residents residing at the facility identified to be at risk for elopement (R1-R8). As a result of the failure, R1 eloped undetected on 9/5/21 through an unlocked/unalarmed door near R1's room. R1 remained unsupervised in the outdoor environment, crossed streets, walked through parking lots, and had physical access to an ungated and unsupervised pond and open buildings. R1 was found approximately two blocks from the facility approximately two hours after she was identified as missing. This applies to 8 of 8 residents (R1-R8) identified by the facility as at risk for elopement in a sample of 8. The findings include: 1. Face sheet, dated 9/20/21, showed R1 was admitted to the facility on 7/24/20 and had diagnoses which included dementia without behavioral disturbance, abnormalities of gait and mobility, weakness, anxiety disorder, and history of falling. Initial Elopement Risk Assessment, dated 9/27/20, shows the assessment questions were left blank resulting in R1 not being assessed for	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6015507	A. BUILDING: _____ B. WING _____	C 09/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN COURTS OF WATERFORD	1991 RANDI DRIVE AURORA, IL 60504

(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
S9999	Continued From page 3 elopement risk. As of 9/5/21 at the time of R1's elopement from the facility, the clinical record showed no Elopement Risk Assessment was performed on R1 since her admission to the facility on 7/24/20. Review of R1's care plan as of 9/5/21 at the time of her elopement from the facility showed the care plan failed to include any elopement focus or interventions to prevent R1 from eloping from the facility. Resident Service Plan, reviewed 3/24/20, shows, "Encourage R1 to walk indoors; she should be accompanied by staff or family if wanting to walk outdoors." On 9/20/21 at 2:30 PM, V4 (CNA- Certified Nursing Assistant) stated on 9/5/21 she saw R1 at approximately 4:30 AM when she took R1's vitals. At approximately 5:30 AM, V4 looked for R1 to dress R1 but was unable to locate her. V4 stated no exit alarms were sounding on the C-Wing and she had not heard any alarms during her shift. When V4 was unable to locate R1 after searching, V4 told V5 (RN-Registered Nurse) and the two staff began searching the XXX-Wing for R1 but were unable to locate her. V4 stated she saw V5 go outside the exit door by R1's room to search for R1 but no alarms sounded when V5 exited. V4 stated she and V5 continued to search and informed other facility staff to assist in the search. V4 stated she exited the building and checked a nearby ungated pond for R1 as well as a nearby building but was unable to locate R1. V4 stated she did not hear any exit alarms during her shift or when the staff exited to search for R1. V4 stated R1, as well as R3 and R4, had a history of wandering and exit seeking while residing on	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6015507	A. BUILDING _____ B. WING _____	C 09/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN COURTS OF WATERFORD	1991 RANDI DRIVE AURORA, IL 60504

(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
S9999	Continued From page 4 the wing. On 9/22/21 at 7:41 AM, V5 (RN) stated the last time he saw R1 on 9/5/21 was approximately 4:30 AM before he began passing medications. V5 stated at approximately 5:30 AM, V4 asked him to assist searching for R1 because V4 was unable to locate her and that a door at the end of R1's hall was left unlocked. V5 stated they both searched the entire wing, were unable to locate R1, and V5 then checked the wing exits. V5 stated the door near R1's room was closed however was not locked and the alarm was disarmed. V5 stated he was able to exit the door without unlocking it and without an audible alarm sounding on the wing. V5 stated he immediately ran to the nearby ungated water to make sure R1 was not there and was relieved not to find her because it was not protected from wandering residents. V5 stated at approximately 6:05 AM he checked the nearby outdoor area and returned to the XXX-Wing to call V3 (Director of Nursing) and told V3 he was calling 911 immediately. V5 stated he alerted the nurses on the other resident wings in the building as well as staff arriving for the next nursing shift. V5 stated when 911 arrived, he printed pictures of R1 and gather information for the police to search for R1. V5 stated it was only after R1 was identified as missing and staff, V3, and 911 were informed, that he noticed a red blinking light on the exit door alarm panel at the nursing station. V5 stated he had not heard any exit alarms during his shift on the wing and was not aware an exit door alarm could be silenced at the nurses' station. V5 stated he left the wing for approximately 10-20-minute intervals during his shift, but that V4 took alarms very seriously and would not have disarmed alarms if they sounded without attending to the exit door. V5 stated he strongly	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6015507	A. BUILDING: _____ B. WING _____	C 09/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN COURTS OF WATERFORD	1991 RANDI DRIVE AURORA, IL 60504

(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
S9999	Continued From page 5	S9999		

believed someone without an exit door key previously silenced the audible alarm at the nursing station and forgot to tell a staff with a key to go back and arm the door lock/alarm at the exit.

On 9/21/21 at 11:00 AM, V7 (CNA) stated she arrived at work on 9/5/21 and noticed staff outside the facility and was told a resident was missing. V7 stated she and another staff got in her car and searched the facility campus, the nearby hospital parking lot, a gas station, a convenience store, and returned to the facility searched around the facility when she got a call from V8 (Housekeeping) who told V7 she found R1 approximately 1-2 blocks away from the facility. V7 ran to V8 and R1 and R1 was standing outside in a gown, an incontinence brief, slip-on shoes with no socks, no glasses, and V7 described R1 as looking tired. V7 stated the outdoor temperature was in the 60's degrees Fahrenheit and R1 told V7 she was cold.

Facility document Interviews, undated, shows V8 stated "After driving around, I saw the patient in the parking lot of (name of business) standing between two parked cars."

Progress note, dated 9/5/21, shows R1 was last seen at approximately 4:30 AM. At 5:30 AM, V5 was told by V4 that V4 was unable to locate R1 in the facility. At 5:45, V5 found the exit door at the back of the hall noted to be "opened." At 6:05 AM 911 was called, at 7:30 AM R1 was located outside the facility and returned to the facility, and at 7:45 AM R1 was transported to the hospital for evaluation.

Incident/Accident Notification, dated 9/10/21 provided to Illinois Department of Public Health,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6015507	A. BUILDING: _____ B. WING _____	C 09/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN COURTS OF WATERFORD	1991 RANDI DRIVE AURORA, IL 60504

(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
S9999	Continued From page 6 fails to show R1 eloped from the facility through an unlocked/unalarmed facility exit door. Review of the investigation documentation shows the facility failed to identify the root cause of R1's elopement and failed to implement interventions to prevent facility staff from silencing exit door alarms without relocking/re-alarming an exit door. On 9/20/21 and 9/22/21, the exit doors on the resident wings were able to be unlocked and opened after the door bars was pushed for 15 seconds. Once unlocked and unopened, the alarms at the door automatically silenced but the alarms at the nurses' station continued to sound. The alarms at the nurses' stations were able to be silenced manually by staff without staff having to investigate the exit door, re-lock the exit door, or re-alarm the exit door alarm. Review of the outdoor environment of the facility on 9/22/21 showed R1 had walking access to several parking lots, streets, open buildings, and an ungated/unsupervised pond that was accessible by walking on the sidewalk near the door she exited. The pathway to the location in which R1 was located included walking across parking lots and crossing a street that supported local traffic. On 9/20/21 at 2:00 PM, V25 (CNA) stated R1 had a history of pushing the outdoor exit doors open and causing the door alarms to sound since she was admitted to the facility. V25 stated R1 always wanted to go outside especially if the weather was nice. On 9/20/21 at 2:08 PM, V9 (CNA) stated R1 was "one we have to keep an eye on." V9 stated staff will catch R1 at the outdoor exit door or in the enclosed patio exit door.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6015507	A. BUILDING: _____ B. WING _____	C 09/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN COURTS OF WATERFORD	1991 RANDI DRIVE AURORA, IL 60504

(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
S9999	Continued From page 7 Progress notes dated 11/21/20 and 11/21/20, 12/6/20, 1/21/21, 2/18/21, 3/4/21, 3/14/21, show R1 walking throughout the night on the wing. Progress notes, dated 9/2/21,9/3/21, 9/4/21, and 9/5/21 show R1 was non-compliant with COVID-19 isolation requirements and was unable to stay in her room "due to dementia and forgetfulness." Behavior monitoring CNA Task, effective 1/9/2015, shows R1 was monitored for feeling restless/anxious/wandering. The documentation shows R1 experienced the behaviors on September 2, 3, 6, 9, 16, 2021. Facility Policy/Procedure, dated 11/2017, shows, "A Social Service/Behavioral Health staff member or designee will conduct the Elopement Risk Assessment at admission (within 14 days of admission), quarterly, annually and episodically, and it will be filed in the medical record or electronically ....." Any necessary changes will be noted in a progress note, or by additional assessment. If no changes are documented, this assessment will be considered representative of the resident's current status and will be considered as supporting documentation for the initial MDS (Minimum Data Set) .... If a resident is evaluated at being "At-Risk" for elopement, the following procedures will be implemented: 1. The resident's picture will be taken and provided to the nursing station of the unit the resident resides on and to the front office for monitoring of the front door to the facility. 2. Increased monitoring will be initiated if there is a change in condition for an elevated concern of elopement. 3. The resident will be re-assessed quarterly and/or as needed to continue monitoring the resident's behavior as it relates to elopement risk.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6015507	A. BUILDING: _____ B. WING _____	C 09/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN COURTS OF WATERFORD	1991 RANDI DRIVE AURORA, IL 60504

(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
S9999	Continued From page 8 IF a resident does elope from the facility, the following procedures will be implemented: A 'Code Green' will be paged overhead .... A head count and search will be conducted to assist in locating the resident ...." 2. Facility document "Correction Plan," undated, shows in response to R1's elopement on 9/5/21, "5. On 9/5/21 V1, V3, and V4 immediately implemented an audit of all residents to assess for elopement risk. Individualized plans of care have been updated based on the assessment. This was completed by 9/7/21." On 9/20/21 at 10:00 AM V3 (DON) provided the document "At Risk for Elopement" which showed only two residents (R1 and R2) were identified as at risk for elopement. The document failed to include R3-R8 as identified as at risk for elopement. On 9/20/21 at 3:34 PM, V19 (Receptionist) stated R1 and R2 were the only residents identified as elopement risks according to the Elopement Risk Binder of at-risk residents kept at the front door. The binder failed to include information regarding R3-R8 as being at risk for elopement. Face sheet, dated 9/20/21, shows R2 was admitted to the facility on 5/14/21 and R2's diagnoses include Alzheimer's disease, conduction disorders, and dementia. Care Plan initiated 05/14/2021 shows R2 was receiving antidepressant psychotropic medication for a diagnosis of Alzheimer's Disease and antipsychotic psychotropic medication for Dementia without Behavioral disturbances. The care plan shows R2's symptoms may include	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6015507	A. BUILDING: _____ B. WING _____	C 09/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN COURTS OF WATERFORD	1991 RANDI DRIVE AURORA, IL 60504

(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
S9999	Continued From page 9 sleep disturbances, low mood, wandering and anxiousness. Review of R2's clinical record shows no Elopement Risk assessment was performed on R2 since admission until 09/07/2021 after R1's elopement. The assessment determined R2 to be at high risk for elopement. On 9/22/21 at 7:41 AM, V5 stated R2 was capable of eloping from the facility because R2 was young, did not look like a typical resident, and visitors often held the door for R2 when they left the wing thinking R2 was another outside visitor and not a resident. Progress notes, dated 5/14/21, shows R2 was ambulating around the wing and entering other residents' rooms. Progress notes, dated 6/2/21 showed R2 was having difficulty with self-control and aggression, throwing items, pushing wheelchairs, becoming angry, and yelled, "I'm just going to leave this place because this is bullshit." The progress note showed R2 was very difficult to redirect and calm down. Progress notes, dated 9/11/21, show R2 was refusing medications, calling staff names, slamming doors, and staff were able to redirect R2. Progress notes, dated 9/20/21, show R2 was sent to the hospital related to behavioral disturbances including throwing chairs, attacking staff, and becoming very physically aggressive Face sheet, dated 9/21/21, shows R3 was admitted to the facility on 5/14/21 and R3's diagnoses include vascular dementia. On 9/20/21 at 2:52 PM, R3 walked toward the outdoor exit door and pushed on the door bar. The door alarm sounded and then silenced when	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6015507	A. BUILDING: _____ B. WING _____	C 09/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN COURTS OF WATERFORD	1991 RANDI DRIVE AURORA, IL 60504

(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
S9999	Continued From page 10 she stopped pushing on the door bar. V4 (CNA) walked to R3 and escorted R3 away from the exit. Elopement risk assessments for R3 showed the following: 5/14/21 - at risk for elopement 9/21/21- low/no risk for elopement and no history of exit seeking behavior Progress notes, dated 5/15/21 and 5/16/21, show R3 was seeking exits several times and required as needed Haldol was administered. On 9/21/21 at 1:14 PM, V22 (LPN-Licensed Practical Nurse) stated she initially performed R3's new admission elopement risk assessment and erroneously identified R3 at high risk because she did not observe R3 exit seeking the day she completed the assessment. V22 stated after she completed the assessment, R3 was exit seeking and she reported the exit seeking to a supervisor. V22 stated she would consider R3 an elopement risk because of R3's subsequent exit seeking behavior. On 9/20/21 at 2:30 PM, V4 (CNA) stated R3 had a history of pushing the exit doors and attempting to elope from the facility. V4 stated R4 also pushes the exit door to get outside and sets off the exit door alarms. Care plan, dated 7/11/21, shows, "R4 expresses the want to 'leave' unit and get cash and cigarettes. Although redirectable, he is exit seeking." Elopement risk assessment, dated 9/7/21, shows R4 was assessed as having no history of elopement or exit seeking attempts, and yet having reported episodes/attempts to leave the	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6015507	A. BUILDING: _____ B. WING _____	C 09/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN COURTS OF WATERFORD	1991 RANDI DRIVE AURORA, IL 60504

(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
S9999	Continued From page 11	S9999		

facility without notification to staff. The document shows, "If the answer to either of the above is YES, place the resident 'AT RISK' and on the Elopement At-Risk Program ...." The assessment concludes R4 was at low risk for elopement.

Elopement Risk Assessment, dated 8/23/21, shows R5 was at low/no risk for elopement.

Elopement Risk Assessment, dated 3/30/21, shows R6 was at low/no risk for elopement.

On 9/20/21 at 2:18 PM, V12 (Activity Aide) stated the staff must monitor R5 because she wanders and likes to lay in other residents' beds.

On 9/20/21 at 2:18 PM, V11 (CNA) stated R5 had a history of attempting to elope by hitting the exit door bar and sounding the alarm to go outside.

On 9/22/21 at 7:41 AM, V5 (RN) stated R5 and R6 were typically exit seeking and elopement risks.

On 9/20/21 at 3:25 PM, V11 (CNA) stated R6 seeks exits and was at risk for elopement at the facility.

On 9/21/21 at 2:39 PM, V6 (Social Services Designee) V6 stated after speaking with direct care staff she reassessed R3-R6 again and revised their risk status to indicate they were all at risk of elopement. V6 stated she began to work at the facility as the Social Services designee approximately two months ago. V6 stated she previously had no experience as a social services designee, was provided four days training at another facility, and had four hours of consultation from the Social Worker Consultant since her hire. V6 stated she was provided an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6015507	A. BUILDING: _____ B. WING _____	C 09/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN COURTS OF WATERFORD	1991 RANDI DRIVE AURORA, IL 60504

(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
S9999	Continued From page 12	S9999		

admission packet of assessments during training and told to complete them for new residents. V6 stated she was never instructed how to complete the facility elopement risk assessment.

On 9/22/21 at 10:00 AM, V1 provided the document "At Risk for Elopement" which showed R1-R6 were identified as being at risk for elopement with R3-R6 newly identified as elopement risks.

On 9/23/21 at 8:50 AM, V1 and V2 stated all facility residents were reassessed again for elopement risk by V24 (Social Services Consultant) and V6 (Social Services Designee) and two more residents, R7 and R8, were added to the list of residents at risk for elopement at the facility.

Elopement Risk Assessment, dated 9/22/21, shows R7's admission date was 7/1/21 and R7 was assessed to be at risk for elopement based on R7's diagnosis of dementia, staff reported episodes of R7 seeking exits or attempts to leave the facility without notifying staff.

Elopement Risk Assessment, dated 9/7/21, shows R8 was assessed as low/no risk for elopement. However, Elopement Risk Assessment, dated 9/22/21, shows R8 was re-assessed to be at risk for elopement related to her diagnosis of dementia and staff reports of R8's exit seeing behavior.

3. On 9/21/21 at 9:36 AM, V1 (Administrator) stated the manager on duty was responsible for checking all door locks/alarms in the facility on weekends since 9/5/21. V1 stated the maintenance department was responsible for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6015507	A. BUILDING _____ B. WING _____	C 09/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN COURTS OF WATERFORD	1991 RANDI DRIVE AURORA, IL 60504

(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
S9999	Continued From page 13 checking all door alarms/locks at the facility during the week. On 9/20/21 at 2:30 PM on the YYY Wing, the door alarm light at the patio door exit was not lit. On 9/20/21 at 2:45 PM with V13 (RN), the patio door exit alarm light continued to be unlit. V13 unlocked the door, pushed the door open, and the alarm did not sound. The door alarm key lock was positioned to the "DISABLED" position. V13 utilized her alarm key and turned the lock to the "ENABLE" position and a red light turned on. V13 pushed open patio exit door again but no alarm sounded. On 9/20/21 at 3:40 PM, V18 (Activity Aide) stated the patio was the designated staff smoking area and she has used the area for some time to smoke when she is working at the facility. V18 she walked through the patio door to smoke earlier in the day and used her key to unlock the exit door to the patio. V18 stated she has never had to disable an alarm to exit through the patio door to smoke and did not think she had a key for any of the door alarms. V18 stated she had never heard a door alarm sound when she unlocked the patio door and opened the door to exit to the patio. On 9/21/21 at 9:36 AM, V20 (Building Manager) stated all door alarms, including patio doors, should be functioning in spite of doors being locked. V20 stated he was not aware that V18 had not needed to disarm the patio door alarm before going out to smoke for some time. On 9/20/21 at 2:45 PM, V13 (RN) stated she checks the exit door alarms and locks at the beginning of each shift and the patio door alarm	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6015507	A. BUILDING: _____ B. WING _____	C 09/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN COURTS OF WATERFORD	1991 RANDI DRIVE AURORA, IL 60504

(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
S9999	Continued From page 14 and lock were functioning at the beginning of her shift that day. On 9/20/21 at 3:07 PM with V1 and V3, V17 (Maintenance) stated that Maintenance checks all door locks and alarms twice a day in the facility. V17 stated the alarm was malfunctioning and required the alarm company to service the device. 4. On 9/22/21 at 11:10 AM with V1 (Administrator), V2 (Consulting Administrator) and V3 (Director of Nursing), V2 stated on 9/5/21 the facility provided all staff training that instructed any facility staff who identifies a missing resident to announce an overhead page alert of "Code Green." On 9/22/21 at 7:41 AM, V5 (RN) stated he was not aware of the term "Code Green" at the facility. On 9/21/21 at 11:00 AM, V7 (CNA) did not state she would call an overhead Code Green when asked what procedures she would follow if she identified a missing resident. On 9/20/21 at 2:08 PM, V9 (CNA) failed to state she would call an overhead Code Green if she identified a missing resident at the facility On 9/20/21 at 2:17 PM, V10 (CNA) failed to identify she would call a Code Green if she identified a missing resident at the facility. On 9/21/21 at 1:21 PM, V23 (CNA) stated he was not aware of a Code Green and was not sure what it meant. On 9/20/21 at 2:18 PM, V11 (CNA) failed to	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6015507	A. BUILDING: _____ B. WING _____	C 09/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN COURTS OF WATERFORD	1991 RANDI DRIVE AURORA, IL 60504

(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
S9999	Continued From page 15 identify she would perform a head count of residents if she identified a missing resident at the facility. A review of the elopement/missing resident policies utilized to in-service facility staff after R1 eloped showed inconsistent procedures for elopement risk/missing residents. The following policies were utilized to train various staff: Missing Resident - dated 2/2011 - no mention of Code Green Wandering (Elopement) - dated 6/1997 - no mention of Code Green Code Green - undated Exit Seeking/Elopement vs. An Unplanned Discharge Policy and Procedure - Rev 11/2017 On 9/22/21 at 11:10 AM, V1, V2 and V3 stated the following multiple policies were utilized to train various facility staff after R1's elopement - some of which did not include instructions to overhead page a Code Green when a missing resident was identified. V2 also stated some of the policies were outdated and no longer in effect: Missing Resident - dated 2/2011, outdated per V2, and no mention of Code Green Wandering (Elopement) - dated 6/1997, outdated per V2, and no mention of Code Green 5. Facility at Risk for Elopement document, provided 9/24/21, shows R1-R8 were identified as elopement risks. Facility roster, updated 9/20/21, showed five residents (R2-R4, R7 and R8) identified to be at risk for elopement resided on the YYY-Wing and three residents (R1, R5, and R6) were identified to be at risk for elopement resided on the XXX-Wing.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6015507	A. BUILDING: _____ B. WING _____	C 09/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN COURTS OF WATERFORD	1991 RANDI DRIVE AURORA, IL 60504

(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
S9999	Continued From page 16 On 9/22/21 at 7:41 AM, V5 stated on 9/5/21 he began his night shift supervising the YYY-Wing and V22 stayed from her previous shift until 8:30 AM to supervise the XXX Wing. V5 stated at 8:30 PM, V22 left her shift, and he took over responsibility for supervising the XXX Wing and half of the YYY Wing. V5 stated after 8:30 PM, V26 (Nurse) was responsible for supervising the LLL Wing and the other half of the YYY Wing. V5 stated he was required to leave the XXX Wing for 10-20 minutes at a time throughout his shift to check on residents in the YYY Wing which left V4 the only staff on the XXX-Wing to supervise both halls. V5 stated each wing had their own call light systems that could not be heard from the other wings. On 9/20/21, tour of the facility showed the facility had three resident wings, LLL-Wing, YYY-Wing, and XXX-Wing. The facility wings were completely independent of one another and were accessible to each other only by walking out the closed doors of one wing, through a foyer, and entering through the closed doors of the next wing. Each wing had two halls - one hall could not be visualized when working in the other hall. Facility Daily Schedule, dated 9/4/21, shows the 10 PM to 6 AM shift had only two nurses (V5 and V26) responsible for the three resident wings from 8:30 AM to 6 AM. The schedule shows only one CNA was assigned to each wing from 10 PM to 6 PM - V4 to XXX-Wing, V27 (CNA) to YYY-Wing, and V28 (CNA) to LLL-Wing. "A"	S9999		