STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510340	A. BUILDING: _____ B. WING _____	C 08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUGAR CREEK ALZHEIMER'S SCC	505 E VERNON AVE NORMAL, IL 61761

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A 000	Initial Comment Facility Reported Incident/IL#196750 Entered on 8/6/25. Exited on 8/7/25 Violation cited. 295.4060 h) 3) A)	A 000		
A4060	Seciton 295.4060 Alzheimer's and Demential Programs This Regulation is not met as evidenced by: Violation Section 295.4060 Alzheimer's and Dementia Programs h) An establishment that offers to provide a special program for persons with Alzheimer's disease and related disorders shall: 3) Develop and implement policies and procedures that ensure the continued safety of all residents in the establishment including, but not limited to, those who: A) May wander; and These requirements were not met as evidenced by: Based on observation, interview, and record review, the establishment failed to keep a known wandering, cognitively impaired resident from leaving the establishment unsupervised for one (R1) of three residents reviewed for elopement. This failure resulted in R1 exiting the	A4060		

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A4060	Continued From page 1	A4060		

establishment, walking approximately one mile across a busy four lane Avenue, getting picked up by local police and evaluated at the local hospital. This failure creates a substantial probability of harm to a resident or residents.

Findings include:

The establishment's Wandering and Elopement Prevention Plan Program, dated 7/12/22, documents "Policy Statement: The purpose of this policy is to provide a system for identification of residents at risk for unsafe wandering and elopement, provide a program of supervision and interventions to minimize risk of resident elopements and elopement attempts, and provide team member education in effective wandering and elopement management through in-services and elopement drills." "Definitions: 3. Elopement - when a resident (who is cognitively or physically impaired) leaves the community/secured area without necessary authorization (i.e., an order for discharge or leave of absence) and/or necessary supervision to do so. 4. Elopement Attempt - when a resident (who is cognitively or physically impaired) without supervision is exit seeking or attempts to leave the community/secured area without necessary authorization but does not cross the threshold of a community/secured area." "Best practice suggestions: C. Instruct staff to maintain a visual line of sight of exit doors, particularly during shift change, mealtimes, and emergencies, as these are times when residents may be able to exit the Community unnoticed while staff attention is diverted."

On 8/6/25, at 11:05am, R1 was in the locked unit wandering around the common area going in/out of dining room carrying a black purse on her left shoulder.

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A4060	Continued From page 2 R1's clinical record documents a move in date of 7/21/25 and includes but is not limited to a diagnosis of Dementia with behavioral disturbance, Severe Early Onset Alzheimer's Dementia with Agitation and is self-ambulatory. R1's initial Resident Safety Plan, dated 7/17/25, documents identified risks of impaired memory and judgment related to dementia diagnosis, exhibits exit-seeking or wandering behavior, and may attempt to leave the facility unsupervised. Goals include but are not limited to "prevent resident from exiting the building unsupervised." R1's Elopement Risk Evaluation, dated 8/5/25, documents a Pre-Admission Score of 18 (Moderate Risk=12-22). The establishment's Initial Elopement Report, dated 8/2/25, documents the following: Date of incident was 8/2/25 at 5:28pm. On 8/3/25, at 7:24pm, (E1 Executive Director/ED) was notified by (E4 Licensed Practical Nurse/LPN) that (R1) had eloped from the facility. At 7:21pm, (E4 LPN) was contacted by (Z1 R1's family member) who had received a call from the local hospital. (Z3 hospital staff) had informed them that (R1) was found walking along a roadside, appearing confused. Upon contact, (R1) stated she had been sexually assaulted but was unable to provide details regarding the location, perpetrator, or events surrounding the allegation. The local police department transported (R1) to the local hospital for evaluation. A thorough examination was conducted by Emergency Room staff, and no evidence or findings support that a sexual assault had occurred. R1's After Visit Summary from local hospital, dated 8/2/25, documents R1 was seen in the	A4060		

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A4060	Continued From page 3 Emergency Department after eloping from her memory care. The establishment's QAPI (Quality Assurance and Performance Improvement) Review: Elopement Event Root Cause Analysis, dated 8/5/25, documents the following: (R1) is ambulatory, incident occurred on 8/2/25 at 7:21pm with a total time missing of two hours and four minutes; no injuries. (R1) was transported by police to local hospital and (R1) was missing, unknown to staff; was discovered outside or in an unsafe/unsecured area; and local police department located resident and transported to local hospital. Prior to elopement (R1) was last seen with (E7 Registered Nurse/RN) going into the dining room on 8/2/25, at 5pm. (R1) was located by local police of community grounds/off campus. Police located (R1) on (named) Avenue outside of the community. (R1) did not have approval to leave the community unsupervised. (R1) has a history of elopement and/or wandering. Note: Upon admission, (R1) attempted to elope from previous facility on 5/25/25. The question "does the resident's care plan reflect appropriate interventions" is left blank. (R1's) pre-admission elopement score of 18 is dated 7/11/25. (R1) had exhibited unsafe wandering or exit seeking behavior in the last 14 days. Note: According to progress notes, resident is displaying increased agitation and continues to express that she wants to go home. (R1) reflected changes in her emotional/mental status, physical condition and/or environment in the last 14 days. Note: According to progress notes (R1) is pacing, refusing meals and has increased tearful episodes more frequently. Note: According to camera footage, resident was let out of the building. Potential interventions include but are not limited to "Staff aware of elopement risk."	A4060		

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A4060	Continued From page 4 On 8/6/25, at 10:39am, E4 Maintenance Director stated that the door to the lobby has a keypad on the resident side and the lobby side with a red button at receptionist desk all of which can unlock the doors. It is not an alarmed door since family go/in out. It has a monitor at the desk for staff to see who wants to be let out. On 8/7/25, at 1027am, E6 Receptionist confirmed E6 was working (10am - 6pm) at the front desk the day R1 eloped from the establishment (8/2/25). E6 stated that E6's nightly routine of cleaning the bathroom and coffee area and locking the book work away is during the time staff are assisting residents with dinner so there isn't always someone available to take my place. It was a busy time with many people coming and going that afternoon and phones ringing. E6 is unsure how (R1) got out of the locked door and confirmed that E6 did not see (R1) leave the building. On 8/7/25, at 11:49am, E1 ED stated that the door keycode is only known by (E1), (E4 Maintenance Director) and his assistant and the receptionists (E6 and E8). They are not to give the code to family or other staff members. At this time, after viewing the remainder of the camera footage, E1 stated the following: (E1) determined that an unknown staff member let (R1)out of the building. This is a locked unit, and residents are not able to get out unless they go out with family or a staff member. Residents should not be let out by themselves. (E6 Receptionist) must have been distracted at the time (R1) got let out. (E6) does have other office duties besides letting people in and out like book work and answering phone calls so it gets very busy at times.	A4060		