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REFLECTIONS MEMORY CARE - CHATHAM	401 N PARK AVENUE CHATHAM, IL 62629

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A 000	Initial Comment Facility Reported Incident Investigation to incident of 03-26-26/IL#201220. 295.4010 a) e) f) g) 1) A) C) 2) 3) 295.4060 h) 3) A) B) 6)	A 000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Type 1 Violation Section 295.4010 Service Plan a) Based on the physician's assessment and establishment evaluation (see Section 295.4000), a written service plan shall be developed and mutually agreed upon by the establishment and the resident. (Section 15 of the Act) The establishment shall respect and accept the resident's choices regarding the service plan. e) The service plan shall be reviewed and revised if necessary immediately after a significant change in the resident's physical, cognitive, or functional condition (see Section 295.4000). f) Based on the physician's assessment, the service plan may provide for the disconnection or removal of any kitchen appliance. (Section 15 of the Act) g) Service plans shall address:	A4010		

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A4010	Continued From page 1 1) The level of service the resident is receiving, including: A) assistance with activities of daily living; C) special accommodations for the resident; 2) The amount, type, and frequency of health-related services needed by the resident; 3) Staff responsible for the provisions of the service plan; Based on interview and record review, the establishment failed to revise a resident's Service Plan following a resident elopement for one of three residents (R1) reviewed for elopement risk in the sample of three. This failure creates a substantial probability of severe harm to a resident or residents. Findings include: The establishment's Memory Care Disclosure Statement (revised 01/18/24) documents the following: "Activity and Service intensity will be determined by the interests, abilities, and functional limitations of the identified resident's needs. An individualized assistance/service plan will be developed for each resident, using a team approach with the resident, family, and staff participation." This Disclosure Statement also documents, "The team will also be trained in all related dementias to assist in properly addressing any changes that may occur in the resident's needs. The team will then modify the resident's care plan as needed when changes arise and contact the resident's responsible party when changes need to be made."	A4010		

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A4010	Continued From page 2 R1's current medical record documents R1's diagnoses to include Alzheimer's Disease. R1's MMSE (Mini Mental Status Examination) Assessment (dated 02/26/26) documents a score of 14, indicating moderate cognitive impairment. The establishment's Incident Report (dated 03/26/26) documents the following: "At 03:20 PM, facility received a phone call from (local police) stating that they had an elderly woman and they wanted to know if she was from our facility. Writer asked the name of the woman and writer informed the police that she (R1) was a resident of our facility. Police stated they would bring her to our facility. Resident returned via police with no injuries." On 04/14/26 at 09:10 AM, E2 (Wellness Director) stated she was working in the building when R1 eloped on 03/26/26. E2 stated, "(R1) left the building at 01:51 PM. We were notified by (local police) that they had an elderly woman. She was able to tell them her name, and we confirmed that she was a resident here. They brought her back to the building. She was not injured. She was found at a local daycare. The police told me that when she arrived at the daycare, she thought it was a restaurant and believed she was meeting her family there. I think the daycare is located approximately 3-4 blocks from (establishment). One of our staff members, (E3, Resident Aide), who had been recently hired left the south unit and entered the north unit. (R1) resides in the north unit and must have been watching the door from a close proximity, because she got to the door and walked out before it closed and latched. I believe (E3) has worked in healthcare in the past, but I do not believe she has worked in a locked unit so it must not have occurred to her to	A4010		

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A4010	Continued From page 3	A4010		

make sure the door was locked and secured before walking away from it. We received the call from the (local police) at 03:20 PM (on 03/26/26), and they brought (R1) back to the building around 03:30 PM." E2 stated R1 did not have an elopement monitoring device in place prior to her elopement, "but she does now."

On 04/14/26 at 02:35 PM, a telephone interview was conducted with E3 (Resident Aide). E3 stated that she was hired at the establishment on 03/02/26 and confirmed that she was working at the establishment on 03/26/26 when R1 eloped from the building. E3 stated, "I was working on the south unit, and it was time for me to take my break. I left the south unit, opened the door to the north unit, and walked in. I did not make sure that the door locked behind me, so (R1) must have gotten out before the door latched. She left the building through the front door in the lobby. The police called about her and brought her back to the building a couple hours later. I believe she has to wear (an elopement monitoring device) now and she has cut the bracelet off of her wrist and her ankles several times. It is now attached to her shoe. She can see it and has asked me about it. I keep telling her it is a fitness tracker." Z1 could not recall receiving specific training related to ensuring the doors to the establishment's north and south units were secured at her time of hire, "They talked to me in detail about the doors after (R1) left the building."

On 04/14/26 at 09:45 AM, E2 (Wellness Director) stated that staff is required to conduct wellness checks on the residents at a minimum of every two hours at the establishment. E2 stated with R1 being out of the building unnoticed from 01:51 PM until 03:30 PM on 03/26/26, a wellness check must have been missed on the day of R1's

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A4010	Continued From page 4 elopement. R1's current Service Plan has no mention of a focus specific to R1's risk for elopement, and has no mention of R1's actual elopement from the building on 03/26/26. R1's Service Plan has no mention of staff conducting Wellness Checks every two hours. On 04/14/26 at 11:20 AM, E2 (Wellness Director) confirmed that R1's Service Plan was not revised to reflect R1's elopement risk following her elopement from the building on 03/26/26, and verified that R1's Service Plan does not document Wellness Checks are to be completed on R1 every two hours.	A4010		
A4060	Seciton 295.4060 Alzheimer's and Demential Programs This Regulation is not met as evidenced by: Type 1 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	A4060		

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A4060	Continued From page 5 B) May need supervision and assistance when evacuating the building in an emergency. 6) Provide an appropriate number of staff for its resident population. The establishment shall provide staff sufficient in number, with qualifications, adequate skills, education, and experience to meet the 24-hour scheduled and unscheduled needs of the residents and who participate in ongoing training, to serve the resident population. At a minimum, at least one staff member shall be awake and on duty at all times; Based on interview, observation and record review, the establishment failed to implement safety procedures to monitor the whereabouts of a cognitively impaired resident who ambulates independently, and failed to ensure staff received adequate training upon time of hire to meet the scheduled and unscheduled needs of the residents. These failures resulted in R1's elopement from the establishment on 03/26/26, and creates a substantial probability of severe harm to a resident or residents. Findings include: The establishment's Resident Assistant/Certified Nurse Assistant Job Description documents the following duties: "Safety and Sanitation: Monitor the phone, front door, call and alarm systems; Understand and follow safety and infection control policies and procedures ..." The establishment's Memory Care Disclosure Statement (revised 01/18/24) documents the following: "The community has designed a secure community for resident safety. All exit doors will be equipped with an electronic entry and exit. In	A4060		

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A4060	Continued From page 6	A4060		

addition, the doors are wired to our nurse call system as well as our fire system and are monitored by our staff. Due to elopement and security risk to our residents, we do not provide the code to enter or exit these doors to family, guests or visitors. We do provide a notification system at the main doors to summon a staff member to the door for ingress and egress to the community."

The establishment's Incident Report (dated 03/26/26) documents the following: "At 03:20 PM, facility received a phone call from (local police) stating that they had an elderly woman and they wanted to know if she was from our facility. Writer asked the name of the woman and writer informed the police that she (R1) was a resident of our facility. Police stated they would bring her to our facility. Resident returned via police with no injuries."

On 04/14/26 at 09:00 AM, E1 (Executive Director) stated the following regarding R1's elopement from the establishment on 03/26/26: "That was my first day of vacation. I was out of town in Arkansas. (E2, Wellness Director) was in the building when (R1) eloped, so she will be able to provide more detail than I can. I implemented a bunch of things when I returned from vacation. It appears that one of the staff members left the unit on the south side of the building and entered the unit on the north side of the building. (R1) must have been watching the door because she was able to get to it and leave the unit before it had latched closed."

On 04/14/26 at 09:10 AM, E2 (Wellness Director) stated she was working in the building when R1 eloped on 03/26/26. E2 stated, "(R1) left the building at 01:51 PM. We were notified by (local

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A4060	Continued From page 7	A4060		

police) that they had an elderly woman. She was able to tell them her name, and we confirmed that she was a resident here. They brought her back to the building. She was not injured. She was found at a local daycare. The police told me that when she arrived at the daycare, she thought it was a restaurant and believed she was meeting her family there. I think the daycare is located approximately 3-4 blocks from (establishment). One of our staff members, (E3, Resident Aide), who had been recently hired left the south unit and entered the north unit. (R1) resides in the north unit and must have been watching the door from a close proximity, because she got to the door and walked out before it closed and latched. I believe (E3) has worked in healthcare in the past, but I do not believe she has worked in a locked unit so it must not have occurred to her to make sure the door was locked and secured before walking away from it. We received the call from the (local police) at 03:20 PM (on 03/26/26), and they brought (R1) back to the building around 03:30 PM." E2 stated R1 did not have an elopement monitoring device in place prior to her elopement, "but she does now."

On 04/14/26 at 09:20 AM, E4 (Resident Aide) stated she was just hired at the establishment approximately one month ago and confirmed that she was working on 03/26/26 when (R1) eloped from the building. E4 stated, "I didn't even know she (R1) had left the building. (E3, Resident Aide) went on break and came into the north unit. It appears (R1) got to the door and slipped out without being noticed before the door closed." E4 stated staff is required to round and conduct wellness checks on the residents during their shifts, "I round at the beginning of my shift and continue rounding every hour or so."

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A4060	Continued From page 8 On 04/14/26 at 02:35 PM, a telephone interview was conducted with E3 (Resident Aide). E3 stated that she was hired at the establishment on 03/02/26 and confirmed that she was working at the establishment on 03/26/26 when R1 eloped from the building. E3 stated, "I was working on the south unit, and it was time for me to take my break. I left the south unit, opened the door to the north unit, and walked in. I did not make sure that the door locked behind me, so (R1) must have gotten out before the door latched. She left the building through the front door in the lobby. The police called about her and brought her back to the building a couple hours later. I believe she has to wear (an elopement monitoring device) now and she has cut the bracelet off of her wrist and her ankles several times. It is now attached to her shoe. She can see it and has asked me about it. I keep telling her it is a fitness tracker." E3 could not recall receiving specific training related to ensuring the doors to the establishment's north and south units were secured at her time of hire and stated, "They talked to me in detail about the doors after (R1) left the building." On 04/14/26 at 12:45 PM, Z1 (local daycare teacher) stated she was working at the local daycare on the afternoon of 03/26/26 when R1 entered the building. Z1 stated, "I remember it was after 03:00 PM because the school buses had already dropped the kids off. An older couple entered the daycare and this lady (R1) entered the building behind them. She handed me a blank note card and told me it was all she had. I asked her how she had gotten here, and she told me she had been dropped off. She was vague with her answers and nothing was adding up. She was very confused and wasn't making any sense. She was upset and thought she was at a restaurant.	A4060		

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The police were called at that time. It was an unusually warm day, and this lady was wearing a sweater and pants. She looked like she was overheated, like she had been walking around for a while. She seemed to get more and more upset after each question I asked her, so I just tried to comfort her until the police arrived. The last thing I wanted to do was upset her any further. When the police arrived, they told me that someone had already called about her because she had been seen wandering through someone's backyard."

On 04/14/26 at 09:45 AM, E2 (Wellness Director) provided video footage of R1's elopement on 03/26/26. The video footage illustrates E3 (Resident Aide) walking from the area of the south unit's main entrance in the direction toward the entrance of the north unit at 01:50 PM. R1 is then seen walking from the area of the north unit's entrance, and subsequently exiting the building through the main door in the front lobby at 01:51 PM. E2 explained that staff is required to conduct wellness checks at a minimum of every two hours at the establishment. E2 stated with R1 being out of the building unnoticed from 01:51 PM until 03:30 PM on 03/26/26, a wellness check must have been missed on the day of R1's elopement.

On 04/14/26 at 03:08 PM, E2 (Wellness Director) pressed the button located on the wall near the north unit that is utilized to open the door to the north unit. The north unit's door opened, and remained open for approximately 10 seconds before it began to close, taking approximately 5 additional seconds to fully close and lock.

R1's current medical record documents R1's diagnoses to include Alzheimer's Disease.

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A4060	Continued From page 10 R1's MMSE (Mini Mental Status Examination) Assessment (dated 02/26/26) documents a score of 14, indicating moderate cognitive impairment. On 04/14/26 at 03:15 PM, R1 was sitting at a table in the common area of the establishment's north unit coloring an adult coloring picture. R1 was dressed and groomed, and a male resident was sitting at the table next to R1 reading the newspaper. R1 appeared to be pleasantly confused at this time, but could answer simple questions. When asked if things were going okay, R1 stated, "I don't have any issues. Everything is fine." R1 had no recollection of her recent elopement when she left the establishment on foot. R1's current Service Plan has no mention of a focus specific to R1's risk for elopement, and has no mention of R1's actual elopement from the building on 03/26/26. R1's Service Plan does not mention staff conducting Wellness Checks every two hours. R1's Task Administration Record (dated 03/01/26 - 03/31/26) documents the following: Nightly Wellness Checks were scheduled to be conducted at 09:00 PM, 02:00 AM and 04:00 AM. During the month of March 2026, staff did not sign off that a Wellness Check was completed on 16 occasions. This same record does not have any other Wellness Checks scheduled to be completed. On 04/14/26 at 11:20 AM, E2 (Wellness Director) confirmed that R1's Wellness Checks have been scheduled incorrectly, and stated staff is not prompted to sign off a Wellness Check for R1 throughout the daytime hours, "Wellness Checks should be scheduled on (R1) every two hours." E2 then confirmed that R1's Service Plan was not revised to reflect R1's	A4060		

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elopement risk following her elopement from the building on 03/26/26, and verified that R1's Service Plan does not document Wellness Checks are to be completed on R1 every two hours.

On 04/14/26 at 11:55 AM, E1 (Executive Director) stated, "The aides are required to check the door and (E3, Resident Aide) did not do that (on 03/26/26). I have told the staff that I want their eyes on the residents during shift change. They should have completed a Wellness Check on 03/26/26 at 02:00 PM during shift change. There is no Wellness Check documented at that time, and one should have been. (E3) received corrective counseling on the building's elopement procedures after (R1) eloped. This is a Memory Care Unit, and the doors have to be observed for the safety of the residents."

E3's Corrective Action Form (dated 03/26/26) documents the following: Corrective Counseling on Elopement with new employee. (E2, Wellness Director) had a conversation with new employee about elopement. Covered with (E3, Resident Aide) that she must always watch the door when exiting or coming onto the unit. Stressed doors must be watched until they are completely closed. Also, it was covered in conversation that when doing rounds, every resident must be checked off on checklist."

On 04/14/26, E1 (Executive Director) provided record of all staff training that has been conducted at the establishment from 01/01/26 - 03/26/26. This record did not document any training had been completed by E3 (Resident Aide).