STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510382	A. BUILDING: _____ B. WING _____	C 07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAS OF HOLLY BROOK & REFLECTIONS PEKIN	2720 S 14TH STREET PEKIN, IL 61554

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A 000	Initial Comment Original Complaint Investigation IL196491 295.4060 h) 3) A) violation 295.6000 a) 13) violation	A 000		
A4060	Seciton 295.4060 Alzheimer's and Demential Programs This Regulation is not met as evidenced by: Section 295.4060 Alzheimer's and Dementia Programs 295.4060 h) 3) A) 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; Violation These requirements were not met as evidenced by: Based on observation, interview, and record review the establishment failed to follow their policy and procedure for one resident (R1) of three residents reviewed for elopement in the sample of four. Findings include: The establishments Memory Care Disclosure Statement documents "We will expand the	A4060		

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activity and service intensity for those dealing with memory loss and offer behavioral management for individuals who may wander and who may be a challenge to manage in a non-specialized community. We will provide an environment, physically, socially, and culturally, that supports the functions of people with dementia or Alzheimer's. We will accommodate behavioral changes, maximize abilities, promote safety, and encourage independence."

The establishments Elopement Risk Management policy and procedures dated 3/26/2019, documents "All residents will be assessed for their potential to wander/elope prior to move-in and on an ongoing basis while he/she resides at the Community." "If a resident develops a tendency to wander in an unsafe manner while residing at the Community the Executive Director should evaluate" whether the resident needs a wandering management device placed. "All residents will be monitored for tendency to wander."

The clinical medical record for R1 documents R1 was admitted to the Memory Care Unit with the following diagnoses, not limited to: Dementia, Anxiety Disorder, Major Depressive Disorder, Hypertension, and Paroxysmal Atrial Fibrillation. R1 can transfer and ambulate independently with the use of a walker and if not using walker is to be reminded to do so. The current Service Plan for R1 documents R1 with memory loss related to Dementia with interventions including "I like to wander within the community, please allow me to do this while supervising from a distance."

The establishments in-service dated 7/19/25 documents "If an alarm is going off and you don't see anyone you must physically look and call a

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head count immediately to ensure everyone is accounted for."

The Progress Note for R1 dated 7/19/25, documented by E4 RN (Registered Nurse), documents E4 RN was assisting another staff member in a resident room and upon exiting heard the door alarm sounding. "This nurse (E4 RN) looked into the foyer and did not see a resident out there so door alarm was disabled and no further investigating was preformed." E4 RN took a break outside and observed R1 walking on the sidewalk with her walker."

On 7/24/25 and 7/25/25, during investigation, R1 was walking about the memory care unit at various times with a wandering management device around her left ankle and a wheeled walker.

On 7/24/25 at 9:20 am, E1 ED stated R1 did not wear a wandering management device prior to the elopement and no negotiated risk was done prior. R1 now has the wandering device on and no negotiated risk assessment has been done due to this is the first time R1 has exited the establishment.

On 7/25/25 at 10:45 am, E4 RN stated she was providing care with E8 RA and did not hear the exit door alarm until she exited an another resident room. E4 RN stated she "briefly checked the area" but did not see anyone in the area and reset the door alarm. E4 RN confirmed she did not go outside and did not do a resident head count. E4 RN stated she went outside later for a smoke break with E6 LPN (Licensed Practical Nurse) and saw R1walking with her walker in the parking lot by the dumpster. E4 RN confirmed there was no head count completed for the

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Memory Care Unit because no one knew R1 had exited the doors and if (E4 RN) had looked outside she may have seen R1.

On 7/25/25 at 12:03 pm, E6 LPN stated she told E7 RA to monitor the dining room while she went to the assisted living side of the establishment to pass medications. After finishing her medication pass (E6 LPN) went outside for a smoke break with E4 RN. E6 LPN stated she saw R1 walking in the parking lot near the dumpster by herself. R1 does wander about the Memory Care Unit and will push the door until it beeps but usually walks away. E6 LPN confirmed there was no head count done at the time the alarm sounded.

On 7/24/25 at 11:05 am and on 7/25/25 at 11:45 am, E5 CNA, and E8 RA respectively stated they were in resident rooms providing cares and did not hear the Memory Care Unit exit door alarming and are unsure if anyone was in the dining room with the residents.

On 7/25/25 at 10:30 am, E3 Maintenance Director stated the establishment does not have a written policy for the exit door alarms. If a door alarm sounds the staff are to go out the door and check around outside and if they don't see anyone, they are to do a head count to ensure all residents are accounted for. If not accounted for then the Elopement procedure would be started. "The Nurse (E4 RN) should have gone outside and looked around before resetting the alarm and then completed a head count."

On 7/24/25 at 9:20 AM, E1 ED stated on 7/19/25 the exit doors on the Memory Care Unit sounded and E4 RN reset the door alarm without checking outside, and did not do a head count. E4 RN should have gone outside to look for whoever set

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A4060	Continued From page 4 off the door alarm and if she didn't see anyone should have done a head count. E1 ED confirmed someone should have been supervising the dining area where residents were sitting waiting for breakfast and E4 RN did not follow proper procedures when a door alarm sounds. The Corrective Action Form for E4 RN dated 7/24/25, documents E4 RN received a written warning for not following the establishments proper procedure related to elopement. "Violated elopement policy."	A4060		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: Section 295.6000 Resident Rights 295.6000 a) 13) a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of his or her status as a resident of an establishment, nor shall a resident forfeit any of the following rights: 13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor. Violation These requirements were not met as evidened by: Based on observation, interview, and record review the establishment failed to prevent a	A6000		

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A6000	Continued From page 5	A6000		

known wanderer from elopement for one (R1) of three residents reviewed for neglect in the sample of four. This failure resulted in R1 exiting the establishment without anyones knowledge and not found for 23 minutes.

Findings include:

The establishments Memory Care disclosure Statement documents "We will expand the activity and service intensity for those dealing with memory loss and offer behavioral management for individuals who may wander and who may be a challenge to manage in a non-specialized community. We will provide an environment, physically, socially, and culturally, that supports the functions of people with dementia or Alzheimer's. We will accommodate behavioral changes, maximize abilities, promote safety, and encourage independence."

The establishments Resident Rights' policy and procedure, dated 3/26/2019, documents residents have the right "to be free of abuse or neglect or financial exploitation or to refuse to perform labor."

The establishments Abuse, Neglect, and Financial Exploitation, dated 3/26/2019, documents "The Community will ensure residents are free from mental, emotional and physical abuse, neglect, and financial exploitation."

On 7/24/25 at 11:45 am, E3 Maintenance Director stated the Memory Care Unit exit door has a safety on it that requires the door to be pushed for 15 seconds prior to it opening. The alarm will sound to alert staff that someone has opened the door and staff should check the surrounding area, door, and outside to see who exited the Memory

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A6000	Continued From page 6	A6000		

Care Unit. A Nurse is the only one approved to reset the alarms.

On 7/25/25 at 10:15 am, E1 ED stated the establishment does not have a policy and procedure for the door alarms.

On 7/24/25 and 7/25/25, during the investigation at various times, R1 was walking about the Memory Care Unit with a walker and a wandering management device bracelet around her left ankle.

The clinical medical record for R1 documents R1 was admitted to the memory care with the following diagnoses, not limited to: Dementia, Anxiety Disorder, Major Depressive Disorder, Hypertension, and Paroxysmal Atrial Fibrillation. R1 can transfer and ambulate with the use of a walker and if not using walker is to be reminded to do so. The current Service Plan for R1 documents R1 with memory loss related to Dementia with interventions including "I like to wander within the community, please allow me to do this while supervising from a distance."

The establishments Incident and Accident Report for R1 dated 7/19/25 at 8:15 am documents R1 was found outside of the establishment on the sidewalk. Staff noted memory care door alarm sounding, nurse assessed the area and did not see anyone. Another nurse went out on break and R1 was found walking on the sidewalk. R1 pushed on door until the door opened. R1 refused to go back into the establishment, became combative, and emergency services was called.

The Elopement Investigation for R1 dated 7/19/25, documents the video footage was watched from 7:35 am through 8:03 am revealing

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A6000	Continued From page 7 R1 pushing the alarmed Memory Care Unit exit door open at 7:35 am; which activated the door alarm. At 7:40 am E4 RN (Registered Nurse) assessed the area, did not see anyone, and disabled the alarm without going outside or doing a head count of the Memory Care Unit. At 8:03 am, 23 minutes later, E4 RN and E6 LPN found R1 outside of the establishment with her walker, by herself.	A6000		