

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0044180		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/09/2026	
NAME OF PROVIDER OR SUPPLIER ALDEN COURTS OF WATERFORD				STREET ADDRESS, CITY, STATE, ZIP CODE 1991 RANDI DRIVE , AURORA, Illinois, 60504			
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S0000	Initial Comments Complaint Investigation: 2671404/2732768		S0000				
S9999	Final Observations Statement of Licensure Violation: 300.610a) 300.1210b) 300.1210d)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 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: 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		S9999				

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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S9999	Continued from page 1 prevent accidents. These regulations were not met as evidenced by Based on interview and record review, the facility failed to prevent a cognitively impaired resident (R1) from eloping through an unalarmed door. The facility also failed to secure an exit door with nonfunctioning alarm in accordance with the facility policy. This failure resulted in R1 exiting the facility unnoticed by staff and discovered outside the facility in cold weather on January 31, 2026, putting R1 at risk for injury due to falls and cold weather, and becoming lost due to cognitive impairment. This past non-compliance occurred from January 30, 2026 -February 4, 2026. This applies to 1 of 3 residents (R1) reviewed for risk of elopement in the sample of 13. The findings include: On March 2, 2026, at 10:04 AM, V1 (Administrator) identified R1 as having left the facility through an unalarmed door undetected by staff and stated that happened a couple weeks ago. V1 stated there was not an incident report, investigation, or progress note in R1's medical record documented at the time of the occurrence. R1's EMR (Electronic Medical Record) showed R1 was 84 years old, readmitted to the facility on October 27, 2025, with multiple diagnoses including unspecified dementia, history of acute respiratory failure with hypoxia, history of fractures of the right humerus and left orbital bones and history of non-displaced fracture of the 6th cervical vertebrae, chronic obstructive pulmonary disease, and chronic diastolic and systolic congestive heart failure. R1's MDS (Minimum Data Set) dated January 9, 2026, showed R1 was severely cognitively impaired and required assistance with ADLs (Activities of Daily Living) including set up assistance with eating, supervision with oral and personal hygiene, bed mobility, sit to stand transfer and ambulation with walker up to 50 feet, partial assistance with bathing, substantial assistance with upper body dressing, and dependent with lower body dressing. Walking greater than 150 feet was not attempted due to medical conditions or safety concerns. On March 3, 2026, at 10:42 AM, V1 (Administrator) stated she was informed the Unit B exit door, to			S9999			

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S9999	Continued from page 2 outside of the building, did not have a working audible alarm at the exit, on January 30, 2026. R1 resided on the B unit, but not on the hallway where the unalarmed exit door was located. On March 2, 2026, at 3:45 PM, R1 was alert but confused about date and time. R1 stated she did recall going out a door into the cold and did not know how to get back into the facility. R1 stated she kept walking until she saw a door with a window and started to knock on the window in order for someone to open the door. R1 stated she remembered feeling cold and felt like she was outside for a long time before someone came. R1 stated she began to say her prayers hoping someone would come and bring her inside out of the cold. On March 2, 2026, at 2:15 PM, V5 (CNA, Certified Nursing Assistant) stated on January 31, 2026, she was working on Unit A on the second shift and was passing dinner trays when V5 saw R1 standing outside the Unit A exit door by herself. V5 stated she alerted V4 (RN, Registered Nurse on Unit B), V6 (CNA on Unit B) and V7 (CNA on Unit B) by walking to Unit B and telling the staff R1 was outside of the facility. V5 explained V7, V6, and V5 went outside the Unit B exit door to R1's location outside (by Unit A exit door). V5 also stated V13 (RN on Unit A) opened the door and let R1, V5, V6, and V7 inside. On March 2, 2026, at 2:34 PM, V6 (CNA) stated he was R1's assigned CNA for the second shift (2 PM - 10 PM) on January 31, 2026. V6 stated at the beginning of the shift staff were made aware that the Unit B exterior door alarm was not working. V6 stated earlier in the week, staff were also made aware of the Unit B exit door alarm was not working. V6 stated dinner had just been completed around 6:00 PM, and while V6 was escorting a resident out of the dining room, V5 came from Unit A to tell staff R1 was outside. V6 stated V7 (CNA) also heard that R1 was outside and went down the hall toward the Unit B exit door to find R1. V6 stated he followed V7 out the exit door. V6 stated no alarm was heard when Unit B exit door was opened. V6 stated he saw R1 standing outside the Unit A exit door. V6 stated R1 had to sit in a wheelchair to come inside. V6 described R1 as being too weak to keep walking and noted R1 was breathing heavy with her shoulders going up and down with each breath. V6 stated R1 kept repeating "I'm cold" and R1's skin was cold to touch. On March 2, 2026, at 2:47 PM, V7 stated she was in			S9999			

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S9999	Continued from page 3 the dining room, which was across from the nurses' station and overheard V5 tell V4 that R1 was outside the exit door of Unit A. V7 stated she just started to run down the hall toward the exit to find R1 outside. V7 stated she found R1 outside the Unit A exit door and stated R1 appeared weak and R1 kept saying "I'm cold" and R1's skin was cold to touch. V7 stated R1 was so weak she was placed in a wheelchair because she could not walk anymore. V7 stated she remembers being told in report both that day and during the previous week that the B wing exit door, near room 112, door alarm was not functioning. On March 2, 2026, at 1:12 PM, V4 stated it was almost the end of her shift (6AM - 6PM) on January 31, 2026, when V5 came to the nurses' station to report R1 was outside of the facility. V4 stated she had talked to R1 about 5 minutes earlier when R1 was walking out of the dining room with her walker and stopped at the nurses' station to talk to V4. V4 stated R1 continued to walk down the hall toward the B wing exit door near room 112. R1's room was located in the other hallway on Unit B. R1 was not redirected to her room away from the unalarmed exit door. V4 stated she did not hear an alarm sound when R1 exited the facility and stated the door panel at the nurse's station only lights up with a red flashing light when an exit door is opened. V4 stated the panel was behind her and when she did not hear an alarm, she had no reason to look at the panel. V4 stated staff were aware and had gotten in report that the exit door alarm was not functioning. V4 stated there were only 3 staff on the 2 PM -10 PM evening shift that day and no one was assigned to just monitor the exit door. V4 stated the CNA staff were in the dining room and finishing the dinner meal when R1 walked out of the unalarmed exit door. V4 stated R1 was wearing only a sweat shirt and sweat pants when she went out the exit door. V4 stated she did not write a progress note in R1's medical record nor did V4 notify the physician or resident representative. V4 stated the only one she notified was V1. According to AccuWeather historical data, the outside temperature for the facility's location showed the temperature on January 31, 2026, was a high of 19F (degree Fahrenheit) and a low of 6F. On March 2, 2026, at 2:18 PM, V5 walked with surveyor the path R1 took from the Unit B nurses station, where R1 was last observed, to where V5 found R1 outside and measured the distance using a pedometer. R1 walked 195 feet before being observed or redirected by staff .			S9999			

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S9999	Continued from page 4 On March 2, 2026, at 4:28 PM, V8 (R1's physician) stated V8 was not informed R1 had exited the facility unnoticed on January 31, 2026. V8 stated R1 leaving the facility unsupervised had potential for harm to R1 due to the risk of injury related to falls or R1 becoming disoriented and lost. The Facility's policy titled "Door Alarm Function Test", undated, showed "Procedure...6. Nonfunctioning alarms ...Until repair is made the door must be made secure by placement of an additional temporary alarm or added supervision." The Facility's policy titled "Elopement and Management of Missing Resident" dated March 28, 2023, showed "Definition: Elopement is defined as a dependent (cognitively impaired, non-decisional) resident leaving the facility without staff awareness and under circumstances that place the resident's health, safety or welfare at risk...2. Responding to a Resident Leaving or Attempting to Leave the facility or Designated Unit...g. Notify attending physician or NP...h. Document occurrence ...p. Upon return of the resident to the facility the Director of Nursing/designee should... j. Conduct a full body assessment and examine for injuries and obtain vitals...vii. Document accordingly in the resident medical record." Prior to March 2, 2026, survey, the facility took the following actions to correct the deficient practice: 1. On January 31, 2026, at 7:00 PM, a head count on all units was completed to make sure no other residents were affected. Every resident was accounted for. 2. On January 31, 2026, at 7:00 PM, all other facility door alarms were checked for proper functionality and in good working order. The door alarm verification checks will be done once per day by Maintenance Director/Building Manager, or Manager on duty, and documented on the form. 3. On February 3, 2026, at 7:00AM, the temporary exit audible door alarm was installed on Unit B exit door. 4. R1's elopement assessment was completed and care plan updated on February 4, 2026. 5. All residents were assessed for exit seeking behaviors. Completed on February 3, 2026. 6. Residents identified at risk for elopement had			S9999			

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S9999	Continued from page 5 their care plans updated on February 4, 2026. 7. The Administrator, Nurse Consultant, and Medical Director reviewed the facility policies related to the occurrence: Door alarms, Routine Resident Checks, and Elopement. Completed on February 3, 2026. 8. The DON/ADON (Director of Nursing/Assistant Director of Nursing) and Social Service/Designee have reviewed and updated all residents safety care plans as needed. Completed on February 4, 2026. 9. The elopement binder was reviewed and updated with current identification picture, face sheet, and elopement care plan on February 3, 2026, and the binders are available at each nurses station. 10. All staff were in-serviced beginning on February 3, 2026 and ending on February 4, 2026, by the Administrator on the following topics: How to redirect wandering residents away from exits, how to promote safer outcomes for residents through supervision, answering door alarms promptly and reporting any changes in cognition or exit seeking behaviors to the nurse, on routine resident check policy, and where to locate the at risk of elopement binders. Everyone that has worked has been serviced. In-servicing will continue until all employees have been educated. Anyone not educated will be educated prior to returning to work. New staff will be educated on procedure upon hire at general orientation. 11. An audit tool to review compliance was developed and an update to the QA Door Alarm Check Verification form was initiated on February 3, 2026. The Audits will be done two times a week for 1 month or until compliance is maintained. 12. An emergency QA (Quality Assurance) meeting was held at 1:00 PM on February 3, 2026, by the Administrator with the Director of Nursing and Medical Director regarding the incident and to discuss the plan. The QA committee agreed with the plan as outlined above. (A)			S9999			