

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145403	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/10/2025
NAME OF PROVIDER OR SUPPLIER  Alden Poplar Creek Rehab & Hcc		STREET ADDRESS, CITY, STATE, ZIP CODE  1545 Barrington Road Hoffman Estates, IL 60169	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to ensure a resident with severe cognitive impairment and a history of wandering was supervised to prevent elopement. This failure resulted in R1 eloping from a secured memory care unit, exiting the building without staff identifying and preventing R1 from eloping. R1 exited the building and ambulated without her walker crossing a six-lane busy intersection and was found approximately 0.8 miles away from the facility wandering outside of the local grocery store. This applies to 1 of 6 residents (R1) reviewed for safety in the sample of 6. The Immediate Jeopardy began on 7/1/25, when R1 got on the elevators with another resident's family on the secured memory unit. R1 exited the first-floor elevators and ambulated out the front entrance without staff identifying R1 was eloping the facility. R1 exited the building and ambulated without her walker crossing a six-lane busy intersection and was found approximately 0.8 miles away from the facility wandering outside of the local grocery store. V1 (Administrator) was notified of the Immediate Jeopardy on 7/10/25 at 8:22 AM. The surveyor confirmed by observation, interview, and record review that the Immediate Jeopardy was removed, and the deficient practice was corrected, on 7/02/25, prior to the start of the survey on 7/08/25, and was therefore Past Noncompliance. This past non-compliance occurred from 7/1/25-7/2/25. The findings include: R1's face sheet shows she is an [AGE] year-old female, with diagnoses including vascular dementia, moderate without behavioral disturbance, hypertension, history of falling, ataxia, primary osteoarthritis, and hyperlipidemia. R1's Exit Seeking/Wandering/Elopement Risk Assessment, dated 6/9/25, shows she is at risk for elopement. R1's Fall Risk Assessment, dated 4/8/25, shows her mobility is unsteady and or/use of ambulatory aide, impaired memory and incontinent. R1's current care plan shows she has short term and memory impairment. she needs supervision and support throughout the day to maintain independence with activities of daily functioning (ADL). R1 has an ADL self-care deficit due to poor safety awareness, poor judgment, impaired balance, unsteadiness on feet and history of falling. R1 has a history of being at risk for elopement related to cognitive impairment. History of exit seeking behavior and physical ability to ambulate with walker. She continues to have compromised safety awareness. Interventions include frequent checks and supervision, monitor behaviors, staff/family escort when off secured unit. R1's facility EHR does not show documentation of R1 eloping from the facility in the medical record. R1's Final Incident Report, dated 7/7/25, shows on 7/1/25, R1 eloped from the facility, facility responded appropriately. R1 was taken to the local hospital for evaluation and returned. R1's Hospital Records, dated 7/1/25 at 8:31 PM, shows, (R1) arrives via EMS (Emergency Medical Services). EMS states someone called police, (R1) wandering around the streets to the grocery store with known baseline of dementia.brought in for evaluation for possible elopement. Family at bedside and they are upset that (R1) was not guarded appropriately and left the facility and found wandering. family and staff confirm (R1) has chronic cognitive impairment with occasional wandering behavior.On 7/8/25 at 11:38 AM, V1 (Administrator) and V2 (Director of Nursing) confirmed R1 eloped from the secured memory unit on 7/1/25. After the dinner meal around 6:30 PM, staff could not locate R1. V9 (Receptionist) said he saw someone who looked like R1 walk out of the building with family. V9 did not recognize R1 was leaving the building without her family. Both said family members had the access code to get on the elevators leaving the secured unit, and there is no alarm that alerts the staff a resident is attempting to exit the secured unit. On 7/8/25 at 9:41 AM, R1 was on the secured memory care unit, sitting in the dining room with her walker next to her. R1 was alert to self only. R1 could not recall the date, time, or where she was. This surveyor asked about the incident on 7/1/25. R1 could not recall the incident and stated, I did that, Oh my God. Did I get hurt? Oh my God, I must be losing my mind. I did not know I did that. On 7/8/25 at 11:52 AM, V7 (Certified Nursing Assistant) said on 7/1/25, she was R1's CNA. R1 was in the dining room at 5:00 PM for the dinner meal. At 5:40 PM, she left the dining room to assist other residents back to their rooms. At 6:30 PM, she could not locate R1. She asked V11 (Activity Aide), who was in the dining room supervising the residents, about R1. V11 said she did not know where R1 was. V7 said she notified V3 (R1's nurse) R1 was missing. (R1) is alert to self; she had a history of wandering when she first came to the facility. (R1) likes to lay down after meals and requires staff assistance to get back to her room. She uses a walker, and she is definitely not safe to leave the facility on her own. (R1) probably got on the elevator with someone else's family. (R1) should have been supervised to prevent her from leaving the unit attended.On 7/8/25 at 1:09 PM V11 (Activity Aide) said on 7/1/25, she was supervising the dining room. She saw R1 leave the dining</p>		