STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145453	A. Building B. Wing	08/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden Terrace of McHenry Rehab	803 Royal Drive McHenry, IL 60050

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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to follow its policy for a resident that left the facility without supervision and staff knowledge for 1 of 3 residents (R1) reviewed for safety and supervision in the sample of 9.The findings include:Findings include:R1's Face sheet dated 8/16/25 showed he was admitted to the facility on [DATE] with diagnoses to include but not limited to COPD (chronic obstructive pulmonary disease), moderate protein-calorie malnutrition, iron deficiency anemia, alcohol dependence, mood (affective) disorder, and hypertension.R1's Physician Order Sheet showed he was allowed to go out on a community pass alone. R1's Elopement Risk Assessment completed 7/17/25 showed he was not at risk for elopement.R1's facility assessment dated [DATE] showed he was cognitively intact and was independent with all Activities of Daily Living (ADLs).On 8/16/25 at 10:55 AM, V7 (Registered Nurse) said she was taking care of another resident when the door alarm went off. V7 said she immediately went to the door and R4 was outside smoking. V7 said R4 reported that R1 had walked out the front door and down the road. V7 said she walked down the street and could not see R1. V7 said she returned to the facility, informed staff to start looking for R1, and called V1 (Administrator). V7 said she did not call the police. V7 said R1 didn't tell anyone he was leaving, and they were all surprised. V7 said they didn't know where R1 was going.On 8/16/25 at 11:21 AM, V9 (police detective) said R1 walked out the front door of the facility on 8/13/25 at 4:45 AM. V9 said the facility reported that R1 set off the door alarm. V9 said the facility didn't notify the police R1 was missing. V9 said time is crucial with a missing person. V9 said the facility staff went to V33's house (R1's family member), in a different town, instead of calling the police. V9 said V33 was out looking for R1, happened to see the police, and filed a missing person report. V9 said a few hours had passed since R1 left the facility. V9 said R1 was located in another state, contact was made by local police, and he was deemed not a risk to himself or others. V9 said their missing persons case for R1 was closed.R1's Progress Note dated 8/13/25 showed R1 left the facility at 4:45 AM against medical advice (AMA). This note showed R1 was observed walking out the front door with his belongings in a handbag. This note showed R1 was alert, oriented, and decisional. This note showed V33 (R1's family member) was notified. This note does not show that the facility notified the police.R1's Police Report showed that V33 (R1's family member) reported him missing on 8/13/25 at 7:09 AM. This report showed the facility video footage was observed and R1 left the facility at 4:45 AM. This report showed that R1 was located in another state; was deemed of sound mind with no mental deficiencies; R1 refused to go to the hospital; and R1 was not appropriate for an involuntary hold.On 8/19/25 at 12:24 PM, V1 (Administrator) said he got a call from V7 (RN) on 8/13/25. V1 said he was told R1 left the building, and they could not find him. V1 said he went to V33's house (R1's family member) to see if R1 went there. V1 said V33 told him that R1 had run off before and she provided a few places to look. V1 said he went to a local hotel and the hospital to look for R1. V1 said he didn't call the police to report R1 missing. V1 said the police called him around 8 AM on 8/13/25 to gather information about R1. The surveyor asked V1 why he didn't follow the facility's policy for Missing Residents. V1 replied, He left AMA. The surveyor asked if the facility knew where R1 was going and he replied, No. The surveyor referenced the facility's policy and V1 said he should have called the police.The facility's Missing Resident Policy dated 9/2020 showed, It is the policy of this facility to report and investigate all reports of missing residents. Procedure: 1. All personnel are responsible for reporting a resident suspected of missing to the Charge Nurse as soon as practical. This includes any resident that did not sign out on pass and/or did not notify a staff member of his or her leaving. 2. Should an employee discover that a resident is missing from the facility, he or she should: .f. Call 911 to report the resident missing. g. The Administrator and Director of Nursing will evaluate the situation and develop a plan of action based on the individual resident. The following steps should occur: .iv. Notify the sheriff and/or police department and file a missing person report. ix. Document appropriate notations in the medical record.