STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146091	A. Building B. Wing	03/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manor Court of Peru	3230 Becker Drive Peru, IL 61354

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to supervise a cognitively impaired resident resulting in R1 opening her bedroom window, removing the screen, climbing through the window, walking approximately 350 yards to the roadway where a bystander saw her, picked her up, and notified the police on [DATE]. This applies to 1 of 4 residents (R1) reviewed for safety and supervision in the sample of 5.The Immediate Jeopardy began on [DATE] when R1 eloped from the facility through the window. V1 (Administrator) and V2 (Director of Nursing) were notified of the Immediate Jeopardy on [DATE] at 4:25PM. The surveyor confirmed by interview and record review that the Immediate Jeopardy was removed on [DATE], but noncompliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the window alarms and the in-service training. The findings include:R1's Progress Notes dated [DATE] at 12:30PM state, Activity Aide noted screen from the window outside on the ground. Missing resident procedure initiated. Resident noted to be within eyesight of the facility. Nurse completed skin assessment and neuro checks with all findings WNL (within normal limits) for resident. POA (Power of attorney) and MD (physician) notified of event.On [DATE] at 10:48 AM V3(RN-Registered Nurse) stated, I had just gotten her back to her room, she was on isolation for COVID and I left the door open because she is a fall risk. A few minutes later her door was shut and (V5- Memory Care Director) went and opened it again and (R1) was still upset but she was sitting in her chair. Then a few minutes later (V4-Resident Assistant) was leaving in the parking lot and he saw the screen was out of the window, so we started looking for (R1) in the building and outside. Then I saw her across the field- she was at the road already. I am pretty sure she had shoes on and I think she was wearing long sleeves. She had never tried to go out the window before. She had tried to exit seek but never out the window. I don't know if the alarms (on the windows) are new or not. I can't remember if her door was open when we found out she was missing or if she had closed it again. She did not use a walker or a cane. She could walk. She had a tendency to fall when she got tired or upset but otherwise, she walked pretty well. From the time I put her in her room to the time the screen was noticed to be missing was about 10-15 minutes. It was lunch time so about 12:00PM- 12:30PM. When I saw her across the field the police car was with her. I think the police called the facility and they also called her family. We called her family too. The police called an ambulance and brought her back here. (R1) knows her name and she had her purse with her, so I don't know if the police got her daughter's number from her purse or how they got it. The family came to the facility a few minutes after the ambulance brought her back here. (EMS- Paramedics) did their assessment and then we did ours. She did not have any injuries. I charted it late because I was not 100% sure how to chart it. I didn't want to miss anything. I did not talk to the police that day, but management might have.On [DATE] at 11:00AM V4 (Resident Assistant) stated, I pass water and help with flowers and decorating and little things that residents need help with. I was leaving so it was about 12:15PM. I noticed the screen was off one of the windows on the memory care unit. I drove around to the front, and I told (V6- Receptionist) and then I went back to the Memory care unit and notified (V5). She went with me right away to search outside, but I never found her or saw her. One of (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 - Immediate jeopardy to resident health or safety Residents Affected - Few	the staff saw her and then I knew she was found so I left. I don't believe there was snow on the ground because there would have been tracks.On [DATE] at 11:23AM V4(Memory Care Director) stated, We were all in COVID isolation on the memory care unit. It was lunch time, but it was a little later lunch for us than it normally is. It was about 12:00PM. I had just gone in R1's room because she kept closing the door and when I opened it she kind of mean mugged me. She was sitting in her chair with her table and her lunch in front of her. Then I went on to help the CNAs pass the trays to the other residents in their rooms. Then V4 came and told me the screen was off the window, and I ran to R1's room and pushed the door open and saw the window was open and R1 was gone. I yelled for the nurses and the CNAs and V3 and another nurse went out the back, and I went out the front to look for her. I looked across the field, and I could see her bright pink sweater and I said, 'there she is'. There was a black pick-up truck and a squad car. It was a Sunday and V3 wanted me to call V1 (Administrator), but I told her I thought V1 was out of town, so I called V2 (Director of Nursing). I ran back to the front because I was ready to go get her and V6 was trying to tell me something and a squad car pulled up and I ran outside and the police officer told me to calm down. He said, Are you missing something? I said yes, is she ok? He said 'yes, she is fine.' I told him I would go get her and he was talking to the other police officer, (on his radio) and they said the EMTs wanted to check her out. Then they brought her back in the squad car. They also called her family because they thought her family was going to come and get her. She had on her pink sweater, and she always wore like dress pants and slip on Sketchers (tennis shoes). She was carrying some pictures and she had her purse. When she got out of the car she thought she had just come back from vacation and she said, the boys will get my luggage. She had never tried to get out the window before, but she has a ton of behaviors. She is very [NAME] and would always question things you tell her. She would exit seek all the time. The alarms have been on the windows, but it did not sound. They have always been there. I don't know if she was smart enough to turn it off before she opened the window.On [DATE] at 12:30PM V7 (Maintenance Director) stated, The windows had older alarms on them, and they did work but we replaced them with new ones after this happened. I got the call on a Sunday, and I was fairly new to my position, so I came in and put the screen back on. The alarm on the Right window (that R1 got out of) was knocked off. They were pretty old. Surveyor and V7 assessed the location that R1 left the building and could see across the field to where she was found.V7 stated, I would say it is about 100-125 yards from here to that street- about the size of a football field- maybe a little further- like 2 city blocks but across a field.A Google Map search of the area shows the approximate distance from the building to the location that R1 was found (near the auto parts store) to be approximately 350 yards.An internet search on Weather Underground shows that temperature on [DATE] was around 32 degrees Fahrenheit from noon to 3:00PM. On [DATE] at 1:20PM V2 (Director of Nursing) stated, R1 has behaviors, always exit seeking. She has been seeing a psych specialist since admission in [DATE]. She is very nice, very sharp. She knows when you are playing her. She is usually compliant with her medications, but sometimes she takes some convincing. We have been gentle with her medication adjustments. Her daughter was living with her and then her husband died and that trauma set off her dementia. She was forgetful but a lot of this is very new to them. I got a call at home that R1 had kicked out the screen and had gotten out the window. I was on the phone with V5 and she was running- I could tell she was running then she said- 'I can see her pink sweater. The police have her. The EMT's just pulled up.' Then the next time she called me the police had brought R1 back and V5 said she was happy and R1 thought she had been on vacation. The nurse did a check and then we called the POA and I called the MD and the NP (Nurse Practitioner) that specializes in psych. We do not have a policy or plan about alarms, and I told V7 today that we need to have a system to check them monthly to make sure they are working. We did not have a system for checking the old alarms. We have never had this happen before. The alarms are there to alert the staff if someone opens the window. It is their right to open the window but then the CNAs (Certified Nursing Assistants) keep an eye on them if the window is open. There are no alarms on the windows outside the memory care unit. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	I have a timeline and I did an internal investigation but there is no incident report on the incident.On [DATE] at 2:30PM V6 (Receptionist) stated, The police called and said they found a woman by (Local) Auto Parts Store and wanted to know if we were missing a resident. At the same time V4 had told me that the window was open on the memory care unit. I told the police the staff were out looking for the resident. I don't know if the police knew R1's name or not or if she told them that she lived at the nursing home.The (R1's) Police Report dated [DATE] states, 12:17PM Caller advising that she has the female in a white Dodge Pickup truck, 12:21PM On Scene, 12:24PM I called (Local Assisted Living Facility) and was advised that R1 does not live there, 12:26PM I called (Facility) and spoke to an employee V6 who stated that R1 does reside there and that staff are outside trying to find R1. I asked how long they have been looking for R1, and the employee was not able to tell me. I advised her to have a supervisor call back when available. 12:26PM Arrived at (Facility), 12:50PM (City) ambulance checked on R1 and spoke to V8 (R1's daughter). V8 stated that R1 did not have to go to the hospital and could be transported back to (Facility). Officers transported R1 to (facility) and left her in medical staff care. The (R1's) (City) Volunteer Ambulance Service Report dated [DATE] states, (City) EMS was requested by (City) police to evaluate an elderly female patient who had been located following elopement from a nearby long-term care facility. The crew proceeded to the scene from quarters and upon arrival found the patient conscious and alert but confused sitting upright in a bystander's pick-up truck with no complaints. The patient was in the care of (City) police officers who reported that the patient was located by bystanders who found the patient wandering near the roadway in a confused state. The police officers reported that they had determined that the patient was a dementia patient who had eloped from a nearby long-term care facility, after which she was moving on foot for an unknown period of time. The police officers reported that they had made contact with the facility, and the staff reported that they had been actively searching for the patient for approximately 10 minutes. The patient was confirmed to have a history of advanced dementia. Upon assessment the patient denied any complaints and denied any injuries. The patient was in possession of various photos and personal belongings and reported she left the house to go and look for help for an unknown issue (Facility) was contacted via telephone and contact was made with the patient's nurse who requested that the patient be returned to the facility. The patient's nurse reported that the patient had eloped from the facility through a window and that she had been out of the facility for approximately 10-15 minutes .R1's Face Sheet shows she is an 83 female resident with diagnoses including Dementia without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety. R1's Care Plan date [DATE] states, R1 is at risk for elopement and is not able to make decisions regarding her safety due to diagnosis of unspecified dementia. Approaches include: Know where R1 is at all times, Offer to do one on one activity with R1 if she seems restless.The facility presented an abatement plan to remove the immediacy on [DATE] at 6:40PM. The surveyor reviewed the abatement plan and was unable to accept the plan. The abatement plan was returned to the facility for revisions. The facility presented a revised abatement plan on [DATE] at 9:56AM, the surveyor reviewed the abatement plan and was unable to accept the plan. The abatement plan was returned to the facility for revisions. The facility presented a revised abatement plan on [DATE] at 11:26 AM, the surveyor reviewed the abatement plan and accepted the abatement plan on [DATE] at 12:50PM.The Immediate Jeopardy that began on [DATE] was removed on [DATE] when the facility took the following actions to remove the immediacy: On [DATE] Maintenance was immediately called in to change the window locks to a lower position in order to prevent resident from opening window more than halfway.On [DATE] Administrator ordered all new window alarms. On [DATE] Memory Care Director/Designee initiated an all-staff in-service on missing resident policy and protocol, alternative call light/call system; to include the frequent monitoring of the residents, including cognitively impaired residents. In-servicing continued to ensure staff not working at that time were also in-serviced. On [DATE] New window alarms were installed on R1's window and all other resident windows in the Memory Care Unit. On [DATE] Maintenance to include checking window (continued on next page)

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