STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145582	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden Estates of Naperville	1525 South Oxford Lane Naperville, IL 60565

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on interview and record review the facility failed to ensure a resident was provided with transportation to get to medical appointments in a timely manner for 1 of 4 residents (R2) reviewed for Quality of Care in the sample of 10. The findings include: R2's face sheet shows he has diagnoses including Gastroesophageal Reflux Disease (GERD). R2's Physician Order Summary report shows an order was entered on 10/27/25 for R2 to be seen for a GI (Gastroenterologist) consult. On 1/20/26 at 10:41 AM, R2 said he was told that he is supposed to be going out to an appointment to see a GI doctor but has yet to get to see one. On 1/20/26 at 11:24 PM, V4 (Appointment and Transportation Scheduler) said there have been some issues with the transportation company the facility uses and getting residents to appointments on time. V4 said unfortunately there are no back up options that the facility uses to get residents to their appointments. V4 confirmed that she has been trying to get R2 to an appointment with the GI doctor and on 12/23/25 the transportation company called and said they were going to be late and the physician office could not accommodate a late appointment so it was rescheduled to 1/12/25. On 1/12/25 the transportation company went to the wrong facility to pick up R2 so again he missed his appointment. V4 said she has made a new appointment for him today for the GI doctor and they cannot get him in until 3/18/26. On 1/20/26 at 2:38 PM, V5 (Nurse Practitioner) said R2 is going to the GI doctor for previous abdominal pain and acid reflux. V5 said she was not aware that R2 had missed his GI appointments and while they are considered non urgent she would still expect the facility to get the resident transported to the appointment on time. The facility provided Transportation policy dated 9/2020 shows that the facility will assist residents in obtaining transportation to their appointments as needed.

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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(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to prevent a resident from cutting his face with a broken razor for 1 of 3 residents (R5) reviewed for safety in the sample of 10. The findings include:On 1/20/26 at 1:02 PM, V19 (R5's POA - Power of Attorney) said on 11/21/25 V20 (R5's family member) went to visit R5 and his face was all scratched up with scabbed blood. V19 said V20 immediately took pictures and sent them to her. V19 said the family (V19 and V20) were constantly aware of R5's razor. V19 said on 11/18/25 the razor was in good condition, but on 11/21/25 it wasn't. V19 said she has pictures of all of this. V19 said the head of R5's razor was damaged and there was a big gouge in the metal part. V19 said it appeared as if the razor had been dropped, but no one reported it. V19 said R5 can't use his right arm, and the staff have to hand him his razor. V19 said the staff shouldn't have given R5 a broken razor. V19 said his face was all cut up because they gave him a razor with metal edges sticking up. V19 said if you try to lightly run your fingers over the damaged area it would scratch you. V19 said she still has the razor. V19 said there was another razor in R5's room that didn't belong to him and she believed the facility was trying to cover up that they damaged R5's razor.R5's Facesheet dated 1/21/26 showed diagnoses to include, but not limited to stroke with right sided weakness, apraxia (motor disorder affecting the brain's ability to coordinate planned, skilled movements), aphasia (language disorder that impairs speaking, understanding, reading and writing), epileptic seizures, and xerosis cutis (severe dry skin). R5's Nurses Note dated 11/21/25 at 4:50 PM, showed R5 had dry spot scratches noted to his left chin and neck due to shaving. This note showed the Nurse Practitioner was notified and orders were received for ointment topically every shift for the scratches until healed. This note showed that V19 (R5's POA) was notified. R5's Concern Form completed by V20 (R5's family member) on 11/21/25 at 8:05 AM showed, R5's razor was dropped, the head of blades was cracked and wasn't working the same. R5's face got all cut up from the broken razor. V20 wrote that staff did not look at R5's face only told him they would replace the razor. This form showed the facility would reimburse V19 (R5's POA) for the razor and the nurse assessed R5 and obtained orders for treatment.The facility's Final Report dated 12/14/25 showed that R5's family alleged it was abuse to give R5 the broken razor to shave his face. The facility did not substantiate abuse. This document showed staff interviews did not reveal how his electric razor broke. This report showed the facility initiated education to staff in regard to personal items that are damaged or broken. The facility's investigation showed that 6 staff members were interviewed, and no one knew how R5's razor broke. The statement from V18 (RN - Registered Nurse) showed that V20 (R5's family member) was screaming at the staff, his face was turning red, and he was scaring the staff. This statement showed that she told V20 she didn't know the razor was broken.The facility's In-Service Meeting Attendance Records dated 12/9/25 showed the in-service covered Personal Belongings Safety. The areas discussed included: 1. Inspect all resident personal belongings before use, including mobility devices, furniture, footwear, and electrical items. 2. Do not allow resident to use any item that appears broken, damaged, unstable or unsafe. 3. If any item is found to be damaged, remove it from use immediately and label it Do Not Use. 4. Notify the nurse manager or supervisor immediately of any broken or unsafe personal item. 5. The manager will arrange repair or replacement or contact the family/POA if the item is privately owned. 6. Document findings and actions taken and communicate concerns during shift report. 6. Immediately report all damaged or broken belongs to the managers. Take them out of circulation if broken. Do not let the resident use broken equipment. On 1/20/26 at 1:58 AM, V15 (CNA - Certified Nursing Assistant) said she regularly works on R5's unit and is familiar with his (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care. V15 said R5 shaved himself most days and we just hand him the razor and put it away when he is done. V15 said she didn't remember the exact date, but remembered V20 (R5's family member was really upset about R5's razor. V15 said was there when V20 was yelling at the nurse (V18). V15 said V20 said someone dropped the razor, it broke, and R5's face had been cut with the razor. V15 said she didn't recall what R5's face looked like and didn't remember is she went in that day. V15 said R5 does get a small [NAME] under his nose from shaving.On 1/20/26 at 1:05 PM, V18 (RN) said she is regularly assigned to R5. V18 said R5 and his family are very particular about his care. V18 said R5 was insistent on shaving himself and the staff just set him up. V18 said there was a day R5 was cut by the razor. V18 said she didn't remember how many cuts or where they were, but she did enter a progress note. V18 said she didn't know how R5's razor was broken (11/21/25), but the family was very upset. V18 said she called the provider, obtained an order for ointment, and notified management.On 1/21/26 at 10:15 AM, V2 (Director of Nursing) said R5 was encouraged to shave himself and the staff should assist him with getting setup. V2 said the staff hand R5 his razor and he shaved himself. V2 said the staff should check the razor for any damage before handing it to the resident. V2 said if the razor head was damaged there would be an increased risk for cutting their face. V2 said she did not look at the razor to see the damage. V2 said the facility did reimburse R5's family for the damaged razor. V2 said the facility had completed an investigation and reported this incident after V19 (R5's POA) made a comment that it was abuse that R5 was provided a broken razor to shave. V2 said abuse wasn't substantiated, but the in-services were provided to the staff and they couldn't determine how the razor was broken. A policy related to Razor Safety was requested and not received.