STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145888	A. Building B. Wing	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden Estates of Northmoor	5831 North Northwest Highway Chicago, IL 60631

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47303 Based on observation, interview, and record review, the facility failed to ensure that two residents (R3 and R4) were provided with incontinent care as needed. This failure resulted in R3 and R4 being wet and soiled with urine for an extended period during the day shift. Findings include: R4 is a [AGE] year old with diagnosis including but not limited to: polyneuropathy, age-related physical debility, morbid obesity and history of falling. R4's BIMS (Brief Interview of Mental Status) score is 15, which indicates cognitively intact. R4's MDS - Function Abilities dated 09/18/2024 documents, R4 is dependent on facility for hygiene; R4 does not have the ability to utilize a toilet due to medical condition. On 10/15/2024 at 11:50 AM, R4 was observed lying in bed. At that time, R4 said, I need to be changed. I've been wet since 6:00 AM. I'm so tired of this happening to me. It happens all of the time. I just want to be treated like a human. They tell me that I need to wait for my turn to be changed. On 10/15/2024 at 11:50 AM, Surveyor asked R4 what was wet. R4 stated that her (R4's) brief and bed was wet. Surveyor then went to the nurse's station to inform V12 (LPN/ Licensed Practical Nurse) that R4 needed incontinent care. On 10/15/2024 at 12:00 PM, V12 (LPN) said that V9 (CNA/Certified Nurse Assistant) was assigned to R4 and would be returning from her (V9's) lunch break soon. On 10/15/2024 at 12:15 PM, V9 returned from her lunch break and entered R4's room to clean and change R4. At that time, V9 (CNA) pulled back R4's bed sheet. (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/15/2024 at 12:15 PM, Surveyor observed R4's saturated incontinence brief and saturated bed sheet with a brown ring on the sheet. Surveyor also noted a strong urine odor in R4's room. Surveyor asked V12 (LPN) to come to R4's room to observe R4's bed. On 10/15/2024 at 12:17 PM, V12 said that he (V12) did not know that R4's bed and incontinent brief were both saturated. Surveyor inquired about the last time that R4 was changed. On 10/15/2024 at 12:35 PM V9 (CNA) said, The previous shift told me that R4 was changed at 7AM. I (V9) checked on her (R4) at 10:00 AM. I (V9) asked R4 if she was wet and she said no, but I know that is part of her behaviors. R4 knows to put her call light on if she needs to be changed. I (V9) was going to change her after lunch, but she never told me that she needed to be changed so I assumed she was dry. I will have to start checking her and make her turn over to make sure that she is not wet. On 10/15/2024 at 1:35 PM, V9 approached Surveyor again in the hall and said, R4 always says no she is not wet, but I know she probably is wet. I didn't check because she said she was not wet. R4 is a heavy wetter. I know that R4 has psychiatric issues and behaviors. Sometimes she refuses care and I document it. I usually go back and recheck her if she says she doesn't need to be changed. Surveyor asked if R4 had refused care or exhibited behaviors today. On 10/15/2024 at 1:35 PM V9 (CNA) said, No. R4 did not refuse care today. She (R4) did not get aggressive today. She (R4) just said 'no' when I asked her if she was wet. I told her (R4) that going forward, I will have to just check her to make sure that she is dry. R3 is a [AGE] year old with diagnosis including but not limited to: contracture of muscle, dependence on supplemental oxygen, encounter for attention to tracheostomy, and posterior reversible encephalopathy syndrome. R3's MDS (Minimum Data Set) - Functional Abilities dated 10/07/2024 documents, R3 is dependent on facility for perineal hygiene and bathing; R3 does not have the ability to utilize a toilet due to medical condition. On 10/15/2024 at 1:42 PM, R3 was observed lying in bed with a strong urine odor in his room. On 10/15/2024 at 1:56 PM, R3's bed sheet and mattress were observed saturated with a brown ring around the bed sheet. At that time, V16 (CNA) said, R3 is a heavy bed wetter. He should actually be changed more frequently than every two hours. The last time that I changed him was around 10 AM. I have about 12 residents assigned to me. On 10/15/2024 at 2:22 PM, V14 (Unit Manager) stated that she (V14) managed all floors in the facility. Surveyor asked about the expectations regarding incontinent care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/15/2024 at 2:22 PM V14 said, It is expected that all residents are clean and dry to prevent wounds and skin breakdown. If a resident is confused or refusing care, we always take a second person to help redirect the resident. If a resident states that he/she are dry, we still have to check because they may be confused. Surveyor asked what should happen if a CNA is stating that a resident is refusing care. On 10/21/2024 at 3:08 PM, V1 (Administrator) said, If a resident refuses care, we should go back with another staff member and try other interventions. Surveyor asked if a resident says that he/she is not wet, would that be considered refusing care. On 10/21/2024 at 3:08 PM, V1 (Administrator) said, No, that would not be considered refusing care. On 10/21/2024 at 3:08 PM, V1 (Administrator) stated that the facility did not have a policy related to incontinent care or ADLs (Activities of Daily Living). Facility policy titled Perineal Care documents, purpose to maintain skin integrity.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47303 Based on observation, interviews and record review the facility failed to ensure that one resident (R1), who has a tracheostomy, was supervised while eating as recommended by Speech Therapy. This failure has the potential to affect thirteen other residents who require feeding assistance in the facility. Findings include: R1 is [AGE] year old with diagnosis including but not limited to: Encounter for attention to tracheostomy, age related physical debility, malignant neoplasm of thyroid gland, paralysis of vocal cord and larynx. R1 has a BIMS (Brief Interview of Mental Status) score of 15, which indicates cognitively intact. On 10/15/2024 at 12:50 PM, R1 was observed in bed having lunch. At that time, no staff member was monitoring R1 while eating. Surveyor asked R1 if any staff usually monitored R1 for choking during meals. R1 said No, no one monitors me while I eat. I can just pull my call light if I ever feel like I may choke. I'm not worried about it because I just eat small bites of food so that it's easier for me to swallow. I can eat solid foods. I don't know why they keep changing my diet order for no reason. On 10/16/2024 at 12:30 PM, R1 was in bed having lunch. At that time, no staff member was monitoring R1 while eating. On 10/17/2024 at 11:10 AM, V7 (Speech Therapist) said, He (R1) recently went out to the hospital and while he was there, he was evaluated by Speech Therapy. When he was admitted back to the facility, his diet order was entered by the nurse as mechanical soft. I did not question the order or reevaluate R1 because I felt like he was safer on mechanical soft diet. R1 has poor safety awareness and I have educated him on the importance of not sneaking and drinking thin liquids from his visitors. R1 also tends to eat fast and leans back while eating. I discharged R1 from speech therapy back on 05/17/2024 with an order for solid foods but with occasional supervision. I'm not sure how R1 is being supervised. After I discharged him and gave my recommendations, it is nursing that should follow and monitor R1 with meals to track his progression and tolerance of his diet. On 10/21/2024 at 4:10 PM, Surveyor inquired about expectations regarding supervision with meals. V1 (Administrator) said, If the care plan says a patient needs supervision, then we have to follow the care plan. Surveyor inquired about the purpose of the care plan. At that time, V1 said the purpose of the care plan is so that we have a plan of care for each resident. On 10/21/2024 at 4:12 PM, Surveyor inquired about R1's Speech Therapist recommendations. V1 said, I didn't know he (R1) had recommendations to monitor with meals. R1's Care plan dated 02/09/2024 documents, R1 has a swallowing problem related to dysphagia; Interventions include: observe R1 for difficulties with swallowing. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Speech Therapy Discharge Summary dated 05/17/2024 documents, Recommendations for occasional supervision with oral intake. MDS (Minimum Data Set) - Functional Abilities and Goals dated 09/17/2024 documents, R1 requires Supervision while eating. Physician order sheet excludes any order to supervise R1 while eating. Facility Feeders list documents thirteen residents who require feeding assistance, but excludes R1. Facility Policy titled Feeding a Resident documents the following: document on meal monitor sheet as applicable and/or report to the nurse if a resident refused a meal or had minimal intake or if a resident had difficulty swallowing or chewing a meal. Facility unable to provide Surveyor with any meal monitor sheets for R1 during investigation.