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	10/25/2024

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15301 Based on interview and record review, the facility failed to investigate and report an injury of unknown origin for one (R1) of three residents in a sample of four. Findings include: R1's face sheet documents R1 is an [AGE] year-old admitted to the facility on [DATE], with diagnoses including but not limited to: Hypertensive Heart Disease with Heart Failure, Spinal Stenosis, Type 2 Diabetes Mellitus, History of Falling, and Generalized Anxiety Disorder. R1's MDS (Minimum Data Set-10/21/2024) documents a BIMS (Brief Interview for Mental Status) of 10 (moderate cognitive impairment). On 10/22/2024, at 10:36 AM, R1 was observed lying in bed. Two greenish bruises/bumps to right side of his forehead and abrasion to the right side of nose was noted. R1 denied falling. R1 said approximately one week ago, a female hit him in his face with a phone. R1 said it was dark out when this occurred. R1 did not provide any other details (time, who female is). R1 said he did not report the incident. On 10/22/2024, at 12:38 PM V2 (Director of Nursing) said, last week staff noted bruising to the side of R1's head. The overnight CNA (Certified Nursing Assistant) reported R1 bumped his head during care. The CNA reported the bruises/bumps to the nurse, the nurse reported to me. I don't remember who the CNA or nurse was. I did not complete an incident report. I did report it to V1 (Administrator). You would have to ask him (V1) if he did an incident report. On 10/22/2024, at 12:48 PM, V1 (Administrator) said, regarding R1, I did not do an incident report. I asked him what happened, he said he didn't know. I asked him if he had any issues with staff, he said no. I asked him if he felt safe, he said yes. I did ask his roommates, they said they didn't notice anything. I spoke with V8 (CNA) who took care of the resident (R1) that night, she said he was combative during the shift during ADL (Activities of Daily Living) care. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/22/2024, at 2:12 PM, V7 (Licensed Practical Nurse) stated the overnight nurse said R1 had a bump and discoloration on R1's forehead. I went there to check on him at the end of my rounds. He was awake/alert, there were two bumps on the right side of the forehead. I asked him if he was in is pain, he shook head no. I assessed his head, there were no other bumps, skin was intact. I did ask him what happened. He did not tell me how he got the bump on his head. He has good days and bad days. Some days he's very energetic, wants to get up; other days he's lethargic, combative. V7 said R1 is more physical with CNAs (Certified Nursing Assistants), and doesn't like to be touched. V7 defined R1's combativeness as refusing ADL (Activities of Daily Living) care and medications. On 10/22/2024, at 2:27 PM via telephone, V8 (CNA) stated I worked 11:00 AM to 7:00 PM, that night (10/14/2024). The nurse, I don't remember her name, called me to help her, that R1 was almost on the floor. When I got to R1's room, he was almost out of the bed. We quickly picked him up. I went back to check on him, he was naked and almost out of the bed again. He wasn't on the floor. He was screaming at me, he was not trying to hit me, he doesn't do that. I saw that he had bumps on his head, I asked him what happened. I don't know what happened to him to cause the bumps. I reported the bumps to the nurse. I don't remember who that nurse was. On 10/22/2024, at 2:46 PM, V5 (Hospice Registered Nurse) said I came in, I got report from the nurse (V7-Licensed Practical Nurse). I was told R1 had unexplainable bumps to his head. I did go to sit with him. He was very lethargic; I did ask him what happened but R1 didn't answer. V5 said, per report he has been combative in the past, he has not been combative with me. My hospice CNAs (Certified Nursing Assistants) and nurses on the unit tell me he's combative during ADLs (Activities of Daily Living). He has never been combative with me. I don't know how he got the bumps. On 10/22/2024, at 3:18 PM, V6 (Licensed Practical Nurse) said, it was endorsed to me that R1 was sent to the hospital for bruising, restlessness, and agitation. He's always restless and confused when CNAs change him. V6 said the bruising was new. V6 said I am not aware of R1 trying to hit a CNA. No CNA has ever come to me to tell me that R1 was combative or refusing care. V6 then said twice R1 was restless; defined restless as R1 doesn't know where R1 is; R1 refused to allow CNA to change him. V6 said R1 has never tried to strike CNA/staff. On 10/23/2024, at 2:45 PM, via telephone, V14 (R1's Physician) said he was informed by staff that R1 was more lethargic than usual and with head trauma of unknown etiology. V14 said, I saw R1 at the facility; there were two bumps/bruises to the side of his head. V14 added, it was unclear to me if R1 was sedated from the Ativan, or the lethargy was a sequelae (consequence or result) of the head injury. V14 said per hospice R1 was more lethargic than usual, I sent him to the hospital for evaluation. R1's CT scans were negative. Hospice note dated 10/15/2024, at 11:52 PM, documents in part: Patient was received in bed appears very lethargic sleeping and was difficult to arouse throughout the assessment. Patient had (head?) noted with an unknown head injury on the right side of the forehead. Noted pt (patient) with 2 bumps, with discoloration & skin intact. Pt noted very sleepy. This writer assessed and stayed with pt for observation. (Patient) pt was less awake and alert. MD (Medical Doctor) came and assessed. (Patient) pt was sent to (local hospital) for AMS (Altered Mental Status). Nurses Note dated 10/15/2024, 12:57 PM, documents in part: Upon morning rounds, outgoing nurse endorsed that the resident had unknown head injury on the right side of the forehead. Noted resident with 2 bumps, discoloration & skin intact. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Emergency Department note for R1 dated 10/15/2024, at 2:09 PM, documents in part presents to ED (Emergency Department) with chief complaint of Head Injury (Unknown Origin). Presents from nursing home for evaluation of right sided head abrasions. Patient unable to answer questions regarding how he sustained the injuries. Decision was made to scan patient's head with a CT and CT C-Spine (neck). CT head was negative for any acute findings as well as CT C-Spine. Patient was stable throughout hospitalization and was stable for discharge to his facility, with no concerns for elder abuse at this time. Abuse Policy (09/20) documents in part under Policy, this will be done by: 7. Filing accurate and timely investigative reports. Documents in part under 4. Identification: Supervisors shall immediately inform the administrator or designee of all reports of potential mistreatment. Upon learning of the report, the administrator or designee shall initiate an incident investigation. The nursing staff is additionally responsible for report on a facility incident report the appearance of bruising of unknown origin.