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	01/26/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to maintain medical records in accordance with accepted professional standards and practices that are accurately documented for one (R1) out of three residents reviewed for resident records. On 01/24/26 at 10:30 AM, V3 (Licensed Practical Nurse) stated that she does not know exactly the date that she was notified by V7 (Certified Nursing Assistant) that R1 was noted with discoloration/bruising on her left side of R1's body. V3 stated but it was after lunch, V7 who is the regular CNA called V3 to the shower because she wanted to show R1's discoloration. V3 said R1 had a bruise on the left side, below armpit, next to the breast. V3 said I asked V2 (Director of Nursing) to see R1 after we transferred her to the bed. V2 looked at it and maybe 20 minutes later, V2 called me (V3) back, she said, let's take an x-ray (electromagnetic radiation). V3 stated R1 is on long-time blood thinner medication. V3 stated that R1's results were negative for any fractures. V3 stated that R1 does tend to lean towards her left side and requires frequent repositioning. V3 stated that V3 was the one who notified the doctor of the results. V3 stated I didn't chart this because I was waiting for the DON (director of nursing) to tell me what to do. She told me just to order an x-ray stat (immediately). V3 said that when this was going on, V4 was present and made aware. V3 stated that it is important to chart and document what is happening to residents because the next shift nurses could continue to follow up. V3 stated I have not documented anything in R1's electronic health record regarding the bruising/discoloration. On 01/24/2026 at 11:31AM, V7 (Certified Nursing Assistant) stated that on Monday January 5th, R1 had a scheduled shower so V7 assisted R1 to the shower and when V7 removed R1's clothes, V7 noted R1 with discoloration/bruising to her left side of R1's body. V7 stated I reported it to V3 (Licensed Practical Nurse) and I put in my charting in the computer. Then when the daughter came in, the nurse told the daughter. The daughter asked me what happened. V7 stated that it was the first time she saw the bruise and V7 did not witness R1 suffer any fall or injuries. V7 said that she told R1's daughter that when I saw the bruise I (V7) immediately notified the nurse.On 1/24/26 at 12:19 PM, V5 (Assistant Director of Nursing) stated if the CNA (certified nursing assistant) is providing care to the resident and notices a skin injury they need to report it to nurse on duty after they take care of the resident. From there on (if there is a skin tear) the nurse will call the doctor depending on the severity. V5 stated that skin injury can include anything such as a scratch, open skin tear, anything out of the ordinary such as skin discoloration. V5 stated that nurses are supposed to chart this in the progress notes and notify the doctor.R1's face sheet documents R3 is a [AGE] year-old individual admitted to the facility on [DATE] and has diagnoses not limited to type 2 diabetes mellitus with diabetic polyneuropathy, dementia, pressure ulcer of sacral region, stage 3.R1's radiology note dated 01/06/2026 9:29 PM documents in part above X-ray (electromagnetic radiation) results relayed to R1's doctor with no new orders.No documentation regarding R1's new discoloration noted to (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	skin and what interventions were done following this discovery.Facility document dated 09/20, titled Change of condition (resident) documents in part to ensure that the resident's physician and responsible party is kept informed regarding the resident's change in condition. Document time of call, physician or nurse practitioner or other person spoken to; reason for call and result or orders received. Change in Condition: When to report to the doctor. Discoloration of Skin; any new skin discoloration without any other symptoms.