

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145888	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/15/2026
NAME OF PROVIDER OR SUPPLIER Alden Estates of Northmoor		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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. Based on observation, interview, and record review, the facility failed to provide adequate supervision and implement effective interventions to prevent elopement for a cognitively impaired resident with impaired safety awareness and wheelchair dependence. This affected 1 (R1) of 3 residents reviewed for supervision and elopement. This failure resulted in R1 exiting the facility without staff knowledge or supervision and was later located approximately one block from the facility. Findings Include: On 6/1/26, R1 eloped from the facility. Upon return, R1 was noted to be emotionally distressed, confused, and unable to explain the circumstances surrounding the elopement. R1's MDS (minimum data set) with review date of 04/01/2026, BIMS (brief interview of mental status) of 7, indicating that R1's cognition is moderately impaired. R1's Care plan with review date of April 1, 2026, documents that R1 has difficulties in effectively communicating his needs and at times does not reflect signs of comprehension or understanding during simple communication with staff, peers, family or friends. R1 has the diagnoses of CVA (cerebrovascular accident) & Aphasia (language disorder) which may be contributing factors in diminishing communication abilities. R1 may show signs of wellbeing and opportunities to socially connect by some of the following: Answer questions appropriately/able to complete task at hand/follow directions/smiling/relaxed facial expressions/relaxed postures by next review. On 06/14/2026 at 9:45 AM, this surveyor observed R1 sitting in his wheelchair while watching television on the second-floor dining room. R1 appears to be dressed appropriately for the weather. R1 is clean, there are no odors coming from the residents. R1 is alert and oriented to self, with some confusion. On 06/15/2026 at 9:50 AM, V4 (Registered Nurse) stated R1 has never exhibited exit seeking behavior. V4 stated on the day of the elopement (6/1/26), R1 was able to wheel himself to the elevator and get past the nurse's station to go outside. V4 stated an incoming staff member found him outside and brought him back safely to the facility. V4 stated R1 currently has a 1:1 supervision, and a wander guard bracelet on his left ankle. V4 stated after the incident R1 is now deemed an exit seeker. On 06/14/2026 at 10:53 AM, V9 (Activity Director) stated she was not working on the day R1 left the facility. V9 stated the last time she had an Inservice on elopement was last week. V9 stated there is a Jogger Binder that is kept at the nurse's station on each unit and in one by the receptionist. V9 stated the binder makes staff aware of the residents that need to be monitored for elopement. V9 stated the day that R1 left the facility was in the morning, there was no receptionist at that time, since the receptionist starts her shift at 8:00 AM. V9 stated a staff member might have left the door unlocked, and due to that reason R1 was able to leave the facility unsupervised. On 6/14/26 at 1:23 PM, V1 (Administrator) stated R1 left the facility between 6:40 AM to 6:50 AM. She stated R1 was found by incoming CNA 10 minutes after he left the facility about a block away. V1 stated unfortunately the front sliding door was left unlocked by one of the staff in the facility. V1 stated the door is supposed to be locked until 8:00 AM when the receptionist is around. V1 stated R1 can use the elevator by himself, and he did not exhibit exit seeking behavior prior to this incident. On 06/15/2026 at 9:24 AM, V14 (Certified Nurse Aide) stated she was on the way to work at approximately 6:30 AM. V14 stated while she was on the bus she was passing through the intersection, and she recognized R1 sitting in his wheelchair. V14 stated once she got off the bus she ran into the facility and told the (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 - Minimal harm or potential for actual harm Residents Affected - Few	him are not always the best. V27 stated R1 seems to be confused, and not always in his right mind. V27 stated upon R1's return to the facility, he ordered labs, urine culture, and there were no physical issues, or any signs of infections. V27 stated R1 has not yet seen a neurologist due to his insurance, and the family being particular and hostile. V27 stated R1 is currently on a 1 to 1 monitor and has a wander guards' bracelet. V27 stated on the day of the elopement the doors were left unlocked, there was no harm however R1 was left unsupervised and unattended while exiting the facility. On 06/15/2026 at 11:30 AM, this surveyor is located on the first unit near the double doors and the exit door that goes to the patio. The wander guard sensor was functional and reliable. The back door exit also has a functional sensor. Facility's elopement binder kept in the reception room reviewed. R1 was included in elopement risk dated 06/2026 with R1's picture and face sheet. Policy titled Wanderers (Elopement) with review date of 09/2020 documents in part, Residents identified as wanderers will have a preventative program to prevent possible injuries. Policy titled Missing Resident, with review date of 09/2020 in part, It is the policy of this facility to report and investigate all reports of missing residents. Should an employee discover that a resident is missing from the facility he or she should immediately report the missing resident to the charge nurse or the nursing supervisor. Call a code green.		