STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145907	A. Building B. Wing	12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden Estates of Evanston	2520 Gross Point Road Evanston, IL 60201

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide privacy during blood glucose monitoring and insulin injections. This deficiency affects one (R60) of two residents in the sample of 16 reviewed for privacy during Medication Administration.Findings include: On 12/16/25 at 11:05AM, Observed V7 LPN (Licensed Practical Nurse) performed peripheral blood glucose/sugar monitoring to R60 in the hallway by the nursing station where visible to other residents and staff members. Then V7 prepared Humalog lispro 5 units and administered to R60's abdominal area subcutaneously. V7 said that R60 prefers to monitor his blood sugar and receive his insulin in the hallway without privacy.On 12/16/25 at 11:10AM, Reviewed R60's comprehensive care plan with V8 Charge Nurse. No care plan addressing R60's preference of monitoring his blood glucose/sugar and receiving insulin in the hallway without privacy. V8 said that R60's preference of having no privacy during monitoring of blood sugar and administration of insulin without privacy should be addressed in care plan.On 12/16/25 at 11:17AM, Informed V9 Resident Coordinator of above observations and concerns. V9 said that she is not aware that R60 prefers to monitor his blood sugar and receives insulin injection in the hallway without privacy. V9 said that his preference should be reflected in his comprehensive care plan.R60 is admitted on [DATE] with diagnosis listed in part but not limited to Hemiplegia and hemiparesis following cerebrovascular disease affecting left non-dominant side, Type 2 Diabetes Mellitus, Chronic Kidney disease. Active physician order sheet indicated: Blood glucose monitoring AC and HS call physician for results less than 70 or greater than 300 before meals and at bedtime. Humalog Kwik pen subcutaneous (SC) solution pen injector 100 unit/ml (Insulin Lispro) inject 5 units SC with meals. Lantus solo star subcutaneous solution pen injector 100 unit /ml (Insulin Glargine) inject 8 unit subcutaneous in the morning. Comprehensive care plan revised by V9 resident coordinator after surveyor discussed concern with her dated 12/16/25 indicated: R60 prefers his blood check and insulin shot if applicable to be done in the hallway or dining area.Facility's policy on Medication Pass Guidelines 04/19 indicated: 6. Privacy*While privacy is always a priority, it is required for the following procedures: -Injections-Blood glucose monitoring.Facility's policy on Comprehensive Care plan 11/2027 indicated:An individualized, person-centered comprehensive care plan, including measurable objectives with timetables to meet resident's physical, psychosocial and functional needs is developed and implemented to each resident. Procedure: 1. In coordination with the resident and resident representative, as applicable, the interdisciplinary team will develop and implement a person centered, comprehensive plan of care. Care plans are comprised of focus statements, goals, and interventions. 8. Assessment of the resident is ongoing and care plans are revised based on the resident condition, preferences, treatments, and goal change.

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure ongoing assessment to revise and updated the resident individualized care plan according to the resident's condition and treatments. This deficiency affects one (R2) of three residents in the sample of 16 reviewed for Care plan revision.Findings include: On 12/16/25 at 10:49AM, Observed R2 lying in bed. He is dependent with ADLs and transfers. He is incontinent of bowel and bladder. He is awake and responsive with but confused. On 12/17/25 at 10:17AM, Observed R2 lying in bed with V7 LPN (Licensed practical Nurse). V7 said that R9 has indwelling catheter when he was admitted but it was discontinued couple months ago. R2 is admitted on [DATE] with diagnosis listed in part but not limited to Cerebral atherosclerosis, Chronic Kidney Disease Stage 4, Type 2 Diabetes Mellitus, Hemiplegia, and hemiparesis following cerebral infarction. Active physician order sheet indicated no order of indwelling urinary catheter, but comprehensive care plan indicated that he requires the use of indwelling catheter with target goal dated 2/11/26. MDS significant change assessment dated [DATE] indicated no usage of indwelling urinary catheter, he is incontinent of bladder. On 12/17/25 at 10:28AM, V9 Resident Coordinator said she updates the resident's care plan for any changes in their condition and plan of care. Reviewed R2's medical records with V9. Informed V9 that R2's indwelling catheter was discontinued on 10/24/25 but it was not updated in R2's comprehensive care plan. V9 said that she updates the care plan if the nurse informed him of the changes. V9 said that she is not aware, and she did not update R9's care plan for discontinued catheter. V9 said that she completed the MDS/Resident significant change assessment for R2 on 11/11/25. V9 said that R2's care plan should be updated of discontinued indwelling urinary catheter. Facility's policy on Comprehensive Care plan 11/2027 indicated:An individualized, person-centered comprehensive care plan, including measurable objectives with timetables to meet resident's physical, psychosocial and functional needs is developed and implemented to each resident. Procedure: 1. In coordination with the resident and resident representative, as applicable, the interdisciplinary team will develop and implement a person centered, comprehensive plan of care. Care plans are comprised of focus statements, goals, and interventions. 8. Assessment of the resident is ongoing and care plans are revised based on the resident condition, preferences, treatments, and goal change.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review the facility failed to ensure resident medications were appropriately stored. This deficiency affected one resident (R79) reviewed for medication storage in a sample of 16. Findings include:On 12/16/25 at 11:10am, observed R79 with medication at bedside table, Ipratropium Bromide nasal spray, said she uses it for allergies. On 12/16/25 at 11:10am, V16 (R79 daughter) said that she is unaware of who brought the medication, said they must have been in her belongings from another place.On 12/16/25 at 11:15am, surveyor made V15 (Licensed Practical Nurse) aware of above findings and said that medications are not to be stored at bedside unless they have a physician order. V15 said that medications should have a physician's order to be administered. On 12/16/25 at 1:20pm, V2 (Director of Nursing) made aware that R79 had medications stored at bedside and made nurse aware of above findings. V2 said that medication should not be at bedside unless there is an order, all medications should have a physician order to be administered by the nurse. V2 was made aware that there was no order for, Ipratropium Bromide nasal spray, in the physician orders for R79, V2 said she was unaware. On 12/18/2025 at 12:15pm, V2 said there is no policy available for medication storage. R79's admission date 12/12/25 with diagnosis in part but not limited to primary osteoarthritis, right wrist, encounter for surgical aftercare following surgery on the genitourinary system, muscle weakness, need for assistance with personal care. Insomnia, and essential hypertension. Physician orders dated 12/15/2025 indicates no order for Ipratropium Bromide nasal spray. Facility Policy for Bedside Medications revision date 03/21Prerequisites:1. Physician order2. Medication Administration Record (MAR) or Electronic Medication Record (Emar)Policy:Bedside storage of medication may be allowed for sublingual, inhalation, eye drops, or select topical forms of drugs and then only upon specific order of the physician.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review the facility failed to use appropriate infection control practices during medication administration. This deficiency affects two (R59 and R81) of 14 residents in the sample of 16 reviewed for Infection Control during Medication Administration. Findings include: On 12/16/25 at 9:48AM, Observed V7 LPN (Licensed Practical Nurse) administered medication to R59. V12 did not perform hand hygiene after medication administration. He answered call light of R83. He attended to R83's needs, turned off the call light. He took the food plate cover and cloth table napkin left on R83's tray table. He then walked toward the nursing station and handed the food plate cover and table napkin to one of the staff members. He then continued to with medication administration without hand hygiene. He prepared medications for R81 then he used hand sanitizer. Informed V7 of above observation. He said that he should performed hand hygiene after administration of medication to R59 and before preparing medications for R81. On 12/16/25 at 11:36AM, Informed V3 ADON (Assistant Director of Nursing) of above observation. V3 said that V7 LPN should performed hand hygiene before and after medication administrations. Facility's policy on Medication Pass Guidelines 04/19 indicated: 1. Hand hygieneHand wash with soap and water or a commercially prepared alcohol gel. When using alcohol gel, use friction for approximately 15 seconds. Allow gel to air dry on hands- do not dry with a paper towel, tissue, wipe etc. Do not use any product containing lanolin as it may weaken the barrier that gloves provide, risking exposure. When hand washing with soap and water, use friction for approximately 20 seconds. Practice hand hygiene under the following circumstances: *Before staring med pass.