STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145259	A. Building B. Wing	01/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden Park Strathmoor	5668 Strathmoor Drive Rockford, IL 61107

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on interview and record review, the facility failed to ensure the correct type of insulin was administered to a resident. This applies to 1 of 3 residents (R1) reviewed for insulin administration in the sample of 3. This past non-compliance occurred from 12/5/2025 -12/9/2025. The findings include: The Facility Medication Correction Form, dated 12/5/25, states, Wrong insulin given, Novolog given instead of Lantus. Insulin in wrong bag. Novolog in Lantus bag (looked at?) label on bag but didn't see pen wrong place.On 1/20/26 at 11:00AM, V6 (LPN-Licensed Practical Nurse) stated, I was doing her insulin, her 8:00PM Lantus (Long-acting Insulin) dose supposed to be 40 units. The bag said Lantus and after I gave the insulin, I noticed the pen was the wrong color- I gave Novolog (Fast acting insulin) instead. The Lantus pen is gray. I got (V2- Director of Nursing) right away- he was working the floor on another wing, and we sent (R1) to the hospital. (V2) took over my cart and did a training with me. We notified the Nurse Practitioner. I checked the bag and it said Lantus, but it was the wrong pen in the bag.On 1/20/26 at 11:20 AM, V2 stated, It was on 12/5 at the HS (Bedtime) medication pass. I was working the back of the E wing, and the nurse (on the D wing) gave (R1) Novolog instead of Lantus. She (V6) came and got me right away and I went and we assessed (R1) and we did her blood sugar again. We called the Nurse Practitioner and the Power of Attorney, and we sent the patient to the ER. The medication pass was still ongoing, so I took over her cart, and I did a competency with her then and another one the next day. I did one 12/5, 12/6 and 12/7. I also did an in-service with all the nurses. Both insulins were in the same bag, and she took out the wrong one. Each one should be in its own bag. (R1) came back from the hospital with no new orders and she had no side effects from the error.R1's Progress Notes, dated 12/5/25 at 9:39 PM, stated, Resident sent out to (Local Hospital) for evaluation and treatment related to blood glucose. Nurse notified Power of Attorney, regarding resident transfer.Resident returned from (Local Hospital) at or around 04:05AM. No new orders noted. Vitals 97.3, 81, 121/73, 18 95% and BS (Blood Sugar) 137. Resident awake in her room engaging in ADLs.R1's Medication Administration Record shows she has orders for Lantus 40 units at bedtime and Novolog per Sliding Scale (depending on her blood sugar) three times a day with meals. R1's Hospital After Visit Summary shows R1's Point of Care Glucose was checked 9 times while in the emergency room, however, there are no results listed. R1's Diagnosis is listed as Insulin Overdose, accidental or unintentional, Hypoglycemia. R1 was monitored, provided education related to the signs and symptoms of hypoglycemia, and sent back to the facility with no further orders. The facility policy entitled Medication Pass Guidelines, dated 4/2019, states, Check the MDP (Multi-Dose Pen): Check the pharmacy label against the eMAR (Electronic Medication Administration Record); Compare the medication name and strength on the manufacturer label vs the pharmacy label. Prior to the survey date of 1/20/26, the facility had taken the following actions to correct the noncompliance:Corrective actions were immediately implemented, including competency retraining for the involved nurse (V6) on 12/5, 12/6 and 12/7.Facility wide in-service education on medication administration and insulin safety on 12/5, 12/6 and (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/8Revisions to medication storage practices- checked all medication carts to ensure all insulins were stored in the correct bags. Separated the types of insulin in the carts.Implementation of quality assurance audits to prevent reoccurrence starting on 12/9/25 and done at least 3x a week by clinical managers. QA meeting scheduled for the end of January 2026.