STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145872	A. Building B. Wing	04/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden Long Grove Rehab &hc Ctr	2308 Old Hicks Road Long Grove, IL 60047

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 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure pain management was provided to a resident related to right tibia fracture. This failure resulted in R1 experiencing severe pain without receiving ordered pain medication for approximately 24 hours. This applies to 1 of 7 residents (R1) reviewed for pain management in the sample of 7. The findings include: R1's face sheet shows she was admitted to the facility on [DATE] with diagnosis including displaced fracture of right tibia, type 2 diabetes, hypertension, difficulty walking, and history of falls. On 4/6/26 at 10:33 AM, R1 was in her room laying in bed. R1 said she came to the facility after falling at home and fracturing her right knee. R1 said she is non-weight bearing to her right lower extremity and wears the immobilizer when she is out of bed. R1 said she was having a lot of pain to her right knee when she came to the facility and increased pain after therapy. She was getting hydrocodone (opioid) pain medication every four hours as needed for pain. R1 stated, I needed pain medication every 4 hours for pain. She would call requesting the pain medication and would have to wait up to 1.5 hours after requesting her pain medication. On two occasions nursing did not have my pain medication available. Nursing reported they were waiting on pharmacy to deliver the pain medication. I was really angry one night because I was in pain. R1 said I exploded at the CNA (Certified Nursing Assistant), because no one was helping me. R1 said she was having pain, and no one would do anything for her pain. R1 said she told two doctors and one said, He doesn't deal with that. R1 said she was so upset she asked to speak to the administrator. R1 said, The administrator came up the next day and I explained to her what was going on. They would run out of pain medication at night, it happened twice. Why were they running out of pain medication?On 4/7/26 at 10:38 AM, V6 (Registered Nurse-RN) said if a resident has narcotics ordered they need a script from the physician and then it's faxed over to pharmacy. Pharmacy delivers medications to the facility at 3:00 PM and the 2nd delivery is at midnight. She is not sure if they can pull narcotics from the emergency medication cart. V6 said R1 had hydrocodone for pain, and she followed up with pharmacy because she did not have R1's pain medication. I was not able to give the narcotic because I did not have the supply. V6 said she did not pull the medication from the emergency supply because pharmacy said it was going to be delivered. On 4/7/26 at 10:55 AM, V5 (RN) said R1 was alert and oriented, and able to express herself. Initially after her admission she would request pain medications every 4 hours. R1 would rate her pain at a 6-7 and was always putting on her call light every 4 hours requesting her pain medication. V5 said there was one time she did not have R1's pain medication to administer. R1's Medication Administration Record (M.A.R.) dated March 2026 shows orders to administer Hydrocodone 5-325 mg (milligrams) one tablet every 4 hours as needed for moderate to severe pain. R1's M.A.R. shows on 3/13/26 and 3/17/26 shows there was no pain medication administered. R1's M.A.R. shows on 3/16/26 hydrocodone was administered at 11:29 PM and the next dose was administered on 3/18/26 at 12:59 AM (approximately 24 hours later). R1's M.A.R. shows pain score 4-8 recorded with hydrocodone administered. R1's Controlled Drug Receipt Record shows 18 pills of hydrocodone were delivered to the facility on 3/12/26. On 3/13/26 the controlled record shows she was medicated for pain at 8:00 PM (This does not reflect on R1's M.A.R.) R1's physician progress note dated 3/13/26 documents (R1) complains of significant pain with any (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145872	A. Building B. Wing	04/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden Long Grove Rehab &hc Ctr	2308 Old Hicks Road Long Grove, IL 60047

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 0697 Level of Harm - Actual harm Residents Affected - Few	pressure or movement of her right leg. R1's progress note dated 3/17/26 documents moderate to severe right knee pain, asking for hydrocodone every 4 hours.R1's progress note dated 3/19/26 by V10 (Previous Assistant Administrator) documents R1 stated, Where the h*ll are my pain meds? Why are you people not getting them pharmacy? V9 explained to her controlled substances have to wait until the day of the last dose for the prescription to be filled. On 4/7/26 at 12:48 PM, V2 (Director of Nursing-DON) said she was not aware of any concerns regarding R1's pain medications not being available. V2 said, If the narcotic is ordered and they are waiting on pharmacy to deliver, I would expect nursing to pull the medication from the emergency supply. Pain should be treated when the resident is requesting pain medication and not delayed. She was not aware V10 spoke with R1 regarding this concern. I don't know why (V10) did not talk to me about (R1's) pain medication. There is a reason why V10 is no longer here. V2 reviewed R1's M.A.R. with this surveyor and confirmed R1 did not receive pain medication over a 24-hour period on 3/17/26. V2 said nursing should have communicated the concern to her and administered the narcotic. R1's current care plan shows to assess pain every shift and monitor the effectiveness of pain relief.The facility's Pain Management Evaluation Policy dated 4/2025 states, Our mission is to facilitate resident independence, promote resident comfort and preserve resident dignity. Residents shall be evaluated for pain upon admission, re-admission, post fall with significant change.pain will be evaluated each shift.