STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145963	A. Building B. Wing	12/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden Estates of Orland Park	16450 South 97th Avenue Orland Park, IL 60467

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to administer medications as ordered by the physician for one resident (R1) in a sample of 8 residents reviewed for quality of care. Findings include: R1 is [AGE] years old with diagnosis including but not limited to: Chronic Kidney Disease, Stage 4, Hypertensive Heart And Chronic Kidney Disease With Heart Failure And Stage 1 Through Stage 4 Chronic Kidney Disease, Functional Quadriplegia, Dementia, Heart Failure , Chronic Obstructive Pulmonary Disease, Hyperkalemia, Acute Kidney Failure, Disorder Of Mineral Metabolism, Pleural Effusion, Pneumonia, Diabetes Mellitus , Cognitive Communication Deficit, Sedative, Hypnotic Or Anxiolytic Dependence, Severe Protein-Calorie Malnutrition, Polyosteoarthritis, Pressure Ulcer Of Sacral Region, Stage 4, Diaper Dermatitis, Erythema Intertrigo, Hypertension, Gout, Obesity, Neuromuscular Dysfunction Of Bladder. R1's BIMS (Brief Interview for Mental Status) score is 6 meaning R1 is not cognitively intact. R1's medication administration record for October 2025 documents the following scheduled medications as not given or the record has a blank box (not documented as given or not given with the reason to why not): Carvedilol (cardiac medication) Oral Tablet 12.5 MG (milligrams) on 10/10/25 and 10/24/25 at 6 pm (order date 10/7/25 at 4:15 pm and discontinued on 11/4/25 at 6:57 pm) Sodium Zirconium Cyclosilicate Oral Packet (Lokelma) (Potassium Lowering medication) 10 GM (grams) on 10/24/25 at 5 pm (Order Date 09/30/2025 6:15 pm and discontinued on 11/04/2025 at 6:57 pm). On 12/13/25 at 9:16 am V11 Registered Nurse (RN) said after she gives a resident medication, she will document in the electronic health record, and she clicks in the MAR (medication administration record) on the medication that was given. V11 said, the MAR will show if the medication was given, if there is a check mark that means given for the scheduled medications, and if the box is blank that means it's not given. On 12/13/25 at 9:28 am V12 (RN) was observed administering medications. V12 said, he is staff here and he has given R1 her scheduled morning medications. V12 said, on the MAR, if there is a blank space that means it was not given, if a medication was held for some reason, there should be a reason documented. On 12/13/25 at 9:46 am V14 (RN) said related to administering medications, if the medication is not checked off or signed out on the medication administration record, that means it was not given. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/13/25 at 12:02 pm V2 Director of Nursing (DON) said V15 Licensed Practical Nurse (LPN) was assigned nurse to R1 on 10/10/25. V2 said, in nursing what is not documented is not done, however that is not always the fact. V2 said, staff were holding R1's medications, due to R1 having an upset stomach, and it should have been documented if the medication was not given with the reason. V2 said, she has spoken to R1's family and made them aware R1 is receiving her medications that are ordered. V2 said, R1's family did ask her about the medication Lokelma and it was few months ago, they asked if she was getting it and V2 informed them R1 was receiving the medication. V2 said, out of the entire month there were 2 days not documented on the mar that medications were given or not given, but V2 believes it was held for emesis. Surveyor asked V2 if R1 was having upset stomach and emesis why other medications were given to her that day, V2 said that even if the medication was held, there is a place on the mar to document as held. Review of R1's progress notes for 10/10/25 and 10/24/25, affirm no progress note was written to any medications being withheld. Facility's staffing sheets document: 10/10/25 V15 (LPN) was working (V2 confirmed she was the assigned nurse to R1) and on 10/24/25 V4 (RN) was assigned to R1. On 12/12/2025 at 2:41pm V2, Director of Nursing (DON) stated, R1 was in the hospital from [DATE] to 9/30/2025. Resident returned to facility with discharge orders from hospital on 9/30/2025. When the resident returns from hospital, the nurse verifies the medication with the physician at the facility. R1 had new medications one topical medication and one Lokelma (Sodium Zirconium) Cyclosilicate. She did not go to the hospital in October. R1 did not get Carvedilol on 10/10/25 or 10/24/25 PM shift (6:00pm dose). I need to see why. If a medication is not given, the nurse will document the reason on the Medication Administration Record. On 10/22/25 Carvedilol was held due to blood pressure. On 10/24/25 I cannot tell why Carvedilol medication was not given. V4, Registered Nurse was the nurse, and no note was written as to why medication was not given. On 10/10/25 V15, Licensed Practical Nurse was the nurse, but she does not work here anymore. She was terminated and there is no note as to why medication was not given. On 12/12/2025 at approximately 3:30pm V4 (RN) stated, I took care of R1 on 10/24/2025 7am-7pm. I give medication according to the order. I sign out medication on the MAR. If not signed, means you either gave and forgot to sign or did not give the medication depending on what happened. You must document why the box is blank or did not give the medication. I am not sure why I did not document. Maybe because R1 was throwing up and it was held. I was supposed to have documented a note, I forgot. She does have emesis, but I would let NP know. I cannot hold medicine for no reason, I think just forgot to document it. Either I forgot to sign out or forgot to document. I cannot really remember what happened. I must have forgotten to sign out when I gave her the medicine or maybe she was having emesis, and the medicine was held but I am not for sure. I am supposed to sign out medicine right away. If I cannot give medicine, I have to document why I cannot give medicine and notify the doctor why I did not give medicine. I should have documented something in the box as to why not given or held and used code. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/12/2025 at 3:52pm V2 stated, box for 10/10/2025 is blank, it could mean missed documentation although medication still given, or I guess that would be the only thing. There should be documentation. After the medication is given, the nurse should document when the medication is given, the nurse should document administration. If not documented not done and there should be a note. R1's Family did speak to me about R1's medication not being given. They asked if she was getting the Lokelma (Sodium Zirconium) Cyclosilicate. The medication was under a different name, and I showed it to her (R1's daughter) that she was getting it. I am not aware of any other medications. On 12/13/2025 at 11:33am V16, RN stated, when medication is given, I document administration immediately after I give the medicine in the box on the MAR. If the resident does not take their medicine, we document using one of the codes in the box and write a note. If the administration box is left blank, it means you did not give the medicine. The box should not be left blank. Facility's JOB DESCRIPTION Staff Nurse (Registered Nurse/License Practical Nurse) documents in part: P. Prepare and administer medications and treatments if appropriate as ordered by the physician. Q. Review medication record for completeness of information, accuracy in the transcription of the physician's order, and adherence to stop order policies. Facility's (3/2021) Medication Administration: General Guidelines documents in part: 5. Each dose administered shall be properly recorded on the resident's MAR, TAR, or eMAR, immediately following administration. On paper records, initials are verified by signature each month in the section provided on the back of the MAR/TAR. 6. If the physician's medication order cannot be followed, the physician should be notified, depending upon the situation. On paper records, the authorized staff initials are circled on the front of the MAR indicating the dose was not given; reason is recorded on the back. If an eMAR is being utilized, document in the record the reason the medication was not given.