

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  146182	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/30/2025
NAME OF PROVIDER OR SUPPLIER  Alden Courts of Waterford		STREET ADDRESS, CITY, STATE, ZIP CODE  1991 Randi Drive Aurora, IL 60504	

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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39182</p> <p>Based on interview and record review, the facility failed to ensure medication orders were transcribed accurately on admission.</p> <p>This applies to 2 of 3 residents (R1 and R2) reviewed for medications in a sample of 3.</p> <p>Findings include:</p> <p>1. R2's Face Sheet showed R2 was initially admitted to the facility on [DATE], went to the hospital on 12/20/24 for a fall, and was readmitted to the facility on [DATE].</p> <p>R2's 12/21/24 hospital discharge orders showed to orally administer the scheduled medications 81 mg of aspirin twice daily, carbidopa-levodopa 10-100 four times daily, dicyclomine 20 mg before meals and at bedtime, vitamin D 100 mcg daily, and to apply hydrocortisone topically twice daily. R2's discharge orders also included to administer the as-needed medications of hydrocodone-acetaminophen 5-325 every four hours as needed, simethicone every six hours as needed, and to apply zinc oxide topically as needed.</p> <p>R2's December 2024 POS (Physician Order Sheet) and MAR did not include any of the above medications.</p> <p>On 1/30/25 at 11:05 AM, V3 ADON (Assistant Director of Nursing) verified that these medications were missed on R2's December 2024 MAR, adding the medications were not made available to R2 and this was a transcription error.</p> <p>R2's 12/21/24 care plan showed to administer medications per Physician orders.</p> <p>2. R1's Face Sheet showed R1 was initially admitted to the facility on [DATE], went to the hospital on 12/28/24, and was readmitted to the facility on [DATE].</p> <p>R1's 1/3/25 hospital discharge orders showed to administer levothyroxine 88 mcg (micrograms) by mouth every morning, alprazolam 0.125 mg (milligrams) every twelve hours as needed, and to use an albuterol inhaler every four hours as needed.</p> <p>(continued on next page)</p>

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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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R1's January 2025 MAR (Medication Administration Record) showed R1 did not start receiving levothyroxine until 1/7/25, missing the scheduled doses on 1/4, 1/5, and 1/6/25. R1's MAR also showed the order for the albuterol inhaler was not entered until 1/6/25. The MAR also showed R1's 1/3/25 alprazolam order incorrectly transcribed as 0.25 mg every twelve hours (instead of 0.125 mg).</p> <p>On 1/29/25 at 3:07 PM, V2 DON (Director of Nursing) stated that during order transcription for R1, the levothyroxine and albuterol orders were missed and then entered on 1/6/25. V2 stated R1 did not receive any of the incorrectly transcribed doses of alprazolam.</p> <p>R1's 1/3/25 Care Plan showed to administer medications per Physician orders.</p> <p>The facility's 6/2022 Re-Admissions policy showed, .C . 2. The facility nurse will clarify and confirm all admission orders (or any changes, additions, or deletions from previous POS) with the attending physician (see P&amp;P P-7037: New Admission Orders) .</p>		