STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146186	A. Building B. Wing	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden Estates Cts of Huntley	12140 Regency Parkway Huntley, IL 60142

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 35174 Based on interview and record review the facility failed to notify a resident and a resident's primary care physician (PCP) of missed medication doses for 1 of 4 residents (R1) reviewed for notification in the sample of 4. The findings include: R1's Admission Record showed R1 is an eighty-two-year-old male resident originally admitted to the facility with diagnoses which include: peripheral vascular disease and a history of pulmonary embolism (blood clot in lungs). R1's March 2025 Medication Administration Record (MAR) showed from March 24 through March 27,2025, R1 did not receive their Warfarin (blood thinner) doses. The MAR showed no order for Warfarin in R1's record for March 24th through March 27th. The MAR showed R1 had an order placed on 3/28/25 with a new order for Warfarin 3mg to give 1 tablet at bedtime related to personal history of pulmonary embolism. On 4/30/25 at 10:05 AM, R1 stated they knew they were on a blood thinner. R1 stated he did not remember anyone telling him he missed any of his medication doses. On 4/30/25 at 10:20 AM, V4 R1's PCP (Primary Care Physician) stated he did not receive a call or text for a Warfarin order on 3/28/25. V4 stated they were reviewing their records during the interview. V4 stated he gave an order for 3mg of Warfarin on 3/24/25, and a new order for 3.5mg on 3/31/25. V4 stated he had not been notified R1 had missed any doses of their Warfarin between 3/24/25 and 3/31/25. V4 stated if he were contacted about any missed doses, he would have ordered labs to be drawn, and a new order based on the lab results. On 4/30/25 at 11:30 AM, V8 R1's Emergency Contact (Family) stated the facility has contacted them in the past when R1 has gone to the hospital and when R1 was put on isolation. V8 stated they have not been notified R1 had any missed medication doses. R1's progress notes dated 3/28/25 at 7:47 PM showed V9 placed an order was for Warfarin 3mg. This progress note has no reference regarding notifying R1's physician at that time for not being admistered the physician ordered medication doses. (continued on next page)

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
	146186	A. Building B. Wing	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden Estates Cts of Huntley	12140 Regency Parkway Huntley, IL 60142

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/30/25 at 12:40 PM, V2 Director of Nursing stated, the physician should have been notified about the missed medication doses when it was realized R1 did not receive them.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146186	A. Building B. Wing	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden Estates Cts of Huntley	12140 Regency Parkway Huntley, IL 60142

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 35174 Based on interview and record review the facility failed to ensure a physician ordered medication was continued for a resident with a history of pulmonary embolisms. This applies to 1 of 4 residents (R1) reviewed for pharmacy services in the sample of 4. The findings include: R1's Admission Record showed R1 is an eighty-two-year-old male resident originally admitted to the facility with diagnoses which include: peripheral vascular disease and a history of pulmonary embolism (blood clot in lungs). R1's Progress notes dated 3/24/25 at 5:58 PM showed V9 Licensed Practical Nurse (LPN) related the blood thinner lab result (PT/INR) to V4 R1's Primary Care Physician (PCP), and received an order to continue R1's blood thinner (Warfarin) at 3 milligrams (mg). R1's Progress Notes dated 3/28/25 at 7:47 PM showed V9 entered an order for Warfarin 3mg. The order was entered 4 days later. R1's March 2025 Medication Administration Record (MAR) showed no order for Warfarin at 3mg was entered on 3/24/25. R1's MAR showed R1 missed 4 doses of Warfarin from 3/24/25 through 3/27/25. R1's MAR showed an order for Warfarin 3mg was entered on 3/28/25 which R1 started receiving. On 3/30/25 at 9:30 AM, V6 LPN stated if there is a problem with a medication order (dose, wrong time, allergy, etc) the physician should be contacted to verify the order. If a resident has received an wrong dose or missing doses of medications the physician should be called to verify a new order and/or if a residents medication order needs to be changed. V6 stated for Warfarin orders there is a binder at the desk we use to verify the current order, when we contact the physician, lab results, verification of the new order, and what date the new order is entered into the computer. On 4/30/25 at 10:20 AM, V4 R1's PCP (Primary Care Physician) stated he did not receive a call or text for a Warfarin order on 3/28/25. V4 stated they were reviewing their records during the interview. V4 stated he gave an order for 3mg of Warfarin on 3/24/25, and a new order for 3.5mg on 3/31/25 for a PT/INR of 1.7. On 3/30/25 at 12:40 PM, V2 Director of Nursing stated they were not sure why R1's Warfarin orders were not continued from 3/24/25 through 3/27/25. V2 stated R1 did not receive their blood thinners for those dates.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146186	A. Building B. Wing	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden Estates Cts of Huntley	12140 Regency Parkway Huntley, IL 60142

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. 35174 Based on interview and record review the facility failed to ensure a resident was free from a significant medication error by missing doses of a blood thinner (Warfarin) which applies to 1 of 4 residents (R1) reviewed for significant medication error in a sample of 4. The findings include: R1's Admission Record showed R1 is an eighty-two-year-old male resident originally admitted to the facility with diagnoses which include: peripheral vascular disease and a history of pulmonary embolism (blood clot in lungs). R1's March 2025 Warfarin Worksheet showed on 3/24/25 V4 R1's Primary Care Physician was notified of R1's Protime results and an order to continue the order for Warfarin 3 milligrams (mg) was given. R1's March 2025 Medication Administration Record (MAR) showed no order for Warfarin 3mg was entered on 3/24/25. R1's MAR showed R1 missed 4 doses of Warfarin from 3/24/25 through 3/27/25. R1's MAR showed the next order for Warfarin was entered on 3/28/25 for the same dosage of 3mg. On 3/30/25 at 9:30 AM, V6 LPN stated Warfarin needs to have lab draws to monitor if it is therapeutic or not. Protime/INR blood tests are used to monitor the medication. We have a binder at the desk we use to verify the current order, when we contact the physician, lab results, verification of the new order, and what date the new order is entered into the computer. V6 stated if someone misses doses of their blood thinner they are at a higher risk for developing blood clots. R1's March Warfarin Worksheet showed an entry for 3/24/25 with a Protime/INR result of 21.5/2.8, V4 R1's Primary Care Provider (PCP) was notified, and a new order for Warfarin 3mg to be continued. This worksheet showed on 3/31/25 R1's Protime/INR was 16.5/1.7, and a new order was given by V4 for Warfarin 3.5mg. There was not entry for an order, physician contact, or lab result dated 3/28/25. On 4/30/25 at 10:20 AM, V4 R1's PCP (Primary Care Physician) stated he did not receive a call or text for a Warfarin order on 3/28/25. V4 stated they were reviewing their records during the phone interview. V4 stated he gave an order for 3mg of Warfarin on 3/24/25, and a new order for 3.5mg on 3/31/25 for a PT/INR of 16. 5/1.7. V4 stated therapeutic levels for Warfarin should be an INR of 2.0 to 3.0. V4 stated the lab result is consistent with R1 missing several doses of blood thinners. V4 stated by not taking Warfarin regularly it can put someone at a higher risk for developing blood clots. R1 has been on Warfarin for a long time for previously having pulmonary embolisms. On 3/30/25 at 12:40 PM, V2 Director of Nursing stated R1's Warfarin order were not continued from 3/24/25 through 3/27/25. V2 stated R1 did not receive their blood thinners for those dates. If a resident misses their blood thinners it puts them at risk for developing blood clots. The facility's Medication Administration Policy dated 9/2020 stated medications will be administered in accordance with the established polices and procedures.