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	02/10/2026

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 - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure a resident was free of significant medication errors for 1 of 3 residents (R1) reviewed for medication errors in the sample of 8. This failure resulted in R1 experiencing iatrogenic hypotension which required hospitalization from 2/2/26 through 2/9/26.The surveyor confirmed by observation, interview and record review that the deficient practice occurred on 2/2/26 and was corrected on 2/2/26 prior to the start of this survey, and was therefore Past Noncompliance.The findings include:R1's face sheet showed she was a [AGE] year-old female, admitted to the facility on [DATE] with diagnoses to include cellulitis of right lower limb, cellulitis of left lower limb, sepsis, anemia in chronic kidney disease, hypertensive heart and chronic kidney disease, acute pulmonary edema, paroxysmal atrial fibrillation, chronic congestive heart failure, and venous insufficiency. R1's admission Assessment showed she was alert to person and time. R1's Initial Nursing assessment dated [DATE] showed she is alert and oriented to person and place and confused at times. R4's face sheet showed she was admitted to the facility 1/26/26 with diagnoses to include gastroparesis, chronic kidney disease, mixed hyperlipidemia, hypertensive chronic kidney disease, nonrheumatic aortic valve insufficiency, atherosclerotic heart disease, peripheral vascular disease, and acute kidney failure. On 2/10/26 at 9:44 AM, V10 (R1's daughter) said, My mom was admitted to the facility on [DATE] after she was treated at the hospital for cellulitis in her legs. She was there Saturday and Sunday and then on Monday, 2/2, I was called by [the acute care hospital] telling me that they had her there. They told me that she had been given her medicine and also another resident's medicine and she was in 'shock'. They had to give her some intravenous medications really quick to bring her blood pressure up. The hospital told me she had been given 4 different blood pressure lowering medications. [the facility] never has told me about the drugs. I asked my mom and she said she remembered sitting at the table and then they gave her some medicine. She said it was around lunchtime so 11ish. Then she said the room got black and she couldn't remember anything after that. [The acute care hospital] told me poison control was involved. She went to the emergency room on the 2/2 and then discharged yesterday (2/9/26) to [another long-term care facility]. She was in ICU (Intensive Care Unit) from 2/2/26 through 2/4/26 because they were administering a medication that they said can only be given in the ICU. On 2/4/26 she was transferred to another floor and then discharged on 2/9/26. I have her discharge paperwork from the hospital it says her diagnoses was Iatrogenic Hypotension (low blood pressure that occurs as a result of medical treatment or intervention, often due to. medication effects) . R1's 2/2/26 Nursing Note entered at 2:02 PM showed, Resident was received at the start of the shift in bed, clean, comfortable, and without signs or symptoms of distress. During morning medication pass, resident was seated in chair and presented without complaints or observable concerns. At approximately 10:00, a nursing assessment was completed. Resident assessment findings were within normal limits and consistent with documented baseline. Scheduled morning medications were administered per physician orders. (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
	146186	A. Building B. Wing	02/10/2026

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 - Actual harm Residents Affected - Few	No immediate adverse reactions were observed. Later in the shift, resident was observed seated in wheelchair at the nurse's station leaning to the left side, which was not consistent with baseline presentation. Immediate nursing assessment was performed. Vital signs were obtained and noted to be outside of the residents established baseline parameters. Due to a cute change in condition, emergency medical services were activated via 911 for urgent evaluation and transport. Resident was transferred by EMS (emergency medical services) without further observed decline at the time of departure. Incident referred for administrative and clinical review. R1's February 2026 eMAR (electronic Medication Administration Record) showed she received Bumetanide 1 mg (diuretic used to treat fluid retention associated with congestive heart failure).R4's February 2026 eMAR (electronic Medication Administration Record) showed the following medications scheduled to be administered at 9:00 AM: Venlafaxine 225 mg (antidepressant), Furosemide 20 mg (diuretic), Carvedilol 25 mg (blood pressure medication), Entresto 97-103 mg (blood pressure medication), Procardia 60 mg (blood pressure medication), aspirin 325 mg, Clopidogrel Bisulfate 75 mg (antiplatelet medication) . R4's 2/2/26 Nurses Note entered at 1:14 PM showed, Resident came to nurse's station questioning her am (morning) medications. Vitals were obtained, resident stated she didn't want her medications and requested to discharge today.R4's Weights and Vitals Tab showed a blood pressure obtained at 7:42 AM on 2/2/26 of 95/60. This blood pressure was then struck out as inaccurate documentation at 12:22 PM. On 2/10/26 at 1:25 PM, V9 LPN (Licensed Practical Nurse) said, First of all I apologize for whatever happened, that day I was doing morning medications, [R1] was new to the facility, I checked the picture in the system, it looked like her, I went up and asked her if her name was [R4's Name] and she nodded yes, I asked her about pain, how she was doing, and she said her day was going good. Her blood was normal, so I didn't give her two of blood pressure pills, I don't remember the name of the medications I didn't give. After that, sometime passed and the other patient [R4] came and asked about her medications. I then realized I might have given other resident (R1) the wrong medications. I called the Director of Nursing and stayed with R1] and checked her vitals. I don't know which medications I held. She was alert and talking to me before and when I checked her again, she was confused. I called the Assistant Director of Nursing right away and the other nurse was with me. I was trying to talk to her. She was responding by nodding her head, we were trying to get her blood pressure, but I don't remember what the numbers were. It was very low. I'm a new nurse. They had me do training with pharmacy and again with the staff. They said I'm safe to pass medications. my DON went through the training with me again. The statement provided by the facility from V9 LPN dated 2/2/26 showed, [V9] went to [R1] who was sitting near nurse's station in wheelchair, verified verbally by asking [R1] if her name was [R4] in which [R1] said yes and nodded yes as well. Checked vitals around 7:30-7:40 AM at this time [V9] noted BP was lower than parameter when she went back and checked the eMAR for [R4]. After preparing medications, she went back to patient and administered the medication with no issues. Around 10:15 AM [V9] realized another resident hadn't gotten her medication yet but medications were not in the cart, she alerted another nurse that she mistakenly gave patient [R1] medication that was supposed to go to patient [R4]. Both nurses immediately assessed [R1] and noted [R1] to be hypotensive, 911 was called, medical director was present during this and also assessed patient with orders to send out.On 2/10/26 at 11:54 AM, V5 RN (Registered Nurse) said, I just got done with all of my medications. [R1] was my last patient I saw. I gave [R1] her medication last. Then another resident came up and started arguing with [V9-LPN] saying that she didn't receive her medications. I noticed that my patient was the only one that had been in that area. I went to assess [R1], and her blood pressure was around 64/40 something. Her head was slumped to the side and her pulse was so faint that I couldn't get her bp (continued on next page)

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	02/10/2026

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 - Actual harm Residents Affected - Few	with a manual blood pressure cuff. When the paramedics got there, I asked them what they got for a blood pressure, and it was 55/30 something if I remember right. I had called 911 immediately as soon as I got that blood pressure because I assumed she was the one who got the other resident's medications and [R1] didn't receive anything from me that would do that to her. she was confused and talking off the wall. In report I got that she was alert and oriented x 2. By the time I got her blood pressure, she was not alert at all. Very lethargic but she was responsive, just inappropriate responses. I was talking to the paramedics when they got there, and I told them she received some kind of medication because the other nurse said she got the two patients confused. I asked to see [R4's] medication list to see what [R1] was given, and she was given blood pressure medications. I wrote out a quick list and sent with the EMS in the case the doctors there would need to see that. Immediately after this, they did in-servicing and they continued it throughout that day. On 2/10/26 at 10:38 AM, V1 (Administrator) said, . In this situation, [V9] has been a nurse for about a year. We had a new patient admitted over the weekend. She went to the resident and asked her, using the name, and [R1] responded back appropriately. She gave her the medications and 30-45 seconds later, [R4] came and asked when she was going to get her medications. she immediately notified the DON or ADON, they stopped, assessed the patient, and sent out 911. She held some of the blood pressure medications, she gave one of the meds that was able to be given with her blood pressure being in the parameters. When [V3 DON] comes in she will bring in the info, she can tell you for sure what she was given. We know exactly the medications that were given because they were checked off in the MAR for the resident who should have received them. (R4's eMAR showed all medications as refused by R4. Nothing was documented as being given.On 2/10/26 at 10:47 AM, V3 DON (Director of Nursing) said, I was alerted by the nurses that [V9 LPN] had administered the medication to the wrong patient. They assessed the patient and because her blood pressure was lower, they sent her out . the bp was the reason why she was sent out. Immediately, we checked the MAR (medication administration record) to see what the medication she was given was. We called the doctor right away; the Medical Director was here in the facility at the time and she was made aware of the incident. We started in-servicing right away. We asked the nurse what happened, she pretty much said that she asked the resident if her name was the other resident's name and she nodded that yes, she was. She said she looked at the picture in the MAR and it looked like the resident. [R1] received [R4's] medications. R1 received venlafaxine, furosemide, aspirin, Entresto, iron, omeprazole, oxybutynin, and Procardia. She also received her own medications that day, she takes Bumex. She doesn't take blood pressure medications.On 2/10/26 at 2:06 PM, V11 (Medical Director) said, There was a medication error, It happened right in front of me actually. I was rounding at that time. The patient was kind of confused, nurse tried checking blood pressure, I tried checking her blood pressure. I was not able to get the blood pressure because it was very feeble. When the paramedics arrived, I think they were able to get one. It was a pretty low hypotensive number. I talked to them that morning regarding that this should not have happened. The facility's policy and procedure dated 03/2021 showed, Medication Administration: General Guidelines. Policy: To ensure that medications are administered safety as prescribed. All medications shall be administered as prescribed by personnel authorized to do so in accordance with standard practice and current regulations. The resident is identified prior to administration by: a. Checking the photograph of the resident and/or; b. Asking the resident to identify him/herself by name. 7. Medications prescribed for one resident shall not be administered to another resident.The facility's Medication Pass (Guidelines/Tips) dated 12/2024 showed, Competency. 7. Nurse must always identify the resident prior to administering any medications or treatments. 9. All medications must be given in the correct strength, route, (continued on next page)

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	02/10/2026

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 - Actual harm Residents Affected - Few	dosage form, time and to the correct resident.