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	06/12/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to administer a resident's (R1) medications as ordered by a physician for 1 of 3 residents reviewed for physician's orders in the sample of 5. The findings include:R1's electronic face sheet dated 6/12/26 showed R1 has diagnoses including but not limited to displaced fracture of right lower leg, subluxation of right ankle joint, type 2 diabetes, asthma, morbid obesity, muscle weakness, obstructive sleep apnea, hypertension, and osteoporosis. R1's facility assessment dated [DATE] showed R1 has no cognitive impairment. R1's care plan dated 2/24/26 showed, (R1) has the potential for pain .administer pain strategies according to MAR/TAR (Medication Administration Record/Treatment Administration Record). On 6/12/26 at 11:37AM, R1 stated, Several times I would have increased pain and wonder why and it was because I didn't have my pain medication. I didn't understand why I had to ask for it when I was always having to ask for it so it should have just been automatic. Lyrica was missed too and I didn't know why I would have to ask for it. R1's medication administration record for February 2026 showed R1's Lyrica 75mg was ordered to be administered at 9AM, 1PM, and 8PM on a daily basis. R1's Lyrica 75mg was not administered on 2/24/26 at 8PM and 2/25/26 at 1PM due to Not Available. On 6/12/26 at 11:02AM, V3 (Director of Nursing) stated, We have 2 delivery times 1AM and 1-2PM every day/7 days per week. Upon arrival to the facility, if there is a billing issue or clarification from the physician that needs to occur about medications, the resident's medications will be on the following delivery cycle. Sometimes hospitals don't send a script or something like that. Pharmacy has a cutoff so if it's too late, they won't send it until the next delivery. If we don't have a prescription, we can't get it out of the emergency supply. Sometimes family can get medications delivered if needed. It would be my expectation that medications are ordered within enough time to be delivered so that the resident does not miss any doses. I'm not sure why (R1) missed her doses of Lyrica because we were in constant communication with the hospital prior to her admission. On 6/12/26 at 12:25PM, V11 (Registered Nurse) stated, If a patient comes earlier in the day, then we would get their medications on the afternoon pharmacy rounds. No reason why they wouldn't be here by the next day. If we don't have a medication, we can check the emergency stock and we need to notify the provider if it's not in there so they can be kept up to date. The facility's policy titled, Medication Administration dated 03/2021 showed, Policy: To ensure that medications are administered safely as prescribed .6. If the physician's medication order cannot be followed, the physician should be notified, depending upon the situation .

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	06/12/2026

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(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident (R1) was free from a significant medication error. This applies to 1 of 3 residents reviewed for physician's orders in the sample of 5. The findings include:R1's electronic face sheet dated 6/12/26 showed R1 has diagnoses including but not limited to displaced fracture of right lower leg, subluxation of right ankle joint, type 2 diabetes, asthma, morbid obesity, muscle weakness, obstructive sleep apnea, hypertension, and osteoporosis. R1's facility assessment dated [DATE] showed R1 has no cognitive impairment. R1's care plan dated 2/25/26 showed, (R1) has the potential for hypo/hyperglycemic reactions secondary to diagnosis of diabetes mellitus .administer medications for diabetes mellitus as ordered . R1's medication administration record for March 2026 showed R1 receives Insulin Glargine 20 units every evening at 8PM. R1's medication administration record for 3/9/26 showed R1's Insulin Glargine 20 units was not given due to Not available.On 6/12/26 at 11:37AM, R1 stated, I don't think they were giving me enough insulin, I know they were scared to give me too much, but I managed my medications before I came there so I know what I can handle. I think the hospital was doing it correctly, but I wasn't eating very well there either so I can't really remember.On 6/12/26 at 12:25PM, V11 (Registered Nurse) stated, Insulin is a critical medication for diabetics and should not be missed. We should be keeping an eye on the amount left for the residents and reordering with enough time to get the new supply in.On 6/12/26 at 11:02AM, V3 (Director of Nursing) stated, It would be my expectation that medications are ordered within enough time to be delivered so that the resident does not miss any doses. Insulin is a crucial medication for diabetics that cannot be missed.The facility's policy titled, Medication Administration dated 03/2021 showed, Policy: To ensure that medications are administered safely as prescribed .6. If the physician's medication order cannot be followed, the physician should be notified, depending on the situation .