

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0054924		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/10/2026	
NAME OF PROVIDER OR SUPPLIER ALDEN ESTATES CTS OF HUNTLEY				STREET ADDRESS, CITY, STATE, ZIP CODE 12140 REGENCY PARKWAY , HUNTLEY, Illinois, 60142			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
S0000	Initial Comments		S0000				
	Complaint Investigation # 2611430/2738290						
S9999	Final Observations		S9999				
	Statement of Licensure Violations:						
	300.690b)						
	300.690c)						
	Section 300.690 Incidents and Accidents						
	b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident.						
	c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence.						
	This REQUIREMENT was NOT MET as evidenced by:						
	Based on interview and record review the facility failed to ensure the state agency was notified of a significant medication error resulting in hospitalization for 1 of 3 residents (R1) reviewed for medication errors in the sample of 8.						

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 The findings include: R1's face sheet showed she was a 98-year-old female, admitted to the facility on 1/30/26 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 1/30/26 showed she is alert and oriented to person and place and confused at times. On 2/10/26 at 9:44 AM, V10 (R1's daughter) said, "My mom was admitted to the facility on 1/30/26 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		S9999				

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S9999	Continued from page 2 documented baseline. Scheduled morning medications were administered per physician orders. 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." On 2/10/26 at 2:03 PM, V1 (Administrator) said incidents that are reportable to the Illinois Department of Public Health are falls with injury and abuse. V1 said significant medication errors resulting in hospitalization of a resident would also be considered reportable to the Illinois Department of Public Health. V1 said this incident was not reported to IDPH. The facility's policy and procedure dated 09/2020 showed, "Incident/Accident Reports... Policy: The Incident/Accident Report is completed for all unexplained bruises or abrasions, all accidents or incidents where there is injury or the potential to result in injury... Procedure: Any accident refers to any unexpected or unintentional incident, which may result in injury or illness to a resident... All situations requiring the emergency services of a hospital... Any condition resulting from an accident requiring first aid, physician visit, or transfer to another health care facility...The Director of Nursing, Assisting Director of Nursing or Nursing Supervisor must notify: a. the Illinois Department of Public Health (IDPH) o any serious incident or accident. "Serious" means any incident or accident that causes physical harm or injury to a resident. b. The facility shall by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident... The facility shall send a narrative summary of each reportable accident or incident to the Department within seven (7) days after the occurrence..." "A"		S9999				