

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145180	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/11/2025
NAME OF PROVIDER OR SUPPLIER  Aperion Care Chicago Heights		STREET ADDRESS, CITY, STATE, ZIP CODE 490 West 16th Place Chicago Heights, IL 60411	

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>45111</p> <p>Based on interviews and records review, the facility failed to administer medications to one (R1) of three residents reviewed for medication administration in a total sample of six.</p> <p>Findings include:</p> <p>Medical diagnosis in R1's current face sheet includes but not limited to: bipolar disorder, unspecified, schizophrenia, unspecified, hemiplegia, unspecified affecting right dominant side, personal history of traumatic brain injury.</p> <p>On 05/10/2025, at 9:30 AM, R1 was observed laying in bed talking to his roommate R4. R1 stated on 4/26/2025 going into 4/27/2025, he did not receive his pain medication during the night and he was in a lot of pain. R1 stated he asked V10 (Registered Nurse-Agency) for his medication but V10 told R1 that his medication was not available. R1 stated he asked for his medication the whole night but V10 kept saying medication was not available and there was nothing V10 could do about it. R1 stated he had to try and sleep with his pain until the following morning when the morning nurse gave him his pain medication.</p> <p>On 05/10/2025, at 4:00 PM, V1 (Administrator) stated V10 (Registered Nurse-Agency) was the nurse who was on duty on 4/26/2025 into 4/27/2025. V10 was responsible for giving R1 his medications. V1 stated on 4/27/2025, R1 complained to V1 that he did not receive his night pain medication on 4/26/2025 into 4/27/2025. V1 stated she called V10 to investigate what happened and why R1 did not receive his medication. V10 stated she checked on R1 at night and he was sleeping therefore, she (V10) did not give R1 his pain medication and did not chart R1 was sleeping. V1 stated after that phone call she (V1) tried to contact V10 on several occasions but V10 did not answer calls after that. V1 stated there was no way for her to know if V10 gave R1 his pain medication because V10 did not chart giving R1 his medication or the reason medication was not given. V1 stated if it's not documented, it is not done.</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>On 05/05/2025, at 2:47 PM, V8 (Director of Nursing -DON) stated nurses are supposed to follow the physician orders and document reason for not administering a medication to a resident. V8 stated pain is what a resident says it is and a resident's pain needs to be taken seriously. Medications are given to prevent residents from walking around in pain. V8 stated on 4/26/2025, late night after midnight, R1 did not receive his pain medication. The following morning he did not receive acid reflux medication that should have been given. V8 stated V10 (Registered Nurse-Agency) was the nurse on duty and V10 stated she gave R1 his medication but did not sign the electronic medical administration record (eMAR). V8 stated if it is not documented, it is not done. V8 stated there is an emergency medication storage in the facility which is accessible to nurses in-case they run out of a medication. V8 stated the nurse calls the pharmacy to open the narcotics emergency box so the nurse can access the medication and administer to the resident.</p> <p>R1's Physician Order Sheet (POS) documents:</p> <p>HYDROcodone-Acetaminophen Tablet 10-325 MG (milligrams). Give 1 tablet by mouth every 6 hours for Pain - Severe.</p> <p>Active 10/29/2024.</p> <p>Omeprazole Tablet Delayed Release 20 MG.</p> <p>Give 1 tablet by mouth one time a day related to Gastro-Esophageal reflux disease without esophagitis at 6:00AM. Active 2/17/2021. Discontinued 5/14/2024</p> <p>Review of R1's electronic Medication Administration Record (eMAR) dated 04/27/2025, documents R1 did not receive requested as needed HYDROcodone-Acetaminophen Tablet 10-325 MG and Omeprazole Tablet Delayed Release 20 MG as ordered on 04/27/2025 at 6:00AM.</p> <p>Policy titled Medication Administration General Guidelines dated 1-11-18 documents:</p> <p>-Medication are administered as prescribed in accordance with good nursing principles and practices and only by persons regally authorized to do so.</p> <p>-Medications are administered in accordance with written orders of the prescriber.</p>		