STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145180	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Chicago Heights	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on interview and record review, the facility failed to follow their Physician's Order Policy by failing to discontinue medication as ordered by the physician. This deficient practice affects one resident of three residents reviewed for medication administration. This failure resulted in R3 receiving extra dosages of antiepileptic medication. Findings Include: R3 admitted in the facility on 2/28/25. R3 has a diagnosis of Symptomatic Epilepsy and Epileptic Syndromes with Complex Partial Seizure. R3 admitted in the facility with medications such as, but not limited to: Brivaracetam 100mg (milligrams) two times daily for seizure, Clobazam 10mg at bedtime for seizure, Divalproex Sodium 500mg two times daily for seizure, and Levetiracetam (Keppra) 750mg two times daily for seizure with order date of 2/28/25. R3's Neurology note dated 5/6/25, reads in part: R3 should NOT be prescribed Levetiracetam (Keppra) at the same time she is taking Briviact (Brivaracetam). Please discontinue Keppra. This was communicated to the ADON in the facility by phone on 4/23/25. After Visit Neurology Summary Note dated 5/8/25, reads in part: STOP Keppra. On 6/4/25 at 12PM, V19 (Nurse from Neurologist Office) stated that on 5/6/25, there was a reminder note faxed to the facility to discontinue Keppra medication, and that this was previously communicated with the V3 (ADON). V19 stated that on 4/23/25 the Neuro doctor office was prompted to call the facility due to the office received a medication record list from the facility from (V6), and upon review, Keppra was still on this list and R3 was not supposed to take Keppra along with Briviact (Anti-seizure medication). Neurologist note on 5/6/25 stated that R3 should NOT be prescribed Keppra at the same time as Briviact. Please discontinue Keppra. Resident telehealth appointment on 5/8/25, showed that R3 was still with order of Keppra, MD again gave an order to discontinue Keppra medication on 5/8/25. On 6/4/25 at 12:30PM, V6 (ADON) stated V6 recall Neuro physician office called asking for medication list to be reviewed before R3's upcoming appointment. V6 stated she did not received a call from the office of Neurologist after V6 faxed the medication list them. So if the doctor's office talked to any of the nurses on the floor that I do not know. In general, if we received orders form a specialist doctor outside the facility, the nurse still have to verify the order to the attending physician. And need to document if either attending physician agreed and disagreed with the new order. (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
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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's progress notes reviewed from April to May 2025. And there is no noted documentation that Keppra was relayed to attending physician, either agreed or disagreed to discontinue the medication. Medication Administration Record reviewed for the month of April and May 2025. From April 23rd to 30th, R3 received Levetiracetam (Keppra) 750mg twice a day, except for the 1800 refusal on 4/23, 424, and 4/30. From May 1st to 8th, R3 received Levetiracetam 750mg twice a day, except for the 1800 refusal on 5/6 and 5/7. Physician Orders Policy with an effective date of 11/3/22, reads in part: To establish the procedure by transcribing new physician orders. To document and give clear indication that physician orders have been processed and action taken. Transcription of physician order: Carefully, review transfer record and discharge summary from the hospital or the transfer record from another health care facility. The licensed nurse should notify the physician of the resident's admission, clinical condition and findings, review and clarify transfer orders and previous orders as applicable.