

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 12/24/2025
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)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (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

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide care in accordance with professional standards for medication administration during an emergency crisis when one resident (R1) was found unresponsive and administered insulin. This failure affected one (R1) of four residents reviewed for medication administration and has the potential to affect 43 residents identified as having diagnosis of Diabetes Mellitus in the facility. Findings include:R1 's medical record showed that R1 was admitted to the facility on [DATE] with diagnosis list that includes but not limited to Type 2 diabetes Mellitus without complications, epilepsy unspecified not intractable with status epilepticus, other seizures, unsteadiness on feet and schizoaffective disorder, depressive type. R1 expired on [DATE] at the hospital.R1's medical record showed that R1 was found unresponsive on [DATE] at 5:30am with blood sugar 290(MG/DL).R1's Medication Administration Record dated [DATE] at 6:00am documents V11, Registered Nurse, administered one unit of Humalog insulin (regular scheduled does) and three units of Humalog insulin (sliding scale order) at 6:00am due to R1's blood sugar of 290. This indicates that V11 administered insulin as ordered to an unresponsive resident before calling a code, 911 (emergency line), or physician.On [DATE] at approximately 8:40am, V2 DON (Director of Nurse's stated, V11 no longer works at the facility, and I can't know why she charted like that it does not make any sense. The note dated [DATE] at 5:30am she went to do the accu-check (Blood Glucose Monitoring) at 5:30am and found R1 unresponsive. CPR started code blue initiated (V2 was reading from the progress note).On [DATE] between 8:53am and 9:00am, V1 (Administrator) read both V11's note dated [DATE] timed 5:30am and 6:53am and said V11 charted backwards, I think she meant at 4:30am R1 was seen alive pacing back and forth during rounds that was done every two hours and at 5:30am she went to do accu- check and give insulin R1 was found unresponsive. V1 stated, V11 no longer work at the facility to be able to explain the notes by herself.On [DATE] between 12:47pm and 12:59pm, V16 (Physician) stated he is familiar with R1 who is overweight, with seizures, and non-compliant with diet. V16 stated that R1 was sent to endocrinologist for follow-ups and has gone to ER (Emergency Room) couple of times. When the surveyor asked V16 in your (V16) professional opinion is it appropriate to administer insulin to resident that was found unresponsive. V16 stated that hypothetically speaking many residents walk around with blood sugar 290 and above so the blood sugar level is not the problem, there must be an underlining problem they may have heart attack. Something else is going on. V16 stated that in case of Hypoglycemia between 20 to 30mg/dl then something with high sugar can be given like Glucagon. I (V16) would have called 911 first and that also comes with experience. The survey then told V16 that V11 documented that she gave 4units of insulin as ordered. V16 stated in part that he ordered it per recommendation from (local hospital recommendation). V16 stated that experience comes in, I would have called 911 first before giving the insulin. V16 stated in part that charting is the only document that we can go by. Nurse decision is off, and clinical judgement is off. V16 stated nursing documentation is very important.On [DATE] at approximately 1:02pm, surveyor asked V2's if V11 should have administered insulin to an unresponsive resident. V2 stated, I would not, but V11 is the only one that can answer that, and she no longer work here.On [DATE] at 1:35pm V1, Administrator, stated the facility does not have any insulin administration policy in general during an emergency crisis.On [DATE] at 11:34 and 11:37am V10 LPN (Licensed Practical Nurse) was on duty on [DATE] when R1 was found unresponsive but was unable to be reached during the course of the investigation.The facility policy on Medication administration General Guidelines documented that medications are administered as prescribed in accordance with good nursing principles and practices legally authorized to do so.</p>		