STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145591	A. Building B. Wing	12/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Wesley	1415 West Foster Avenue Chicago, IL 60640

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. (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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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow their policies and procedures to ensure wound treatment orders were obtained upon resident's admission, and failed to ensure medications and wound treatments were administered for one (R1) out of three residents reviewed for improper nursing care. Findings Include:R1's clinical records show an admission date to the facility on [DATE] with included diagnoses but not limited to Type 2 Diabetes Mellitus with other skin complications, Peripheral Vascular Disease, and Acquired Absence of Left Foot. R1 was discharged from the facility on 12/2/25.R1's admission assessment signed by V26 (Licensed Practical Nurse/LPN) dated 11/25/25 revealed R1 was admitted with wound infection. Skin integrity documented in part: left thigh stitches, groin stitches, and left foot amputee. R1's WOUND ASSESSMENT DETAILS REPORT completed on 11/26/25 performed by V2 (Director of Nursing) documented in part: full thickness [skin has been damaged through all layers] surgical left foot wound, full thickness left ankle vascular wound, and partial thickness left abdomen vascular wound. R1's Order Summary Report/Physician Order Sheet (POS) revealed wound treatment orders were not entered until 11/28/25. R1's Treatment Administration Records (TAR) revealed ordered wound treatments were not signed off as done on 11/28/25 and 11/29/25.R1's Medication Administration Record (MAR) revealed R1 had ordered medications of: TraZODone HCl Tablet 50 MG Give 1 tablet by mouth one time a day related to DEPRESSION start date 11/26/25 at 8:00 PM but was not signed as administered, Atorvastatin Calcium Tablet 40 MG Give 1 tablet by mouth at bedtime related to PERIPHERAL VASCULAR DISEASE start date 11/26/25 at 8:00 PM was not signed as administered, Advair Diskus Aerosol 1 inhalation inhale orally every 12 hours was not signed as administered on 11/26/25 at 9:00 PM, and Amoxicillin-Pot Clavulanate Tablet 875-125 MG every 12 hours for bacterial infection was not signed as administered on 11/26/25 at 8:00 PM. On 12/7/25 at 12:31 PM, V2 (Director of Nursing) stated that nurses are to sign the MAR after administering the medications to the resident to show that they were given with no issues. V2 also said that the TAR is also signed after treatment is done with the resident. V2 stated that R1's TAR had holes which means they were not signed off. V2 said, Legally if they did not document it, it means it's not done. V2 stated that V24 (Wound Care Nurse/LPN) was on vacation the day R1 was admitted , and the floor nurses were supposed to be doing the treatments. V2 stated that she was also not in the facility, so the floor nurses were supposed to do them.On 12/7/25 at 3:36 PM, a follow up interview was conducted with V2 (Director of Nursing) and V2 stated that R1 came in the facility on 11/25/25. V2 said she instructed the admitting nurse to enter the treatment orders but when V2 came in on 11/28/25, they were not entered in R1's electronic health records so V2 entered them that day. V2 said she did not do R1's wound treatments that day because the night shift nurse was supposed to do them.On 12/7/25 at 1:55 PM, a phone interview was conducted with V10 (Registered Nurse). V10 said he worked night shift on 11/28/25 and 11/29/25 and did not do R1's wound treatments because he thinks they were not assigned to him. V10 said that the night shift nurses are responsible to do the wound treatments for the residents on Saturday and Sunday and if V2 gives instruction that they need to be done.On 12/8/25 at 8:37 AM, a phone interview was conducted with V23 (Licensed Practical Nurse) and stated that R1 came in the facility on 11/25/25 at 1:45 PM and she was the nurse who was assigned to R1. V23 said that R1's wound treatments were not entered in the orders because she did not do the assessment for her [R1]. V23 said that R1 came in so late and V23 only did the note and verified the medication from the office of V25 (R1's Physician). V23 said V25's office was closed so she had to call the on-call doctor to verify medication. V23 stated that R1 came in around 1:45 PM and their cut off is 2:00 PM. Surveyor asked what V23 means by cut off. V2 stated cut off means that any patient admitted on the 7-3 shift after 2:00 PM she just writes the note, put the resident in the system, and verify the medications. V23 stated she did not do R1's body assessment and she endorsed it to the evening shift nurse. V23 said she did not enter any orders in the system. On 12/8/25 at 1:41 PM, a phone interview was conducted with V26 (Licensed Practical Nurse) and V26 stated that she did the full body assessment for R1 upon admission. V26 said that she completed the admission assessment and entered the medication orders in the electronic health records, but did not enter wound treatment orders. V26 stated that the medications orders were verified with V25 (R1's Physician) and V26 notified V2 (Director of Nursing) and V24 (Wound Care Nurse/LPN) about R1's wounds. V26 stated R1 had left leg amputation that was freshly done in the hospital and came in the facility for wound care. V26 stated that when she notified V2 and V24, they both assessed