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	03/06/2026

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 0580 Level of Harm - Actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to notify the physician in a timely manner of a change in condition of one (R74) resident out of three residents reviewed for change in condition in a total sample of twenty. This failure resulted in R74 requiring hospitalization with diagnosis of stroke. Findings Include:R74's Minimum Data Set (MDS) dated [DATE] noted she was cognitively impaired. R74's Electronic Medical Record (EMR) noted she was initially admitted to the facility on [DATE]. She was [AGE] years old with diagnoses not limited to personal history of transient ischemic attack, cerebral infarction due to embolism of right middle cerebral artery, Alzheimer's disease, paroxysmal atrial fibrillation, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, and unspecified dementia. On 03/03/26 at 11:49 AM, via telephone V19 (R74's Family Member) stated that she was the principal care giver for R74 for so many years. On 9/19/25 she visited R74 during the morning shift, V24 (Licensed Practical Nurse/LPN), V25 (Certified Nursing Assistant/CNA) and V50 (Registered Nurse Hospice) were on duty. V18 (Family Member) also came to visit R74 in the facility around evening time, and because he is an eye Surgeon, he was able to immediately recognize the sign of stroke when he saw R74. On 03/03/26 at 12:45 PM, V25 (CNA) stated that she has been in the facility for thirteen years, she works 6:30am-2:30 pm shift, and she is familiar with R74. On 09/19/25, she observed that R74's face was shifted to the right, she was not talking, so she notified V24 (LPN).On 03/03/26 at 1:25 PM, via telephone, V24 (LPN) stated that she has been in the facility for eighteen years, she works 7am-3pm shift on the fourth floor, and she is familiar with R74. On 09/19/25 towards the end of the morning shift, she observed that she was not talking, eyes closed, she checked her vitals, she called the hospice. After she called, V50 (Registered Nurse/RN Hospice) came with V19 at the bed side. V24 stated that she left because R74 was on hospice, and it is the policy of the facility to notify the physician and family when there is any change in condition. On 03/03/26 at 2:05 PM, via telephone V16 (R74's Physician) stated that on 9/19/25, no staff member told her about R74's facial drooping to the right which is a sign of stroke, until V18 spoke with her and she sent R74 to the hospital. She also stated that if V24 or V28 (LPNs) had notified her, she would have sent R74 to the hospital immediately because the initial ninety-minute observation window is very important. On 03/03/26 at 3:48 PM, via telephone V18 (R74's Family Member) stated that on 09/19/25, he came all the way from O'Hare airport to visit R74 in the facility after dinner, and he observed that R74 had suffered stroke because her face was deviated to the right, but V28 (LPN) on duty had not contacted V16 immediately about the change in R74's condition. He requested that V28 call V16 right away so he can speak with V16. He spoke with V16, and she told him that no one reported R74's change in condition to her, so after he spoke with her, she gave order to send R74 to the hospital for evaluation, and she was admitted with diagnosis of stroke.On 03/04/26 at 4:05 PM, via telephone V28 (LPN) stated that she has been in the facility for about twenty years, she works 3pm-11pm shift, full time on the 4th floor. On 9/19/25, she worked 3pm-11pm shift with R74, the outgoing V24 (LPN) endorsed to her that R74 was not doing good, but she did not ask if she notified V16 because R74 was on hospice. V28 also stated that upon her initial rounds around 3:30 PM, she (continued on next page)

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	03/06/2026

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 0580 Level of Harm - Actual harm Residents Affected - Few	saw R74's mouth deviated to the right, and when she was feeding her with boost drink around dinner time at 5:00 pm with V19 at bedside. V28 stated she did not call V16 at that time, until when V18 came around 7:00 pm, he requested to speak with V16, then she called V16, and she gave order to send R74 to the hospital for immediate evaluation. V28 stated that she should have notified V16 immediately for further instruction after she observed the facial shifting or drooping because that was a change in condition, and she also stated that shifting of her face to the right is a sign of stroke, but she did not notify the physician because R74 was under hospice care. On 03/05/26 at 9:54 AM, V24 (LPN) stated that she did not observe R74's facial deviation to the right, and she did not tell V28 that she saw R74's mouth deviated to the right during 7am-3pm shift. She also stated that she did not call V16 (R74's Physician), and she would have informed V16 if she observed facial drooping because that was a change in condition which should be reported to V16 immediately. An attempt was made to contact V50, but V1 (Vice President Operation) stated that V50 is no longer working for the Hospice company.On 03/05/26 at 10:19 AM, V2 (Director of Nursing/DON) stated that she has been in this facility for two years. She also stated that it is her expectation that nurses will notify the physician with any change in condition to prevent delays in care. R74 was on hospice, the hospice doctor was notified and made aware of the change in condition, but it was not documented.On 03/05/26 at 11:33 AM, via telephone V31 (R74' Hospice Physician) stated that on 09/19/25, a female hospice nurse)he cannot remember her name), called him around the morning shift (7am-3pm shift) that R74 had weaknesses. He cannot remember the side of the body, and he was not given the details of the change in condition as face shifting/facial drooping to the right side. He would have called V18 before sending her to the hospital, and the delay in care could have contributed to her sustaining stroke. He also stated that R74 was on hospice for comfort care, and he did not know that R74's Physician Orders for Life Sustaining Treatment/POLST form has the option for selective treatment which includes hospitalization. Documents reviewed for this investigation are not limited to the following:R74's Face Sheet, Minimum Data Set (MDS), Physician Order Sheet/POS, Medication Administration Record/MAR, and Care Plan. R74's electronic medical record (EMR) Progress notes dated 9/19/25, noted that V28 notified V16 after V18 request.F74's POLST dated 10/27/22 documents in part: Selective treatment, transfer to hospital, if indicated.R74's Hospital record dated 9/20/25-9/24/25 document in part: Stroke due to embolism of right middle cerebral artery.Physician-Family Notification-Change in Condition policy dated 11/13/18 documents in part; To ensure that medical care problems are communicated to the attending physician or authorized designee and family/responsible party in a timely, efficient, and effective manner.

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	03/06/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to have an individualized comprehensive care plan for two (R10, and R74) residents out of a total sample of twenty residents. Findings Include: R74's Minimum Data Set (MDS) dated [DATE] noted she was cognitively impaired. R74's Electronic Medical Record (EMR) noted she was initially admitted to the facility on [DATE]. She was [AGE] years old with diagnoses not limited to personal history of transient ischemic attack, cerebral infarction due to embolism of right middle cerebral artery, Alzheimer's disease, paroxysmal atrial fibrillation, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, and unspecified dementia. Physician Order Sheet dated 9/4/25 hospice consult. On 03/05/26 at 10:19 AM, V2 (Director of Nursing/DON) stated that she has been in this facility for two years, and comprehensive resident-centered care plan is important to ensure that residents receive specific care tailored to specific medical conditions. R74 should have a comprehensive person-centered care plan tailored to her hospice care to ensure collaboration between the hospice team and that the facility staff ensure her wishes for the end of life are respected and met. She also stated that R74 should have a care plan for her hospice care so that identified interventions are reviewed and implemented. V2 reviewed R74's comprehensive care plan with no documentation of hospice. R74's electronic medical record (EMR) noted R74's had no care plan for hospice care. Comprehensive Care Plan Policy dated 11/17/17, documents read in part: The facility will develop and implement a comprehensive person-centered care plan for each resident consistent with the resident rights. R10's admission Record documents in part a diagnosis of vascular dementia. R10's admission date to the facility was 11/17/2025. R10's 11/28/2025 MDS (Minimum Data Set) assessment documents in part that R10's cognition is severely impaired. It also documents in part that R10 had wandering behavior that occurred 4 to 6 days during the assessment period. R10's November 2025 progress notes document in part multiple incidents of staff finding R10 in the stairwells, near exits, or on different units (11/17/2025, 11/23/2025, 11/24/2025, 11/25/2025, and 11/29/2025). Progress notes document in part wandering and exit-seeking behavior. R10's 11/21/2025 Elopement Risk & Community Survival Skills Assessment documents in part that R10 is at risk to elope and should be placed on the Elopement Risk Protocol. A care plan for Elopement is indicated. Rational for decision: [R10] is exit seeking and is at risk for elopement. R10's 2/25/2026 Elopement Risk & Community Survival Skills Assessment documents in part that R10 is at risk to elope and should be placed on the Elopement Risk Protocol. A care plan for Elopement is indicated. It reads although R10 is stable at this time, R10 has a recent history of exit (continued on next page)

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	03/06/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	seeking behavior. On 3/03/2026 at 2:14 PM, R10 was oriented to self and city but disoriented to date or situation. R10 could not provide medical history or reason for being at the facility. R10 wore a wander alarm bracelet to the left wrist. R10 ambulated independently. On 3/05/2026 at 8:46 AM, V8 (Nurse) stated when R10 admitted to the facility, R10 wanted to go home. V8 stated R10 wandered and tried to exit the facility. On 3/05/2026 at 8:53 AM, V33 (Certified Nurse Aide Supervisor) stated R10 had behaviors of trying to go out the doors and trying to find a way out to go home. V33 stated R10 is now more involved in activities with less behaviors but remains an elopement risk. R10's current Care Plan Report did not contain focuses for R10's wandering behaviors or elopement risk. On 3/05/2026 at 9:38 AM, V40 (MDS Coordinator) reviewed R10's current comprehensive care plan with surveyor. V40 stated did not see a focus for wandering or elopement risk. On 3/05/2026 at 9:49 AM, V3 (Social Service Director) stated facility's electronic medical record resolved or cancelled out R10's wander/elopement risk care plan. V3 stated [V3] had to reactivate the care plan for it to be active. Facility's history record for R10's wander/elopement risk care plan documents in part that V3 resolved it on 1/05/2026. V3 did not reinstate it until 3/05/2026 (date of survey). Facility's Comprehensive Care Plan policy (last revised 11/17/17) documents in part: To develop a comprehensive care plan that directs the care team and incorporates the resident's goals, preferences, and services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.