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	06/23/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview and record review, the facility failed to provide the residents with bath linen that is in good condition. This failure affected all 75 residents that reside in the facility.Findings include:On 06/15/26 at 12:00pm observed one 4th floor linen cart empty with no linen and one 4th floor linen cart with 1 small towel, 1 gown, 1 pillow case and multiple cut pieces of a bath blanket. Observed one half empty bag of soiled linen in soiled linen bin and no available line in the linen closet.On 06/15/26 at 12:07pm V3 (Housekeeper) stated that the facility does not always have linen available. V3 stated that the CNA's (Certified Nursing Assistants) have to go find linen.On 06/15/26 at 12:16pm V4 (Licensed Practical Nurse/LPN) stated that the facility doesn't really have linen. V4 stated that they are always told that linen has been ordered. V4 stated that sometimes they don't have linen for the whole shift or until the shift is almost over.On 06/15/26 at 12:32pm observed 3rd floor with two empty linen carts, no soiled linen in the soiled linen container and no available linen in the linen closet.On 06/15/26 at 12:53pm V5 (CNA) stated that sometimes the staff have to cut up sheets and blankets to wash the residents. V5 stated that there have been times that she has not received linen the whole shift. V5 stated that the facility provides wipes but the wipes are not enough to wash the residents whole body.V5 stated that she has had to leave the residents bed without a sheet because there was no sheets available to make the beds.On 06/15/26 at 1:14pm observed V6 (Housekeeper) in laundry room folding linen. V6 stated that there is definitely not enough linen in the facility. Linen count done with V6 that included 14 fitted sheets, 3 bath blankets, 2 large towels and 2 washcloths. V6 stated that the majority of the linen is still on the nursing units. On 06/15/26 at 1:30pm V7 (Maintenance Director) stated that he orders a large amount of line every month. V7 stated that he doesn't know what the staff does with the linen and he believes that they must be throwing the line away. V7 stated that it takes time to wash the linen, but it goes to the floors as soon as it is done.On 06/16/26 at 1:02pm V9 (Laundry Aide) stated that she gets complaints from the staff that there is not enough linen, but she gives them what she has. V9 stated that she tells the facility to order more linen but what is ordered is never enough.On 06/22/26 at 2:03pm V2 (Assistant Director of Nursing/ADON) stated that there is a lack of linen but the problem is the staff hide the linen. V2 stated that linen is ordered but staff hide linen or throw linen in the garbage. V2 stated that there is still a gap in linen. V2 stated that cutting up blankets to wash residents is not acceptable. V2 stated that sometimes staff inform him that they don't have line and V2 goes to find linen in other resident's rooms. V2 stated that staff should not have to search for towels, they should be readily available. V2 stated that not having linen available could hinder care to the residents.V2 stated that staff are improvising to wash residents up and they should not have to.

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
	145591	A. Building B. Wing	06/23/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview and record review, the facility failed to prevent one cognitively impaired resident (R1) with Dementia and a history of elopement risk and stating he wants to go home from exiting thru a facility door into the community. This failure affected 1 of 3 residents reviewed for safety. As a result, R1's whereabouts were unknown for approximately 5 hours until R1 was located wandering approximately 10 miles from the facility.R1's medical diagnoses include but are not limited to dementia, hypertensive heart disease, myocardial infarction, chronic diastolic heart failure. R1 was admitted to the facility 10/15/25. R1's Minimum Data Set, dated [DATE] has a Brief Interview for Mental Status score of 10, indicating R1's cognition is moderately impaired.R1's progress noted dated 04/04/26 documents in part, Standing by elevator to go downstairs.R1's progress note dated 04/05/26 documents in part, Resident noted absent from unit. Observed on 4th floor during day shift prior to shift change; report given and care endorsed. Per report, resident exited facility approximately 3:10pm. At approximately 4:30-5:30, resident noted not present. 911 notified per protocol.R1's risk management form dated 04/05/26 documents in part, During evening medication pass NOD (nurse on duty) made rounds and resident was not in dining room or room. NOD initiated a code pink and conducted a head count and floor and facility search. NOD asked assigned CNA (Certified Nursing Assistant) when was the resident seen last? CNA responded that she thought he was in activities. A second statement that R1 was last seen at 3:30PM.R1's Elopement Risk and Community Survival Skills assessment dated [DATE] documents in part, 4. Behavioral Observations: c. Becomes agitated, confused and/or disoriented? yes. Recommendations: Elopement risk decision. The resident presently appears to be: 1. At risk to elope and should be placed on the Elopement Risk Protocol. A care plan for Elopement is indicated. Rational for decisions: Has hx (history) of exit seeking behavior, at times attempts to wander off floor. Resident is at risk for elopement. Wander guard in place.On 6/15/26 at 12:40PM R1 asked surveyor are you here to take me out of here? R1 said I want to go back to my family and they won't let me go. R1 said ain't no police take me to the hospital. These people here caught me and brought me back here. R1 said I used to live on the southside of the city. They told me that I have to stay here and I can't leave. I have a bracelet on my arm, they tell me that I be trying to run away or something. R1 said when I ran out of here, I got on the bus, I'm over 65 so I got a bus pass. I don't know why they won't let me go home, I don't have a disease and I won't contaminate anybody.On 06/15/26 at 12:16pm V4 (Licensed Practical Nurse/LPN) stated that R1 has always been exit seeking since R1's admission. V4 stated that R1 needs constant redirection. V4 stated that she has not reported V4's elopement attempts to R1's physician because R1's physicians are already aware of R1's behaviors.V4 said there is the alarm by the back elevator, when it goes off, we can't hear that well. On 06/16/26 at 12:10pm The surveyor observed numbers written on the keypads located along the doors.V7 (Maintenance Director) stated that the numbers on top of the keypads were the codes for the keypads. V7 stated that he guesses that the residents can put the right code into the keypad. V7 stated that the exit doors when pushed have a 15 second delay before the doors will open. V7 stated that before R1's elopement, the exit door alarms could not be heard if no one was nearby. V7 stated that some wander guards are working properly, and some are not. V7 stated that the facility is continuing to work and fix the wander guards. V7 said the wander guard system is still being worked on (today) and per the contracted company will be fully functioning in approximately 2 weeks. On 06/15/26 at 12:53pm V5 (Certified Nursing Assistant/CNA) stated that sometimes the elevator doors open and there is no one on the elevator. V5 stated that when the elevators doors open and there is no one on it, the staff have to stop the residents from getting on the elevator.On 06/16/26 at 10:47am V8 (Licensed Practical Nurse) stated that she did not see R1 at the beginning of her shift that started on 4/5/26 at 3pm. V8 stated that it is not normal for her to not see R1 at the (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	06/23/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	beginning of her shift, but due to an altercation with other residents, V8 did not see R1. V8 stated that it was R1's normal behavior to try and get on the elevator, he wants to go home, and would sometimes become aggressive. V8 said R1 is at high risk for elopement. V8 said it has been reported to her by other staff that R1 has gotten off the floor and to keep an eye on him. V8 stated that she noticed R1 was not in R1's original location for dinner time and began looking for R1. V8 stated that while looking for R1, V8 noticed a door on the first floor was slightly open, which leads to the street. V8 stated that she ran out of the open door onto the street and began looking for R1 and asking people if they had seen R1. V8 stated that when she could not locate R1, V8 called the police and made a police report. V8 stated that R1 was found by the police on the south side and taken to the hospital for an evaluation. V8 stated that R1 had gotten off the unit multiple times before R1 eloped. V8 stated that when R1 was found and returned to the facility that R1 stated that R1 will leave again.On 06/17/26 at 12:31pm V11 (Restorative Nurse) stated that R1 goes in and out of being confused. V11 stated that R1 is not safe to be outside by himself. V11 stated that R1 has been confused since R1's admission. V11 stated that there have been times that she has had to redirect R1 back to R1's floor on the locked unit.On 06/18/26 at 2:24pm V12 (Certified Nursing Assistant/CNA) stated that sometimes the elevators open by itself and if staff are not watching the residents, the residents will try to get on the elevator. V12 stated that she has observed residents attempting to push numbers on the keypad and has to redirect the resident.On 06/22/26 at 9:54am V20 (Social Service Director) stated that elopement risk assessments are done on admission and quarterly. V20 stated that exit seeking behaviors are residents trying to get to the ground floor by themselves, trying to go to the stairwell and a resident verbalizing they are trying to leave. V20 stated that although R1's quarterly assessment wasn't due on 02/23/26, she did an audit and determined R1 was no longer an elopement risk and R1's wander guard bracelet was removed. V20 stated that R1 was not exit seeking and stable for months before R1's wander guard was removed on 02/23/26. Surveyor asked V20 if R1's elopement risk assessment dated [DATE] was incorrect, V20 stated that the assessment dated [DATE] was not an incorrect assessment. V20 stated that staff are aware to notify her if a resident is exit seeking. V20 stated she was never notified by staff that R1 was having exit seeking prior to R1's elopement from the facility.On 06/22/26 at 2:03pm V2 (Assistant Director of Nursing) stated that R1 was already an elopement risk before R1 eloped from the facility. V2 said I know R1 eloped previously but he was not a super at risk person for elopement. V2 said if a resident is attempting to get on the elevator or the stairs and saying they want to go home then they are super at risk for elopement. V2 stated that he is unsure of how R1 was able to get off the locked unit; R1 has Dementia, but V2 said I believe R1 left the unit via the elevator. V2 stated that sometimes the elevator opens and residents take the opportunity to get on the elevator if no one is paying attention. V2 stated that it is possible that R1 could have put the code in the keypad since the code was written on the keypad. V2 stated that having the numbers written on the keypad poses a risk for residents to get off the unit. V2 stated that rounds should be made at least every 2 hours. V2 stated that R1 was gone for more than 2 hours before the staff discovered that R1 was missing; rounds were not made within that 2 hours to check on him. V2 stated that R1 could have gotten injured being out in the community alone and riding the train by himself.On 06/22/26 at 3:19pm V1 (Administrator) stated that he was informed via phone that R1 had eloped from the building. V1 said according to the nurse the exit alarm was sounding. V1 stated that after viewing the facility's cameras, it was discovered that R1 exited the facility through the door on the 1st floor. V1 stated that it was daylight outside when R1 exited the facility. V1 stated that when he arrived at the facility, it was already dark and R1 was still missing. V1 stated that in search of R1, V1 went to 2 local hospitals and 1 local grocery store. V1 stated that while searching the area for R1, V1 received a phone call from the police stating that R1 was found at the train station on the south side. V1 stated that he requested for police to take R1 to the local hospital for evaluation. V1 stated that he was informed by the nurse that the first-floor alarm was sounding and the exit door was found slightly open. V1 stated that 1st floor door alarm at the time of (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	06/23/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	R1's elopement could only be heard locally in the area of the door. V1 stated that it is probably not a good idea for the codes to be on top of the keypads. V1 stated that the codes on top of the keypads unlock the units, and someone could go down the stairs or out the door. V1 stated that the wander guard system is being upgraded and is ongoing.On 6/22/26 at 1:35PM V21, Operations Manager, said some of the wander guards were not responding to the old code so we had to switch them out. The maintenance guy did his rounds and informed us that the code/s were not working.R1's emergency room record dated 4/5/26 at 9:11PM (over 5 hours since last seen) notes presents after being found by police department wandering. Has history of Dementia. Facility requested medical evaluation before returning to facility. Plan to return to the facility. R1's Psychiatry Note dated 2/20/26 [in part] describes R1 engaging but appears mildly irritable, and pt appears confused with irrelevant or tangential responses consistent with cognitive impairment. Pt reports participating in various activities during the day and coming to the dining room but is unable to elaborate further due to impaired recall and limited insight. Insight and Judgment are poor. R1's Elopement Risk and Community Survival Skills assessment dated [DATE] documents in part, 4. Behavioral Observations: c. Becomes agitated, confused and/or disoriented? no. g. Resident can safely maneuver in community and is without debilitating physical impairment making resident unsafe. no. Recommendations: Elopement risk decision. The resident presently appears to be: 1. Not at risk to elope at this time and placement on the Elopement Risk Protocol is not indicated. d. Rational for decisions: Although resident has a hx of attempting to leave the floor unsupervised he no longer presents with this behavior. Wander guard removed on 02/23/26R1's document titled Progress Note - Chronic Care Management dated 02/19/26 documents in part, Cognition: Patient has Severe Impairment cognitive status. Assessment/Plan: Progressive, exit-seeking, impulsive, frequent agitation and care rejection. Wander guard, behavioral strategies. involve social work/family; monitor for safety.R1's psychiatry note dated 02/20/26 documents in part, Staff report pt (patient) has recently appeared more anxious, agitated, and restless, and at times becomes verbally aggressive toward staff and is not easily redirectable which represents a change from baseline.R1's document titled Progress Note - Chronic Care Management dated 03/03/26 documents in part, Assessment/Plan:. At risk for elopement. R1's progress note dated 04/13/26 documents in part, Resident observed standing near elevator and stairwell area, attempting to access other floors and exit facility. He stated, I want to go home.R1's care plan initiated on 10/20/25 includes interventions for fall risk, impaired cognition, and elopement risk. Intervention includes placing wander guard on R1's wrist.Facility's policy titled Elopement Device reviewed 02/27/26 documents in part, Purpose: To establish procedures for ensuring personal elopement devices are used in accordance with identified risk, physician orders an to ensure the security system is inspected to identify malfunctions should they occur. Policy: It is the policy of this facility to use elopement alert systems and devices when an assessment has identified the risk of elopement. Procedure: 1. Elopement alert devices will be used as a interventional tool to prevent resident elopements.Facility's policy titled Code Pink - Missing Resident /Elopement reviewed 02/27/26 documents in part, Guideline: 1. All personnel are responsible for reporting a cognately resident attempting to leave the premises, or suspected of missing, to the Charge Nurse as soon as practical. This includes any resident that did not sign out on pass and/or did not notify a staff member of his or her leaving. 2. Should an employee observe a cognitively impaired resident leaving the premises or attempting to exit the premises, he or she should:. Notify the attending physician of the resident's attempt to leave the facility. Complete a new Elopement Risk Assessment and update the plan of care with appropriate interventions as indicated. (1) Examples of interventions may include but are not limited to: (a) Wander guard bracelet. (b) Increased monitoring such as 15 minute visual checks, 1:1 supervision.

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	06/23/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation, interview and record review, the facility failed to separately launder personal resident items and facility laundry. This failure has the potential to affect all 75 residents that reside in the facility.Findings include:On 06/15/26 at 1:14pm V6 (Housekeeper) observed folding basket of laundry containing facility sheets and towels, and resident personal clothing.On 06/15/26 at 1:14pm V6 (Housekeeper) stated that the facility always washes resident personal belonging with facility's shared linen items. V6 stated that it is okay to mix the resident's personal clothing with facility shared linen.On 06/15/26 at 1:30pm V7 (Maintenance Director) stated that the resident's personal items should be washed separate from the facility's sheets and towels. V7 stated that washing all the items together is an infection control concern.On 06/16/26 at 1:02pm observed washing machine with personal resident items and facility shared laundry items. On 06/16/26 at 1:02pm V9 (Laundry Aide) stated that all the items observed in the washing machine came from one resident's room. V9 stated that the items in the washing machine are a mix of resident personal belongings and facility shared items. V9 stated that personal items and facility shared items should not be laundered together.Facility's policy titled Infection Prevention and Control Program dated 11/28/27 documents in part, Purpose: To comply with a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement. Guidelines: 1. The facility has established an Infection Control Program which addresses all phases of the organization's operation to reduce or prevent the risks of nosocomial infections in residents and health care workers. 14. All facility personnel are required to routinely wash hands and use appropriate barrier precautions to prevent transmission of infections. 15. All facility personnel shall adhere to the Infection Control Program in the performance of their daily assignments.Facility's policy titled Linen Handling-Laundry Department dated 01/11/18 documents in part, Purpose: To ensure the proper handling, storage, processing, and transport of all linens and laundry in accordance with accepted national standards in order to produce hygienically clean laundry and prevent the spread of infection to the extent possible. Guidelines: The facility staff should handle all used laundry as potentially contaminated and use standard precautions. 7. Laundry personnel shall sort the linen and personal laundry into separate hampers for washing.