STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145960	A. Building B. Wing	09/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ascension Resurrection Life	7370 West Talcott Avenue Chicago, IL 60631

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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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to clean and empty a resident's ileostomy bag in a timely manner. The facility also failed to ensure an accurate skin assessment upon admission. These failures affect one (R1) out of three residents reviewed for ostomy care. Findings include: R1's Face sheet documents that R1 was admitted to the facility on [DATE] and discharged on 08/26/2025. On 09/13/2025 at 12:51PM, V4 (Registered Nurse/RN) states R1 was admitted to the facility from the hospital on [DATE]. V4 states she was the nurse assigned to care for R1 on 08/26/2025. V4 states sometime after lunch around 12:30PM, V6 (R1's Family Member) asked the staff to change R1's colostomy bag because it was soiled and full. V4 states V5 (Certified Nursing Assistant/CNA) had begun cleaning R1's body before V4 arrived to R1's room. V4 states then V5 alerted her that while V5 was cleaning on the right side of R1's body, there was a [NAME] of fluids from what appeared to be a surgical wound that was located underneath R1's skin fold. V4 states this surgical wound was not visible unless R1's skin fold was lifted up. V4 states this wound was located on the opposite side of R1's ileostomy site, which was located on R1's left side. V4 states she checked R1's skin assessment and whoever performed R1's skin assessment upon admission, did not document the surgical wound because she did not see it documented on R1's skin assessment. V4 states she then read R1's hospital records and this is how she was made aware of R1's surgical wound on her right side. V4 states she observed there was a very small opening on R1's right lower abdomen and she was not aware that it was there until it began leaking. On 09/13/2025 at 1:52PM, V3 (Business Development Coordinator) states she received an email from V6 (R1's Family Member) addressed to herself and V1 (Administrator). V3 states per V6's email, V6 made concerns related to a skin tear near R1's stoma and R1 having a possible UTI. On 09/13/2025 at 2:20PM, V5 (CNA) states she was assigned to care for R1 on 08/26/2025. V5 states it was around breakfast time, and she was passing trays when she was informed by physical therapy that R1's ileostomy bag needed to be changed. V5 states after passing trays, she went inside of R1's room and saw that R1's ileostomy bag was overflowing and needed to be changed so she informed V4 (RN). V5 states at some point, V6 (R1's Family Member) came to the facility to visit R1. V5 states V6 was located in R1's room and informed her that R1's ileostomy bag needed to be changed. V5 states she does not recall what time it was, but she told V6 that she'll be in to assist R1. V5 states she gathered her supplies and believes it was about 15-20 minutes later when she arrived in R1's room. V5 states she began washing R1's genital area using soap, water, and a towel. V5 states R1's colostomy bag is on the left side of her body and R1 has skin folds. V5 states she then called V4 (RN) because V4 was going to reapply a new ileostomy bag. V5 states V4 took R1's ileostomy bag off and they both worked together to care for R1 because R1's ileostomy bag was over-filled with poop. V5 states she did not pay attention to R1's colostomy bag and does not know what kind of ileostomy bag it was. V5 states she did not clean on the right side of R1's body and she began cleaning on R1's left side around R1's stoma with soap and water. V5 states V4 stepped out of the room and that's when she found that R1 had a slit underneath one of her abdominal folds. V5 states the slit was draining liquid when she pressed R1's stomach. V5 states the slit was located on the right side of R1's stomach. V5 states she then called V4 (RN) back into the room to inform her and V4 came right away. V5 states V6 (R1's Family Member) was riled up and kept asking what is going on, what are you guys doing? On 09/13/2025 at 3:25PM, V2 (Director of Nursing/DON) states she was called by V4 (RN) and made aware of fluid mixed with blood coming from the right side of R1's abdomen. V4 states she was in the facility and went to assess R1 herself. V2 states upon her assessment, there was a slit that appeared to be a surgical wound that was open. V2 states from her understanding, R1 had just had surgery on her ileostomy. V2 states R1's cut was very clean and there were no sutures or ripped wound edges. V2 states clear fluid mixed with blood was leaking out of R1's right side. V2 states she then called the doctor for R1 to be sent to the ER. V2 states R1's slit was in her abdominal folds and at first you cannot see it, but if it is pressed, then it opens up. V2 states the ambulance came to transport R1 to the ER pretty quickly. V2 states she was not made aware that R1 was soiled and had to wait a long time to be changed. V2 states she was not aware of an email communication sent by V6 (R1's Family Member) regarding concerns of R1 waiting 90 minutes to be changed. V2 states she expects the nursing and CNA staff to respond to the needs of the resident as soon as possible. V2 states it is not acceptable for any resident to have to wait an hour and a half to have care rendered. V2 states she is not sure who signed and completed R1's initial skin assessment. V2 states