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	01/16/2026

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow call light policy and procedure on accessibility of call light for 1 out of 1 resident (R102) for a total sample of 26 residents reviewed for environment. Findings include: R102 is a [AGE] year-old resident of the facility. R102 was admitted on [DATE] due to fracture of neck of femur and right hip pain. R102's cognition is intact based on brief interview of mental status done on 12/29/2025 with perfect score of 15. R102 needs substantial or maximal assistance for bed mobility transfer and does not ambulate. On 01/13/2025 at 12:01 PM, R102 was seen laying on her bed alert and able to express her needs well. R102 said that she came to the facility about 2 and a half weeks ago for hip replacement and was doing rehabilitation or therapy. R102 stated that she cannot leave her bed because of her surgery and needs facility staff to help her with her needs. R102 stated that it bothers her so much that it takes facility staff three (3) hours to respond with her call light. And her (R102) call light was unreachable most of the time because it is not attached to the wall where she can reach it. Writer and R102 were trying to locate the call light that was seen on the floor 2 to 3 meters away from R102. R102 said, It is kind of sad, soaked with wet diapers for 3 hours. I even know what's going on. I pity those that do not know what is happening. On 01/13/2026 at 01:05 PM, V26 (Certified Nursing Assistant) was seen inside R102's room from the hallway. R102's call light was still visible on the floor when V26 came out. V26 was asked in the hallway if R102 can use her call light or within reach. V26 replied yes. V26 went back to R102's room, found the call light on the floor, picked it up and clipped it on the left side of R102's linen. V26 went out of the room and stated that R102's call light was not reachable that it needs to be clipped on resident's gown, cloth or linen because it needs to be reachable. On 01/14/2026 at 02:26 PM, V3 (Director of Nursing) stated that nursing staff need to ensure that the call light always within reach to attend to resident's needs. Answering the Call Light policy and procedure dated 12/2017:The purpose of this procedure is to respond to the residents' requests and needs. The community should be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to an associate or to a centralized associate work area. General guidelines require that when resident is in bed or confined to a chair be sure the call light is within reach of the resident. Answer the call light as soon as possible.

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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(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and review of record, the facility failed to meet quality of care of professional standards related to pharmaceutical services for 2 (R57 and R61) out of 26 residents in the sample reviewed for quality of care. Findings include: 1.) R61 is a [AGE] year-old resident, with diagnosis of type 2 diabetes mellitus. R61 was admitted to the facility on [DATE]. R61 started with tablet medication for diabetes Metformin 500 MG 1 tablet twice a day from 12/17/2025 to 12/18/2025. On 12/18/2025, Metformin 500 MG was changed to Glimepiride 4 MG schedule to take 1 tablet once daily. Per Medication administration record Glimepiride 4 MG was not documented as administered on 12/27/2025, 12/28/2025 and 01/07/2026. R61's MAR (Medication Administration Record) does not document blood sugar results that it was checked per physician order on 12/23/2025, 12/26/2025, 121/27/2025, 12/28/2025, 01/02/2026, 01/06/2026 and 01/11/2026. R61's blood sugar result was increasing reaching more than 300 starting 01/10/2026. On 01/12/2026 and 01/13/2026, R61 was ordered to receive single dose five (5) units of Humalog Lispro insulin. R61's Glimepiride increased from 4 MG to 5 MG. On 01/14/2026, R61 received an order from the physician to monitor blood three (3) times per day with insulin administration depending on blood sugar result. On 01/14/2026 at 10:05 AM during medication administration review, V25 (Registered Nurse) administered two (2) units of insulin Humalog Lispro to R61 via subcutaneous injection did not perform blood sugar check stated that it was checked earlier with 200 results. Management of Diabetes in Long Term Care and Skilled Nursing Facilities: A Position Statement of the American Diabetes Association dated 02/2016: Diabetes are more common in older adults, has a high prevalence in long-term care (LTC) facilities and is associated with significant disease burden and higher cost. Framework for considering diabetes management goals for long term care includes glucose monitoring or blood sugar check with monitoring frequency based on complexity of regimen and risk of hypoglycemia. Under advantages, disadvantages, and caveats in using glucose-lowering agents in LTC population. Insulin is at a high risk for hypoglycemia, especially due to irregular eating patterns. 2.) R57 an [AGE] year-old resident in the facility from 12/12/2025 to 12/29/2025. R57 was admitted with medical diagnosis for congestive heart failure. R57 was ordered by the physician to receive Bumetanide (Bumex) 1MG three (3) tablets for a total of 3 MG three (3) times a day on 12/12/2025 upon admission, two (2) times a day from 12/13/2025 to 12/17/2025, once daily from 12/20/2025 to 12/22/2025 and increased back to two (2) times a day from 12/22/2025 to 12/29/2025 when R57 was discharged . R57's weight increased significantly from 115 LBS on 12/21/2025 to 127 LBS on 12/22/2025 an increase of 12 LBS a single day. R57's weights maintained after significant increase 126.4 LBS on 12/23/2025, 129 LBS on 12/24/2025, 127.3 LBS on 12/26/2025, 125.7 on 12/27/2025 and 12/28/2025. R57's medication administration record shows that facility did not document Bumetanide (Bumex) 1MG three (3) tablets for a total of 3 MG as being administered to R57 twice on 12/26/2025, once on 12/27/2025 and once on 12/28/2025. Per nursing notes dated 12/29/2025, it documents that R57 was transferred to the hospital due to requests by V28 (Family of R57) expressing concern that R57 may be experiencing fluid overload. R57 was admitted to the hospital for observation. Per facility pharmacy Bumetanide (Bumex) medications are indicated for the treatment of edema (excessive fluid retention) associated with congestive heart failure, hepatic and renal disease, including nephrotic syndrome. HEALTHIER LIVING WITH HEART FAILURE: Managing Symptoms and Reducing Risk by American Heart Association dated 2025 reads: The effects of heart failure can be felt throughout the body. You're likely to have one or more of the following symptoms: EDEMA If you have heart failure, your heart doesn't pump blood with enough force. This means that not enough blood is pumped out of the heart with each heartbeat. Then, because the heart isn't (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	emptying as it should, blood returning from the body can't enter the heart and backs up in the veins. This forces fluid from the blood vessels into other tissues, causing swelling (edema). Edema can occur in the feet, ankles, legs and fingers, as well as in the abdomen and in other tissues and organs. As a result, weight gain is common. MEDICATIONS COMMONLY USED TO TREAT HEART FAILURE The following are some of the most common medications used to treat heart failure: Diuretics furosemide, bumetanide, torsemide, hydrochlorothiazide Lasix, Bumex, Demadex, HCTZ. Reduce excess fluids and salt to decrease the buildup of fluid in the lungs and other parts of the body, such as the ankles, legs and abdomen. Make it easier for the heart to pump blood. On 01/14/2026 at 02:26 PM, V3 (Director of Nursing) stated that the expectation for nurses to follow and implement physician order. On 01/15/2026 at 10:40 AM, V3 stated that medications that are scheduled to be given before meals need to be scheduled at 06:00 AM. And those medications that are scheduled with meals must align with breakfast time. V3 stated she will address with nurses why medication was given at around 10:00 AM not during breakfast. Per mealtime schedule, breakfast comes at 07:45 AM. Facility's policy and procedure on Administering Medication dated 12/2025, requires that medication shall be administered in a safe and timely manner, and as prescribed.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and review of record, the facility has the following failures related to pharmaceutical services: the facility failed to follow their policy and store controlled substances in a safe and secure manner and ensure an accurate controlled drug form for R129. This was true for 2 out of 4 medication carts reviewed for medication storage. Facility also failed to administered medicine properly by leaving medication at the bedside. Failed to administer medications as ordered by physician. These failures apply to 8 residents (R24, R57, R61, R67, R93, R102, R129, R143) receiving pharmaceutical services in the facility that may affect their healthcare needs.Findings include: 1.) On 1/13/2026 at approximately 11:35 AM, a medication cart was outside of R52's room. R52's room door was closed. The nurse responsible for the medication cart was not present. The medication cart's lock was not engaged. Surveyor was able to open medication drawers including the drawer that contained the locked narcotic bin. Surveyor also noted a set of keys with a blue spring keychain on top of the medication cart. On 1/13/26 at 11:39 AM, V7 (Nurse) exited R52's room. V7 stated [V7] was responsible for the mediation cart. V7 stated [V7] was applying a cream to R52 and needs to administer Tylenol. V7 grabbed the keys that were on top of the medication cart and placed them inside scrub pocket. V7 donned personal protective equipment, went back inside R52's room, and closed the door. V7 did not engage the medication cart's lock. On 1/13/26 at 11:46 AM, V7 exited R52's room. Surveyor reviewed V7's medication cart with V7. V7 stated only nurses should have access to medication carts. V7 stated the nurse assigned to the cart carries the specific keys associated with the cart. V7 verified it was the same keys with the blue spring keychain that were left on top of the cart unattended. V7 demonstrated that the key to the medication cart and the narcotic bin were among the keys on the keychain. Narcotic bin had multiple controlled medications including Tramadol and Morphine. 2.) On 1/14/2026 at 10:14 AM, surveyor reviewed the 2B and 2C medication cart with V11 (Agency Nurse). V11 stated the cart contained medications for about 15 residents. At 10:22 AM, surveyor reviewed the narcotic count with V11. R129's Controlled Drug Receipt/Record/Disposition Form for clonazepam (Brand Klonopin – a controlled substance) documents in part that there should be 26 tablets left in the medication blister pack. However, R129's clonazepam blister pack contained 25 tablets. V11 stated V11 did not administer the medication to R129 because it is an evening medication. V11 stated conducting the narcotic count last night with the outgoing nurse during shift change, but did not note that the count was off. V11 stated we did the count so not sure if we went too fast or what. On 1/15/2026 at 10:40 AM, V3 (Director of Nursing) stated the facility investigated the issue and found that the evening nurse charted administrating the clonazepam to R129 in the electronic medical record but failed to put it down on the narcotic logbook. V3 stated nurses should document in the computer and in the narcotic book immediately after administration. Facility's Storage and Labeling of Medications policy (last revised 11/2024) documents in part: The community shall store all drugs and biologicals in a safe, secure, and orderly manner appropriately. All drugs and biologicals will be stored in locked compartments (i.e. medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls. Only authorized (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	personnel will have access to the keys to locked compartments. During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart. Facility's Controlled Substances policy (last revised 06/2020) documents in part: The community shall comply with laws, regulations, and other requirements related to handling, storage, disposal, and documentation of schedule II-V and other controlled substances. Only authorized nursing and/or pharmacy personnel shall have access to Schedule II controlled drugs maintained on premises. Keys to controlled substance containers shall be on a single key ring that is different from any other keys. The associate administering medications, who confirmed count at the start of the shift, will maintain the keys to controlled substance containers. Keys are passed from associate to associate at the time of count. Associates to count controlled medications at the end of each shift. The associate coming on duty and the associate going off duty are to make count together. The number total number of controlled substances are counted and confirmed. Changes that occurred to the count are documented on the shift to shift count sheet. The leaving associate will read the count for each controlled substance. The oncoming associate will compare to the individual controlled substance. They must document and report any discrepancies to the Director of Nursing Services, or designee. The associate ending their shift is not to leave until Director of Nursing, or designee, gives approval. 3.) On 01/13/2025 at 12:01 PM, R102 was seen laying on her bed alert and able to express her needs well. R102 was seen with medication cup on her bedside table with white oval tablet inside. R102 stated I don't know what is that medication they must have placed it there while I was sleeping. R102 expressed that she was not satisfied with current services related to call light that was seen on the floor unreachable to R102. R102 stated, you stated that I have medicine. Then took the medication cup, picked up the white tablet medicine, and put it inside her mouth. R102 was asked what is that medicine she just took. R102 replied, I don't know, I just take it even when I don't know. V9 (Registered Nurse) at the nurse station stated that she is assigned to R102. V9 said that medicine should not been left at the bedside. 4.) R57 an [AGE] year-old resident in the facility from 12/12/2025 to 12/29/2025. R57 was admitted with medical diagnosis for congestive heart failure. R57 was ordered by the physician to receive Bumetanide (Bumex) 1MG to take three (3) tablets for a total of 3 MG. Bumetanide (Bumex) 3 MG scheduled to take three (3) times a day on 12/12/2025 upon admission. Changed to two (2) times a day from 12/13/2025 to 12/17/2025. Changed to once daily from 12/20/2025 to 12/22/2025 and increased back to two (2) times a day from 12/22/2025 to 12/29/2025 when R57 was discharged . R57's weight increased significantly from 115 LBS on 12/21/2025 to 127 LBS on 12/22/2025 an increase of 12 LBS a single day. R57's weights maintained after significant increase 126.4 LBS on 12/23/2025, 129 LBS on 12/24/2025, 127.3 LBS on 12/26/2025, 125.7 on 12/27/2025 and 12/28/2025. R57's medication administration record shows that facility did not document Bumetanide (Bumex) 3 MG as being administered to R57 twice on 12/26/2025, once on 12/27/2025 and once on 12/28/2025 in accordance with physician order. Per nursing notes dated 12/29/2025, it documents that R57 was transferred to the hospital due to requests by V28 (Family of R57) expressing concern that R57 may be experiencing fluid overload. R57 was admitted to the hospital for observation. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Per facility pharmacy Bumetanide (Bumex) medications are indicated for the treatment of edema (excessive fluid retention) associated with congestive heart failure, hepatic and renal disease, including nephrotic syndrome. HEALTHIER LIVING WITH HEART FAILURE Managing Symptoms and Reducing Risk by American Heart Association dated 2025 reads: The effects of heart failure can be felt throughout the body. You're likely to have one or more of the following symptoms: EDEMA If you have heart failure, your heart doesn't pump blood with enough force. This means that not enough blood is pumped out of the heart with each heartbeat. Then, because the heart isn't emptying as it should, blood returning from the body can't enter the heart and backs up in the veins. This forces fluid from the blood vessels into other tissues, causing swelling (edema). Edema can occur in the feet, ankles, legs and fingers, as well as in the abdomen and in other tissues and organs. As a result, weight gain is common. MEDICATIONS COMMONLY USED TO TREAT HEART FAILURE The following are some of the most common medications used to treat heart failure: Diuretics furosemide, bumetanide, torsemide, hydrochlorothiazide Lasix, Bumex, Demadex, HCTZ. Reduce excess fluids and salt to decrease the buildup of fluid in the lungs and other parts of the body, such as the ankles, legs and abdomen. Make it easier for the heart to pump blood. 5.) Medication Administration Records for December 2025 and January 2026 were reviewed for R61, R67, R143, R93 and R24 residents have multiple medications that were not documented (initialed/signed) as being administered. On 01/14/2026 at 02:26 PM, V3 (Director of Nursing) stated that medication needs to be administered by physician order. Nurses need to document that medicine was administered right after giving medication on the eMAR (Medication Administration Record) and it should not be left blank. When there is no documentation, medication cannot be proven as administered. Nurses are not supposed to leave medication at the bedside. Nurses need to stay with the resident until resident swallows the medication. Documentation of Medication Administration policy dated 12/2025: The community will maintain a medication administration record to document medications administered. A nurse or certified medication tech shall document the medication administered to each resident on the resident's medication administration record (MAR). Administration of medication to be documented after it is given. Administering Medication policy dated 12/2025: Medication shall be administered in a safe and timely manner, and as prescribed. Only persons that are licensed or permitted by this State to prepare, administer and document the administration of medications. The individual administering the medications to document on the MAR or eMAR after giving each medication and before administering the next ones.