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A 000	Initial Comment Complaint Investigation: IL00202106/ 2686685- Substantiated 295. 3000 a) 295. 4040 a) 295. 5000 f) 5) 295. 6000 a) 13)	A 000		
A3000	Section 295.3000 Personnel Requirmts, Qualifns, and Trng This Regulation is not met as evidenced by: Type 1 Violation Section 295.3000 Personnel Requirements, Qualifications and Training a) The establishment shall have staff sufficient in number with qualifications, adequate skills, education and experience to meet the 24 hour scheduled and unscheduled needs of residents and who participate in ongoing training to serve the resident population. (Section 35(a)(3) of the Act) This requirement was not met as evidenced by: Based on interview and record review, the establishment failed to ensure a licensed nurse was on duty to assess and provide pain medication as needed affecting 17 (R2, R3, R5, R7, R8, R9, R11, R12 R13, R14, R18, R19, and R20) of 17 residents reviewed for pain medication. The establishment also failed to ensure a nurse was on duty to assess one (R21) resident who had episode of hyperglycemia resulting in a delay in care. This failure creates the substantial probability of	A3000		

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A3000	Continued From page 1 severe harm to a resident or residents. Findings include: On 6/9/26 at 9:24 am, E2 (Director of Clinical Operations) confirmed the following staff shift schedule: Caregiver: 7am-3pm, 3pm-11pm, 11pm-7am Nurse: 7am-3:30pm, 3:00pm-11:30pm, 11:30pm-7:30am On the list provided by E2 (Director of Clinical Operations Assisted Living) titled "PRN (as needed) Medication", there are 23 residents who have orders for PRN pain medication. These residents include but are not limited to R2, R3, R5, R7, R8, R9, R11, R12 R13, R14, R16, R17, R18, R19, and R20. On 6/9/26 at 3:05pm, E3 (Registered Nurse) said, at times there is no nurse on duty on the night shift. E3 said, R5 have Tramadol (pain reliever) at 6am, when there is no night shift nurse, the pm shift nurse will prepare the medication, put the pill in medication cup, it is usually left on top of R5's microwave. On 6/9/26 at 5:00pm, E5 (Certified Nursing Assistant-CNA) works the night shift. E5 said when a resident complained of pain during the night shift and there's no nurse on duty, depending on the intensity of the pain, if it is strong, the resident has to go the hospital. "If not strong, we tell them there is no nurse and if they can wait for AM nurse. If they cannot, they have to go to the hospital." On 6/10/26 at 7:39am, E6 (CNA) night shift CNA, also said it happened a few times, a resident	A3000		

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A3000	Continued From page 2	A3000		

asked for pain medication and there was no nurse, E6 would apologize to resident and let resident know, there is no nurse on duty, and 99% of the time the resident would say ok. E6 said she would sit with the resident and play music, then in the morning will let the am nurse know to check on resident.

On 6/10/26 at 1:19pm, E7 (CNA) said usually there is no resident asking for pain medications during the night, because the PM shift will take care of it before they leave. But a while back, R13 complained of lower back pain and asked for medication. "I said we do not have nurse, but I will gladly call the paramedics if she has a bad pain ...After I offered the paramedics, she said "It is not that serious, I will wait for the morning ..."

On 6/10/26 at 2:02pm, E8 (CNA) said, usually there are no residents asking for pain medications because the PM nurse will take care of it, but one time, R5 after coming back from surgery requested for pain medication but there was no nurse, so instead, E8 gave R5 ice pack.

R5's Physician Order sheet documented these orders:
-Tramadol 50 mg every 8 hours: 6:00am, 2:00pm, 10:00pm (5/1/26). This order was changed on 6/9/26 (day of survey) to Tramadol 50 mg 1 tab. May leave pain medication at bedside three times a day: 8:00am, 2:00pm, 10:00pm.
-Acetaminophen 325 mg 2 tabs by mouth every 6 hours.
R5's Service plan dated 4/15/26 documented:
-Medication: Resident is dependent upon Care team for safe administrations of medications.
-4/15/26 Chronic low back pain- controlled with scheduled Tramadol and Tylenol. 5/15/26 Lidoderm Patch. 5/28 Tramadol decreased from

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A3000	Continued From page 3 6 hours to TID (every 8 hours). 6/9/26- Tramadol time changed to 8a-2pm-10pm. According to R4's Physician orders, R4 is on: Tramadol 50 mg 1 tablet every 8 hours as needed and Acetaminophen 500mg one tab by mouth three times a day. R4's Service plan dated 4/15/26, documented: Nurse gives (R4) her medication packets daily and she self-administers them. 4/15/26 has chronic left shoulder pain and decreased ROM due to history of fracture. Tramadol PRN to control her pain. According to R6's Physician order, R6 is on: Resident requires medications to be administered. Tramadol 50 mg every 6 hours PRN (as needed). According to R7's Physician order, R7 is on: Acetaminophen 500 mg take one tablet by mouth every 6 hours as needed. Not to exceed 3 grams in 24 hours (3/10/26). According to R8's Physician order, R8 is on -Acetaminophen 500mg 1 tablet by mouth every four to six hours as needed for pain and Tramadol 50 mg one tab as needed one time a day as needed. R8's diagnosis includes but is not limited to Rheumatoid Arthritis. R8's Service plan, stated in part: Cognition: Occasional confusion and some difficulty recalling details, Care team to provide occasional prompting and or/ reorientation. Has days where her orientation to time and day are wrong. Has short term memory deficits. Medications: Resident is dependent upon Care team for safe administrations of Medications 4/16/26 Pain related to RA (Rheumatoid Arthritis) has elbow pain usually worst at night. Scheduled	A3000		

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Tylenol and Tramadol, diclofenac gel and PRN Tramadol.

According to R21's face sheet, R21's diagnoses include but are not limited to Diabetes Mellitus and Vascular Dementia. At the time of survey, R21 no longer reside in the community.

R21's Progress notes dated 11/12/26 7am: I was notified that (R21) was sent to ER due to elevated blood sugar. Her blood sugar results during the night were as follows: 12am 253, 1am 323, 2am 346, 3am 391, 4am error, 5am Hi. (R21) was sleeping every time staff checked her sensor for a reading. She left the facility at 5:10am. Notified daughter at 7:30am of the above information. 8am (Physician) was notified of transfer. 2pm: will be admitted for Uncontrolled DM, Hyperglycemia, and AKI (Acute Kidney Injury)" This progress notes were entered by E2.
R21 has had a history of hyperglycemia as indicated on R21's progress notes dated 10/16/25 10am, it indicated, "Per night RA (Resident Assistant) (R21) was sent to ER at 1am because sensor Libre sensor wasn't able to her blood sugar. It said "high" ...
R21's service plan signed on 9/24/25 indicated: Diabetes: Total Assist. Comments: Has sensor ... Medication administration: Total Assist

On 6/10/26 at 11:58am, E2 said, establishment is not legally required to have a nurse. There are two staff always on duty during the night. E2 said there was no nurse on duty on the night shift when R21's blood sugar was high and eventually transferred to the hospital.

These staff were asked about the procedure followed when a resident has high or low blood sugar during the night shift and there was no

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A3000	Continued From page 5 nurse on duty. E5 said the instructions given when there are complications of low or high blood sugar, the resident will send out to the hospital. E6 said, the resident will be sent to the hospital. E7 said, "If it is high call paramedics to take them to hospital. If it is low, provide them with juice or peanut butter sandwich. It happened in the past, not as of recent, once or twice in past, I just gave them the juice, I just made sure to continue to check the sugar levels. "	A3000		
A4040	Section 295.4040 Communicable Disease Policies This Regulation is not met as evidenced by: Type 2 Violation Section 295.4040 Communicable Disease Policies a) The establishment shall meet the Control of Communicable Diseases Code (77 Ill. Adm. Code 690). This requirement was not met as evidenced by: Based on interview and record review, the establishment failed to follow their Policy and Procedure for one (R1) resident positive for C. Difficile. This deficient practice has the probability to cause harm to residents through the spread of highly contagious infection. This failure creates the substantial probability of harm to a resident or residents. Findings include:	A4040		

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A4040	Continued From page 6 R1's face sheet, progress notes and other documents were reviewed. R1's Progress notes dated 4/16/26 at 4:35pm documented R1's arrival to the establishment accompanied by family member. R1's Hospital documents indicated R1's stool tested positive for C. Difficile on 4/14/26. According to attached information on R1's hospital documents, "C. diff can spread easily to others ...When you visit someone in the hospital or nursing home, wear a gown, gloves or other protection. Try to stay away from people with watery poop" R1's move-in notes did not document R1 were placed on isolation precautions. Succeeding shift (night shift) nursing notes dated 4/17/26 12:45am also did not document isolation protocols. Nursing notes dated 4/17/26 at 10am, documented, nurse reviewed hospital notes, and it indicated R1 was positive for C. Difficile and was put on Contact Precaution and had x1 loose stool that morning. 4/26/26 nursing notes still indicate R1 remained on isolation, remains to have loose stool. On 4/27/26 Isolation was discontinued, after the antibiotic regimen was completed. On 6/9/26 at 4:19pm, E4 (Registered Nurse) was the nurse on 4/17/26 night shift. E4 said there was no communication received from the previous nurse that R1 was positive for C. Diff. E4 said, was R1 was not on isolation during the shift. On 6/10/26 at 11:58am, E2 (Director of Clinical Operations Assisted Living) said there was mistake since day 1. R1 was not put on isolation on the day of move in. E2 said, it was when E2	A4040		

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A4040	Continued From page 7 was reviewing R1's hospital records that E2 discovered R1 had tested positive for C. Diff. R1's progress notes dated 4/17/26 at 10:00am, documented R1 was placed on Contact precautions. R1 had loose stool also observed that morning. Progress notes dated 4/25/26 and 4/26/26 documented R1 still had loose stool and remained on isolation and on antibiotic. Establishment's Policy and Procedure titled "Procedure: Clostridium Difficile" stated in part; J. Residents with diarrhea associated with C. difficile (i.e., residents who are colonized and symptomatic) will be placed on Contact Precautions. 1. Healthcare workers will wear gloves and gowns upon entering the room of a resident with C. difficile infection and will remove gowns and gloves prior to exiting the room. 2. Visitors will be encouraged to wear gowns and gloves, and instructed on proper hand hygiene.	A4040		
A5000	Section 295.5000 Medication Reminders, Supervision of Self Med This Regulation is not met as evidenced by: Type 1 Violation Section 295.5000 Medication Reminders, Supervision of Self-Medication, Medication Administration and Storage f) If an establishment provides medication administration or supervision of self-administered medication, the establishment's medication policies and procedures shall be approved by a	A5000		

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physician, pharmacist, or registered nurse and shall address:

5) Recording of medication assistance provided to residents and maintenance of medication records.

These requirements were not met as evidenced by:

Based on interview and record review, the establishment failed to:

-Administer Vancomycin as ordered by physician, indicated to treat C. Difficile a highly contagious infection, affecting one (R1) resident.

- Administer pain medication as ordered by physician for one (R8) resident with medical history of Rheumatoid Arthritis.

This deficient practice affected two (R1, R8) residents and has the probability of causing serious harm to resident (s).
This failure creates the substantial probability of severe harm to a resident or residents.

Findings include:

R1
R1's face sheet, progress notes and other documents were reviewed. R1's Progress notes dated 4/16/26 at 4:35pm documented R1's arrival to the establishment accompanied by family member.
R1's Hospital documents indicated R1's stool tested positive for C. Difficile on 4/14/26.
According to attached information on R1's hospital documents, "C. diff can spread easily to

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others ..."
R1's Physician order indicated, R1 has an order of Vancomycin 50mg. Take 2.5ml every 6 hours x 8 days.
R1's MAR indicated the 12am doses were not administered from 4/18/26 to 4/23/26.

On 6/10/26/at 11:58am, E2 said it was noticed that the midnight doses of the Vancomycin were not being administered.

On 6/9/26 at 4:19pm, E4 (Registered Nurse) who was then the night shift nurse said there was poor communication between the nurses that caused this medication error.

R8

According to R8's face sheet, R8 is 83 years old. R8's diagnoses include but are not limited to Alzheimer's Disease, Rheumatoid Arthritis, and Essential Hypertension.

On 6/9/26 at 1:46pm, R8 was seen inside R8's apartment. Attempted to ask questions concerning medication pass, however R8 was not alert enough to answer questions appropriately.

On 6/9/26 at 4:19pm, E4 (Registered Nurse) said, R8's Tramadol (pain medication) was signed out in the Medication Administration Record-MAR despite R8 not receiving the pills to alleviate pain. E4 said, R8 woke up in the night in pain, until R8 got the Tramadol. The Tramadol PRN was not being given which caused the resident pain, this incident occurred around February or March.

On 6/10/26 at 3:04pm, E2 (Director of Clinical Operations Assisted Living) said, E12 (Former Employee- Registered Nurse) did not administer

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the Tramadol to R8. E2 said E12 noted it on the MAR but not on the Narcotic sheet, she was claiming there was no order.

E2's email dated 6/11/26 indicated the following: "Original order for tramadol was written on 1/16/26 for 1 tab every HS for 30 days. On 2/19/26 we received a new order for tramadol 50 every HS with no end date. (E12) signed out the tramadol on 2/24,2/25, 2/26 and 2/27 but did not give the medication. She still had a PRN order and the active order as of 2/19. The issue is that the pharmacy did not send a new card for the scheduled tramadol so that is the reason (E12) did not give the medication. She stated that the original order was only for 30days, which is true, but she did not look to see there was a new order in the chart dated 2/19/26 (R8) which is confused but often does not sleep well complaining of pain to her elbow which is why the Tramadol was ordered ... I spoke with (E12) and said it was a med error she went back and circled the medication on the MAR."

R8 Service plan dated 4/16/26, stated in part; Cognition- Occasional confusion and some difficulty recalling details, Care Team to provide occasional prompting and/or reorientation. Medications: Resident is dependent upon Care Team for safe administrations of Medications (4/16/26) Pain R/T (related to) RA (Rheumatoid Arthritis) has elbow pain usually worse at night. Scheduled Tylenol and Tramadol, Diclofenac gel and PRN Tramadol.

Establishment document titled "Safety Event Manager" with incident date: 2/24/26 stated in part; stated in part; (R8) ...missed scheduled Tramadol doses at 8pm on February 24th, and 25th, 2026. The MAR (Medication Administration

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A5000	Continued From page 11 Record) indicated the medication was administered but this was not reflected on the narcotic sheet. The nurse stated there was no current order for the medication, despite a signed order in the chart dated February 19, 2026. The physician did not communicate the reordered medication to the pharmacy, preventing a new medication card from being sent. Although a PRN Tramadol order was in place, the nurse did not administer it, citing the 30-day duration listed on the MAR." Establishment's Policy and Procedure titled: Assisted Living "Administering Medications" stated in part; Policy Interpretation and Implementation C. Medications shall be administered in accordance with the orders.	A5000		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: Type 1 Violation Section 295.6000 Resident Rights a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of his or her status as a resident of an establishment, nor shall a resident forfeit any of the following rights: 13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor; This requirement was not met as evidenced by:	A6000		

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A6000	Continued From page 12 Based on interview and record review, the establishment failed to ensure pain medication was administered as ordered by physician for one (R8) resident with medical history of Rheumatoid Arthritis. The establishment also failed to ensure a nurse was onsite to assess one (R21) resident who has history of high blood sugar. This deficient practice has the probability of causing serious harm to resident (s). This failure creates the substantial probability of severe harm to a resident or residents. Findings include: R8 According to R8's face sheet, R8 is 83 years old. R8's diagnoses include but are not limited to Alzheimer's Disease, Rheumatoid Arthritis, and Essential Hypertension. On 6/9/26 at 1:46pm, R8 was seen inside R8's apartment. Attempted to ask questions concerning medication pass, however R8 was not alert enough to answer questions appropriately. On 6/9/26 at 4:19pm, E4 (Registered Nurse) said, R8's Tramadol (pain medication) was signed out in the Medication Administration Record-MAR despite R8 not receiving the pills to alleviate pain. E4 said, R8 wake up in the night in pain, until R8 receive the Tramadol. The Tramadol PRN was not being given which caused the resident pain, this incident occurred around February or March. On 6/10/26 at 3:04pm, E2 (Director of Clinical Operations Assisted Living) said, E12 (Former Employee- Registered Nurse) said, did not administer the Tramadol to R8. E2 said E12 noted it on the MAR but not on the Narcotic	A6000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510280	A. BUILDING: _____ B. WING _____	C 06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASCENSION LIVING RESURRECTION VILLAGE	7262 W PETERSON AVE CHICAGO, IL 60631

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A6000	Continued From page 13	A6000		

sheet, she was claiming there was no order.

E2's email dated 6/11/26 indicated the following: "Original order for tramadol was written on 1/16/26 for 1 tab every HS for 30 days. On 2/19/26 we received a new order for tramadol 50 every HS with no end date. (E12) signed out the tramadol on 2/24,2/25, 2/26 and 2/27 but did not give the medication. She still had a PRN order and the active order as of 2/19. The issue is that the pharmacy did not send a new card for the scheduled tramadol so that is the reason (E12) did not give the medication. She stated that the original order was only for 30days, which is true, but she did not look to see there was a new order in the chart dates 2/19/26 (R8) is confused but often does not sleep well complaining of pain in her elbow which is why the Tramadol, was ordered. Fare I spoke with (E12) and said it was a med error she went back and circled the medication on the MAR."

R8 Service plan dated 4/16/26, stated in part; Cognition- Occasional confusion and some difficulty recalling details, Care Team to provide occasional prompting and/or reorientation. Medications: Resident is dependent upon Care Team for safe administrations of Medications (4/16/26) Pain R/T (related to) RA (Rheumatoid Arthritis) has elbow pain usually worse at night. Scheduled Tylenol and Tramadol, Diclofenac gel and PRN Tramadol.

Establishment document titled "Safety Event Manager" with incident date: 2/24/26 stated in part; stated in part; (R8) ...missed scheduled Tramadol doses at 8pm on February 24th, and 25th, 2026. The MAR (Medication Administration Record) indicated the medication was administered but this was not reflected on the

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A6000	Continued From page 14	A6000		

narcotic sheet. The nurse stated there was no current order for the medication, despite a signed order in the chart dated February 19, 2026. The physician did not communicate the reordered medication to the pharmacy, preventing a new medication card from being sent. Although a PRN Tramadol order was in place, the nurse did not administer it, citing the 30-day duration listed on the MAR."

R21
According to R21's face sheet, R21's diagnoses include but are not limited to Diabetes Mellitus and Vascular Dementia. At the time of survey, R21 no longer reside in the community.

R21's Progress notes dated 11/12/26 7am: I was notified that (R21) was sent to ER due to elevated blood sugar. Her blood sugar results during the night were as follows: 12am 253, 1am 323, 2am 346, 3am 391, 4am error, 5am Hi. (R21) was sleeping every time staff checked her sensor for a reading. She left the facility at 5:10am. Notified daughter at 7:30am of the above information. 8am (Physician) was notified of transfer. 2pm: will be admitted for Uncontrolled DM, Hyperglycemia, and AKI (Acute Kidney Injury)" This progress notes were entered by E2.

R21 has had a history of hyperglycemia as indicated on R21's progress notes dated 10/16/25 10am, it indicated, "Per night RA (Resident Assistant) (R21) was sent to ER at 1am because sensor Libre sensor wasn't able to her blood sugar. It said "high" ...

R21's service plan signed on 9/24/25 indicated: Diabetes: Total Assist. Comments: Has sensor ... Medication administration: Total Assist

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A6000	Continued From page 15 On 6/10/26 at 11:58am, E2 said, establishment is not legally required to have a nurse. There are two staff always during the night. E2 said there was no nurse on duty on the night shift when R2's blood sugar was high and eventually transferred to the hospital. Establishment's Policy titled "Change in a Resident's Condition or Status" stated in part; Policy Statement: Our community shall promptly notify the resident, his or her healthcare provider, and representative of changes in the resident's medical/mental condition and/or status .... Policy and Interpretation and Implementation A. The nurse will notify the resident's Health care provided or physician on call when there has been a (an): 4. significant change in the resident's physical/emotional/mental condition 5. Need to alter the resident's medical treatment significantly 6. need to transfer the resident to a hospital /treatment center. C. prior to notifying the health care provided, the nurse will make detailed observations and gather relevant and pertinent information for the provider ...	A6000		