STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510356	A. BUILDING: _____ B. WING _____	C 09/26/2025

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A 000	Initial Comment Complaint Investigation Survey: #2578539/IL#197393 295.4010a) b) d) e) g) h) 295.4060a) b) h) 3) 5) 6) 295.6000a) 13) 295.6010a) 2) b)	A 000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Type 2 Violation Section 295.4010 Service Plan a) b) d) e) g) h) i) a) Based on the physician's assessment and establishment evaluation (see Section 295.4000), a written service plan shall be developed and mutually agreed upon by the establishment and the resident. (Section 15 of the Act) The establishment shall respect and accept the resident's choices regarding the service plan. b) The service plan shall be developed by 1) The resident, resident's representative or any individual requested by the resident. 2) The manager or manager's designee; and 3) A registered nurse, if the resident is receiving nursing services or medication	A4010		

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	ASL510356	A. BUILDING: _____ B. WING _____	C 09/26/2025

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A4010	Continued From page 1 administration or is unable to direct self-care. d) The service plan, which shall be reviewed annually, or more often as the resident's condition, preferences, or service needs change, shall serve as a basis for the service delivery contract between the provider and the resident (see Section 295.2030). (Section 15 of the Act). e) The service plan shall be reviewed and revised, if necessary, immediately after a significant change in the resident's physical, cognitive, or functional condition (see Section 295.4000). g) Service plans shall address: 1) The level of service the resident is receiving, including: A) assistance with activities of daily living. B) dietary needs, if the establishment provides therapeutic diets; and C) special accommodations for the resident. 2) The amount, type, and frequency of health-related services needed by the resident. 3) Staff responsible for the provisions of the service plan. 4) Any risk being negotiated; and 5) Whether the resident requires medication reminders, supervision of self-administered medication, or medication	A4010		

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	ASL510356	A. BUILDING: _____ B. WING _____	C 09/26/2025

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A4010	Continued From page 2 administration. h) The service plan shall include all support services provided or arranged for by the establishment. i) Disclosure of the risks of refusing services or approaches must be documented in the service plan. These requirements were not met, as evidenced by: Based on interview and record review of the facility failed to: 1. Follow and implement R4's service plan to provide supervision and to conduct a visual check on R4. 2. Implement interventions and identify new measures to provide and protect residents' safety. 3. Implement the facility policy on elopement management. These failures resulted in: R4's elopement from a locked memory care unit on the third floor; R3 was found in the parking lot on September 5, 2025. Staff was not aware of the missing resident (R4) or how long R4 had been missing from the unit. This failure creates a substantial probability of harm to a resident or residents. The findings include: On September 9, 2025, at 3:18 PM, E1	A4010		

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	ASL510356	A. BUILDING: _____ B. WING _____	C 09/26/2025

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A4010	Continued From page 3	A4010		

(Executive Director) and E2 (Area Resident Care Director/RN) confirmed that R4 was identified as "at risk for elopement, needing monitoring and supervision." R4 was in a locked memory care unit on the 3rd floor. R4 was identified with dementia and continued to wander in the unit. R4 was observed to specifically watch the elevator with a suspected desire to exit.

R4's nurses notes document R4 as demonstrating exit seeking behavior:
- August 18, 2025, R4 continued to pack all their belongings and paced all night and all this morning. Continued to say they were trying to go home, continued to try to get on elevator each time door opened.
- September 4, 2025- R4 expressed the desire to exit the building by asking about the way to the community and standing by the elevator multiple times throughout the shift.

The elopement management program, managing the service plan read:
- "An individualized intervention is developed using the assessment and planning process in partnership with the resident's family and team members. Intervention must be customized based on the resident identified risk factors and behavioral needs."

Reviewing the service/care plan:
- Patient to address resident preferences, interest, previous daily routines, and target known triggers.
- Schedule activities to engage the resident a key time (after meals and during the afternoon chains of shift of team member), when the risk of elopement is greater
- Engage the life enrichment manager for more personalized activity program.

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	ASL510356	A. BUILDING: _____ B. WING _____	C 09/26/2025

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SUNRISE OF WILLOWBROOK	6300 CLARENDON HILL RD WILLOWBROOK, IL 60527

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A4010	Continued From page 4 These programs were not found in R4's service plan or observed during this survey. On September 9, 2025, at 1:24 PM, R4 was noted to be walking in the hallway without any walking device. At 2:00 PM, R4 was seen in the hallway, heading towards the elevator, pushing a rolling walker with six hangers holding clothes which were rested on top of the walker. No staff were observed at this time to redirect R4. An activity staff member was seen sitting on the couch, with her back to the elevator watching TV with the residents. R4's service plan dated July 17, 2025, show the following: - Elopement and safety Please do visual check on me, I tend to roam around the unit, and I might get into the elevator. - Memory and cognition Provide me with supervision as needed to ensure that I do not compromise my safety. I do not remember that I lived here, and I will try to exit seek to the first floor if I am not supervised. These interventions were not followed, resulting in R4's elopement from a "secured" Memory Care Unit; R4 was found in the parking lot on September 5, 2025.	A4010		
A4060	Seciton 295.4060 Alzheimer's and Demential Programs This Regulation is not met as evidenced by: Type 2 Violation Section 295.4060 Alzheimer's and Dementia Programs-a)b)h)3)5)6) -	A4060		

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	ASL510356	A. BUILDING: _____ B. WING _____	C 09/26/2025

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A4060	Continued From page 5 a) In addition to this Section, Alzheimer and dementia programs shall comply with all of the other provisions of the Act. (Section 150(a) of the Act) b) No person shall be admitted or retained in an assisted living or shared housing establishment if the establishment cannot provide or secure appropriate care, if the resident requires a level of service or type of service for which the establishment is not licensed or which the establishment does not provide, or if the establishment does not have the staff appropriate in numbers and with appropriate skill to provide such services. (Section 150(b) of the Act) h) An establishment that offers to provide a special program for persons with Alzheimer's disease and related disorders shall: 3) Develop and implement policies and procedures that ensure the continued safety of all residents in the establishment including, but not limited to, those who: A) May wander; and B) May need supervision and assistance when evacuating the building in an emergency; 5) Provide, in the service plan, appropriate cognitive stimulation and activities to maximize functioning, which include a structure and rhythm that are comfortable and predictable; offer an appropriate balance of rest and activity and private and social time; allow residents to express their accustomed social roles, whatever they may be; offer residents access to familiar activities that they enjoyed doing and that tap	A4060		

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	ASL510356	A. BUILDING: _____ B. WING _____	C 09/26/2025

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A4060	Continued From page 6	A4060		

memories and retained abilities; and provide the flexibility to accommodate variations in the resident's mood, energy level, and inclination;

6) Provide an appropriate number of staff for its resident population. The establishment shall provide staff sufficient in number, with qualifications, adequate skills, education, and experience to meet the 24-hour scheduled and unscheduled needs of the residents and who participate in ongoing training, to serve the resident population. At a minimum, at least one staff member shall be awake and on duty at all times.

These requirements were not met, as evidenced by:

Based on interview and record review of the facility failed to:
1. Conduct a personalized fall risk assessment.
2. Develop and implement a fall prevention plan.
3. Identify the possible root causes and implement an individualized intervention based on the assessed needs and risk factors.
4. Implement the service plan to provide R2 with the necessary monitoring and supervision.
5. Provide meaningful and stimulating activities to residents living with dementia.
This was found in 1 of 8 residents (R2) reviewed.

These failures resulted in:

R2's decline in physical mobility, from walking with a walker, to utilizing a wheelchair and into a specialized positioning wheelchair (Broda chair). R2 sustained multiple unwitnessed falls; 10 unwitnessed falls during August 2025 and three falls during September 2025. This failure creates a substantial probability of harm to a resident or

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SUNRISE OF WILLOWBROOK	6300 CLARENDON HILL RD WILLOWBROOK, IL 60527

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A4060	Continued From page 7	A4060		

residents.

The findings include:

R2 moved into the community on January 21, 2025, with diagnoses of dementia and osteitis deformans (unspecified bone).
On September 11, 2025, at 11:00 AM, E1 (Executive Director) and E2 (Area Resident Care Director/RN) identified R2 as confused and disoriented. At "high risk for fall", requires two-person assistance with all activities of daily living, with unsteady gait and tries to ambulate independently. R2 was noted to forget to use their walker, requiring reminders and supervision. E2 stated, "In July 2025, it was documented that R2 still walks with a walker. R2 sustained a lot of falls. Yes, mostly unwitnessed falls."
R2's nurses notes show the following unwitnessed fall incidents:
A. July 9, 21 and 23, 2025.

Power of Attorney requested for R2 to be enrolled with physical therapy."
B. On August 5, 2025, at 2:55 PM, Physical Therapist found R2 on the floor, with pain rated at 6 / 10. R2 was unable to walk and was placed on a wheelchair.

R2 nurses' notes include instruction to: Assist resident with ambulation as - resident may lose balance while walking. Ensure to offer assistance to bathroom after meals was not able to walk.

- August 12, 2025, at 7:37 AM - found in the bathroom.
- August 13, 2025, at 14:24 - found in the bathroom.
- August 18, 2025, at 1:00 AM - found by the bathroom.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A4060	Continued From page 8 o Check on me at frequent intervals throughout the day and night when I am in my room alone to see if I need any assistance and remind me that I need assistance with walking around with my gate has changed recently. - August 20 at 5:15 AM- heard a loud thump, R2 was found on the floor - August 21 at 11:35 AM- on the hallway not using assistive device o Remind me to use my call device (pull cord), I often forget to use my walker or wheelchair, and my gait is unsteady please remind me often that I need my assistive device for ambulation. (R2 with diagnosis of Dementia). - August 24, at 1:08 AM- in the room - August 26 at 1:13PM, on the floor, attempted to use the bathroom - August 27, at 11:40 AM, and August 31, 2025. C. September 2,2025, at 2:57 PM, found in the bathroom. - September 5 at 1:00 PM, found in the bathroom. On September 11. 2025, at 10:00 AM, R2's service plan identified R2 as at risk for fall related to unsteady gait and the need to use a walker/wheelchair. The interventions identified are: 1. Educate the residents. 2. Remind residents to: a. Rise and change position slowly. b. Use the assistive device when ambulating. R2 has diagnoses to include dementia 3. Check at frequent intervals throughout the day and night ... This intervention was not implemented. R2 sustained multiple unwitnessed fall incidents. The facility was unable to provide any documentation that R2's unwitnessed fall	A4060		

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SUNRISE OF WILLOWBROOK	6300 CLARENDON HILL RD WILLOWBROOK, IL 60527

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A4060	Continued From page 9 incidents were investigated/analyzed. These findings were discussed and confirmed by E1 and E2 on September 11, 2025. On September 9, 2025, at 11:20 AM and at 2:45 PM, confidential interviews disclosed that the community does not have enough staff to provide care and to monitor the residents.	A4060		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: Type 2 Violation Section 295.6000 Resident Rights (a) (13) 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. These requirements were not met, as evidenced by: Based on observation, interview and record review of the facility failed to: 1. Implement a comprehensive safety approach, specifically failing to: a. Provide adequate supervision and monitoring to R4 identified as an elopement risk.	A6000		

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	ASL510356	A. BUILDING: _____ B. WING _____	C 09/26/2025

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A6000	Continued From page 10 b. Provide a secure environment by implementing intervention to provide "visual checks" to R4 c. Provide physical monitoring of the main entrance/exit doors. 2. Have sufficient staff to monitor and provide unscheduled needs/services of R4. This was found in 1 of 3 residents (R4) reviewed. These failures resulted in neglect. R4 exited from a secured unit (with electronic lock requiring codes) on the third floor, walked pass the concierge desk, and opened the two separate entrance doors. R4 was found in the parking lot at 5:30 PM; The facility staff was not aware of R4's unauthorized exit (elopement) from the community and was unaware of how long R4 was missing from the unit on September 5, 2025. This failure creates a substantial probability of harm to a resident or residents. The findings include: R4 moved into the community on July 15, 2025, with diagnoses to include Alzheimer's disease, anxiety, hypertension, atrial fibrillation. On September 9, 2025, at 1:24 PM, R4 was noted walking in the hallway without any walking device. Attempts to interview R4 were unsuccessful due to R4's restlessness and inability to focus. R4 persevered, repeatedly saying "I got to go!" At 2:00 PM, R4 was noted in the hallway pushing a rolling walker with six hangers of clothes rested on top of the walker, heading towards the elevator. No staff were observed at this time except an activity staff member sitting on the couch, sitting with her back	A6000		

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	ASL510356	A. BUILDING: _____ B. WING _____	C 09/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF WILLOWBROOK	6300 CLARENDON HILL RD WILLOWBROOK, IL 60527

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A6000	Continued From page 11	A6000		

to the elevator and watching TV with the residents.

At 2:30 PM, E8 (Lead Care Manager- second shift) said, "E4 (Sales Coordinator) found R4 in the back parking lot. No, there's no alarm that went off. No, we didn't know that R4 got out. There are so many residents here with behaviors, R4 was always waiting in front of the elevator and tried to sneak out. No, no one monitors the elevator. We were short staffed that day, there's supposed to be three but it's just me and E10."

At 3:11 PM, E1 (Executive Director) explained the incident of R4's elopement as follows:
"One of our staff E4 (Sales Director) was on her ways home at around 5:30 PM and saw R4 at the parking lot; brought R4 back to the Unit. No, there was no one at the concierge desk at the time. No, the staff were not aware R4 was missing."
At 3:34 PM, E4 (Sales Director) explained, "I was walking towards my car when I saw R4 in the parking lot. R4 was carrying hangers with clothes on it. R4 was shuffling (gait), and said 'I am looking for my car!' I took R4 back to the Unit and presented R4 to the Care Manager. The Care Managers (E8 and E10) were in the [unit] kitchen. No, I didn't ask if they knew that R4 was missing but I texted E1 (Executive Director) and E3 (Reminiscence Coordinator).

At 4:08 PM, E5 (Concierge), I work from 4:00PM-8:00PM, I do not know what time it was. E4 told me that R4 was found in the parking lot. I was in the kitchen to get supplies to stock up the bistro. I didn't know R4 got out until E4 told me. No, I was not at the desk, no one was!"

At 4:36 PM, E9 (LPN) stated, "I saw R4 with E4. No, I didn't know R4 was missing. The Care

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A6000	Continued From page 12 Managers were not aware either. We were short staffed; we normally have three Care Managers at that day we only have two. It's hard for them because our census is almost full (19), we have too many behaviors, residents that requires two-person assistance, we serve dinner, feed some residents, wash dishes, toilet and put residents back to bed. I help the Care Givers too, it's hard to monitor everyone with just two!"	A6000		
A6010	Section 295.6010 Abuse, Neglect, and Financial Exploitation Pr This Regulation is not met as evidenced by: Type 2 Violation Section 295.6010 Abuse, Neglect, and Financial Exploitation Prevention and Reporting a) 2) b) a) When the establishment has a reasonable belief that a resident has been the victim of abuse, neglect, or financial exploitation, the establishment shall: 2) Investigate and develop a written report within 14 days after the initial report. The establishment shall send the written report to the Department within 24 hours after it is completed and shall maintain a copy of the written report on the premises for 12 months after the date of the report. b) A written report of the investigation conducted pursuant to subsection (a)(2) shall contain at least the following: 1) Dates, times, and description of the	A6010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF WILLOWBROOK	6300 CLARENDON HILL RD WILLOWBROOK, IL 60527

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A6010	Continued From page 13 alleged abuse, neglect or financial exploitation. 2) Description of any injury to the resident. 3) Description of any change in the resident's physical, cognitive, functional, or emotional condition. 4) Any actions taken by the licensee. 5) A list of individuals and agencies interviewed or notified by the establishment. 6) Names of witnesses to the alleged abuse, neglect, or financial exploitation; and 7) If the abuse, neglect, or financial exploitation is substantial, a description of the action to be taken by the establishment to prevent the abuse, neglect or financial exploitation from occurring in the future. These requirements were not met, as evidenced by: Based on interview and record review of the facility failed to: 1. Submit a written report of R4's elopement to the Department. 2. Conduct and submit an investigation (14 days after the incident date) to identify the possible root cause of R4's elopement and to identify new interventions to prevent further occurrences. This was found in 1 of 3 residents (R4) reviewed. These failures resulted in non-compliance with the required regulation in reporting and	A6010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510356	A. BUILDING: _____ B. WING _____	C 09/26/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A6010	Continued From page 14	A6010		

investigation of a neglect related to R4's elopement incident on September 5, 2025. This failure creates a substantial probability of harm to a resident or residents.

The findings include:

On September 9, 2025, at 3:18 PM, E1 (Executive Director) and E2 (Area Resident Care Director/RN) confirmed that R4 was identified as, "At risk for elopement and needs monitoring and supervision." R4 was in a locked memory care unit on the third floor. R4 was identified with dementia and continued to wander in the unit and particularly watching the elevator with the desire to exit.

R4's nurses notes show:
- R4 expressed desire to exit (September 4, 2025)
- August 18, 2025, R4 continued to pack all belongings and was pacing all night and all this morning. Continued to say they was trying to go home, continued to try to get on elevator each time door opened.

- Staff interviews (E3 - Reminisce Coordinator, E6, E7, E8 - Care Managers and E9- LPN) on September 9, 2025, all confirms R4 exhibit an exit seeking behavior and was "always watching the elevator" for an exit route.

On September 11, 2025, at 10:00 AM, E1 (Executive Director) and E2 (Area Resident Care Director/RN) confirmed that the community did not report R4's elopement incident on September 5, 2025, to the Department because the resident remained in the area, "just in the parking lot!"

E2 was unable to present documentations that R4 was allowed to exit the locked unit on the 3rd

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510356	A. BUILDING: _____ B. WING _____	C 09/26/2025

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A6010	Continued From page 15 floor of the community and be in the parking lot alone.	A6010		