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A 000	Initial Comment Complaint Investigation: #2599123/IL197655 - 295.6000 a) 1) 2) 5) 6) 8) 12) Facility Reported Incident: 9/19/2025/IL197655 - 295.4010 a) b) 1) c) d) g) 1) A) C) 3) h) i) 295.6000 a) 1) 2) 5) 6) 8) 12)	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) 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; c) The service plan shall be signed and dated by all individuals involved in its	A4010		

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A4010	Continued From page 1 development. 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) g) Service plans shall address: 1) The level of service the resident is receiving, including: A) assistance with activities of daily living; C) special accommodations for the resident; 3) Staff responsible for the provisions of the service plan; h) The service plan shall include all support services provided or arranged for by the establishment. i) Nothing in this Part limits a resident's ability to direct his or her own care and negotiate the terms of his or her own care. Residents have the right to refuse certain services or approaches that would otherwise be recommended based on the physician's assessment if the resident has received clear information regarding the risks and benefits of such a choice and the choice does not put other residents or staff at risk. Disclosure of the risks of refusing services or approaches must be documented in the service plan.	A4010		

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A4010	Continued From page 2 This requirement was NOT MET as evidenced by: Based on observation, interview and record review, the facility failed to adequately supervise three cognitively impaired residents (R3, R4, R5) in the common area; ensure two residents (R1, R2) or their representatives signed and dated service plans; update one resident's service plan with shower preferences and disclose and document the risks associated with one resident's (R2) refusal of services.This deficient practice affected five residents (R1-R5) reviewed for service plan compliance in a sample of five. This failure creates a substantial probability of harm to a resident or residents. Findings include: R1 was a 88-year-old male, initial move in date of 9/9/2025 and expired on 10/9/2025 with diagnoses of Dementia In Other Diseases Classified Elsewhere, Unspecified Severity, Without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, And Anxiety, Type 2 Diabetes Mellitus With Diabetic Neuropathy, Unspecified, Muscle Weakness (Generalized), Type 2 Diabetes Mellitus Without Complications, Essential (Primary) Hypertension, Nontraumatic Subdural Hemorrhage, Unspecified, Nontraumatic Subarachnoid Hemorrhage, Unspecified Service Plan Report dated 9/9/2025 in part shows, Focus: date initiated 9/9/2025, Goal: date initiated 9/9/2025, Interventions: Date Initiated: 9/9/2025. Name, Signature, and Date Blank. On 10/13/2025 at 12:29am via email, E2	A4010		

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A4010	Continued From page 3	A4010		

(Resident Care Director/LPN) stated, R1 is still schedule and hasn't happened. R1 was a resident at facility 9/9/2025 to 10/9/2025, service plan was not signed by resident or resident representative.

R2 is a 67-year-old female, initial move in date of 8/18/2025 with diagnoses of Pain, Unspecified, Gastro-Esophageal Reflux Disease Without Esophagitis, Constipation, Unspecified Postural Orthostatic Tachycardia Syndrome [Pots], Essential (Primary) Hypertension

Service Plan Report dated 8/18//2025 in part shows, Focus: date initiated 8/18//2025, Goal: date initiated 8/18//2025, Interventions: Date Initiated: 8/18//2025. Date of when R2 signed left blank.

R2's shower documentation Survey Report September 25 in part shows Intervention/Task Bathing Sunday and Wednesday PM (3-11) standby female only, RR= resident refused, NA = resident not available
Shower dates: 9/3/2025 Female (F), 9/7/25 RR (F), 9/10/025 NA Male (M), 9/14/2025 (left blank), 9/17/25 RR (M), 9/21/25 RR (M), 9/28/2025 RR (M), 10/1/2025 RR (M), 10/5/2025 (F), 10/8/2025 NA (M)

R2's POC (Plan of Care) Response History shows: Resident R2, Task: Bathing Sunday and Wednesday PM standby female only
BATHING: SUPPORT PROVIDED - How resident takes full-body bath/shower, sponge bath, bed bath and includes transfers in/out of tub/shower (excludes washing of back and hair)
R2's Task History shows:
Bathing Sunday and Wednesday Pm standby female only Revision Date: 8/22/2025 By E3

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A4010	Continued From page 4 Bathing Sunday Pm standby female only Revision Date: 8/22/2025 By E3 Bathing Sunday Pm Revision Date: 8/22/2025 By E3 Bathing (prefers: specify) Revision Date: 8/18/2025 By E2 On 10/10/2025 at 1:57pm R2 was sitting in lobby with walker, dressed, groomed, wearing shoes. R2 was alert and oriented and able to make needs known. R2 stated, the administration here is not helpful. I have not gotten a shower in weeks. I want a shower, but I am not getting showers. I want my shower in the morning and female only to assist. I talked to someone, but nothing has changed. I still am supposed to get my showers in the evening. I want my showers in the morning. I do not know why I cannot have my showers in the morning. I have refused to take a shower with a male, I am not refusing the shower, I am refusing male assistance. I feel unsafe with men helping me shower. I have told the administration and they have not done anything about it, the staff are nice it is the administration, E1 (Executive Director), E2 (Resident Care Director), and E3 (Resident Care Coordinator). They do not care, I want to work with them, but they are unwilling to help me. They have not come to me to ask me why I am not taking a shower. I am paying a lot of money to live here; it is very expensive. On 10/11/2025 at 12:33pm E2, Resident Care Director (RCD) stated, I am familiar with R2. R2 is a standby assist for showers. If a resident refuses a shower, can offer a different time and work with resident to come up with a different time. I am not aware R2 is not getting showers. If this is consistently happening, we should be calling the family and seeing what is going on. I	A4010		

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A4010	Continued From page 5	A4010		

am not sure what happened. We have to call the POA (Power of Attorney) and talk to R2 and find out how can we make it happen to see what is going on and see if she prefers another day and time. Nurse should be notified. E2 stated, service plan should be updated based on needs of the resident. I need to check with the care managers. This should have been flagged with us as a refusal so E3 or I can take action. E3, Resident Care Coordinator and I work together to update service plans. R2's service plan has not been updated regarding a shower.

On 10/12/2025 at 9:52am E15, Care Manager stated, I am familiar with R2. I have been telling E3 (Resident Care Coordinator) to change her showers and she only wants a female. I told my Lead Care Manager (E16) too. When I marked refuse or not available, she does not refuse her showers she just prefers a female and for her showers to be in the morning. I work the evening shift usually on Wednesday and she says I do not want to take a shower on the evening shift, I want a shower in the morning. I told E16 about it, and she has been telling E3 and it still stays the same. E3 is the one that takes care of the scheduling. We have been telling him. I never told E2 because I have always been told to report to E3. I would like to get this changed for R2. If R2 wants to take her shower in the morning and she wants a female, she should get what she wants.

On 10/12/2025 at 3:00pm E13, Care Manager stated, I usually work on AL (Assisted Living) side. I have taken care of R2 a couple of times. I never had her on my assignment I was helping out and taking food to her. I worked on assignment when I first trained. I never had to give her a shower. I do not know why my name is on her POC (plan of care). POC Documentation

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A4010	Continued From page 6	A4010		

and assignment sheets for 9/17/2025 and 9/28/2025 shows E13 was R2's care manager for evening shift and verified with E2.

On 10/12/2025 at 3:49pm E3 (Resident Care Coordinator) stated, I am familiar with R2. R2 keeps refusing her showers. I tried to reschedule her showers, but she keeps refusing. R2 can get a shower when she wants to. She only wants female caregivers to help with her shower. If a male caregiver is assigned, they will switch residents to accommodate resident. I have had conversations with R2 about her showers about two to three weeks ago. I did not document our conversation; I did not document anything. I am not sure if the care givers told me or not that she wanted to change her shower days and only wants a female care giver. I did not document anything in her medical record. If a resident refuses, the caregiver should ask the resident why they are refusing and try to come back and see if resident will take a shower later. They also document in POC (plan of care) and everyone will see it. I am the one to follow up with the resident and update the service plan. E3 verified that E13, E15, and E18 are male caregivers. Usually, the female caregiver will help with the female and the male will take care of the male. They are supposed to go and ask resident because they are male caregivers. If they documented refused that means they asked the resident. I asked if she wants the shower in the morning and she said she was fine with day and time. I am not sure if they told me or not, but I spoke to her because of the refused shower but R2 stated she wanted to keep the same date and time. I did not document anything in the record.

R3 is an 83-year-old female, initial move in date of 7/11/2025 with diagnoses of Dementia in Other

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A4010	Continued From page 7 Diseases Classified Elsewhere, Unspecified, Severity, Without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, And Anxiety, Essential (Primary) Hypertension On 10/10/2025 at 1:11pm observed R3 confused but able to make needs known and has to be given reminders. R3 confused but stated she has not had any recent falls. R3 observed sitting in high back wheelchair dressed, groomed, hunched over to the right. On 10/10/2025 at 1:39pm E9, Care Manager stated, R3 likes to talk a lot. I believe she fell about 2 weeks ago. She slides down. When she fell, she was sitting on walker then slid down, but she was still holding onto the walker. The nurse was called. She said she wanted to stand up and we told her she had to wait for the nurse to come. She has to be watched. R4 is an 89-year-old female, initial move in date of 9/30/2025 with diagnoses of Type 2 Diabetes Mellitus With Diabetic Chronic Kidney Disease, Vitamin D Deficiency, Unspecified, Unspecified Hyperlipidemia Hyperosmolality and Hypernatremia, Dementia, Unspecified Severity, With Agitation Primary Insomnia Neurocognitive Disorder With Lewy Bodies, Essential (Primary) Hypertension, Nonrheumatic Aortic (Valve) Stenosis Dilated Cardiomyopathy, Chronic Atrial Fibrillation, Unspecified, Atrial Fibrillation Heart Failure, Unspecified Primary Generalized (Osteo) Arthritis Muscle, Weakness (Generalized), Other Abnormalities of Gait And Mobility On 10/10/2025 at 1:07pm R4 observe sitting in her room in wheelchair, wearing glasses, dressed, groomed and wearing shoes. Alert and confused but able to answer simple questions. R4	A4010		

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A4010	Continued From page 8	A4010		

stated, she does not know if she has fallen, but she does not think so, but she found herself on the floor and does not remember what happened. R4 stated, she can stand up. R4's room clean, without clutter or debris. Floor mats observed in room.

On 10/10/2025 at 1:39pm E9, Care Manager stated, R4 is alert, likes to stand up so you have to watch her. she is weak so she is not allowed to walk.

R5 is a 78-year-old female, initial move in date of 8/23/2025 with diagnoses of Vascular Dementia, Unspecified Severity, With Agitation

On 10/11/2025 at 11:25am during tour of memory care unit, R4 sitting in activity room in wheelchair, wearing glasses, dressed, clean, alert and wearing shoes. R3 sitting in activity room alert but confused, talking, groomed, dressed, and wearing shoes. Observed no staff supervision with residents in activity room. R5 observed sitting in activity room without staff supervision. During this time E2 walked into activity room and stated, there should always be staff supervision when residents are present. E2 stated, staff is taking residents to dining room to eat. E2 asked again, if activity room should have staff member present when a resident is in the room. E2 stated, yes for resident safety.

On 10/11/2025 at 11:55am E11, Lead Care Manager stated, we are supposed to be with residents and not leave residents alone in the dining room or activity room. When residents are going to dining room from activity, someone bring resident to dining room and someone stays in the activity room with the resident. Sometimes we will ask the nurse to watch the residents if busy.

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A4010	Continued From page 9 Facility Policy: Individualized Service Plan dated 5/15/25 documents in part: Responsible Parties: Executive Director, Resident Care Director, Team Members Policy Statement: It is the policy of the community to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, This community supports the resident's right to be informed of, and participate in, his or her care planning and treatment (implementation of care). Definitions: Service Plan -An individualized plan of care developed by evaluating/assessing the resident. The plan addresses advanced directives, allergies and interventions to meet the preferences, psychosocial, cognitive, physical, safety and functional needs of the resident. Procedure:1. The Resident Care Director (RCD)/Licensed Nurse (LN) ensures that each resident has an Individualized Service Plan (ISP) 3. The ISP is reviewed and updated: c. Additional revisions shall be made with changes in needs and/or at the resident or resident's responsible party request. 4. ISP development is a collaborative process with input from an Interdisciplinary Team (IDT) that may include but is not limited to: a. Resident, resident's responsible party or family i. The resident has the right to or not to invite/include individuals of their choice to participate in the service planning process. 5. The service plan must address the individual needs, activities of daily living, preferences, and strengths of the resident. The service plan must be designed to help the resident maintain the highest possible level of physical, cognitive, and social functioning. a. Information from the most current comprehensive assessment or evaluation shall be used to establish an individualized service plan. b. Input	A4010		

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from resident / responsible party. 7. Documentation: d. The IDT prints and signs the ISP as required by state/province regulations. e. The resident and/or responsible party signs the ISP as required by state/province regulation.

Fall Management Program V3.1 dated 8/2022 documents in part: Preamble INTRODUCTION The impact of falls on older adults can be serious. The Fall Management Program helps community team members identify residents at risk of falling, address identified risks in the resident's Service/Care Plan and determine root cause after a fall so interventions can be put into place to prevent recurrence. Like many complex tasks, it takes a team to succeed. Every team member, resident, family member, and health care provider play an important role in preventing and managing falls. GOAL The goal of this program is to help residents attain or maintain their highest level of well-being and prevent and/or manage falls. OBJECTIVES Using evidence-based interventions, standards of practice, and the APIE methodology, this guideline helps the resident care team to: Identify residents who are at risk for falls Implement interventions to help prevent falls Ensure a focus on a safe environment and reduce the likelihood of injury from a fall TABLE 1 - INTRINSIC & EXTRINSIC RISK FACTORS Cognitive impairment Confusion/disorientation Impaired balance Impaired mobility Prior history of falling V. Roles and Responsibilities It is the responsibility of every Sunrise team member, regardless of position or department to: Support the rights of residents Assist in managing resident fall risk Promote a safe environment for our residents.

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A6000	Continued From page 11	A6000		
A6000	Section 295.6000 Resident Rights	A6000		

This Regulation is not met as evidenced by:
Type 2 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:

1) The right to live in an environment that promotes and supports each resident's dignity, individuality, independence, self-determination, privacy, and choice and to be treated with consideration and respect;

2) The right to respect for bodily privacy and dignity at all times, especially during care and treatment;

5) The right to receive the services specified in the service plan, to review and renegotiate the service plan at any time; and to be informed of the cost of the changes;

6) The right to direct his or her own care and negotiate the terms of his or her own care;

8) The right to exercise free choice in selected activities, schedules, and daily routine;

12) The right to be free of chemical and physical restraints;

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A6000	Continued From page 12 This requirement is NOT MET as evidenced by: Based on interview and record review, the facility failed to ensure Resident (R1) was free from physical restraints and ensure Resident (R2) was treated with dignity, allowed freedom of choice, and received services as outlined in the service plan. This deficient practice affected two of three residents (R1 and R2) reviewed for resident rights. This failure creates a substantial probability of harm to a resident or residents. Findings include: R1 was an 88-year-old male with medical diagnoses that include Dementia In Other Diseases Classified Elsewhere, Unspecified Severity, Without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, And Anxiety, Type 2 Diabetes Mellitus With Diabetic Neuropathy, Unspecified, Muscle Weakness (Generalized), Type 2 Diabetes Mellitus Without Complications, Essential (Primary) Hypertension, Nontraumatic Subdural Hemorrhage, Unspecified, Nontraumatic Subarachnoid Hemorrhage, Unspecified R1 was admitted on hospice and expired in the memory care unit of the facility on 10/9/2025. R1 was dependent on staff for all ADLs (activities of daily living). Establishment provided incident report with incident date of 9/19/2025 which documents in part that R1 had an unwitnessed fall at bedside and head/neck had limited in range of motion due to bed mobility device. Action Taken: R1's upper body and head carefully assisted away from beside mobility device and lowered to the floor by E17, Care Manager. 911 was called due to	A6000		

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limited responsiveness. R1 was transferred to local hospital and returned bac to community on 9/20/2025 with diagnosis of fall. Intervention: Bedside mobility device immediately removed. Hospice was advised to provide an ultralow hospital bed and thick bedside floor mats. Outcome of incident: R1 returned back to community evening of 9/20/2025. Investigation completed. E17 clarified that R1's body was not limited in mobility by the bed device. R1 was observed facing his bed, on his knees, with chin resting against the bed mobility device. It was also further clarified that resident was verbally responsive but appeared more tired than his baseline. Resident remains in stable condition post incident.

R1's Service Plan Report dated 9/9/2025 in part Focus Mobility and Transferring Needs Date Initiated: 9/9/2025 Goal My mobility needs will be met through the next review date Date Initiated: 9/9/2025 Interventions I need physical assist of 1 person with mobility Date Initiated: 09/09/2025 need physical assist of 2 persons with transferring using mechanical lift Date Initiated: 09/09/2025

Focus Fall risk Date Initiated: 9/9/2025 Goal My risk for falls will be minimized through the next review date 9/9/2025 Interventions Provide me with a safe environment (Specify: support/assistive devices are available and in good repair, bed in lowest position t night, device within reach)

Focus I have had an actual fall Date Initiated: 9/9/2025 Revision on:10/62025 Goal My fall risk will be minimized by (Increased Supervision, Individualized Activities, ETC.) through the next review date Intervention Bedside mobility device

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immediately removed. Hospice was advised to provide an ultralow hospital bed and thick bedside floor mats. Bed is to be in the lowest position and floor mats next to bed. Date Initiated 9/19/2025

There is no documentation on service plan regarding bedside mobility device until 9/19/2025 which states to remove bed mobility device immediately which is the day R1 had an unwitnessed fall.

On 10/10/2025 at 3:06pm E4, LPN Med Care Manager stated, I remember when R1 fell, I was the nurse. I was called to memory care by E17, Care Manager because of fall. When I came into R1's room, I saw R1 laying on right side with a pillow under his head. E17 was with him. E17, told me how she found resident. There was a little rail on his bed, so I checked his vitals, and he did not respond to me, but was breathing but not responsive to me so I immediately called 911. E17 said, he was on his knees and his head was on the bed, not on the floor and slightly turned to bed rail. I assume he might have been restrictive breathing. I called 911 because I was concerned with position they found him. She explained to me that his body was on the floor and his neck and head in the bed rail. I wanted him to be evaluated and he make sure he did not have any oxygen restriction. E17 told me she took him to the floor from the back and lowered him to the floor and put pillow under his head. It was a short bed rail. R1 could easily sit down and lay down, he could grab, and it could help him get up easier, not a restrictive bed rail. When he returned from the hospital, the bed rail was not put back. It was not put back because of safety concerns. It was not clear if he was caught between mattress and bed rail, so to avoid a repeat of fall, we did not put the side rail back. Just used mattresses next to bed

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and keep bed in low position, we do not use side rails. He did not have floor mattress at that time, hospice does assessment and will provide fall mats and hospital bed. I think he was in a hospital bed, but it was not in the lowest position. This was the first time I took care of him. Residents are put in bed and care managers will monitor residents and I am called if they need nurses' assistance.

On 10/10/2025 at 3:33pm E17, Care Manager stated, I am familiar with R1. I was here the day he fell. I walked into his room to do his laundry. I found him halfway on the floor and halfway in his bed and bed was all the way lowered. His neck was partially between the side rail and the bed and that is probably why his body was partially on the floor and his head on the side rail. His neck was in between the side rail of the bed. I had to lift him out of there and set him on the ground. He was not able to say what happened. He said, I do not know. He was completely immobile, and we used a mechanical lift for him. I am not sure why he had side rails, that was the first time I took care of him and barely knew anything about him. I put him to bed that night and I put a pillow underneath the fitted sheet to prevent him from sliding off the bed. When I found him, the pillow I had put underneath the fitted sheet was on the floor. He had one side rail towards the wall and one on the opposite side, they were small and square. I do not think other residents use side rails we usually lower the bed and put a big black pad on the side of the bed and sometimes we will double the black pad on top of each other. There was not a pad in his room and the next time I took care of him there was a black pad, and his bed was low, and he did not have side rails. I am not sure why he had side rails. They were just on his bed in his room when I walked in to take care

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of him. When I came into work that day, he was new and no one communicated why he had side rails, or he need that high level of assistance. We do crossover and update but nothing about mechanical lift or side rails was mentioned. That is why I use a pillow because I thought he was at risk for falling and I assumed the rails were there to help him. When I found him, he was not talking and say maybe a few words. I called the nurse, and E4 came, and others came to help out. He was sent to the hospital. I did fill out an incident report and took his vitals. I was not trained on side rails.

On 10/11/2025 at 12:33pm E2, Resident Care Director (RCD) stated, I am familiar with R1. E17 observed R1 kneeling on the floor and leaning on the mattress and head leaning on the halo bar. His body was down, and he was kneeling on the floor. E17 lowered him to the floor and called the nurse. The nurse did assessment and she sent him to the hospital to make sure he was okay. R1 came back the following day and no injuries and had history of subdural hematoma and he was fine. Halo bar is like a circle with a square. Hospice provided it for him to move around. it was not a side rail; it is screwed on the bed. R1's head and neck resting against the mobility device. Care managers are not supposed to move them until the nurse comes. The nurse needs to make sure there is no further injury. Device was removed because incident that occurred. He then received a thick fall mat and bed that could be lowered and had hospice evaluate if he needed halo bar or not. I did not document, the hospice nurse and Durable Medical person (made sure bed could go all the way down). I was there and we discussed what interventions to put in place. All staff nurses and care givers are educated, and town hall meetings

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are educated on fall policy, and we continue to educate.

On 10/11/2025 at 1:53pm E2 stated, education is not only for fall prevention but for turning and bed always in lower position. Just safety protocol. For halo bar. Regarding documentation of training for device and hospice documentation for assessment for device, E2 stated, they do not keep hospice documentation it was discarded. E2 stated, we do not use restraints.

R2 is a 67-year-old female, initial move in date of 8/18/2025 with diagnoses of Pain, Unspecified, Gastro-Esophageal Reflux Disease Without Esophagitis, Constipation, Unspecified Postural Orthostatic Tachycardia Syndrome [Pots], Essential (Primary) Hypertension

On 10/10/2025 at 1:57pm R2 was sitting in lobby with walker, dressed, groomed, wearing shoes. R2 is alert and oriented and able to make needs known. R2 stated, she does not want facility to retaliate against her. R2 stated, there was a medication mix-up and the nurse got upset when I refused to take the wrong medication. I am not dependent on staff to take my medication. When I came, I wanted to do self-administration. I do not need help. I keep track of my medications. They treat us like we are children. On September 20, 2025, E12, LPN Med Care Manager came into my room and woke me up and said take these meds. I asked her what the meds were for because it was a different medication than I take. I told her I could not take the meds because that medication was not my medication, and the medication was for another resident. I told the nurse that and she then took the medication and left my room. I do not trust them to give me my medication. I cannot remember the nurses name,

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but it was in the morning on September 20, 2025. If I had not said anything, she would have given me the wrong medication. I do not feel safe with them giving me my medication. There was confusion with my Tramadol and Oxycodone but it was corrected with my doctor and my doctor said I could take my own medication. I have my medication and I am able to take myself. I am not sure how the nurse had the wrong patient because my name is on my door and my room number is on my door. I do have a pendant and will use it, if I need help. I told E2 that a nurse tried to give me the wrong medication and nothing was done. The administration here is not helpful.

On 10/11/2025 at 12:23pm E12, LPN Med Care Manager stated, I usually work in memory care, but I remember R2 she lives in AL. E12 stated, she worked in Assisted Living (AL) on 9/20/2025 and she was unfamiliar with working over there. She had a one-day training prior to working there on 9/20/2025. I worked in that area by myself went into R2's with med packets and open meds in front of the resident. When I went in the room, she said no that is not my medicine and I asked to confirm her name and in fact that was not her medication, so the medicine was never opened and I apologized and left room. She said she takes her own medicines. I was not familiar with residents. I used the master key to access room just in case resident is tired or cannot hear. I do not remember if I did an incident report or reported it to E2.

On 10/11/2025 at 12:33pm E2, Resident Care Director (RCD) stated, I am familiar with R2, she is new. I am not aware of her being awaken and nurse attempted to give her the incorrect medication. R2 is a standby assist for showers,

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female only. We will offer different time of day and reschedule. If a resident refuses a shower, can offer a different time and work with resident to come up with a different time. I am not aware R2 is not getting showers. If this is consistently happening, we should be calling the family and seeing what is going on. I am not sure what happened. We have to call the POA (Power of Attorney) and talk to R2 and see how we can make it happen to see what is going on and see if she prefers another day and time. Care manger should notify the nurse and service plan updated based on needs of the resident. I need to check with the care managers. This should have been flagged to us if a refusal we need to take action. E3, Resident Care Coordinator and I work together to update service plans. R2's service plan has not been updated regarding a shower. If the nurse went into R2's room to give medication that was not the resident's E12 should have reported that to me and an incident filled out.

On 10/12/2025 at 9:52am E15, Care Manager stated, I am familiar with R2. I have been telling E3 (Resident Care Coordinator) to change her showers and she only wants a female. I told my lead caregiver (E16) too. When I marked refuse or not available, she does not refuse her showers she just prefers a female and for her showers to be in the morning. I work the evening shift usually on Wednesday and she says I do not want to take a shower on the evening shift, I want a shower in the morning. I told E16 Lead Care Manager about it, and she has been telling E3 and it still stays the same. E3 is the one that takes care of the scheduling. We have been telling him. I never told E2 because I have always been told to report to E3. I would like to get this changed for R2. If R2 wants to take her shower in the morning and she wants a female, she

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should get what she wants.

On 10/12/2025 at 3:00pm E13, Care Manager stated, I usually work on AL side. I have taken care of R2 a couple of times. I never had her on my assignment I was helping out and taking food to her. I worked on assignment when I first trained. I never had to give her a shower. I do not know why my name is on her POC (Plan of Care). POC Documentation and assignment sheets for 9/17/2025 and 9/28/2025 shows E13 was R2's care manager for evening shift and verified with E2.

On 10/12/2025 at 3:49pm E3 (Resident Care Coordinator) stated, I am familiar with R2. R2 keeps refusing her showers. I tried to reschedule her showers, but she keeps refusing. R2 can get a shower when she wants to. She only wants female care givers to help with her shower. If a male caregiver is assigned, they will switch residents to accommodate resident. I have had conversations with R2 about her showers about two to three weeks ago. I did not document our conversation; I did not document anything. I am not sure if the caregivers told me or not that she wanted to change her shower days and only wants a female caregiver. I did not document anything in her medical record. If a resident refuses, the caregiver should ask the resident why they are refusing and try to come back and see if resident will take a shower later. They also document in POC and everyone will see it. I am the one to follow up with the resident and update the service plan. E3 verified that E13, E15, and E18 are male care givers. Usually, the female caregiver will help with the female and the male will take care of the male. They are supposed to go and ask resident because they are male caregivers. If they documented refused that

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means they asked the resident. I asked if she wants the shower in the morning and she said she was fine with day and time. I am not sure if they told me or not, but I spoke to her because of the refused shower but R2 stated she wanted to keep the same date and time. I did not document anything in the record.

Service Plan Report dated 8/18//2025 in part shows, Focus: date initiated 8/18//2025, Goal: date initiated 8/18//2025, Interventions: Date Initiated: 8/18//2025. Date of when R2 signed left blank.

R2's shower documentation Survey Report September 25 in part shows Intervention/Task Bathing Sunday and Wednesday PM (3-11) standby female only, RR= resident refused, NA = resident not available, M= Male, F= Female Shower dates: 9/3/2025 (F), 9/7/25 RR (F), 9/10/025 NA (M), 9/14/2025 (left blank), 9/17/25 RR (M), 9/21/25 RR (M), 9/28/2025 RR (M), 10/1/2025 RR (M), 10/5/2025 (F), 10/8/2025 NA (M)

R2's POC (Plan of Care) Response History shows: Resident R2, Task: Bathing Sunday and Wednesday PM standby female only
BATHING: SUPPORT PROVIDED - How resident takes full-body bath/shower, sponge bath, bed bath and includes transfers in/out of tub/shower (excludes washing of back and hair)
R2's Task History shows:
Bathing Sunday and Wednesday Pm standby female only Revision Date: 8/22/2025 By E3
Bathing Sunday Pm standby female only Revision Date: 8/22/2025 By E3
Bathing Sunday Pm Revision Date: 8/22/2025 By E3
Bathing (prefers: specify) Revision Date:

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A6000	Continued From page 22 8/18/2025 By E2 Facility Policy Bed Safety Program v2.0 Assisted Living (2-19) documents in part: Between 1985 and 2013 the FDA documented 901 incidents of life threatening bed entrapments in the US. Of those reports, 531 resulted in death. These entrapment events have occurred in openings within the bed rails, between the bed rails and mattresses, under bed rails, between split rails, and between the bed rails and head or foot boards. Entrapment - describes an event in which a resident is caught, trapped, or entangled in the space in or about the bed rail, assistive devices. Restrictive/Mechanical Devices - are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body. Key Body Parts at Risk for Entrapment three key body parts at risk for life-threatening entrapment. The three key body parts at risk are the head, neck, and chest. Neck To reduce the risk of neck entrapment, openings in the bed system should not allow a small neck to become trapped. The entrapment zones and measurement evaluations can apply to any installed assistive device, such as the Halo Safety Ring. Sunrise does not approve of the utilization of side/bed rails in our communities. Assessment Considerations: If the resident is a fall risk, consider: Position the bed in the lowest position, When the individual is at risk of falling out of bed, place mats next to the bed; How often the resident should be monitored or checked on, Implementing a raised perimeter mattress/cover (the resident must be able to independently exit the bed). A resident is evaluated to be unsafe in	A6000		

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bed, or at high risk for injury, as defined by these factors or possible underlying conditions: cognitive/mental status changes, ability to adequately communicate needs or problems, inability to transfer safely to and from the bed to a wheelchair. The Resident's ISP should include the following: Type of assistive device being used, Reason for the use of the assistive device, When to use the assistive device, Monitoring and resident specific care instructions, Difficulties or changes in the residents ability to utilize the device, Changes to the resident's bed environment, including the addition or removal of assistive devices. SECTION 4: EVALUATION Monitoring and Evaluating the Effectiveness of the Plan: Based on the date set for each goal, determine if goals/outcomes were achieved per resident with a bed system/assistive device. Were the assistive device interventions effective? Updated or revise the ISP as needed. If a resident has a significant change in condition re-evaluate the bed system/assistive device. Training/Educational Requirements Direct care team members are to be trained on the Bed Safety Program. Frequency of Training Upon hire of a new Team Member, Annually, After incidents involving an assistive device

Fall Management Program V3.1 dated 8/2022 documents in part: Preamble INTRODUCTION The impact of falls on older adults can be serious. The Fall Management Program helps community team members identify residents at risk of falling, address identified risks in the resident's Service/Care Plan and determine root cause after a fall so interventions can be put into place to prevent recurrence. Like many complex tasks, it takes a team to succeed. Every team member, resident, family member, and health care provider play an important role in preventing and

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	ASL5105843	A. BUILDING: _____ B. WING _____	C 10/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF PROSPECT HEIGHTS	708 N ELMHURST ROAD PROSPECT HEIGHTS, IL 60070

(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
A6000	Continued From page 24 managing falls. GOAL The goal of this program is to help residents attain or maintain their highest level of well-being and prevent and/or manage falls. OBJECTIVES Using evidence-based interventions, standards of practice, and the APIE methodology, this guideline helps the resident care team to: Identify residents who are at risk for falls Implement interventions to help prevent falls Ensure a focus on a safe environment and reduce the likelihood of injury from a fall TABLE 1 - INTRINSIC & EXTRINSIC RISK FACTORS Cognitive impairment Confusion/disorientation Impaired balance Impaired mobility Prior history of falling V. Roles and Responsibilities It is the responsibility of every Sunrise team member, regardless of position or department to: Support the rights of residents Assist in managing resident fall risk Promote a safe environment for our residents.	A6000		