STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510346	A. BUILDING: _____ B. WING _____	C 10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF FLOSSMOOR	19715 GOVERNOR'S HWY FLOSSMOOR, IL 60422

(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
A 000	Initial Comment Complaint Investigation: 25910138/IL198097- 295.2050a)b)	A 000		
A2050	Section 295.2050 Incident and Accident Reporting This Regulation is not met as evidenced by: TYPE 3 VIOLATION Section 295.2050 Incident and Accident Reporting a) An establishment shall report to the Department an incident or accident that has a significant negative effect on a resident's health, safety or welfare. A significant negative effect shall be assumed whenever an unplanned or unscheduled visit to a hospital is necessary as a result of that incident or accident, treatment is provided, and follow-up care is required. b) The report shall be made by contacting the Department of Public Health Central Complaint Registry or by fax or by other electronic means within 24 hours after the occurrence of the incident or accident. These requirements were NOT MET as evidenced by: Based on record review and interview, the establishment failed to ensure that a fall incident was reported to the state agency. This was found in 1 of 3 residents (R1) reviewed. Findings Include: R1 was admitted to the establishment on 4/23/23.	A2050		

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A2050	Continued From page 1 R1 was receiving hospice care services. R1 expired on 4/25/25. An interview was conducted with Z1 (daughter) on 10/27/25 at 9:57 AM stated ," On 4/25/25 from 1:00 AM to 5:00 AM, R1 was observed lying on the floor in her room. The observation was from a video camera that was installed in R1's room. Z1 sustained abrasions to the face,wrists; perhaps falling on the shoulder. E 1 (Executive Director), E2 (Director of Resident Care) and E3 (Resident Care Coordinator) were all notified of the fall." An interview was conducted with E1 on 10/27/25 at 11:07 AM stated," Observed the video footage of R1's fall from 4/25/25. E6 (Lead Care Manager) did not document R1's fall in a timely manner.. The identified bruises were consistent with a fall injury." The personnel file of E6 was reviewed on 10/28/25. E6 was terminated on 5/5/25 for not documenting R1's fall incident of 4/25/25. The establishment did not complete an incident report and did not report R1's 4/25/25 fall with injury to the state agency within 24 hours after occurrence.	A2050		