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 10/22/2025

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

(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 Investigation IL00198145 conducted on 10/22/2025. Type 1 Violation: 295.6000 a) 1) 2) 13)	A 000		
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: 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; 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:	A6000		

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A6000	Continued From page 1 Based on interview and record review, the establishment failed to ensure that a resident was free from physical abuse. This failure involves 1 of 3 residents reviewed for this requirement (R1). This failure resulted in R1 being physically abused by staff (E1). This failure has the probability to affect all residents in the establishment. This failure creates a substantial probability of severe harm to a resident or residents Findings include: R1 has a diagnosis of dementia and is oriented to person and place only. During an interview with E2 (Executive Director) on 10/22/2025 at 11:21 AM they stated, "This is still an open investigation. We actually have a call about this in 10 minutes." During an interview with E3 (Resident Care Director) on 12/22/2025 at 12:17 PM they stated," "[E1] is suspended. We are calling her today to terminate her. The abuse was not substantiated but because of her demeanor toward residents we just decided she was not a good fit." During an interview with E4 (Care Manager) on 10/22/2025 at 1:28 PM they stated, "The concierge, she called me to assist [R1] because he was disrespectful to a server. I came and talked nicely to him to get him to leave the dining room. He didn't want to leave because he hadn't finished his coffee. So I said we could take his coffee to his room for him. He agreed. Then [E1] said "Don't treat him like a child." He turned to [E1] and she grabbed his hand and said "Don't touch me". He went with me to his room no	A6000		

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A6000	Continued From page 2	A6000		

problem. There was no problem after we got to his room. I spoke to [E1] and told her she needed to work on communication with the residents. We just need to be patient with them."

During record review on 10/22/2025 at 10:04 AM R1's 10/15/2025 incident report was reviewed. The report states the investigation is still pending. The report states, "On 10/16/2025, a witness, [E4] came forward and stated that the resident reached out to touch the server and that the server grabbed resident "firmly" and told him not to touch her. She reported that the resident never actually made physical contact with the server before she had grabbed his hand ... Upon skin assessment, 3 small bruises were seen to residents L hand. This writer asked the resident where the bruises came from, he reported they were from his watch (watch was seen on L wrist)." The report was sent to the Illinois Department of Public Health (IDPH) within 24 hours of the establishment being informed of the incident. Other establishment incident reports were reviewed and found to also have been sent within the required 24 hour reporting window.

During record review on 10/22/2025 at 11:25 AM the establishment's abuse policy was reviewed and deemed appropriate. This policy defines abuse as "infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish."

During record review on 10/22/2025 at 12:03 PM R1's progress notes were found to corroborate the report sent to IDPH. Three small bruises were documented on R1's left hand. R1's representative was notified of the incident.

During record review on 10/22/2025 at 12:26 PM

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A6000	Continued From page 3 R1's service plan was reviewed and updated on 10/18/2025 after the incident and again on 10/21/2025. R1's service plan addressed R1's mood, behavior, and skin integrity. During record review on 10/22/2025 at 12:29 PM R1's progress notes documented that R1 was assessed by a physician in the establishment on the same day, after the incident. During record review on 10/22/2025 at 12:40 PM E1's employee file was reviewed. E1's date of hire was 7/26/2024. E1's background check was valid and current. E1 had all required training completed. During record review on 10/22/2025 at 12:45 PM it was found that E1 had 4 disciplinary meetings for excessive and unexcused absences and no call/no shows. There were no disciplinary meetings regarding abuse. During record review of the establishment's summary of statements on 10/22/2025 at 1:10 PM it was found that on 10/17/2025 E1 admitted to grabbing R1's hand. During record review on 10/22/2025 at 1:20 PM the establishment's 2025 resident council minutes were reviewed. There were no abuse concerns noted.	A6000		