| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | ASL510347 | A. BUILDING: _____ B. WING _____ | 04/09/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNRISE OF FOUNTAIN SQUARE | 2210 FOUNTAIN SQUARE LOMBARD, IL 60148 |

| (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<br><br>Annual Licensure Survey Conducted | A 000 | | |
| A2040 | Section 295.2040 Disaster Preparedness<br><br>This Regulation is not met as evidenced by:<br>Annual Licensure Survey<br>Entrance 4/3/25, Exit 4/9/25<br><br>Type 3 Violation<br><br>Section 295.2040 Disaster Preparedness<br><br>c) At least six drills shall be conducted per year on a bimonthly basis. At least two of the drills shall be conducted during the night when residents are sleeping. All drills shall be held under varied conditions to: ...<br><br>e) Drills shall include residents, establishment personnel, and other persons in the establishment ...<br><br>g) Drills shall involve the actual evacuation of residents to an assembly point as specified in the emergency plan and shall provide residents with experience using various means of escape. If an establishment has an evacuation capability classification of impractical, those residents who cannot meaningfully assist in their own evacuation or who have special health problems shall not be required to participate in the drill; however, other requirements of the Life Safety Code will apply.<br><br>h) A written evaluation of each drill shall | A2040 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | ASL510347 | A. BUILDING: _____ B. WING _____ | 04/09/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNRISE OF FOUNTAIN SQUARE | 2210 FOUNTAIN SQUARE LOMBARD, IL 60148 |

| (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 |
|---|---|---|---|---|
| A2040 | Continued From page 1<br>be submitted to the establishment manager and shall be maintained for one year from the date of the drill. The evaluation shall include the date and time of the drill, names of employees participating in the drill, and identification of any residents who received assistance for evacuation.<br><br>This requirement was not met, as evidenced by:<br><br>Based on interview and record review, the establishment failed to show documentation that residents were included in all drills. They failed to document any resident who received assistance for evacuation during drills on the written evaluation.<br><br>The findings include:<br><br>On 4/7/25, establishment tornado and fire drills were reviewed.<br><br>There was no documentation to show the following drills included residents:<br><br>-Fire drills - 8/22/24, 10/30/24, 12/18/24, 1/23/25, 2/13/25, and 3/25/25<br><br>There was no documentation to show which residents received assistance for evacuation during the following drills:<br><br>-Tornado drills - 2/2/25, 2/18/25, 2/12/25<br><br>-Fire drills - 8/22/24, 10/30/24, 12/18/24, 1/23/25, 2/13/25, and 3/25/25 | A2040 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | ASL510347 | A. BUILDING: _____ B. WING _____ | 04/09/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNRISE OF FOUNTAIN SQUARE | 2210 FOUNTAIN SQUARE LOMBARD, IL 60148 |

| (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 |
|---|---|---|---|---|
| A2040 | Continued From page 2<br>On 4/7/25, E2 (Resident Care Director), confirmed the findings. | A2040 | | |
| A3000 | Section 295.3000 Personnel Requirmts, Qualifns, and Trng<br><br>This Regulation is not met as evidenced by:<br>General Violation<br><br>Section 295.3000 Personnel Requirements, Qualifications and Training<br><br>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)<br><br>b) The establishment shall have on duty at all times at least one direct care staff person who has obtained cardiopulmonary resuscitation (CPR) training specific to adults, which includes a demonstration of the individual's ability to perform CPR, and who has current certification in CPR.<br><br>This requirement was not met, as evidenced by:<br><br>Based on interview and record review, the establishment failed to ensure at least one direct care staff person who has obtained cardiopulmonary resuscitation (CPR) training specific to adults, which includes a demonstration of the individual's ability to perform CPR, was on duty at all times. This applies to all residents who | A3000 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | ASL510347 | A. BUILDING: _____ B. WING _____ | 04/09/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNRISE OF FOUNTAIN SQUARE | 2210 FOUNTAIN SQUARE LOMBARD, IL 60148 |

| (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 |
|---|---|---|---|---|
| A3000 | Continued From page 3 | A3000 | | |

reside in the establishment. This failure creates a substantial probability of severe harm to a resident or residents, in that staff who did not demonstrate the ability to perform CPR may not perform it adequately or correctly in an emergency situation.

The findings include:

During the annual licensure survey, the establishment nurse and caregiver schedules were reviewed for 2/1/25-4/3/25 and compared with CPR certified staff. The review showed there was no direct care staff on duty with (CPR) training specific to adults, which included a demonstration of the individual's ability to perform CPR, or who had current certification in CPR, for the following dates/time:

8:00 PM - 7:00 AM on 2/1, 3/11, 3/12, 3/15, 3/25, 3/26, and 3/29

On 4/3/25, E11's (Licensed Practical Nurse) CPR certification - American Health Care Academy, Date Completed 3/14/24, Valid Until 3/14/26, was an online course with no return demonstration. On 4/7/25, E2 (Resident Care Director) provided E11's updated CPR certification with return demonstration - National CPR Foundation, Date 4/3/25, Renew 4/3/27. E11 was scheduled from 8:00 PM - 7:00 AM on the above dates, and the establishment could not provide documentation to show those dates were covered for CPR.

On 4/7/25, E2 provided E12's (Lead Care Manager) CPR certification - American Heart Association, Issue Date 2/15/23, Renew by 02/2025. The March 2025 care partner schedule showed E2 worked on 3/25 and 3/26, but E2's

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | ASL510347 | A. BUILDING: _____ B. WING _____ | 04/09/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNRISE OF FOUNTAIN SQUARE | 2210 FOUNTAIN SQUARE LOMBARD, IL 60148 |

| (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 |
|---|---|---|---|---|
| A3000 | Continued From page 4<br>CPR certification expired at the end of February.<br><br>On 4/8/25, E2 confirmed she provided all CPR certifications and could not verify CPR coverage for the above dates/time.<br><br>On 4/8/25, E1 (Executive Director) was not aware of the requirement for return demonstration. | A3000 | | |
| A4010 | Section 295.4010 Service Plan<br><br>This Regulation is not met as evidenced by:<br>Type 2 Violation<br><br>Section 295.4010 Service Plan<br><br>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)<br><br>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) ...<br><br>g) Service plans shall address:<br><br>1) The level of service the resident is receiving, including: | A4010 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | ASL510347 | A. BUILDING: _____ B. WING _____ | 04/09/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNRISE OF FOUNTAIN SQUARE | 2210 FOUNTAIN SQUARE LOMBARD, IL 60148 |

| (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 |
|---|---|---|---|---|
| A4010 | Continued From page 5<br>A) assistance with activities of daily living;<br><br>B) dietary needs, if the establishment provides therapeutic diets; and<br><br>C) special accommodations for the resident;<br><br>2) The amount, type, and frequency of health-related services needed by the resident;<br><br>3) Staff responsible for the provisions of the service plan;<br><br>4) Any risk being negotiated; and<br><br>5) Whether the resident requires medication reminders, supervision of self-administered medication, or medication administration.<br><br>h) The service plan shall include all support services provided or arranged for by the establishment ...<br><br>This requirement was not met, as evidenced by:<br><br>Based on interview and record review, the establishment failed to follow their policy and state regulation when they did not individualize the plan of care to the residents needs and address health related services. They did not address the reason for and use of psychotropic medications, opioids, and blood thinners. They did not address dietary needs. They did not review the service plan and update interventions with each fall incident. This applies to 8 of 9 residents (R1, R2, R3, R5, R6, R7, R8, R9) | A4010 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | ASL510347 | A. BUILDING: _____ B. WING _____ | 04/09/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNRISE OF FOUNTAIN SQUARE | 2210 FOUNTAIN SQUARE LOMBARD, IL 60148 |

| (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 |
|---|---|---|---|---|
| A4010 | Continued From page 6 | A4010 | | |

reviewed for this requirement. This failure creates a substantial probability of harm to a resident or residents, in that it cannot be determined that the establishment is aware of the needs and safety concerns of the residents.

The findings include:

During the annual licensure survey, the service plan for R1-R9 was reviewed and the following concerns were found:

1. R1's medical record showed R1 moved into the establishment on 4/1/25 and has multiple diagnoses, including diabetes mellitus type 2, atherosclerotic heart disease, and partial traumatic amputation of right foot.

R1's Brief Interview for Mental Status (BIMS), dated 4/2/25, showed R1 is cognitively intact.

R1's Service Plan, dated 4/3/25, showed R1 self-administers medications.

R1's Service Plan did not accurately address R1's dietary needs. R1's service plan showed "Provide me with the diet as ordered by my physician (REGULAR DIET)". R1's Order Summary showed a dietary order for "CCHO (controlled carbohydrate) diet Regular texture".

R1's Service Plan showed R1 is independent with insulin administration but did not indicate insulin is administered through subcutaneous injections and insulin pump, and R1 is responsible for management. R1's Order Summary showed R1 takes insulin Degludec (long-acting) via injection and Humalog and Novolog via insulin pump, through unsupervised self-administration.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | ASL510347 | A. BUILDING: _____ B. WING _____ | 04/09/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNRISE OF FOUNTAIN SQUARE | 2210 FOUNTAIN SQUARE LOMBARD, IL 60148 |

| (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 |
|---|---|---|---|---|
| A4010 | Continued From page 7<br><br>R1's Service Plan did not address the reason for and use of psychotropic medication and blood thinners and what to monitor for. R1's Order Summary showed R1 takes psychotropic medications - scheduled Duloxetine (antidepressant) and scheduled Trazadone (antidepressant), but R1 did not have a diagnosis of depression, so it was unclear if these were used for alternate therapeutic reasons. R1's Order summary showed R1 takes Eliquis (blood thinner). These medications increase risk of fall and or injury with falls, and R1's service plan showed R1 is a fall risk.<br><br>2. R2's medical record showed R2 moved into the establishment on 1/8/25 and has multiple diagnoses, including syncope and collapse, falls, osteoporosis, abnormalities of gait and mobility, and need for assistance with personal care.<br><br>R2's Service Plan, dated 1/9/25, showed R2's medications are nurse administered.<br><br>R2's Service Plan was not reviewed, and interventions updated for fall incidents. R2's Progress Note, dated 4/4/25 at 1:30 (PM), showed R2 fell in the bathroom, was unable to move all extremities, and was sent to the hospital for evaluation.<br><br>R2's Service Plan did not address the use of blood thinners and what to monitor for. R2's Order Summary showed R2 takes scheduled Eliquis (blood thinner). This medication increases the risk of injury with falls, and R2's service plan showed R2 is a fall risk and has a history of falls. | A4010 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | ASL510347 | A. BUILDING: _____ B. WING _____ | 04/09/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNRISE OF FOUNTAIN SQUARE | 2210 FOUNTAIN SQUARE LOMBARD, IL 60148 |

| (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 |
|---|---|---|---|---|
| A4010 | Continued From page 8<br><br>3. R3's medical record showed R3 moved into the establishment on 9/12/22 and has multiple diagnoses, including benign prostatic hyperplasia, chronic kidney disease stage 3, and hypertension.<br><br>R3's Service Plan, dated 2/28/25, showed R3's medications are self-administered.<br><br>R3's Service Plan did not address the use of straight catheter for urine collection and who is responsible for management. The establishment's survey binder identified R3 for the use of straight catheter on list of residents with catheters. On 4/8/25, E2 (Resident Care Director) confirmed R3 used a straight catheter.<br><br>R3's Service Plan did not address use of blood thinners and what to monitor for. R3's Order Summary showed R3 takes scheduled Xarelto (blood thinner). This medication increases the risk of injury with falls, and R3's service plan showed R3 is a fall risk and has a history of falls.<br><br>4. R5's medical record showed R5 moved into the establishment on 9/16/21 and has multiple diagnoses, including hypertension and retention of urine.<br><br>R5's Service Plan, dated 10/30/24, showed R5's medication are nurse administered.<br><br>R5's Service Plan did not address weekly weights and who is responsible for the provision. R5's Order Summary showed weekly weights every day shift every Tuesday.<br><br>5. R6's medical record showed R6 moved into the | A4010 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | ASL510347 | A. BUILDING: _____ B. WING _____ | 04/09/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNRISE OF FOUNTAIN SQUARE | 2210 FOUNTAIN SQUARE LOMBARD, IL 60148 |

| (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 |
|---|---|---|---|---|
| A4010 | Continued From page 9 | A4010 | | |

establishment on 8/11/21 and has multiple diagnoses, including right and left artificial hip joint, bilateral primary osteoarthritis of hip joint, chronic fatigue, and low back pain.

R6's Service Plan, dated 1/13/25, was not reviewed, and interventions updated for fall incidents. R6's Progress Note, dated 1/18/25 at 15:09 (3:09 PM), showed R6 had a fall that resulted in a bump to the head, but R6 was not sent out, per doctor's orders.

6. R7's medical record showed R7 moved into the establishment on 12/27/24, resides in memory care, and has multiple diagnoses, including hypertension, muscle weakness, falls, Parkinson's disease, and dementia.

R7's Service Plan, dated 12/27/24, was not reviewed, and interventions updated for fall incidents. R7's Progress Notes showed falls on 1/16/25, 1/30/25, 2/1/25, 2/27/25, 3/9/25, and 4/6/25.

7. R8's medical record showed R8 moved into the establishment on 12/10/21, resides in memory care, and has Alzheimer's disease.

R8's Service Plan did not accurately address R8's dietary needs. R8's service plan showed R8 has a regular diet with regular consistency. R8's Order Summary showed a regular diet with mechanical soft texture.

R8's Service Plan did not address the reason for and use of psychotropic medication and opioids. R8's Order Summary showed R8 takes scheduled risperidone (antipsychotic) for

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | ASL510347 | A. BUILDING: _____ B. WING _____ | 04/09/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNRISE OF FOUNTAIN SQUARE | 2210 FOUNTAIN SQUARE LOMBARD, IL 60148 |

| (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 |
|---|---|---|---|---|
| A4010 | Continued From page 10<br>dementia behaviors, as needed alprazolam (antianxiety) for anxiety, as needed Norco (analgesic opioid) for pain, and hospice comfort medications - as needed lorazepam (antianxiety) and as needed morphine (analgesic opioid). These medication increase the risk for falls, and R8's service plan showed R8 is a fall risk.<br><br>8. R9's medical record showed R9 moved into the establishment on 11/38/22, resides in memory care, and has multiple diagnoses, including general history of falling, anxiety disorders, altered mental status, and dementia.<br><br>R9's Service Plan did not address the reason for and use of psychotropic medication and blood thinners and what to monitor for. R9's Order Summary showed R9 takes scheduled escitalopram (antidepressant), as needed lorazepam (antianxiety), and Eliquis (blood thinner). These medications increase the risk for falls and/or injury with falls, and R9's service plan showed R9 is a fall risk.<br><br>The establishment's policy titled Individualized Service Plan (ISP) (Effective Date: 11/2/98) showed: Policy Statement ...Note: State/province specific requirements are followed. 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 ...Action Steps ...3) Documentation: ...c) The ISP is updated by the Department Coordinator and/or RCD (Resident Care Director)/HCM (Health Care Manager) as dictated by state/province | A4010 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | ASL510347 | A. BUILDING: _____ B. WING _____ | 04/09/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNRISE OF FOUNTAIN SQUARE | 2210 FOUNTAIN SQUARE LOMBARD, IL 60148 |

| (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 |
|---|---|---|---|---|
| A4010 | Continued From page 11<br>regulations.<br><br>On 4/7/25, concerns were reviewed and confirmed with E2 (Resident Care Director). | A4010 | | |