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SUNRISE OF NAPERVILLE NORTH	535 W OGDEN AVE NAPERVILLE, IL 60563

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A 000	Initial Comment Annual Licensure survey Violations: 295.2060 a) 295.3000 n) 295.3040 295.4010 e) g) 1) 2) h) 295.4060 i) 1) B) 2) i-v) C) i-x))	A 000		
A2060	Section 295.2060 Quality Improvement Program This Regulation is not met as evidenced by: Type 2 Violation Section 295.2060 Quality Improvement Program a) The establishment shall establish an effective quality improvement program that encompasses oversight and monitoring, resident satisfaction, and ongoing quality improvement and implementation of any plan that addresses improved quality services. The quality improvement process implemented by the establishment must benchmark performance, be customer centered, be data driven, and focus on resident satisfaction. (Section 30(a) of the Act) For the purpose of this Section, "benchmark" means creating points of reference from which measurements can be made. This requirement was not met as evidence by: Based on record review, policy review, and interview, the establishment failed to address: Dinning services, incorrect orders, service delays, food unavailability; and develop and implement a process to resolve these issues. This repeated failure of dining service concerns indicated in the	A2060		

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A2060	Continued From page 1 resident council meetings dated 12/22/2025 and 2/28/2026 creates a substantial probability of harm to residents. Findings include: On 4/22/26 at approximately 10:15 AM, the Resident Council meeting minutes were reviewed. The meeting minutes dated 12/22/2025 contained issues regarding, a nurse described as "unfriendly", dining service delays, incorrect orders, and residents told that certain food items were not available. The meeting minutes dated 2/28/2026 contained, "Repeated dining-room service failures occur: Wrong orders, premature order taking, misinformation, running out of menu items". The establishment's policy titled; Quality Assurance Performance Improvement" was reviewed on 4/23/26 approximately at 1:40 PM. The policy included, " ...The Executive Director is the QAPI (Quality Assurance Performance Improvement) Committee leader at the community and is responsible for overall quality leadership ... and facilitating QAPI meetings that focus on data rends, and the initiation of improvement action plans ..." The above findings were reviewed during an interview with E1 (Executive Director) , E2 (Resident Care Director), and E3 (Resident Care Coordinator) on 4/25/2026 approximately 1:30 PM. This writer asked if any of these concerns were addressed and resolved. E1 (Executive Director) responded, "No ..." As of 4/24/2026, the establishment failed to provide documentation on plans to address and improve the issues identified above.	A2060		

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A3000	Continued From page 2	A3000		
A3000	Section 295.3000 Personnel Requirmts, Qualifns, and Trng This Regulation is not met as evidenced by: Type 1 Violation Section 295.3000 Personnel Requirements, Qualifications and Training n) Prior to employing any individual in a position that requires a State professional license, the establishment shall contact the Illinois Department of Professional Regulation to verify that the individual's license is active. A copy of the verification shall be placed in the individual's personnel file. This requirement was not met as evidence by: Based on document review and interview, the establishment failed to ensure the license of the professional staff was verified by the Illinois Department of Financial and Professional Regulation (IDFPR). This was found in 16 of 17 (E2, E7, E11, E12, E13, E14, E15, E16, E17, E18, E19, E20, E21, E22, E23, and E24) personnel files of licensed staff that provide resident care. This failure creates a substantial probability of severe harm or death to residents. Findings include: On 4/22/26 at 10:13 AM, reviewed professional license verifications with E10 (Business Office Coordinator). The following nursing files lacked verification of the professional license with the IDFPR: E2 (Resident Care Director) hire date 7/26/2024.	A3000		

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A3000	Continued From page 3 E7 (Assisted Living LPN Med Care Manager) hire date 10/10/2008. E11 (Assisted Living LPN Med Care Manager) hire date 5/31/2023. E12 (Wellness LPN Med Care Manager) hire date 6/12/2024. E13 (Wellness LPN Med Care Manager) hire date 7/1/2024. E14 (Wellness LPN Med Care Manager) hire date 10/29/2018. E15 (Wellness LPN Med Care Manager) hire date 7/25/2022. E16 (Wellness Nurse - LPN) hire date 8/13/2024. E17 (Wellness LPN Med Care Manager) hire date 8/28/2024. E18 (Wellness LPN Med Care Manager) hire date 11/12/2024. E19 (Wellness LPN Med Care Manager) hire date 2/6/2025. E20 (Wellness Nurse - LPN) hire date 2/14/2025. E21 (Wellness LPN Med Care Manager) hire date 6/19/2025. E22 (Wellness LPN Med Care Manager) hire date 8/7/2025. E23 (Wellness LPN Med Care Manager) hire date 1/23/2026. E24 (Wellness LPN Med Care Manager) hire date 2/18/2026. On 4/22/2026 at 10:13 AM, an interview with E10 (Business Office Coordinator) that stated, "Professional licenses we check " ...", it's a public website that tells if unencumbered or encumbered, and their license number, active or inactive ... I only use this site, not the IDFPR because..." During the same interview, the above findings were confirmed.	A3000		

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A3040	Continued From page 4	A3040		
A3040	Section 295.3040 Health Care Worker Background Check This Regulation is not met as evidenced by: General Violation Section 295.3040 Health Care Worker Background Check An establishment shall comply with the Health Care Worker Background Check Act and the Health Care Worker Background Check Code. This requirement was not met as evidenced by: Based on interview and document review, the establishment failed to log into the Health Care Worker Registry Web Portal initially and/or annually, complete the Health care Worker Background process that includes employment verification, and maintain documents in the file per regulations. This was found in 3 of 4 (E6, E8, and E9) personnel files of unlicensed employees that provide resident care and/or service. This failure has the probability to affect all residents Findings include: On 4/22/2026 at 8:32 AM, an interview was conducted with E10 (Business Office Coordinator) that stated, the Health Care Worker Background Check Web Portal printouts presented were the only ones contained in the personnel files. The following files were reviewed: E6 (Reminiscence Lead Care Manager) hire date 9/26/2005. Two (2) printouts were presented, both dated 12/31/21 that lacked annual employment verification with this establishment	A3040		

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A3040	Continued From page 5 for 2025. E8 (Reminiscence Care Manager) hire date 1/29/2026. . Two (2) printouts were presented, dated 1/5/26 and 1/21/26, both lacked initial employment with this establishment in 2026. E9 (Reminiscence Care Manager) hire date 3/13/2026. Two (2) printouts were presented, both dated 2/20/26 that lacked initial employment with this establishment in 2026. During the same interview on 4/22/2026 at 8:32 AM, the above findings were reviewed and confirmed with E10 (Business Office Coordinator).	A3040		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Type 1 Violation Section 295.4010 Service Plan 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: 2) The amount, type, and frequency of health-related services needed by the resident; h) The service plan shall include all support services provided or arranged for by the establishment.	A4010		

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A4010	Continued From page 6 This requirement was not met as evidenced by: Based on record review, and interview, the establishment failed to: 1. Integrate R1's end-of-life hospice care/treatment into the service plan. 2. Develop and individualize service plans for R2 and R6 to identify the residents for high risk for falls. 3. Implement R'2s intervention to use skin protector to prevent skin injury. These failures resulted in R2's fall incidents 4 times during April 2026; and R6's fall incidents 6 times in November 2025, and 2 times in February 2026. This was found in 3 of 7 (R1, R2, and R6) resident records reviewed. This failure creates a substantial probability of severe harm or death to residents. Findings include: 1. R1's record was reviewed on 4/22/26 at 1:15 PM. Diagnoses included, but not limited to, other Alzheimer's Disease, Essential Hypertension, Age-Related Osteoporosis without current Pathological Fracture, and Restlessness and agitation. The service plan last updated on 11/7/2025 included a section titled, "Coordination of Care" with the intervention "Hospice care is provided by... The nurse usually visits 2x a week and the CNA (Certified Nursing Assistant) visits 2x a week during the week days in the mornings.." The service plan lacked the end-of-life care provided by the hospice; and the establishment's responsibility of that care in the absence of the hospice. 2. R2's record was reviewed on 4/22/26 at 2:30	A4010		

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A4010	Continued From page 7	A4010		

PM. Diagnoses included, but not limited to, Type 2 Diabetes Mellitus with Hyperglycemia, Unspecified Fall, Unspecified Dementia, Unspecified Severity, without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety. The progress notes included documentation that R2 was high risk for falls with falls on 4/5/26, 4/6/26, 4/11/26, 4/12/26, and going back to December 2025. The progress note dated 4/14/2026 contained, "Resident wake up at 1:00 AM and slid down to the floor mat". The service plan included an intervention with initiation date of 12/28/2025, "I will receive 24 hour private caregiver 7 days a week due to my increased falls."

An interview was conducted with E1 (Executive Director), E2 (Resident Care Director), and E3 (Resident Care Coordinator) on 4/24/2026 at 12:06 PM. This writer asked if a 24-hour caregiver was initiated on 12/28/25, where was the caregiver during the falls from 4/5/2026 to 4/14/2026? E2 responded that the sitter was initiated on 12/28/25 for overnights from 8:00 PM to 8:00 AM, 7 days per week, but the sitter was stopped on 1/2/2026 due to R2 was hospitalized, and after the hospital, R2 was transferred to a rehabilitation facility. R2 returned to the community on "01/26/2026". The E1 (Executive Director) and E#2 (Resident Care Director) stated, the sitter was re-initiated on 01/26/2026, however R2 did not receive a sitter from 3/3/26 to 4/12/26.

The establishment failed to implement individualized interventions to prevent falls that occurred from 4/5/2026 to 4/12/2026. This writer asked, Where was the sitter on 4/14/26 (1:00 AM) when E2 "slid down to the floor mat"? No response received from the staff. This writer

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A4010	Continued From page 8	A4010		

asked, "Have you analyzed the root cause of the falls? Have you modified the service plan based on the root cause(s) you discovered?" E2 (Resident Care Director" stated, "He is trying to get to the toilet, he wants to sit on the toilet" As of 4/24/2026, the service plan lacked set time frames for staff to toilet R2.

The service plan last updated on 1/16/2026 included, "...ensure tubi-grip sleeves are on at all times". Observed R2 on 4/22/26 at 11:17 AM, examined R2's arms which were pale, skin was tissue-like thin and fragile. Dressing intact to left arm, no tubi-grip or other protective dressing to the right arm. Staff failed to follow instructions/interventions included in the service plan.

3. R6's record was reviewed on 4/24/26 at 8:40 AM. This 104-year-old resident had multiple diagnoses that included, but not limited to, Unspecified Heart Failure, Essential (Primary) Hypertension, Unspecified Glaucoma, Unspecified Constipation, and Unspecified Edema. The progress notes included documentation of multiple falls that occurred on: 11/5/2025 at 12:20 PM, unwitnessed fall with head injury, abrasion to left forehead. Service plan updated for "Staff to provide check in 2 times during day shift and address any needs also have therapy evaluate me for gait and balance".

11/5/2025 at 10:00 PM, unwitnessed fall in residents room. "Service plan has been reviewed, no updates needed at this time".

11/6/2025 at 6:50 AM, R6 observed sitting on floor by bed ... increased confusion, sent to emergency room. "Service plan has been reviewed and updated. Educate resident how to

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A4010	Continued From page 9	A4010		

use pendant for help/assistance, reminded resident to wait for assistance before getting up, check on resident frequently."

11/6/2025 "approximately 1530, "...attempting to get out his chair unassisted... taken off all of his clothes... New orders received: Psyche evaluation/treatment, start Olanzapine 5mg every morning for hallucinations.

11/8/2025 (14:26) "Resident noted this AM with swelling and bruising to left eye... states that he fell last night... Abrasions to forehead and nose..."

11/12/2025 IDT note with home health for fall risk, resident had several falls recently. Family pays privately for 1:1 companion from 10 pm-7am.... being evaluated for PT/OT..."

11/14/2025 (3:50 AM) "Fall was unwitnessed in residents room... No injury noted at time fall..." Service plan has been reviewed, no updates needed at this time."

The record included documentation of additional falls on 2/1/2026 at 5:45 AM, and 2/26/2026 at 3:10 AM.

During an interview with E1(Executive Director), E2 (Resident Care Director) , and E3 (Resident Care Coordinator) on 4/24/2026 at 12:06 PM. E2 stated the 1:1 companion began for overnight stays on "11/7/2025" and ended on "11/13/2026". The service plan included the intervention, " Staff check on me at frequently to see if I need any assistance and to offer me reassurance..." This writer asked E2 (Resident Care Director), does "frequently" have set intervals? E2 responded "No it does not". During the same interview, E2 stated "We should have re-implemented the 1:1

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A4010	Continued From page 10 because he had another fall." The above findings were reviewed and confirmed with E1 (Executive Director), E2 (Resident Care Director) , and E3 (Resident Care Coordinator) on 4/24/2026 at 12:06 PM.	A4010		
A4060	Seciton 295.4060 Alzheimer's and Demential Programs This Regulation is not met as evidenced by: Type 1 Violation Section 295.4060) Alzheimer's and Dementia Programs - i) 1) B) 2) B) i-v) C) i-x) i) Training requirements for individuals working in a special program: 1) Manager qualifications and training: B) The manager or supervisor must complete, in addition to the training required in subsection (i)(2) of this Section and in Section 295.3020, six hours of annual continuing education regarding dementia care. 2) Staff training: B) Direct care staff must receive 16 hours of on-the-job supervision and training within the first 16 hours of employment following orientation. Training must cover: i) encouraging independence in and providing assistance with the activities of daily living; ii) emergency and evacuation procedures specific to the dementia population; iii) techniques for creating an environment that minimizes challenging behaviors; iv) resident rights and choice for persons with dementia, working with families, caregiver stress;	A4060		

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A4060	Continued From page 11 and v) techniques for successful communication. C) Direct care staff must annually complete 12 hours of in-service education regarding Alzheimer's disease and other related dementia disorders. Topics may include: i) assessing resident capabilities and developing and implementing service plans; ii) promoting resident dignity, independence, individuality, privacy and choice; iii) planning and facilitating activities appropriate for the dementia resident; iv) communicating with families and other persons interested in the resident; v) resident rights and principles of self-determination; vi) care of elderly persons with physical, cognitive, behavioral and social disabilities; vii) medical and social needs of the resident; viii) common psychotropics and side effects; ix) local community resources; and x) other related issues. This requirement was not met as evidenced by: Based on interview and record review, the establishment failed to ensure employees receive on-the-job 16 hours training, or 12 hours annually of training pertaining to Alzheimer's disease and related dementias. This failure affected 8 of 8 (E1, E2, E3, E4, E6, E7, E8, and E9) employees with direct contact with residents. This failure creates a substantial probability of severe harm to residents. Findings include: Personnel files were reviewed on 4/22/2026 at 8:32 AM with E10 (Business Office Coordinator). The following files lacked the required hours of	A4060		

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A4060	Continued From page 12 Alzheimer's disease and related dementias training: E1 (Executive Director) hire date 7/30/2018. Lacked 10 of 12 hours of annual training in 2025. E2 (Resident Care Coordinator) hire date 7/26/2024. Lacked 9 of 18 hours of annual training in 2025. E3 (AL/Reminiscence Resident Care Coordinator) hire date 3/27/2003. Lacked 1.75 hours of annual training in 2025. E4 (Maintenance Coordinator) hire date 12/10/2024. Lacked 9 of 12 hours of annual training in 2025. E6 (Reminiscence Lead Care Manager) hire date 9/26/2005. Lacked 1.50 hours of annual training in 2025. E7 (LPN Assisted Living Med Care Manager) hire date 10/10/2008. Lacked 4.50 hours of annual training in 2025. E8 (Reminiscence Care Manager) hire date 01/29/2026. Lacked 16 hours of on-the-job training. E9 (Reminiscence Care Manager) hire date 3/13/2016. Lacked 16 hours of on-the-job training. During an interview with E10 (Business Office Coordinator) on 4/22/2026 at 8:32 AM, E10 reviewed each employee's education printout, counted the hours received pertaining to Alzheimer's dementia training, and verified the hours indicated above. During the same interview, E10 (Business Office Coordinator) confirmed the employees failed to receive there required hours of Alzheimer's dementia training.	A4060		