STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510348	A. BUILDING: _____ B. WING _____	C 06/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF GURNEE	500 N HUNT CLUB RD GURNEE, IL 60031

(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 Facility Reported Incident Survey conducted: IL192148 Violations: 295.2000 a) 295.3000 a)	A 000		
A2000	Section 295.2000 Residency Requirements This Regulation is not met as evidenced by: General Violation Section 295.2000 Residency Requirements a) No individual shall be accepted for residency or remain in residence if the establishment cannot provide or secure appropriate services, if the individual requires a level of service or type of service for which the establishment is not licensed or which the establishment does not provide, or if the establishment does not have the staff appropriate in numbers and with appropriate skill to provide such services. (Section 75(a) of the Act) This requirement was not met as evidenced by: Based on interview and record review, the establishment failed to ensure that one resident (R1) has appropriate staff numbers to provide appropriate services. This failure resulted in R1 having multiple falls. Findings Include: On 6/2/2025 at 1:16PM, observations were done	A2000		

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A2000	Continued From page 1	A2000		

to Memory Care Unit. There were 7 residents in dining room area and no staff visible. At 1:19 PM there was one resident resting on the couch in common area. There were 2 Caregivers rendering care in an apartment. No staff visible monitoring the resident in common areas. R3 was observed in dining area sitting at the table. At 1:46PM One resident in dining area and 4 residents were watching TV. One Caregiver was putting dishes away and another Caregiver observed in the laundry room, doing laundry. Nobody monitoring residents.

According to R1's EHR, R1 was 87 years old. R1 moved to the Assisted Living (Memory Care Unit) on 11/4/2024. R1's diagnoses include but not limited to Contusion of Lower Back and Pelvis, Difficulty in Walking, Muscle Wasting, Essential Hypertension, Abdominal Pian, Alzheimer's Disease, Hypokalemia, Anxiety Disorder, Major Depressive Disorder, Hypothyroidism, Atrial Fibrillation, History of Falling.

R1' s Nurses Notes indicated the following falls:
5/6/2025- Fall was unwitnessed in residents' room 05/06/2025 7:00 AM. resident was found on the floor.
the resident c/o back and hip pain. It was also noted that the resident's right leg appeared shorter than the left. Fall resulted in an injury to the resident: RCD called local Hospital, and resident fractured her right femur.
5/5/2025-Fall was unwitnessed in dining room 05/05/2025 12:00 AM. No injury noted at time of fall.
4/16/2025- Fall was unwitnessed in residents' room 04/16/2025 6:50 AM. the resident was observed sitting on her buttocks near her bed. The resident denied any pain or discomfort and reported no head injury. No injury noted at time of

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A2000	Continued From page 2 fall. 4/10/2025- Fall was unwitnessed in residents' room 04/10/2025 3:30 AM. resident scream and found resident lying supine on the floor next to the bed with left forehead bleeding. This writer carefully assessed resident and noted hematoma and a small cut on resident's forehead. Resident was transported to local Hospital ER (Emergency Room). 4/3/2025- Fall was unwitnessed in resident's bathroom 04/03/2025 2:10 AM. Resident was trying to go to the bathroom and then she fell on her butt. No injury noted at time of fall. 3/27/2025-Fall was unwitnessed in residents' room 03/27/2025 8:50 PM. Resident found on the floor by a care manager. Resident verbalized hitting her head. She informed her legs, back, and head were hurting, and her face was grimacing. Fall resulted in an injury to the resident: Resident verbalized intense pain all over her body. 3/21/2025- Fall was unwitnessed in resident's bathroom 03/21/2025 7:15 AM. resident had an unwitnessed fall in her bathroom. No injury noted at time of fall. 3/11/2025- Fall was unwitnessed in other location: Resident was found in room 118 (Unwitnessed fall) 03/11/2025 1:30 PM. Resident was in room 118 laying on the floor in a supine position and near the door. stated" she hit her head". Resident was sent to local Hospital. No injury noted at time of fall. 2/5/2025- Fall was unwitnessed in residents' room 02/05/2025 9:00 PM. Resident states she was trying to ambulate without assistance to the restroom when she fell. No injury noted at time of fall. 1/27/2025- Fall was unwitnessed in residents' room 01/27/2025 12:00 AM. Resident was lying in a supine position by her bed. resident had a skin	A2000		

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A2000	Continued From page 3	A2000		

tear on her left middle finger. The resident c/o back pain and neck pain. sent out to hospital. No injury noted at time of fall.
1/1/2025- Fall was unwitnessed in resident's bathroom 01/01/2025 12:20 AM. Resident was laying on the floor, next to the toilet on a supine position. no injury observed.
12/31/2024- Fall was witnessed in dining room 12/31/2024 3:00 PM. Resident was ambulating without walker and tripped. Fall resulted in an injury to the resident: Resident fell on left shoulder and left side face.
12/23/2024- Fall was unwitnessed in residents' room 12/23/2024 10:00 AM. Resident was laying on the floor, next to her bed on a supine position. No injury noted at time of fall.
12/20/2024- Fall was unwitnessed in residents' room 12/20/2024 1:30 PM. Resident was laying on the floor, next to her bed on a supine position. Resident also stated," she bumped her head". Resident was sent out to local Hospital.
12/1/2024- Fall was unwitnessed in residents' room 12/01/2024 7:45 AM. she just fell and got up by herself. noticed resident standing. checked for injuries, bruises, no injuries and bruises noted.

R1's Progress Notes indicates the following:
1/29/2025- : "RC (Reminiscence Coordinator) spoke to POA (Power of Attorney) regarding the need for 1x1 companion in morning and afternoon. This would allow for resident to continue independence, be engaged, and to be reminded to be safe in order to avoid falls."
1/31/2025- "RCD (resident Care Director) and RC also spoke with the POA regarding a possible companion for the resident. POA stated he has been too sick to research at this time."
2/6/2025- "Ed and RC left VM for POA. Attempted to LVM for second contact, VM was not available. ED and RC called regarding follow

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A2000	Continued From page 4 up on request for companion services. Companion services have been requested by Sunrise to assist in fall prevention." 2/19/2025- "Continued calls have been placed to the family for one-on-one companionship." 2/27/2025- "RC has made multiple attempts to reach both POA and residents second contact. Second contact does not have a voicemail set up. RC previously lvm asking for update on companion care status." 4/10/2025- "RCD and RCC (Resident Care Coordinator) have continued to attempt communication with family about resident having a personal companion." On 6/2/2025 at 3:30PM, E2 (Resident Care Director) said that R1 was very impulsive, which contribute to many of the falls. E2 said that R1 responded well to someone sitting with her but if the Care Manager moves R1 will get up right way. E2 said that it was requested a 24-hour Caregiver to the family, but family did not respond to multiple calls. E2 said that "we did what we could possibly do." But R1 is very impulsive and when she is put to bed, she will get up without assistive devices. E2 said that R1 has not the cognitive ability to use the call light to ask for assistance.	A2000		
A3000	Section 295.3000 Personnel Requirmts, Qualifns, and Trng This Regulation is not met as evidenced by: General Violation Section 295.3000 Personnel Requirements, Qualifications and Training	A3000		

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A3000	Continued From page 5 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) This requirement is not met as evidence by: Based on interview and record review the establishment failed to ensure two (R, R2) residents were properly monitored. This resulted in R1, R3 sustaining multiple falls with/without injury. This deficient practice has the probability to affect all residents. Findings include: On 6/2/2025 at 1:16PM, observations were done to Memory Care Unit. There were 7 residents in dining room area and no staff visible. At 1:19 PM there was one resident resting on the couch in common area. There were 2 Caregivers rendering care in an apartment. No staff visible monitoring the resident in common areas. R3 was observed in dining area sitting at the table. At 1:46PM One resident in dining area and 4 residents were watching TV. One Caregiver was putting dishes away and another Caregiver observed in the laundry room, doing laundry. Nobody monitoring residents. According to R1's EHR, R1 was 87 years old. R1 moved to the Assisted Living (Memory Care Unit) on 11/4/2024. R1's diagnoses include but not limited to Contusion of Lower Back and Pelvis, Difficulty in Walking, Muscle Wasting, Essential Hypertension, Abdominal Pian, Alzheimer's	A3000		

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A3000	Continued From page 6	A3000		

Disease, Hypokalemia, Anxiety Disorder, Major Depressive Disorder, Hypothyroidism, Atrial Fibrillation, History of Falling.

R1' s Nurses Notes indicated the following falls:
5/6/2025- Fall was unwitnessed in residents' room 05/06/2025 7:00 AM. resident was found on the floor. the resident c/o back and hip pain. It was also noted that the resident's right leg appeared shorter than the left. Fall resulted in an injury to the resident: RCD called local Hospital, and resident fractured her right femur.

5/5/2025-Fall was unwitnessed in dining room 05/05/2025 12:00 AM. No injury noted at time of fall.
4/16/2025- Fall was unwitnessed in residents' room 04/16/2025 6:50 AM. the resident was observed sitting on her buttocks near her bed. The resident denied any pain or discomfort and reported no head injury. No injury noted at time of fall.

4/10/2025- Fall was unwitnessed in residents' room 04/10/2025 3:30 AM. resident scream and found resident lying supine on the floor next to the bed with left forehead bleeding. This writer carefully assessed resident and noted hematoma and a small cut on resident's forehead. Resident was transported to local Hospital ER (Emergency Room).

4/3/2025- Fall was unwitnessed in resident's bathroom 04/03/2025 2:10 AM. Resident was trying to go to the bathroom and then she fell on her butt. No injury noted at time of fall.
3/27/2025-Fall was unwitnessed in residents' room 03/27/2025 8:50 PM. Resident found on the floor by a care manager. Resident verbalized hitting her head. She informed her legs, back,

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A3000	Continued From page 7	A3000		

and head were hurting, and her face was grimacing. Fall resulted in an injury to the resident: Resident verbalized intense pain all over her body.

3/21/2025- Fall was unwitnessed in resident's bathroom 03/21/2025 7:15 AM. resident had an unwitnessed fall in her bathroom. No injury noted at time of fall.
3/11/2025- Fall was unwitnessed in other location: Resident was found in room 118 (Unwitnessed fall) 03/11/2025 1:30 PM. Resident was in room 118 laying on the floor in a supine position and near the door. stated" she hit her head". Resident was sent to local Hospital. No injury noted at time of fall.

2/5/2025- Fall was unwitnessed in residents' room 02/05/2025 9:00 PM. Resident states she was trying to ambulate without assistance to the restroom when she fell. No injury noted at time of fall.

1/27/2025- Fall was unwitnessed in residents' room 01/27/2025 12:00 AM. Resident was lying in a supine position by her bed. resident had a skin tear on her left middle finger. The resident c/o back pain and neck pain. sent out to hospital. No injury noted at time of fall.
1/1/2025- Fall was unwitnessed in resident's bathroom 01/01/2025 12:20 AM. Resident was laying on the floor, next to the toilet on a supine position. no injury observed.

12/31/2024- Fall was witnessed in dining room 12/31/2024 3:00 PM. Resident was ambulating without walker and tripped. Fall resulted in an injury to the resident: Resident fell on left shoulder and left side face.

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A3000	Continued From page 8	A3000		

12/23/2024- Fall was unwitnessed in residents' room 12/23/2024 10:00 AM. Resident was laying on the floor, next to her bed on a supine position. No injury noted at time of fall.
12/20/2024- Fall was unwitnessed in residents' room 12/20/2024 1:30 PM. Resident was laying on the floor, next to her bed on a supine position. Resident also stated," she bumped her head". Resident was sent out to local Hospital.

12/1/2024- Fall was unwitnessed in residents' room 12/01/2024 7:45 AM. she just fell and got up by herself. noticed resident standing. checked for injuries, bruises, no injuries and bruises noted.

Service Plan dated 1/30/2025 indicates in part:
Fall risk factors: Observe and report any changes in my gait and/or balance
Interventions: Check on me 2-4 times a shift and as needed to see if I need any assistance and to offer me reassurance.

The frequency of rounding was not consistent to each staff interviewed and service plan. There was no plan on how the staff can deal with R1's impulsivity making her prone to falls.

According to R3's EHR, R3 is 78 years old. R3 moved to the Assisted Living on 12/22/2021. R3's diagnoses include but not limited to Alzheimer's Disease, Major Depressive Disorder, Hypothyroidism. Gastro-Esophageal Reflux Disease, Impaired Glucose Tolerance, Osteoarthritis, Rosacea, Hyperlipidemia, Vitamin Deficiency Peripheral Vertigo, Polymyalgia.

R3's Nurses' Notes indicated the following falls:
4/2/2025- Fall was unwitnessed in residents' room 04/02/2025 8:45 PM. found resident lying on the floor in the room next the recliner.

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A3000	Continued From page 9 Resident stated she was trying to go to the bathroom and hit hard. No injury noted at time of fall. resident c/o pain to lower back right hip and right leg. Resident was transported to local Hospital ER. 3/20/2025- Fall was unwitnessed in residents' room 03/20/2025 4:00 PM. found resident on the floor wedged in the corner of the tv and the window. Resident stating hitting the back of her head when she fell. Resident was found on her back with her head against the wall. sent to local hospital. No injury noted at time of fall. 12/25/2024- Fall was unwitnessed in residents' room 12/25/2024 11:18 AM. resident was found sitting on the ground between her recliner and tv. No injury noted at time of fall. 11/29/2024- Fall was unwitnessed in residents' room 11/29/2024 9:40 PM. No injury noted at time of fall. R3's Service Plan dated 3/4/2025 indicates in part: Fall risk factors: I am at risk for potential fall due to my hypotension. Observe me for any changes. Interventions: Care Manager to check on me 2 to 4 times per shift and as needed. On 6/2/2025 E3 (Resident Care Coordinator), E4 (Lead Care Manager), E5 (Care Manager) were interviewed, all were able to state interventions to prevent falls. However, none of them stated that residents needed to be monitored 2 to 4 times per shift as indicated on the service plan.	A3000		