STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510349	A. BUILDING: _____ B. WING _____	C 05/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF HIGHLAND PARK	1601 GREEN BAY ROAD HIGHLAND PARK, IL 60035

(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: dated; 3-12-2026/ 00200944. Violations Cited: Section 295.4010	A 000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Type 1 Violation Section 295.4010 Service Plan g) Service plans shall address: 1) The level of service the resident is receiving, including: A) assistance with activities of daily living; C) special accommodations for the resident; 3) Staff responsible for the provisions of the service plan; h) The service plan shall include all support services provided or arranged for by the establishment. Disclosure of the risks of refusing services or approaches must be documented in the service plan. This requirement was not met as evidenced by: Based on interview and record review the facility	A4010		

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A4010	Continued From page 1	A4010		

failed to ensure staff followed the resident's interventions that were included in the resident's service plan. This failure resulted in R1 falling requiring an emergnt transfer to a local hospital emergency room and diagnosed with facial laceration and subarachnoid hemorrhage.
This failure caused harm to one resident (R1) in a sample of 3 residents. This failure creates a substantial probability of severe harm to a resident or residents.

Findings include:

R1 is an 80-year-old male with medical diagnosis that include and are not limited to: dementia with agitation, unspecified psychosis and major depressive disorder.
According to facility reported incident dated: 3-12-2026 reads; while R1 was assisted to get ready for the morning, R1 ambulated towards the restroom and had a fall sustaining a facial laceration to the left side of the eyebrow. R1 was emergently transferred to a local hospital.

Per local hospital discharge instructions dated: 3-12-2026 read: diagnosis blunt head trauma, facial laceration and subarachnoid hemorrhage.

On 5-2-2026 at 12:30 PM. E7 (LPN) said, I was on the 1st floor passing medication and the care manager called me after R1 had fallen. R1 was actively bleeding from the left side of the head. R1 was on the floor in front of the bathroom door. I sent him to the hospital via 911. R1 is supposed to be using the rolling walker, he was not using the walker, R1 did not have any behaviors on that day, R1 was calm. R1 is a high risk for falls. I do not remember if he had a gait belt, but I expect the care manager to use the gait belt and for him to have the walker when walking in the room and

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A4010	Continued From page 2	A4010		

or the hall way, that is the only way he will have some balance while in standing position, that is part of the service plan.

On 5-2-2026 at 12:40 PM E8 (Care Manager) said, I was assisting E9 (care manager) to get R1 out of bed, he was very aggressive sitting in his bed you were assisting with dressing putting his socks and R1 stood up from the bed. I do not know where R1's walker was. R1 walked towards the restroom and had a fall, I called the nurse immediately and 911 came and took the patient out. He did not have his walker, R1 is supposed to be reminded to use the walker when standing and walking becuase R1 is high risk for falls.

On 5-2-2026 at 12:53 PM E9- (Care Manager) said, I do remember the day R1 had a fall, I asked another coworker E8 to come and help me get R1 up. R1 was sitting at the edge of the bed when we were providing daily hygiene. R1 stood and started to walk towards the bathroom and stumbled landing on the floor. R1 has a walker but he was not using one. R1 needs at least two people's assistance because he is very combative. The resident service plan indicates R1 needs to be reminded to use the walker when ambulating.

On 5-3-2026 at 2:45 PM E2 (resident Care Director) said, R1's fall took place in the presence of two care managers they were helping him to get ready for the day, the care managers were in the process of taking R1 from his bed to the bathroom and R1 sustained a fall. R1 was not using the walker to help him with his balance while ambulating to the bathroom. R1 was assessed to be a high risk for falls since admission.
My expectation is for the nursing staff to know the

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A4010	Continued From page 3 interventions included in the individualized service plan. All staff need to follow the service plan and implement the interventions. R1 has an intervention for staff to remind him to use a walker when ambulating. E1 (Executive Director) presented undated policy titled: Individualized Service Plan Service Plan, reads: Service Plan: an individualized plan of care developed by evaluating/assessing the resident. The Licensed Nurse/designee will notify team members responsible for carrying out the interventions specified in the individualized service plan of their roles and responsibilities initially and when changes are made.	A4010		