STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510087	A. BUILDING: _____ B. WING _____	10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE VILLA OLYMPIA FIELDS	3633 BREAKERS DRIVE OLYMPIA FIELDS, IL 60461

(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 Annual Licensure Survey 295.3000 e) 2) A) B) 295.4010 a) e) Facility Reported Incdent IL197033 295.3000 e) 2) A) B) 295.4010 a) e)	A 000		
A3000	Section 295.3000 Personnel Requirmts, Qualifns, and Trng This Regulation is not met as evidenced by: Type 3 Violation Section 295.3000 Personnel Requirements, Qualifications and Training e) A file shall be maintained for each employee containing the following: 2) Documentation of: A) Freedom from pulmonary tuberculosis; B) Employee orientation This requirement is not met as evidenced by: Based on review of employee files, and staff interview, the establishment failed to provide documentation of staff's tuberculosis screening and employee orientation. This failure involves 2 of 8 employee files reviewed (E5, E8) . Findings include: E5 (night supervisor) has a start date of 5/29/25. Review of employee's file showed no evidence of an employee orientation.	A3000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510087	A. BUILDING: _____ B. WING _____	10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE VILLA OLYMPIA FIELDS	3633 BREAKERS DRIVE OLYMPIA FIELDS, IL 60461

(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 1 E8 (nurse) has a start date of 11/6/23, Review of the employee's file showed no evidence of current tuberculosis screening. During an interview with E2 (Health and Wellness Director), the above findings were confirmed.	A3000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Type 2 Violation Section 295.4010 Service Plan a) Based on the physician's assessment and establishment evaluation (see Section 295.4000), a written service plan shall be developed and mutually agreed upon by the establishment and the resident. (Section 15 of the Act) The establishment shall respect and accept the resident's choices regarding the 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). This requirement is not met as evidenced by: Based on review of clinical records, observation and interview the establishment failed to revise service plans by developing and implementing new interventions and goals when it became	A4010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510087	A. BUILDING: _____ B. WING _____	10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE VILLA OLYMPIA FIELDS	3633 BREAKERS DRIVE OLYMPIA FIELDS, IL 60461

(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 2	A4010		

apparent those interventions in place at the times of a resident's falls were ineffective. These failures resulted in 1 of 3 sampled residents (R1) receiving a vertebral fracture after a fall. These failures create a substantial probability of harm to other residents.

Findings include:

Review of R1"s clinical record showed the resident was admitted to the facility with diagnoses that includes Vascular Dementia, Malignant Neoplasm of Bladder and Seizures. R1's FAST (Functional Assessment Staging Tool/cognitive assessment) score assessed the resident as "6" indicating moderately severe dementia.

Review of Incident Reports documented R1 fell 5/23/25 and was found on the bathroom floor in the apartment. R1 complained of right hip pain and stated she had hit her head. The resident was transferred to the hospital for evaluation.

A second Incident Report dated 8/8/25 documented R1 fell in the room while performing ADLs (Activities of Daily Living).The resident was transferred to the hospital and diagnosed with a T9 Vertebral Fracture.

R1's Progress Notes (PNs) dated 5/23/25 and 8/8/25 documented the resident's falls both of which resulted in the resident's transfer to the hospital. On 5/23/25's, transfer to the hospital R1 sustained bruises and the fall on 8/8/25 resulted in R1's transfer to the hospital for evaluation where the T9 vertebral fracture was diagnosed.

Review of R1's cognitive and memory assessment assessed her as being cognitively

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510087	A. BUILDING: _____ B. WING _____	10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE VILLA OLYMPIA FIELDS	3633 BREAKERS DRIVE OLYMPIA FIELDS, IL 60461

(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 3 impaired. Review of R1's current service plan dated 5/23/25 mentioned the resident was a fall risk due to her confusion and use of assistive devices and listed interventions that included reminding resident to ask for assistance and using R1's assistive device (walker). R1's fall and fractured T9 vertebrae was mentioned, but didn't address the need for monitoring the resident's mobility or pain. Interventions listed included reminders to ask for assistance, to be seen by therapy, to have staff "round" on resident but doesn't indicate how often staff is to make rounds on this confused, cognitively impaired resident. New interventions and goals were not developed and implemented when it was apparent those intervention currently in place were not effective. Review of R1's 5/23/25 Post Fall Evaluation assessed the resident as being forgetful with a short attention span and confused about the environment with an unsteady gait. An intervention listed was R1 to being seen by therapy. The 8/8/25 Post Fall Evaluation also assessed R1 as being forgetful with a short attention span, to have an unsteady gait and the intervention was the same as that of 5/23/25. On 8/20/25 at 4:30PM E7 (Care Manager) stated R1 is confused, more so at sundown and walking is slightly unsteady. Before the last fall staff would see R 1 walking without using the walker and would redirect or assist the resident to the chair. R1 is confused and doesn't always ask for help to transfer or walk despite being instructed to. E7 stated she was working 8/8/25 when R1 fell. E7 heard R1 in her room and when E7 entered R1 was on the floor. Staff assisted her off the floor and assessed her and R1 denied being hurt or in	A4010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510087	A. BUILDING: _____ B. WING _____	10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE VILLA OLYMPIA FIELDS	3633 BREAKERS DRIVE OLYMPIA FIELDS, IL 60461

(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 4	A4010		

pain but did go to the hospital. R1 now uses a walker all the time and does stand in the hall yelling, usually at night. Staff check her more often, every 1-2 hours to try to prevent more falls. When asked about R1's fractured vertebrae E7 stated she was unaware of the fracture.

On 8/21/25 at 2:00PM E2 (Health and Wellness Director) stated R1's fractured T9 vertebral was discovered after she fell and was sent to the hospital.

On 8/21/25 at 4:45PM R1 was observed in her apartment sitting in a chair with her walker in front of her. R1 remembered having fallen earlier in month but couldn't remember the date. R1 stated she was alone when she fell while using a walker to go to the bathroom when the resident's foot got "caught" on the carpet and fell. R1 denied having back pain since falling and denied knowledge of any fractured vertebrae. R1 stated she yells because she wants to go home and no one is helping her. During the interview this surveyor noted that the longer R1 spoke the more her speech and thoughts became disorganized and tangential.

On 8/21/25 at 5:00PM E8 (nurse) stated she was working the day R1 fell. R1 was described as confused Staff had been toileting the resident when the fall occurred. R1 didn't complain of pain, but when the resident stood R1's feet were unable to move. Since falling R1 doesn't complain of pain and uses the walker, will yell if help is needed and is frustrated, is confused, disorganized and tangential with conversation. When asked what staff does to try to prevent R1 from further falls E8 stated staff check on her more often to try to prevent further falls because R1 doesn't always ask for help to transfer or walk.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510087	A. BUILDING: _____ B. WING _____	10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE VILLA OLYMPIA FIELDS	3633 BREAKERS DRIVE OLYMPIA FIELDS, IL 60461

(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 The establishment failed to follow its fall policy when new fall interventions and goals weren't developed and implemented post falls. and failed to provide fall assessments when asked on 8/21/25 and when emailed for the information on 8/28/25.	A4010		