STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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SUNRISE OF WESTMONT	407 W 63RD ST WESTMONT, IL 60559

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A 000	Initial Comment Facility Reported Incident Investigation: Facility Reported Incident of 4/21/2026/IL201452 - 295.4010a), 295.6000a)1)2)5)13) Facility Reported Incident of 5/16/2026/IL202024 - 295.3000a)h)2)3), 295.4010a), 294.2050a)b)c), 295.6000a)1)2)5)13)	A 000		
A2050	Section 295.2050 Incident and Accident Reporting This Regulation is not met as evidenced by: Violation 295.2050 Incident and Accident Reporting a) An establishment shall report to the Department any serious incident or accident. For the purposes of this Section, "serious" means any incident or accident that causes physical or emotional harm or injury to a resident. A change in an individual's (resident's) condition that is due to health or medical decline is not a reportable incident or accident. b) The report shall be made by contacting the Department of Public Health Division of Assisted Living via email at DPH.LTCAL@illinois.gov or as requested by the Department within 24 hours after the occurrence of the incident or accident. c) A copy of the report shall be maintained by the establishment for one year after the date of the incident or accident. (Source: Amended at 47 Ill. Reg. 13264,	A2050		

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A2050	Continued From page 1 effective August 30, 2023) This REQUIREMENT was not met as evidenced by: Based on interview and record review the facility failed to report in a timely manner to Illinois Department of Public one resident (R2) that experienced a choking episode requiring the Heimlich maneuver to be done three times before R2's airway was cleared for one of three residents reviewed for reporting. Findings include: R2 admitted to facility on 4/27/2025 with diagnosis not limited to: Parkinson's Disease, Essential (Primary) Hypertension, Repeated Falls, Major Depressive Disorder, Single Episode, Unspecified, Gastro-Esophageal Reflux Disease without Esophagitis, Hyperlipidemia, Unspecified, Cellulitis of Left Toe, Anxiety Disorder, Unspecified, Unspecified Atrial Fibrillation, Unspecified Diastolic (Congestive) Heart Failure, Chronic Kidney Disease, Unspecified, Chronic Obstructive Pulmonary Disease, Unspecified, Unspecified Dementia, Unspecified Severity, Without Behavioral Disturbance, Psychotic Disturbance, Dementia Other Diseases Classified Elsewhere Facility Reported Incident dated May 18, 2026, at 12:50pm documents in part: Incident/Accident Date 5/16/2026, Time: 12:30pm Resident: R2 Location of Incident/Accident: Assisted Living Dinng Room 13, Licensed Practical Nurse (LPN) was notified of choking episode in dining room. E13 responded immediately. Upon getting to R2, it was reported R2 was able to independently expel a piece of meat. R2's diet order	A2050		

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(Mechanical Soft) was not followed at time of incident. New information obtained on 5/18/2026 that abdominal thrusts were administered by staff. New order for chest x-ray and ST evaluation. R2 remains in stable condition.

R2's Health Status Note dated 5/16/2026 at 13:01 by E13 documents in part: Writer was called down to dining room during lunch stat upon entering dining area observed care manager and activity coordinator standing at the table where resident was sitting they both stated he was choking on meat resident was able to expel the meat without any assistance before writer reaching dining room. Resident able to talk with no difficulty after food was expelled resident stated he was ok. Food taken away and resident was asked what else would he like he stated eggs, resident able to eat the eggs with no concerns.

On 5/302026 at 11:34am E13, LPN Care Manager stated, she is familiar with R2 and incident that occurred on 5/16/2026 when he was choking. R2 was in the first-floor dining room. It was a page on walkie to have nurse to dining room stat. E13 answered the page and when she got off the elevator, she saw the Care Manager (E19) and E10 Activity Volunteer Coordinator standing at R2's table. When E13 got to the table they said he was choking and expelled it out. The meat was on the floor, and someone picked it up and threw it away. It was cut into squares. R2 is on mechanical soft diet. E13 did not see his tray, they had taken it away and brought him more food out. By the time E13 got there the food was out. I do not know who gave him the Heimlich. I did not ask if he got the Heimlich, E19 said what happened. R2 was alert and able to speak and able to eat the eggs that came out. E13 stated

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A2050	Continued From page 3	A2050		

she stayed down and monitored him and he was okay. E13 stated that she asked E11, Cook what type of diet he is supposed to be on and E11 said, regular. E13 then stated, R2 is supposed to be on mechanical soft diet. I asked the nurse manager how dietary sees resident diet order. E8, Area Resident Care Director said dietary can see what we see in PCC. E19 told me that everyone was complaining that the meat was too thick. E13 further stated, the nurse puts the diet order in PCC but the Cook is supposed to make sure the resident gets the right meal and the server gives the resident the right meal.

On 5/30/2026 at 10:53am E1 stated, he sent the reportable on 5/18/2026 after he found out additional information that made it a reportable incident. E1 stated, what was initially he was told was R2 choked on his meal and was able to expel the food. E2 stated he found out on 5/16/2026 that day R2 was served the incorrect meal.

On 5/30/2026 at 11:01am E1 stated, he looked at his email and we did not report it on 5/16/2026 we reported it on 5/18/26 after E1 obtained information that the Heimlich was done. We knew on May 16th he was served the wrong diet, and he expelled the food independently and he did not need the hospital. The MD was notified, and E1 was not told of abdominal thrusts. If there is substantial harm to the residents it is reportable. We were prepared to send R2 to the ER (Emergency Room) but doctor said to monitor and ordered chest x-ray and speech evaluation. At the time this occurred no one said the Heimlich was administered. Our regional nurse was managing remotely that day. The staff should know what should be told to E1. The nurse should know if he choked and received the

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A2050	Continued From page 4	A2050		

Heimlich that should be reported. E1 stated, he did not know if the nurse asked if the Heimlich was administered and E1 or E2, Resident Care Director will send in the reportable. The following week (5/21/2026) the facility had modified diet training for culinary, nurses, and caregivers in attendance and education nurses and caregivers is continuing. The staff should know what information needs to be given so a state report can be made if required. A staff member came in and told me R2 choked, and they had to do the Heimlich. E1 stated, he did not know R2 choked, and this should have been reported on Saturday. E1 initiated his investigation to make sure everything was okay and gathered more facts and submitted initial on 5/18/2026 and final on 5/27/2026.

On 5/30/2026 at 2:56pm E2, Resident Care Director stated, she is familiar with R2 incident and found out when she returned to work. R2 was in dining room and was choking. Not sure of diet or what he choked on. The care manager (E19) and E10 were in the dining room. E19 said resident said out loud he was choking and she went over to R2 and called nurse and E10 came out of kitchen and assisted and called she needed a nurse in the dining room stat. E2 stated she did not know what he was choking on and what he had. They said they had to do Heimlich and a piece of meat came up. The nurse arrived and she staying in dining room to make sure R2 was okay.R2 asked for eggs and was given eggs and he was okay. I am not sure who did Heimlich on R2. I assume E1 investigated this. My area nurse covered for me (E8, Area Resident Care Director) but E2 thinks E1 reported and did investigation. E1 reported this. E2 stated, she reports within 24 hours, but she was not sure how that was carried. It should have been reported

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A2050	Continued From page 5 within the time frame of the regulation. Facility Policy Incident and Event Reporting dated 4/24/2025 documents in part: Policy Statement: It is the policy of the community to ensure that team members promptly and accurately report and document incidents to promote early intervention, improve quality of care for our residents, improve safety for residents, team members and visitors, and reduce the risk of harm. Definitions: Event: A confidential Sunrise internal report regarding an adverse resident event. An event is an unanticipated occurrence or set of circumstances that caused or could cause harm to a resident. Incident: A report required by the applicable state/province licensing agency regarding an adverse or unusual incident involving a resident. Purpose: To advise the appropriate authorities of incidents that occur in the community. 2. It is the ED/designee's responsibility that incidents and events are documented following the Sunrise internal event reporting process. Reporting includes resident events, adverse community events, and criminal activity. 3. The ED/designee shall identify and document resident injuries for which the origin of the injury was not observed by or otherwise known by team members and investigate, including determining if the resident knows how the injury occurred. 4. In addition to and separate from internal reporting, the ED/ designee is responsible for validating all incidents/events are reported timely in accordance with state/federal/provincial laws and regulations. 11. If the ED is not in the community at the time of the incident/event, s/he will be notified of the incident/event as soon as practicable. 12. The ED/designee will investigate each incident/event to determine the circumstances of the incident/event and institute	A2050		

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A2050	Continued From page 6 appropriate measures to prevent similar future situations. If able, the resident's version of the events leading to the incident/event will be obtained and documented. 14. For resident events, the Resident Care Director (RCD)/ designee will: a. Review the report for accuracy, clarity and completeness. b. Ensure responsible party and health care practitioner are notified and notification is documented in the resident record. c. Review resident progress notes and team member documentation. d. Investigate the cause and facts of the incident/event. e. Coordinate with the ED regarding notification of appropriate parties in accordance with state/federal/provincial law or regulation: 18. The ED/designee shall ensure that team member and volunteers receive orientation and annual training based on state/province regulations. Topics include but are not limited to: a. Incident, injury, and accident prevention. b. Incident reporting & documentation.	A2050		
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 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) h) The establishment shall have sufficient	A3000		

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A3000	Continued From page 7 personnel to provide the following for its current resident population: 2) Services established in each resident's service plan; 3) Service to meet the needs of each resident, including 24 hour scheduled and unscheduled needs, general supervision, and the ability to intervene in a crisis; This REQUIREMENT was not met as evidenced by: Based on interview and record review the facility failed to ensure dietary staff knew the correct diet order for one (R2) resident. This failure resulted in R2 being served a regular diet and R2 choking on a piece of meat requiring the Heimlich maneuver to be performed. This failure caused harm to one resident (R2) in a sample of 3 residents. Findings include: R2 admitted to facility on 4/27/2025 with diagnosis not limited to: Parkinson's Disease, Essential (Primary) Hypertension, Repeated Falls, Major Depressive Disorder, Single Episode, Unspecified, Gastro-Esophageal Reflux Disease without Esophagitis, Hyperlipidemia, Unspecified, Cellulitis of Left Toe, Anxiety Disorder, Unspecified, Unspecified Atrial Fibrillation, Unspecified Diastolic (Congestive) Heart Failure, Chronic Kidney Disease, Unspecified, Chronic Obstructive Pulmonary Disease, Unspecified, Unspecified Dementia, Unspecified Severity, Without Behavioral Disturbance, Psychotic Disturbance, Dementia Other Diseases Classified Elsewhere Facility Reported Incident dated May 18, 2026, at	A3000		

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A3000	Continued From page 8 12:50pm documents in part: Incident/Accident Date 5/16/2026, Time: 12:30pm Resident: R2 Location of Incident/Accident: Assisted Living Dinng Room 13, Licensed Practical Nurse (LPN) was notified of choking episode in dining room. E13 responded immediately. Upon getting to R2, it was reported R2 was able to independently expel a piece of meat. R2's diet order (Mechanical Soft) was not followed at time of incident. New information obtained on 5/18/2026 that abdominal thrusts were administered by staff. New order for chest x-ray and ST evaluation. R2 remains in stable condition. R2's active order dated 2/15/2026 documents in part: NAS (No Added Salt) diet Mechanical soft texture, Honey consistency, Per Hospital Report, Moderate Thick Liquids, Soft Diet. For Wheezing On 5/29/2026 at approximately 4:00pm E11, Chef stated, we can see the order on the ticket or the nurses give us the paperwork and it tells us what their diet is supposed to be. E11 stated he is familiar with R2, he gets mechanical soft. The chef is responsible for making mechanical soft diet. E11 stated, he thinks one of the servers took the wrong plate to him. Once we get tickets in and get the food on the plate the ticket is under the plate, and we could have been rushing, and wrong plate was handed to him. E11 heard he got the wrong tray. E11 did not recall who gave him the tray or who told me he received the wrong tray. All the caregivers and managers came down when that happened. Mechanical eats food on the line and go to machine that grinds into mechanical form and eat off the line unless they cannot and make mechanical. Always served with gravy. There was a meeting after this happened, and we were questioned. We are aware of how mechanical diet is supposed to be. The ticket goes under the plate and hangs out so you can	A3000		

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see their name and diet. E11 stated that he does not know if additional training was done for servers. The cook makes the meal, and the server serves the meal.

On 5/29/2026 at 4:46pm E1, ED stated, he is covering the kitchen right now and he is familiar with R2 and incident that occurred on 5/16/2026. E1 stated it happened during lunch, and he got call from nurse saying choking incident with R2. He choked and cleared on his own. There were no concerns. They offered him correct diet, and he was able to eat and everything was ok. The server E7 made a mistake. Servers are aware of diet orders. Server took wrong plate to R2. When the server brings up diet, prints diet and bolds diet with restrictions. On Saturday they sent diet roster reports of residents on different/special diets and pay close attention to the tickets. E11 was the cook that day that prepared the diet. E1 stated he did not know the specifics. E1 spoke to E11 when this happened, and he said he was the cook. R2 was served regular roast beef and not mechanical diet roast beef. Servers had previous training of how regular, mechanical and puree diets look. All dietary staff were in attendance of training by dietitian. In-service was done and nurses' education done as well. Coaching conversation with server that made the mistake.

On 5/30/2026 at 10:19am E12 Cook stated, he knows R2. E12 stated, he was not sure if he was here on 5/16/2026 on the day he choked. E12 heard about it. E12 cooked dinner that day. E11 and E12 overlap on days that we work. E12 heard he was choking, and his food was not properly chopped up or not chopped up at all. We have a POS system that print out tickets and has date, name and order and under that diet requirement. We can clearly see it. When diet is changed there

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are only certain items they can order. For example, if there was baked chicken for R2 it would print out ground chicken. Once we prepare the food, we put the ticket on or beside the plate then the server will take it to the resident. The server is supposed to look at the ticket. I do not know how he got the wrong plate. Could have been put out and was not mechanical or someone took the wrong plate. The dietitian came and held a class on food preparation for all dietary staff in AL and memory care had to attend. Now we make sure the servers are on the same page, we put a cover on his food and if R2 asks about other food, the server knows they must come and ask the cook if he can have that because we do not want that to happen again.

On 5/302026 at 11:34am E13, LPN Care Manager stated in part, she is familiar with R2 and incident that occurred on 5/16/2026 when he was choking. R2 was in the first-floor dining room. It was a page on walkie to have nurse to dining room stat. E13 answered the page and when she got off the elevator, she saw the Care Manager (E19) and E10 Activity Volunteer Coordinator standing at R2's table. When E13 got to the table they said he was choking and expelled it out. The meat was on the floor, and someone picked it up and threw it away. It was cut into squares. R2 is on mechanical soft diet. E13 stated that she asked E11, Cook, what type of diet he is supposed to be on and E11 said, regular. E13 then stated, R2 is supposed to be on mechanical soft diet. E13 asked the nurse manager how dietary sees resident diet order. E8, Area Resident Care Director said dietary can see what we see in PCC (Point Click Care). E19 told me that everyone was complaining that the meat was too thick. E13 further stated, the nurse puts the diet order in PCC but the Cook is

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A3000	Continued From page 11	A3000		

supposed to make sure the resident gets the right meal and the server gives the resident the right meal.

On 5/30/2026 at 10:53am E1 stated, he found out on 5/16/2026 later that day he was served the incorrect meal.

On 5/30/2026 at 10:41am E11 stated, he cooked brunch food. After I cook the food, someone else does the actual plating. E12 cooked lunch and plated the food. If he says he came that day late, then E11 prepared it, Servers are not allowed to prepare plates. The mechanical plate was prepared, and the server took the wrong plate. When we got the plate from R2, that was not his plate. R2's plate was still in the window. The server took the wrong plate to R2. The tickets have the servers name on the ticket. There were a lot of people and there can be confusion so on brunch days it is kind of hectic. Since that day, we make sure that that ticket goes to the right person. We are well aware of who gets special tray they and we make sure that plate goes to the person.

On 5/30/2026 at 12:58pm R2 stated, he remembers when he got choked about a week ago. R2 stated, they pounded me on my back and picked me up in the air and pounded on me. They were behind me and pointed to his rib cage and kept pounding on him until the food came out. R2 stated, he does not know who did it but it was welcomed. R2 stated, he does have some soreness around the area and point around his rib cage.

On 5/30/2026 at 1:01pm E7, Server stated, he does not know what was under R2's name but under impression R2 got a regular meal and

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A3000	Continued From page 12 apple juice. Ticket said thicken juice. R2 was not mechanical but regular or sliced food. E7 stated, he did not know R2 was on mechanical diet or thickened drinks. He gets applesauce. We are now paying attention to him. E7 stated he did not actually see him choking. We all got education, but they should also tell the chefs. Many more modifications have been put in place since that happened. The in-service was helpful. E7 stated, he did not know if he served him his meal, but if they said he did, he guessed he did. He cannot remember.	A3000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Type 1 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. This REQUIREMENT was not met as evidenced by: Based on interview and record review the facility failed to ensure staff followed the resident's interventions that were included in the resident's	A4010		

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A4010	Continued From page 13 service plan. This failure resulted in R2 being served an incorrect diet and choked on a piece of meat requiring the Heimlich maneuver. This failure caused harm to one resident (R2) and creates a substantial probability of severe harm to a resident or residents. Findings include: R2 admitted to facility on 4/27/2025 with diagnosis not limited to: Parkinson's Disease, Essential (Primary) Hypertension, Repeated Falls, Major Depressive Disorder, Single Episode, Unspecified, Gastro-Esophageal Reflux Disease without Esophagitis, Hyperlipidemia, Unspecified, Cellulitis of Left Toe, Anxiety Disorder, Unspecified, Unspecified Atrial Fibrillation, Unspecified Diastolic (Congestive) Heart Failure, Chronic Kidney Disease, Unspecified, Chronic Obstructive Pulmonary Disease, Unspecified, Unspecified Dementia, Unspecified Severity, Without Behavioral Disturbance, Psychotic Disturbance, Dementia Other Diseases Classified Elsewhere Facility Reported Incident dated May 18, 2026, at 12:50pm documents in part: Incident/Accident Date 5/16/2026, Time: 12:30pm Resident: R2 Location of Incident/Accident: Assisted Living Dinng Room 13, Licensed Practical Nurse (LPN) was notified of choking episode in dining room. E13 responded immediately. Upon getting to R2, it was reported R2 was able to independently expel a piece of meat. R2's diet order (Mechanical Soft) was not followed at time of incident. New information obtained on 5/18/2026 that abdominal thrusts were administered by staff. New order for chest x-ray and ST evaluation. R2 remains in stable condition.	A4010		

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A4010	Continued From page 14 R2's Health Status Note dated 5/16/2026 at 13:01 by E13 documents in part: Writer was called down to dining room during lunch stat upon entering dining area observed care manager and activity coordinator standing at the table where resident was sitting they both stated he was choking on meat resident was able to expel the meat without any assistance before writer reaching dining room. Resident able to talk with no difficulty after food was expelled resident stated he was ok. Food taken away and resident was asked what else would he like he stated eggs, resident able to eat the eggs with no concerns. R2's active order dated 2/15/2026 documents in part: NAS (No Added Salt) diet Mechanical soft texture, Honey consistency, Per Hospital Report, Moderate Thick Liquids, Soft Diet. For Wheezing R2 Service Plan dated 4/29/2026 Focus: Dining, Nutrition and Eating Needs Date Initiated: 04/24/2025 Revision on: 04/27/2025 Goal: My meal/snack preferences will be honored through the next review date. Date Initiated: 04/24/2025 Interventions: Provide me with the diet as ordered by my physician (NAS diet, mechanical soft texture, honey thick fluids) Date Initiated: 04/27/2025 On 5/30/2026 at 10:19am E12 Cook stated, he knows R2. I am not sure if I was here on 5/16/2026 on the day he choked. I heard about it. I cooked dinner that day. E11 and E12 overlap on days that we work. E12 heard he was choking, and his food was not properly chopped up or not chopped up at all. We have a POS system that print out tickets and has date, name and order and under that diet requirement. We can clearly see it. When diet is changed there are only	A4010		

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A4010	Continued From page 15	A4010		

certain items they can order. For example, if there was baked chicken for R2 it would print out ground chicken. Once we prepare the food we put the ticket on or beside the plate then the server will take it to the resident. The server is supposed to look at the ticket. I do not know how he got the wrong plate. Could have been put out and was not mechanical or someone took the wrong plate. Now we make sure the server are on the same page, we put a cover on his food and if R2 asks about other food, the server knows they have to come and asks the cook if he can have that because we do not want that to happen again.

On 5/30/2026 at 10:53am E1 stated, he found out on 5/16/2026 later that day he was served the incorrect meal.

On 5/30/2026 at 10:41am E11 stated, he cooked brunch food. After I cook the food, someone else does the actual plating. E12 cooked lunch and plated the food. If he says he came that day late, then E11 prepared it, Servers are not allowed to prepare plates. The mechanical plate was prepared, and the server took the wrong plate. When we got the plate from R2, that was not his plate. R2's plate was still in the window. The server took the wrong plate to R2. The tickets have the servers name on the ticket. There were a lot of people and there can be confusion so on brunch days it is kind of hectic. Since that day, we make sure that that ticket goes to the right person. We are well aware of who gets special tray they and we make sure that plate goes to the person.

On 5/302026 at 11:34am E13, LPN Care Manager stated, she is familiar with R2 and incident that occurred on 5/16/2026 when he was

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A4010	Continued From page 16	A4010		

choking. R2 was in the first-floor dining room. It was a page on walkie to have nurse to dining room stat. E13 answered the page and when she got off the elevator, she saw the Care Manager (E19) and E10 Activity Volunteer Coordinator standing at R2's table. When E13 got to the table they said he was choking and expelled it out. The meat was on the floor, and someone picked it up and threw it away. It was cut into squares. R2 is on mechanical soft diet. E13 did not see his tray, they had taken it away and brought him more food out. By the time E13 got there the food was out. I do not know who gave him the Heimlich. I did not ask if he got the Heimlich, E19 said what happened. R2 was alert and able to speak and able to eat the eggs that came out. E13 stated she stayed down and monitored him, and he was okay. E13 stated that she asked E11, Cook, what type of diet he is supposed to be on and E11 said, regular. E13 then stated, R2 is supposed to be on mechanical soft diet. I asked the nurse manager how dietary sees resident diet order. E8, Area Resident Care Director said dietary can see what we see in PCC (Point Click Care). E19 told me that everyone was complaining that the meat was too thick. E13 further stated, the nurse puts the diet order in PCC but the Cook is supposed to make sure the resident gets the right meal and the server gives the resident the right meal. R2 has an order for mechanical soft diet, and it is in his service plan.

On 5/30/2026 at 12:58pm R2 stated, he remembers when he got choked about a week ago. R2 stated, they pounded me on my back and picked me up in the air and pounded on me. They were behind me and pointed to his rib cage and kept pounding on him until the food came out. R2 stated, he does not know who did it but it was welcomed. R2 stated, he does have some

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A4010	Continued From page 17 soreness around the area and point around his rib cage. On 5/30/2026 at 1:01pm E7, Server stated, I do not know what was under R2's name but under impression R2 got a regular meal and apple juice. Ticket said thicken juice. R2 was not on mechanical but regular or sliced food. E7 stated, he did not know R2 was on mechanical diet or thickened drinks. E7 stated, he did not know if he served him his meal, but if they said he did, he guess he did. E7 stated, he cannot remember. On 5/30/2026 at 4:06pm E10, Activity Volunteer Coordinator stated, she is familiar with incident. We were having brunch on Saturday brunch and E10 came out of the dining room and someone yelled he is choking and E19 had him (R2) up doing the Heimlich and E10 saw food come out and land on the floor. He sat down and was trying to clear his throat and E10 did Heimlich and more came out and E19 did Heimlich again and more came out. The nurse came down and he seemed to be okay. The nurse took over and E10 left. E10 stated she gave E1 a statement on Monday, and asked nurse if she was going to notify everyone. E10 told E1 on Monday and gave a statement. E10 stated she did tell the nurse that he was choking but E10 cannot say if anyone told her the Heimlich was done. He was choking on meat. She is not sure who gave R2 his plate. Facility Policy Individualized Service Plan dated 5/15/2025documents in part: Policy Statement: It is the policy of the community to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's	A4010		

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A4010	Continued From page 18 medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment or evaluation. This community supports the resident's right to be informed of, and participate in, his or her care planning and treatment (implementation of care). 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. The Resident Care Director (RCD)/Licensed Nurse (LN) ensures that each resident has an Individualized Service Plan (ISP) in accordance with state/province regulations regarding training, development, content, time frames of development and review and provision of the ISP to the resident/responsible party. 5. The service plan must address the individual needs, activities of daily living, preferences, and strengths of the resident. The service plan must be designed to help the resident maintain the highest possible level of physical, cognitive, and social functioning. The IDT shall include the following in the ISP as indicated or as required by state/province regulations: a. Information from the most current comprehensive assessment or evaluation shall be used to establish an individualized service plan. b. Input from resident / responsible party. c. Cultural, spiritual, and personal preferences.	A4010		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: Type 1 Violation	A6000		

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A6000	Continued From page 19 295.6000 Resident Rights a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of his or her status as a resident of an establishment, nor shall a resident forfeit any of the following rights: 1) The right to live in an environment that promotes and supports each resident's dignity, individuality, independence, self-determination, privacy, and choice and to be treated with consideration and respect; 2) The right to respect for bodily privacy and dignity at all times, especially during care and treatment; 5) The right to receive the services specified in the service plan, to review and renegotiate the service plan at any time; and to be informed of the cost of the changes; 13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor; This REQUIREMENT was not met as evidenced by: Based on interview and record review, the facility failed to ensure one of three residents (R1) lived in an environment that supported resident dignity and privacy and failed to provide services for two of three residents (R1, R2) according to their service plan. These failures resulted in R1 being photographed during incontinence care and feeling embarrassed and R2 being served a regular diet which resulted in R2 choking on a piece of meat required the Heimlich Maneuver. These failures create a substantial probability of severe harm to a resident or residents.	A6000		

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A6000	Continued From page 20 Findings include: R1 admitted to facility on 5/30/2024 with diagnosis not limited to: Hypertensive, Unspecified Chronic Kidney Disease, Chronic Kidney Disease, Stage 3b, Acute Kidney Failure, Unspecified, Pressure Ulcer of Right Buttock, Unspecified Stage, Pressure Ulcer of Left Buttock, Unspecified Stage, Chronic Diastolic (Congestive) Heart Failure, Chronic Atrial Fibrillation, Unspecified, Lymphedema, Orthopnea, Generalized Edema, Muscle Weakness (Generalized), Unspecified Dementia, Unspecified, Psychotic Disturbance, Mood Disturbance, and Anxiety, Unspecified, Pressure Ulcer of Sacral Region, Unspecified Stage, Abnormalities of Gait And Mobility, Pain, History of Falling Facility Reported Incident of 4/21/2026 reported to IDPH on 4/22/2026 by E18, Former Executive Director documents in part: Incident/Accident Date: 4/21/2026 Time unknown Location: R1's apartment. On 4/21/2026 E18 and E9, Resident Care Coordinator were notified of a privacy concern involving a resident. It was reported that an overnight care staff member used a personal cell phone to record a resident who had experienced a large loose bowel movement, with the stated intent of notifying the nurse of the extent of care needed and requesting assistance. At the time of reporting. there was no Indication of resident Injury. Based on initial Information., the video was not shared or distributed. The allegation Involved a potential violation of resident rights and dignity related to unauthorized recording. The staff member Involved was immediately removed from duty pending investigation. A thorough investigation was	A6000		

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A6000	Continued From page 21 conducted. including interviews with all staff involved and review of the circumstances surrounding the Incident. Findings confirmed that the staff member did record the resident using a personal device during care. Interviews Indicated there was no malicious or intentional harmful intent; the staff member reported the purpose of the recording was to demonstrate the extent of care needs and request additional assistance to clean this resident. The Investigation further confirmed: The video was not shared on any social media. However, it was transmitted to one individual a nurse on duty that evening. The video was deleted from all staff member's personal devices. The recording did not include the resident's face? and no identifiable features were captured. Despite the absence of malicious intent, the action constituted a violation of resident rights. dignity, and company policy regarding resident privacy and the use of personal devices. Corrective Action Taken· The staff member responsible for the recording was terminated. All additional staff involved were counseled regarding resident rights, dignity and appropriate communication protocols. Immediate in-service education conducted for all staff on resident privacy during a town hall which included strict prohibition of personal device use for recording residents. Allegation was substantiated for violation of resident rights and privacy. R1's Service Plan documents in part: Focus: Toileting Assistance and Incontinence Care needs date-initiated 6/25=4/2024 Goal: My toileting assistance and incontinence care needs will be met through the next review date Target Date: 6/17/2026 Interventions: R1 needs physical assist of 1 person with toileting assistance and incontinence care	A6000		

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A6000	Continued From page 22 On 5/29/2026 at 3:38pm E5, Care Manager/Server stated, she heard about a staff person that tried to show picture of resident in an indecent state. We had in-service on not taking pictures and videos of residents and we cannot take any pictures. On 5/29/2026 at 3:55pm R1 sitting in wheelchair in the dining room talking with other residents. R1 dressed, groomed and wearing shoes. R1 alert and oriented and able to make needs known and wearing pendant and knows how to use pendant to call for help. R1 stated, she is very happy with facility and staff always help her. R1 stated, she had diarrhea a few weeks ago and she had to call for help. R2 stated it was terrible, but she needed help, so she had to call the caregiver, and the caregiver came and cleaned her up. R1 stated, she could not get to the bathroom. R1 stated, she does not remember anyone taking a picture of her nor anyone asking if they could take a picture of her. R1 stated it was an embarrassing and terrible situation, she felt bad having to ask for help. On 5/30/2026 at 2:56pm E2, Resident Care Director stated she is familiar with R1 and incident that occurred on 4/21/2026. E2 stated, she was informed by the RCC (E9, Resident Care Coordinator) that they put someone on administrative leave while the investigation was done. E2 stated she never saw the pictures but was told about it and she does not do anything with the care managers, but staff cannot take pictures of residents. No nurses reported anything to me, if the nurse was aware they should have reported to me. E2 stated, she knew the staff person was put on administrative leave, but she does not know anything else about what happened.	A6000		

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A6000	Continued From page 23 On 5/30/26 at 4:16pm E9, Resident Care Coordinator stated, she is familiar with R1 it was reported to her by E23, Care Manager that she had been shown a picture of a resident from another team member to make sure you are toileting residents. She said the picture showed R1 covered in BM and told E23 the resident's name. We connected with Human Resources and suspended pending investigation. E20, Care Manager said she took the picture. The picture was taken on her phone, and she showed the staff a picture. E20 denied showing anyone but wanted to show the nurse how this resident was done and had bad diarrhea. At that time E20 was Immediately suspended and she never returned to work. We terminated her for breach of company policy. We did full training on company policy on taking pictures of residents and personal belongings. I dealt with the care manager, but E9 was not sure about anyone else that involved a caregiver. E23 told another team member and that team member (E22, Care Manager) told her to make sure she told me E23 was shown a picture that she did not think was right. We did train immediately. On 5/30/2026 at 4:27pm E18 (Former ED) stated, she was familiar with pictures taken of R1. It was brought to my attention that a staff member had taken a picture of a resident to prove a point of other staff not doing what they were supposed to do. I listened to the report and brought in staff member (E20, Care Manager) with her supervisor (E9, Resident Care Coordinator) and asked if true and E20 showed me pics on her personal phone and E18 stated she explained company policy and E18 had her delete pictures and E18 saw her delete the pictures and she said she did not show others but showed it to the nurse to prove a point	A6000		

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A6000	Continued From page 24	A6000		

and told her that could not be done and we terminated her. E18 explained to E20 why this should not have been done, E18 stated, she did not think this was malicious, but this should not be done. E18 stated, she contacted the family and explained what had happened. R1 could not protect herself. E18 stated, she was told she did not do it to anyone else and we did staff meeting and town hall to remind staff of the policy. E18 stated she did see the picture and picture was of R1 lying in bed with BM over her. There is never a reason to do what she did. E20 wanted to explain why it took so long to clean this resident. E18 stated there was no documentation in the resident in the chart. E20 was complaining and using pictures as an explanation. E18 stated we have an internal investigation that was sent to legal department, but we do not share outside of facility. Initial and final sent. E18 made sure the family was aware, and she felt every step taken was done and done appropriately. R1 did not know pictures were taken and the resident was not able to give consent. E20 should have asked the nurse to come in but her concern was about workload. There were ongoing issues with this staff member. E20 took a picture on her personal phone, and we discussed dignity all the time.

During investigation E21, Licensed Practical Nurse (LPN) and E19, Care Manager (CM) were not available.

R2 admitted to facility on 4/27/2025 with diagnosis not limited to: Parkinson's Disease, Essential (Primary) Hypertension, Repeated Falls, Major Depressive Disorder, Single Episode, Unspecified, Gastro-Esophageal Reflux Disease without Esophagitis, Hyperlipidemia, Unspecified, Cellulitis of Left Toe, Anxiety Disorder, Unspecified, Unspecified Atrial Fibrillation,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF WESTMONT	407 W 63RD ST WESTMONT, IL 60559

(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
A6000	Continued From page 25 Unspecified Diastolic (Congestive) Heart Failure, Chronic Kidney Disease, Unspecified, Chronic Obstructive Pulmonary Disease, Unspecified, Unspecified Dementia, Unspecified Severity, Without Behavioral Disturbance, Psychotic Disturbance, Dementia Other Diseases Classified Elsewhere Facility Reported Incident dated May 18, 2026, at 12:50pm documents in part: Incident/Accident Date 5/16/2026, Time: 12:30pm Resident: R2 Location of Incident/Accident: Assisted Living Dinng Room 13, Licensed Practical Nurse (LPN) was notified of choking episode in dining room. E13 responded immediately. Upon getting to R2, it was reported R2 was able to independently expel a piece of meat. R2's diet order (Mechanical Soft) was not followed at time of incident. New information obtained on 5/18/2026 that abdominal thrusts were administered by staff. New order for chest x-ray and ST evaluation. R2 remains in stable condition. R2's Health Status Note dated 5/16/2026 at 13:01 by E13 documents in part: Writer was called down to dining room during lunch stat upon entering dining area observed care manager and activity coordinator standing at the table where resident was sitting they both stated he was choking on meat resident was able to expel the meat without any assistance before writer reaching dining room. Resident able to talk with no difficulty after food was expelled resident stated he was ok. Food taken away and resident was asked what else would he like he stated eggs, resident able to eat the eggs with no concerns. R2's active order dated 2/15/2026 documents in part: NAS (No Added Salt) diet Mechanical soft	A6000		

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A6000	Continued From page 26 texture, Honey consistency, Per Hospital Report, Moderate Thick Liquids, Soft Diet. For Wheezing R2 Service Plan dated 4/29/2026 Focus: Dining, Nutrition and Eating Needs Date Initiated: 04/24/2025 Revision on: 04/27/2025 Goal: My meal/snack preferences will be honored through the next review date. Date Initiated: 04/24/2025 Interventions: Provide me with the diet as ordered by my physician (NAS diet, mechanical soft texture, honey thick fluids) Date Initiated: 04/27/2025 Facility Policy undated documents in part: Use of Recording Devices Taking photographs or recording visual images of residents, resident rooms is prohibited unless appropriate authorization is obtained. Illinois Long-Term Care OMBUDSMAN PROGRAM RESIDENTS' RIGHTS | LONG-TERM CARE dated (Rev. 11/18) documents (in part): Your rights to safety Your facility must be safe, clean, comfortable and homelike. The right to privacy and confidentiality of records. The right to freedom from abuse, neglect, and exploitation Illinois Department of Public Health Assisted Living in Illinois documents (in part) In Illinois, assisted living facilities are required to provide a safe environment for residents. This includes adherence to building codes related to accessibility, fire safety, and sanitation, such as adequate lighting, ventilation, and emergency exits, including smoke detectors and fire extinguishers. Facilities must also ensure that the environment is safe, clean, comfortable, and homelike, with reasonable arrangements to meet residents' needs and choices. Privacy: Residents have the right to privacy regarding mail, phone calls, and visitors, and to respect for bodily	A6000		

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A6000	Continued From page 27 privacy during care.	A6000		