STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL5105850	A. BUILDING: _____ B. WING _____	C 06/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF WESTMONT	407 W 63RD ST WESTMONT, IL 60559

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A 000	Initial Comment Facility Reportable Investigation of 5-20-26/IL202141 295.4060 h)6) 295.4010 d)	A 000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Type 1 Violation Section 295.4010 Service Plan d) The service plan, which shall be reviewed annually, or more often as the resident's condition, preferences, or service needs change, shall serve as a basis for the service delivery contract between the provider and the resident (see Section 295.2030). (Section 15 of the Act) This requirement was not met as evidenced by: Based on interview and record review the facility failed to ensure care was provided according to the service plan to meet the residents needs for 1 out of 3 residents reviewed. This failure resulted in R1 being left alone in the dining room, having an unwitnessed fall and sustaining a subdural hematoma. This failure creates a substantial probability of sever harm or death to a resident or residents. Findings include: R1 is 95 years old with diagnosis but not limited	A4010		

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A4010	Continued From page 1 to: Dementia, Glaucoma. Facility's 5/22/26, incident time 4:15 am, state reportable regarding R1 documents in part: Resident with dementia residing In a secured memory care unit was found lying on her right side on the dining room floor. Care manager called nurse to assess. Resident was crying out in pain and complained of pain to back of her head and neck. Due to reslдent·s complaints of pain and concern for Injury, resident was not moved by staff pending emergency response. Nurse lmmedlately called 911 for evaluatlon and treatment. Resident was transported to ER (emergency room). Description of action taken by establishnet as result of incidnet/accident: Nurse responded immediately to assess the resident after fall. Resident remained on floor until 911 arrived due to complaints of head and neck pain. 911 called for emergency transport and evaluation. PCP (primary care provider) and POA notified of incident and transfer to the hospital. Resident returned from hospltal same day following evaluatlon after unwilnessed fall. Hospital diagnosed resident with subdural hematoma. No new orders. Resident remains at high risk for falls related to dementia, impaired judgement. and poor safety awareness. Hospital discharge Instructions reviewed and Implemented. Resident assessed by nurse for pain. and decline In condition. Service plan updated to reflect the following: 1. recurrent falls and subdural hematoma diagnosis. 2. Hospice consultation for 5/26/26 with pending order for hi-low bed to replace standard bed. 3. Frequent rounding/safety checks with staff assistance for mobllity and redirection as needed. 4. Clutter free environment to reduce Injury. PCP and POA notified of residents return.	A4010		

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A4010	Continued From page 2 R1 had a fall earlier that evening. R1's 5/21/2026 at 11:04 pm note documents: Type: Fall Progress Note Fall event details : Fall was unwitnessed in residents room 05/21/2026 at 10:30 PM. Resident unable to describe the event and how they felt just prior to falling. No injury noted at time of fall. R1's 5/21/2026 at 11:20 pm progress note documents in part: The writer was called by care manager to come to room around 10:30pm. Went there and observed resident sitting on the floor in between her bed and nightstand next to her bathroom door. Per care manager observed resident sitting on the floor when doing resident checks. Resident unable to describe what happened. Resident denies of hitting her head on the wall. Was able to move her extremities when assessed. Vitals: Bp-113/68, T-97.1, P-76, R-18. Resident was assisted back to bed with the help of the writer and care manager. The writer notified POA (power of attorney) around 10:41pm and advise her if she can consider putting resident on hospice. Resident bed does not go down to the lowest level, always complaining of pain, does not eat much during dinner and needs specialized chair for her comfort. On 6/12/26 at 11:16 am E4 LPN said residents are not to be left alone in the dining room for safety reasons. On 6/12/26 at 11:18 am E5 (Care Manger) said, residents are not to be left alone in the dining room, they can fall and anything can happen. E5 said, she monitors residents every 2 hours and some are every 30 minutes to 1 hour. On 6/12/26 at 11:19 am E3 (Care Manger) said residents are not to be left alone in the dining room and can fall.	A4010		

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A4010	Continued From page 3 On 6/12/26 at E6 at 11:42 am E6 (Licensed Practical Nurse) said, she was the nurse on duty for R1 when she had a fall in the dining room around 4 am. E6 said, the care giver called her she does not remember who that was, E6 was on the assisted living side so she went to the memory care unit. E6 said, R1 was on the floor by the table, by the kitchenette area, she was lying there, she yelled out in pain, E6 didn't not get her blood pressure as R1 was in pain. E6 said, she was in assisted living side, she was the only nurse on duty at night, she does not recall if R1 fell earlier, she is not sure if she fell on another shift earlier that day. E6 said, this incident happened around 4:30 am, R1 has been up thru the night and was having trouble sleeping. E6 said, around 4 am care managers they round on residents around that time. E6 said, she is not sure why R1 was up and was in the dining room, she thought R1 could not sleep. E6 said, there are 2 care givers on the memory care side at night. E6 said, she saw her with the caregivers 30 minutes before the incident, R1 was sitting in the tv area with the care givers 30 minutes before. E6 said, R1 could not sleep so they were sitting with her. E6 said, she has seen residents being left alone in the dining room before, but those who are a fall risk they are not to be left alone in the dining room. On 6/12/26 at 12:40 pm E7 (Care Manger) said she was assigned to R1 on 5/21 the night shift. E7 said that shift R1 fell twice, she was doing her 10 o'clock rounding and E7 found R1 around 10:20 pm, and she was sitting on her bottom on the floor by the edge of the bed , she was between the night stand and her bed on the floor, the nurse came in and evaluated R1 and placed her back to bed. E7 said, when she came back to	A4010		

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A4010	Continued From page 4 R1's room for another round, at 11:30 pm she was getting out of bed, she was up and awake and alert and moving. E7 said, she did not want R1 to fall so she put R1 in her wheelchair and she sat R1 outside in the common area with her, they sat by the sofas , she sat with her until around 4:20 am. E7 said, the whole time, R1 kept trying to stand up and get up from the wheelchair. E7 said, R1 was up the whole night, she would have gotten up and E7 didn't want her to fall again. E7 said, she was able to watch her until E7 had a motion sensor that went off and she had to attend to another resident, and she left R1 in the wheelchair. E7 said, she moved her to the dining room, right in front of a table, gave her water and locked the chair and when she retuned, she was on the floor, her arms were on the right side, there was no bleeding, she called E6 right away. E7 said, there was another caregiver on duty, E8 and at that time E8 was attending to other residents as well and she was not able to help with R1. E7 said, R1 was a fall risk, there is always 2 care givers that night, the nurse majority of the time stays in the memory care. E7 said, residents are not to be left alone in the dining room, it was a particular hour if she would leave her a the original place she would get up and fall, they don't really leave them alone in the dining room as well. E7 said, when she returned R1 was on the floor. On 6/12/26 at 1:02 pm E9 (Licensed Practical Nurse) said, her shift was about to end on 5/21/26, she works 3 pm-11 pm. E9 said, they called her to come to R1's room, she was observed on the floor, she could not tell what happened, she did not have any injuries, she was able to stand up and they put her back to bed. E9 said, she called poa and pcp and notified E2 (Resident Care Director) and E9 did a fall note.	A4010		

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A4010	Continued From page 5 E9 said, she was alert and verbally responsive, after a fall they chart on them for 3 days. E9 said, every shift they make sure R1 is ok, during the shift they go and check on her every hour. E9 said, if a resident has any injuries, she will call 911 and send the resident out. E9 said, if a resident is having a behavior and is trying to get up , E9 will make sure care manager will stay with the resident. E9 said, if a fall risk resident is trying to get up, care managers will stay close to them, and another option is 1 on 1 for the resident. E9 said, she gave report to the oncoming nurse that R1 had a fall. On 6/13/26 at 8:46 am E2 (Resident Care Director) said, due to her falls R1 was to be checked on every 30 minutes to 1 hour. E2 said,on 5/22/26 R1 was brought in the common area because she was having a behavior. E2 said, they kept her up in the chair so someone can keep an eye on her so she does not fall. E2 said, this behavior was not common for her to be up all night, this was a change in condition for R1. E2 said, fall interventions should be specific to the incident. E2 said, residents should not be left alone in the dining room. E2 said, staffing for the memory care unit for overnight has 2 care givers and 1 nurse and the nurse is the 3rd person there, the nurse is the 3rd person if they need anything. E2 said, the nurse for the night shift is for the whole building. E2 said, she feels staffing is adequate, but more hands can be used in the case of R1. E2 said, If this would be a pattern of being up all night for R1, they would ask for 1 on 1 sitter for her. E2 said, there are 29 to 30 residents in memory care. Surveyor read Facility's 5/22/26 fall interventions for R1 falling in the dining room to E2 which were: recurrent falls and subdural hematoma diagnosis. Hospice consultation for 5/26/26 with pending order for	A4010		

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A4010	Continued From page 6 hi-low bed to replace standard bed. Frequent rounding/safety checks with staff assistance for mobility and redirection as needed. Clutter free environment to reduce Injury. E2 said, those care plan interventions do not address the fact R1 was left in the dining room. On 6/12/26 at 11:58 am E8 (Care Manger) was called was called without response. R1's care plan documents in part: I have had an actual fall Date Initiated: 03/28/2026. Goal: I will resume usual activities without further incident through the next review date, Target Date: 06/09/2026. Interventions: Frequent rounding/safety checks with staff assistance for mobility and redirection as needed. Clutter free environment to reduce injury. Date Initiated: 05/21/2026. . Facility's contract with R1 documents in part: E.Resident Service Plan. A Service Plan will be developed based on the Physician's Report, the Psychiatric Examination (if applicable) and the Assessment. The Resident's service plan will be developed with the Resident and/or any individual the Resident designates, including any Responsible Party. The service plan will outline the services the Resident is to receive and shall be updated annually or more frequently as necessary to reflect service needs.	A4010		
A4060	Seciton 295.4060 Alzheimer's and Demential Programs This Regulation is not met as evidenced by: Type 1 Violation	A4060		

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A4060	Continued From page 7 Section 295.4060 Alzheimer's and Dementia Programs h) An establishment that offers to provide a special program for persons with Alzheimer's disease and related disorders shall: 6) Provide an appropriate number of staff for its resident population. The establishment shall provide staff sufficient in number, with qualifications, adequate skills, education, and experience to meet the 24-hour scheduled and unscheduled needs of the residents and who participate in ongoing training, to serve the resident population. At a minimum, at least one staff member shall be awake and on duty at all times. This requirement was not met as evidenced by: Based on interview and record review the facility failed to ensure sufficient staffing were available to meet the residents needs for 1 out of 3 residents reviewed. This failure resulted in R1 being left alone in the dining room, having an unwitnessed fall and sustaining a subdural hematoma. This failure creates a substantial probability to cause of severe harm or death to a resident or residents. Findings include: R1 is 95 years old with diagnosis but not limited to: Dementia, Glaucoma. Facility's 5/22/26, incident time 4:15 am, state reportable regarding R1 documents in part: Resident with dementia residing In a secured memory care unit was found lying on her right	A4060		

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A4060	Continued From page 8 side on the dining room floor. Care manager called nurse to assess. Resident was crying out in pain and complained of pain to back of her head and neck. Due to reslдent·s complaints of pain and concern for Injury, resident was not moved by staff pending emergency response. Nurse Immedlately called 911 for evaluatlon and treatment. Resident was transported to ER (emergency room). Description of action taken by establishnet as result of incidnet/accident: Nurse responded immediately to assess the resident after fall. Resident remained on floor until 911 arrived due to complaints of head and neck pain. 911 called for emergency transport and evaluation. PCP (primary care provider) and POA notified of incident and transfer to the hospital. Resident returned from hospltal same day following evaluatlon after unwilnessed fall. Hospital diagnosed resident with subdural hematoma. No new orders. Resident remains at high risk for falls related to dementia, impaired judgement. and poor safety awareness. Hospital discharge Instructions reviewed and Implemented. Resident assessed by nurse for pain. and decline In condition. Service plan updated to reflect the following: 1. recurrent falls and subdural hematoma diagnosis. 2. Hospice consultation for 5/26/26 with pending order for hi-low bed to replace standard bed. 3. Frequent rounding/safety checks with staff assistance for mobllity and redirection as needed. 4. Clutter free environment to reduce Injury. PCP and POA notified of residents return. R1 had a fall earlier that evening. R1's 5/21/2026 at 11:04 pm note documents: Type: Fall Progress Note Fall event details : Fall was unwitnessed in residents room 05/21/2026 at 10:30 PM. Resident unable to describe the event and how they felt just prior to falling. No injury noted at time of fall.	A4060		

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A4060	Continued From page 9 R1's 5/21/2026 at 11:20 pm progress note documents in part: The writer was called by care manager to come to room around 10:30pm. Went there and observed resident sitting on the floor in between her bed and nightstand next to her bathroom door. Per care manager observed resident sitting on the floor when doing resident checks. Resident unable to describe what happened. Resident denies of hitting her head on the wall. Was able to move her extremities when assessed. Vitals: Bp-113/68, T-97.1, P-76, R-18. Resident was assisted back to bed with the help of the writer and care manager. The writer notified POA (power of attorney) around 10:41pm and advise her if she can consider putting resident on hospice. Resident bed does not go down to the lowest level, always complaining of pain, does not eat much during dinner and needs specialized chair for her comfort. On 6/12/26 at 11:16 am E4 LPN said residents are not to be left alone in the dining room for safety reasons. On 6/12/26 at 11:18 am E5 (Care Manger) said, residents are not to be left alone in the dining room, they can fall and anything can happen. E5 said, she monitors residents every 2 hours and some are every 30 minutes to 1 hour. On 6/12/26 at 11:19 am E3 (Care Manger) said residents are not to be left alone in the dining room and can fall. On 6/12/26 at E6 at 11:42 am E6 (Licensed Practical Nurse) said, she was the nurse on duty for R1 when she had a fall in the dining room around 4 am. E6 said, the care giver called her she does not remember who that was, E6 was	A4060		

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A4060	Continued From page 10	A4060		

on the assisted living side so she went to the memory care unit. E6 said, R1 was on the floor by the table, by the kitchenette area, she was lying there, she yelled out in pain, E6 didn't not get her blood pressure as R1 was in pain. E6 said, she was in assisted living side, she was the only nurse on duty at night, she does not recall if R1 fell earlier, she is not sure if she fell on another shift earlier that day. E6 said, this incident happened around 4:30 am, R1 has been up thru the night and was having trouble sleeping. E6 said, around 4 am care managers they round on residents around that time. E6 said, she is not sure why R1 was up and was in the dining room, she thought R1 could not sleep. E6 said, there are 2 care givers on the memory care side at night. E6 said, she saw her with the caregivers 30 minutes before the incident, R1 was sitting in the tv area with the care givers 30 minutes before. E6 said, R1 could not sleep so they were sitting with her. E6 said, she has seen residents being left alone in the dining room before, but those who are a fall risk they are not to be left alone in the dining room.

On 6/12/26 at 12:40 pm E7 (Care Manger) said she was assigned to R1 on 5/21 the night shift. E7 said that shift R1 fell twice, she was doing her 10 o'clock rounding and E7 found R1 around 10:20 pm, and she was sitting on her bottom on the floor by the edge of the bed , she was between the night stand and her bed on the floor, the nurse came in and evaluated R1 and placed her back to bed. E7 said, when she came back to R1's room for another round, at 11:30 pm she was getting out of bed, she was up and awake and alert and moving. E7 said, she did not want R1 to fall so she put R1 in her wheelchair and she sat R1 outside in the common area with her, they sat by the sofas , she sat with her until around

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A4060	Continued From page 11 4:20 am. E7 said, the whole time, R1kept trying to stand up and get up from the wheelchair. E7 said, R1 was up the whole night, she would have gotten up and E7 didn't want her to fall again. E7 said, she was able to watch her until E7 had a motion sensor that went off and she had to attend to another resident, and she left R1 in the wheelchair. E7 said, she moved her to the dining room, right in front of a table, gave her water and locked the chair and when she retuned, she was on the floor, her arms were on the right side, there was no bleeding, she called E6 right away. E7 said, there was another caregiver on duty, E8 and at that time E8 was attending to other residents as well and she was not able to help with R1. E7 said, R1 was a fall risk, there is always 2 care givers that night, the nurse majority of the time stays in the memory care. E7 said, residents are not to be left alone in the dining room, it was a particular hour if she would leave her a the original place she would get up and fall, they don't really leave them alone in the dining room as well. E7 said, when she returned R1 was on the floor. On 6/12/26 at 1:02 pm E9 (Licensed Practical Nurse) said, her shift was about to end on 5/21/26, she works 3 pm-11 pm. E9 said, they called her to come to R1's room, she was observed on the floor, she could not tell what happened, she did not have any injuries, she was able to stand up and they put her back to bed. E9 said, she called poa and pcp and notified E2 (Resident Care Director) and E9 did a fall note. E9 said, she was alert and verbally responsive, after a fall they chart on them for 3 days. E9 said, every shift they make sure R1 is ok, during the shift they go and check on her every hour. E9 said, if a resident has any injuries, she will call 911 and send the resident out. E9 said, if a	A4060		

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(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
A4060	Continued From page 12 resident is having a behavior and is trying to get up , E9 will make sure care manager will stay with the resident. E9 said, if a fall risk resident is trying to get up, care managers will stay close to them, and another option is 1 on 1 for the resident. E9 said, she gave report to the oncoming nurse that R1 had a fall. On 6/13/26 at 8:46 am E2 (Resident Care Director) said, due to her falls R1 was to be checked on every 30 minutes to 1 hour. E2 said,on 5/22/26 R1 was brought in the common area because she was having a behavior. E2 said, they kept her up in the chair so someone can keep an eye on her so she does not fall. E2 said, this behavior was not common for her to be up all night, this was a change in condition for R1. E2 said, fall interventions should be specific to the incident. E2 said, residents should not be left alone in the dining room. E2 said, staffing for the memory care unit for overnight has 2 care givers and 1 nurse and the nurse is the 3rd person there, the nurse is the 3rd person if they need anything. E2 said, the nurse for the night shift is for the whole building. E2 said, she feels staffing is adequate, but more hands can be used in the case of R1. E2 said, If this would be a pattern of being up all night for R1, they would ask for 1 on 1 sitter for her. E2 said, there are 29 to 30 residents in memory care. Surveyor read Facility's 5/22/26 fall interventions for R1 falling in the dining room to E2 which were: recurrent falls and subdural hematoma diagnosis. Hospice consultation for 5/26/26 with pending order for hi-low bed to replace standard bed. Frequent rounding/safety checks with staff assistance for mobility and redirection as needed. Clutter free environment to reduce Injury. E2 said, those care plan interventions do not address the fact R1 was left in the dining room.	A4060		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL5105850	A. BUILDING: _____ B. WING _____	C 06/14/2026

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A4060	Continued From page 13 On 6/12/26 at 11:58 am E8 (Care Manger) was called was called without response. Facility's Alzheimer's Care Disclosure Statement documents in part: 4. Staff and Staff Training- staffing patterns and ratios in the neighborhood are dependent upon the needs of the resident population.	A4060		