STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510346	A. BUILDING: _____ B. WING _____	C 05/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF FLOSSMOOR	19715 GOVERNOR'S HWY FLOSSMOOR, IL 60422

(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 Investigation of Facility Reported Incident of 3/29/25, IL190058- Substantiated. Violations 295.6000 a)13)	A 000		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: General Violation Section 295.6000 Resident Rights a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the Sate 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: 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 observation, interview and record review the facility failed to ensure a resident was free from abuse for 1 of 3 residents (R1) reviewed for abuse in the sample of 3. The findings include: R1's move in record shows she moved in on 8/15/24 with a diagnosis of unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood	A6000		

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A6000	Continued From page 1	A6000		

disturbance and anxiety.

R1's 8/15/24 service plan notes she is unable to remember specific or recent events, and has impaired cognitive function related to the dementia. The service plan documents unsafe behavior and R1 to be at risk for abuse.

The facility's incident report for the events of 3/29/25 documents R1 was overhead by staff stating "you hit me". Upon investigation and assessments, R1 was found to have a skin tear to her left forearm. R1 could not recall the events.

On 5/31/25 at 11:45 AM, R1 was observed on the memory care unit. She was alert, and oriented to her name but could not state where she was or how long she had been there. She did not recall any of the 3/29/25 incident.

On 5/31/25 at 11:00 AM, E4 Life Enrichment Manager described R1 as alert and oriented to her name, and had no behaviors. She said when she arrived to the memory care unit on 3/29/25 and made rounds to check on residents. R1 was very upset and told her she just wanted staff to stop hitting her, and that was not usual behavior or something R1 would say, so she knew something happened. E4 said she asked R1 who hit her, and R1 was unable to name any staff.

On 5/31/25 at 11:18 AM, E6 Director of Sales said on 3/29/25 she arrived in the office early. She has an office with a door attached to the memory care unit, and can hear staff and residents on the unit. She said that morning she heard yelling and something about "don't touch this", and recognized R1's voice and one of the care managers. E6 said she heard a bang of

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A6000	Continued From page 2	A6000		

some sort, and did not know what it was, then R1 said "Owe". E6 said she went around to the kitchen and saw R1 with E9 Care Manager and R1 was had blood on her arm from a scratch or a skin tear. She said E9 had a coffee pot in her hand, and R1 said E9 hit her. E6 said she immediately removed E9 from the memory care unit and returned to R1 and took her to the nurse. E6 said there was no other staff in the immediate area. She said R1 appeared defeated, and was not angry, she just kept touching her arm and saying "she hit me".

The nursing progress notes of 3/29/25 show E7 LPN (Licensed Practical Nurse) assessed R1 and found her to have a skin tear about 7-8 cm (centimeters) on the left arm. R1 said to E7, a team member had been inappropriate with her.

In a written statement on 3/29/25, E9 reported she saw R1 trying to pour a cup of tea, and thought it was hot tea and asked her to put the pot down. She writes R1 began swinging the pot and she was trying to keep R1 from burning herself. She documents R1 was hitting, kicking and screaming.

On 5/31/25 at 1:10 PM, E1 Executive Director said she was notified on the morning of 3/29/25, E6 had overheard loud noises and 2 people going back and forth with words, and a resident saying "you hit me". E6 reported she saw blood on the resident. E1 said based on the interviews and the new skin tear R1 had at the time of the event, she did believe there was injury related to the incident.

The facility's 4/24/25 policy for Abuse, Neglect & Exploitation documents the definition of abuse to be the infliction of injury, unreasonable

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A6000	Continued From page 3 confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. Physical abuse is the willful infliction of bodily injury or physical harm upon any resident. Physical abuse includes hitting, slapping, pinching, kicking and any form of corporal punishment.	A6000		