

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ASL510351	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/08/2025
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NAME OF PROVIDER OR SUPPLIER SUNRISE OF NAPERVILLE NORTH	STREET ADDRESS, CITY, STATE, ZIP CODE 535 W OGDEN AVE NAPERVILLE, IL 60563
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A 000	Initial Comment Licensure Survey - No deficiency Facility Reported Incident (FRI) IL189202 (3/28/25) 295.3000 cited 295.4010 cited	A 000		
A3000	Section 295.3000 Personnel Requirmts, Qualifns, and Trng This Regulation is not met as evidenced by: General 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 personnel to provide the following for its current resident population: 1) All mandatory services; 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	A3000		

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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A3000	<p>Continued From page 1</p> <p>the ability to intervene in a crisis.</p> <p>This requirement is not met as evidenced by:</p> <p>Based on record review and interview the facility failed to follow it's elopement policy, failed to document elopement assessments for two residents residents (R5, R6), failed to document staff assessments of and the condition and or appearance of one resident's nephrostomy site and tubing (R3), failed to document care/assessment of one resident's leg wound (R2) and failed to adequately monitor one resident who had been assessed and found to be an elopement risk (R1) allowing this confused resident (R1) to elope from the facility where he was injured while outside the facility. These failures caused harm to R1 and creates a substantial probability of harm to R2, R3 and other residents with wounds, care needs, those assessed as fall risks and those residents assessed as elopement risk.</p> <p>Findings include:</p> <p>1). R1 was admitted to the Assisted Living (AL) section of the facility 1/25/24 with diagnoses that included Dementia and BPH (Benign Prostate Hypertrophy). R1's Functional Assessment Staging of Alzheimer's Disease (FAST), a cognitive assessment, indicated the resident had early dementia. The facility also assessed R1 and determined he was at risk of elopement.</p> <p>R1's Progress Notes periodically documented the resident was confused. Staff interviewed stated the resident was occasionally confused, with E1 (Executive Director) and E9 (Resident Care Director), both stating the resident had been</p>	A3000		

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A3000	<p>Continued From page 2</p> <p>assessed as an elopement risk and was alert with some confusion. There wasn't any elopement assessment in the record.</p> <p>Continued review of R1's record and sign out ledger showed the resident had previously signed out of and into the facility. March 28, 2025's Progress Note and the sign out ledger documented On 3/28/25 R1 signed out at 5:22 PM but didn't sign in again.</p> <p>On 4/23/25 E1 and E9 stated staff did look for R1 inside and outside the facility. Z1 (an employee at a sister facility) contacted the facility and told them R1 had fallen and had been seen at a nearby gas station. E10 (Maintenance Director) and E11(Lead Care Manager) went to the gas station and verified the resident was R1. The resident was sent to the hospital for evaluation and admitted with a diagnosis of Shortness of Breath (SOB).</p> <p>When interviewed 4/23/25 E10 and E11 gave the same information stating after being informed R1 hadn't returned from outside they'd looked in the facility and when R1 wasn't found looked outside. E10 stated that Z1 told him he'd seen R1 sit on the curb at the gas station and R1 had seemed confused.</p> <p>R1's service plan (SP) didn't mention or address the resident's elopement risk.</p> <p>2). R5 and R6 were identified as elopement risks. Review of their records failed to show evidence of an elopement assessment having been done. There wasn't any documentation of staff having assessed or monitored the residents for signs of elopement attempts.</p>	A3000		

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A3000	<p>Continued From page 3</p> <p>Neither E1 or E9 were able to provide evidence of an elopement risk assessment. E9 stated the elopement assessments are part of the resident's SEHA (Service Evaluation and Health Assessment) but after several requests failed to provide evidence on the resident's SEHA's. On 5/1/25 this surveyor contacted E9 via phone and via email again requesting the information and asked that the assessments clearly showing the residents were elopement risk be identified but the information was never received.</p> <p>Review of the facility's Elopement Management Program (Policy) stated Assisted Living (AL) and Reminiscence residents are assessed for elopement risk and cognitive status using the Brief Interview for Mental Status (BIMS) as part of the comprehensive assessment upon move in and every six months or as needed.</p> <p>The policy also stated the assessments are to be used to develop "customized" individualized interventions based on identified risks and behaviors. This wasn't done for R1, R 5 and R6.</p> <p>3). R2 was admitted to the facility 3/22/24 with diagnoses including Hypertension (HTN) and Atrial fibrillation. Documentation indicated R2's vascular wound was on her right leg, but review of wound care notes showed the wound was actually on the left leg. The resident has a vascular wound on her left lower leg which is being treated by home health. Review of R2's record showed multiple entries of wound care being done by a home health nurse but failed to mention staff's assessment of the resident's wound or dressing between home health nursing visits and dressing</p>	A3000		

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A3000	<p>Continued From page 4</p> <p>changes. When interviewed 4/28/25 R2 stated that the home health nurse changes her dressing on her leg, not facility staff that staff doesn't check her leg.</p> <p>4). R3 was admitted 9/2/22 with diagnoses including Chronic Obstructive Pulmonary disease (COPD), Paralytic Syndrome following Cerebral Infarct affecting left side. R3 also has a nephrostomy which documentation shows is cared for by the hospice nurse.</p> <p>Review of R3's Progress Notes failed to consistently document the facility's staff monitoring and or assessment of the appearance and functioning of the nephrostomy tube between hospice nurses visits.</p> <p>The facility's Quick Reference Guide to be used in the care of nephrostomy tubes listed interventions that were recommended as part of a resident's individual service plan. Staff was instructed to indicate the presence and location of the nephrostomy tube, drainage collection device used and reason for using the tube. The procedure and care to be used when changing the bedside bag was identified. There was no evidence the policy was followed by the facility staff. There wasn't documentation the interventions from the Guide in the care of nephrostomy were used by the facility in the care of R3.</p> <p>On 4/28/25 when interviewed R3 was observed wearing a leg bag which was attached to the nephrostomy tubing. R3 stated facility staff doesn't wash his nephrostomy tubing they only change the bag.</p>	A3000		

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A3000	Continued From page 5 Z2 (hospice nurse) stated hospice nurses provides care of R3's nephrostomy, tubing and changes the bags. E9 stated nurses notify the hospice nurse if the nephrostomy bag leaks between hospice visits nurses are expected to address the issue, there are items in the supply room.	A3000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: General 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. 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) e) The service plan shall be reviewed and revised if necessary immediately after a significant	A4010		

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A4010	<p>Continued From page 6</p> <p>change in the resident's physical, cognitive, or functional condition.</p> <p>This requirement is not met as evidenced by:</p> <p>Based on record review and interviews the facility failed to develop and implement individualized goals and interventions to address 3 residents (R1, R5 and R6) who were assessed and identified by the facility as elopement risks, failed to develop and implement goals and individualized interventions for one resident (R2) who has a vascular wound on her right leg and failed to develop goals and individualized interventions for one resident (R3) who has a nephrostomy as written in the facility's "Quick Reference Guide for Nephrostomy Tubes". These failures have caused harm to R1 and creates a substantial probability of harm to other residents.</p> <p>Findings include:</p> <p>1). R1 was admitted to the Assisted Living (AL) section of the facility 1/25/24 with diagnoses that included Dementia and BPH (Benign Prostate Hypertrophy). R1's Functional Assessment Staging of Alzheimer's Disease (FAST), a cognitive assessment, indicated the resident had early dementia. The facility also assessed R1 and determined he was at risk of elopement.</p> <p>R1's Progress Notes periodically documented the resident was confused. Staff interviewed stated the resident was occasionally confused, with E1 (Executive Director) and E9 (Resident Care Director) both stating the resident had been assessed as an elopement risk and was alert with some confusion.</p>	A4010		

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A4010	<p>Continued From page 7</p> <p>Review of R1's record and sign out ledger showed the resident had previously signed out of and into the facility. March 28, 2025's Progress Note and the sign out ledger documented R1 had signed out of the facility at 5:22 PM but didn't sign in again.</p> <p>Staff looked for R1 inside and outside the facility until E12 (an employee at another facility) contacted the facility and informed them R1, who appeared, confused was at a nearby gas station sitting on the curb. When E10 (Maintenance Director) and E11 (Lead Care Manager) arrived at the gas station R1 was already in an ambulance and police informed them the resident was being transferred to an area hospital for evaluation where he was admitted.</p> <p>Review of R1's service plan (SP) in use at the time of the resident's elopement showed the elopement risk wasn't addressed prior to his leaving the facility 3/28/25 and his subsequent transfer to the hospital.</p> <p>2). R5 and R6 were identified as elopement risks. Neither resident's SP addressed the residents elopement risk.</p> <p>3). R2 was admitted to the facility 3/22/24 with diagnoses including Hypertension (HTN) and Atrial fibrillation. Review of wound care notes showed the resident had a vascular wound on her left leg which is being treated by home health. Review of R2's SP showed the vascular wound was not addressed at all.</p> <p>4). R3 was admitted 9/2/22 with diagnoses including Chronic Obstructive Pulmonary disease</p>	A4010		

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A4010	Continued From page 8 (COPD), Paralytic Syndrome following Cerebral Infarct affecting left side. R3 also has a nephrostomy which is cared for by the hospice nurse. Review of the resident's SP showed the facility failed to detail the type of care the hospice nurse provided and failed to address the care facility staff provides to R3's nephrostomy as identified in the facility's policy on nephrostomy care.	A4010		