STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510354	A. BUILDING: _____ B. WING _____	C 09/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF PARK RIDGE	1725 BALLARD RD PARK RIDGE, IL 60068

(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 Type 2 Violations Facility Reported Incident IL00193527: 295.4010 a) b) 1) 2) 3) c) d) e) cited Facility Reported Incident IL00196315: 295.5000 a) f) 1) 2) h) 1) 3) cited	A 000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Type 2 Violation Section 295.4010a)b)1)2)3)c)d)e) 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. b) The service plan shall be developed by: 1) The resident, resident's representative or any individual requested by the resident; 2) The manager or manager's designee; and 3) A registered nurse, if the resident is receiving nursing services or medication administration, or is unable to direct self-care. c) The service plan shall be signed and dated by all individuals involved in its development. d) The service plan, which shall be reviewed	A4010		

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A4010	Continued From page 1	A4010		

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 change in the resident's physical, cognitive, or functional condition (see Section 295.4000).

These requirements were not met as evidenced by:

Based on record review and interview, the establishment failed to revise a service plan following multiple falls and/or implement appropriate fall interventions to prevent further fall incidents for one resident (R1); failed to implement appropriate fall interventions in a timely manner after a fall for another resident (R4); and failed to have an effective fall management policy and procedure in place to prevent resident falls. This failure affected two of three residents with cognitive impairment reviewed for service plans and fall interventions in a sample of four. This failure creates a substantial probability of harm to a resident or residents.

Findings include:
1. R1's face sheet provided by facility on 09/13/2025 documented a move-in date of 04/28/2025 with a past medical history not limited to dementia, mild cognitive impairment, and hypertension.

Review of facility incident reports showed R1 had a fall in her room on 05/13/2025 and fell in the hallway on 05/23/2025 and 05/28/2025. R1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510354	A. BUILDING: _____ B. WING _____	C 09/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF PARK RIDGE	1725 BALLARD RD PARK RIDGE, IL 60068

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A4010	Continued From page 2	A4010		

sustained minor injuries and was sent to the local emergency room after each fall for further evaluation and treatment with no significant findings.

R1's facility incident report dated 05/30/2025 indicated R1 was observed on the bathroom floor in her room with complaints of left hip pain that was "shooting down her foot". R1 was hospitalized and diagnosed with a left hip fracture that required surgical intervention.

Service Plan Report last reviewed 04/30/2025 indicated R1 is a fall risk with previous fall incidents, initiated 05/16/2025. Interventions included but not limited to inform me and my caregivers about safety reminders and what to do if a fall occurs; remind me to rise and change positions slowly, both initiated 04/28/2025.

R1's fall interventions after her 05/15/2025 fall incident included to check on resident at frequent intervals as per policy; observe for and report any changes in gait and/or balance; remind resident to rise and change positions slowly; immediately report any new onset of confusion, sleepiness, inability to maintain posture, agitation, all initiated 05/16/2025.

R1's fall interventions after her 05/23/2025 fall incident included no new interventions.

R1's fall interventions after her 05/28/2025 fall incident included for care manager to check on resident two to four times per shift and as needed and remind resident not to sit on her walker and wheel it backwards, both initiated 05/29/2025.

R1's fall interventions after her 05/30/2025 fall incident included, after falling and before moving

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510354	A. BUILDING: _____ B. WING _____	C 09/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF PARK RIDGE	1725 BALLARD RD PARK RIDGE, IL 60068

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A4010	Continued From page 3	A4010		

resident, evaluate her for changes in range of motion; have me seen by therapy for strength and mobility/balance after I have fallen as ordered by my physician; remind me to use my assistive device(s): walker; remind me to use my call device call light for any assistance I may need, all initiated 05/30/2025.

R1's progress note dated 06/07/2025 at 12:02 AM documented resident returned to facility, "post fall incident ...had left hip fracture and underwent left hip arthroplasty" ...

R1's physician note dated 06/12/2025 indicated resident was seen and examined for admission and documented under history of present illness (HPI), "brought into the [emergency room] from assisted living facility for eval of hip pain after she fell. Patient was found to have left hip fracture" ... Past surgical history (PSH) included hemiarthroplasty left hip ...

On 09/13/2025 at 12:31 PM, E3 (Licensed Practical Nurse) said R1 is a high fall risk and when she first admitted, R1 was very agitated and combative and always wanted to stay in her room. E3 added that most of R1's falls occurred in her room while she was attempting to do various things by herself.

On 09/13/2025 at 12:44 PM, R1 was observed on fourth floor unit seated in common area. R1 recalled falling "a few times" then said after her last fall, she had "pain to her leg" (pointed to her left leg) and "had to have surgery on it". R1 voiced no falls since returning to the facility after her surgery.

On 09/13/2025 at 05:06 PM, E2 (Director of Nursing) said R1 was noted with behaviors when

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510354	A. BUILDING: _____ B. WING _____	C 09/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF PARK RIDGE	1725 BALLARD RD PARK RIDGE, IL 60068

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A4010	Continued From page 4	A4010		

she first came in and refused to take her psych meds. E2 then said that R1 had falls on 05/15/2025, 05/23/20225 and 05/28/2025 with interventions put into place after each fall. E2 added that staff were trying to increase monitoring every few hours and tried to keep R1 in common areas.

2. R4's face sheet provided by facility on 09/13/2025 documented a move-in date of 10/05/2024 with a past medical history not limited to lack of coordination, difficulty in walking, cognitive communication deficit, and hypertension.

Review of R4's fall incident note dated 09/06/2025 at 06:45 AM indicated resident was observed sitting on the floor in the hallway outside of her room door and sustained abrasions to the right eyebrow and cheekbone.

R4's care plan provided by facility on 09/13/2025 indicated resident is a fall risk and had an actual fall with date initiated of 09/12/2025. Interventions included to remove potential hazards and remind resident to use her call device, both initiated 09/12/2025.

On 09/13/2025 at 01:00 PM, observed R4 in fourth floor dining room standing near a table with her walker next to the table. R4 was alert to self and did not recall any details regarding her fall.

On 09/13/2025 at 05:10 PM, E2 (Director of Nursing) said fall interventions are updated within 72 hours of a fall incident. At 5:32 PM, E2 said that R4 moved to the fourth floor on 09/12/2025 and no fall interventions were implemented for R4 so E2 added them on 9/12/2025. E2 added that R4's interventions should have been done within

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510354	A. BUILDING: _____ B. WING _____	C 09/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF PARK RIDGE	1725 BALLARD RD PARK RIDGE, IL 60068

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A4010	Continued From page 5 three days of her fall on 09/06. Requested fall policy and procedure from facility and received the "Safe Resident Movement Program" policy and procedure (see below). Safe Resident Movement Program last updated 12/04/2019 reads in part: the safe resident movement program is a sunrise resident care approach that utilizes the APIE (assess, plan, implement, and evaluate) approach to care giving ...the goal is to provide residents and care managers with an environment that promotes safety while minimizing the risk of injury to both the care giver and our residents. This goal can be accomplished by using prevention, equipment, management strategies and education and training ...	A4010		
A5000	Section 295.5000 Medication Reminders, Supervision of Self Med This Regulation is not met as evidenced by: Type 2 Violation Section 295.5000 a) f) 1) 2) h) 1) 3) Section 295.5000 Medication Reminders, Supervision of Self-Medication, Medication Administration and Storage a) An establishment may provide medication reminders, supervision of self-administered medication, and medication administration as an optional service. f) If an establishment provides medication administration or supervision of self-administered medication, the establishment's medication	A5000		

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	ASL510354	A. BUILDING: _____ B. WING _____	C 09/14/2025

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A5000	Continued From page 6	A5000		

policies and procedures shall be approved by a physician, pharmacist, or registered nurse and shall address:
1) Obtaining and refilling medication;
2) Storing and controlling medication;
h) Any medication stored by the establishment shall meet the following requirements:
1) Medication shall be stored in a locked container, cabinet, or area that is inaccessible to residents;
3) Medication shall be stored in the original labeled container, except for medication organizers, and according to instructions on the medication label;

These requirements were not met as evidenced by:

Based on record review and interview, the establishment failed to ensure that a resident's (R2) medication was stored and controlled properly by not performing an accurate count with two authorized staff members at each shift change that led to medication diversion. This failure affects one of three residents reviewed for medications in a sample of four. This failure creates a substantial probability of harm to a resident or residents.

The findings include:
R2's face sheet documented move-in date of 01/26/2024 and a discharge date of 06/29/2025. Past medical history included but not limited to malignant neoplasm to bronchus or lung, brain and cerebellum, bone and chronic obstructive pulmonary disease.

R2's facility incident report dated 06/24/2025 indicated that one box of resident's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510354	A. BUILDING: _____ B. WING _____	C 09/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF PARK RIDGE	1725 BALLARD RD PARK RIDGE, IL 60068

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A5000	Continued From page 7	A5000		

loratadine/pseudoephedrine (pse) 10mg-240 mg (milligram) was not accounted for and reported missing on 06/22/25 at 09:00 PM during shift change. Interviews were conducted, R2's apartment was searched along with medication carts, storage areas and the wellness office but R2's medication was not found. Pharmacy confirmed the medication was dispensed.

Review of R2's discontinued physician's orders and medication administration record (MAR) that showed orders to take one tablet of loratadine/pse 10-240 mg by mouth daily as needed for nasal congestion with start dates of 06/15/2025 to 06/30/2025 and 06/19/2025 to 06/30/2025. MAR showed the medication was never administered to R2.

R2's "controlled drug receipt/record/disposition form" documented quantity of ten loratadine/pse 10-240 mg (rx# 19336152) were received on 06/17/2025 and was signed as being received by E7 (Licensed Practical Nurse/Night Supervisor) on 06/18/2025.

R2's controlled substance inventory log documented resident received controlled medication(s) on 06/18/2025 and was signed off by nursing staff. Requested original order for R2's loratadine/pse 10-240 mg and pharmacy delivery record from facility that was not provided upon exit of survey.

On 09/13/2025 at 11:40 E2 (Resident Care Director) indicated that E6 (Licensed Practical Nurse) reported to E9 (Registered Nurse) on 06/22/2025 that R2 had a missing medication. E2 said at that time when she was informed, she was not aware that the medication was a controlled substance until after reaching out to her regional

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510354	A. BUILDING: _____ B. WING _____	C 09/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF PARK RIDGE	1725 BALLARD RD PARK RIDGE, IL 60068

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A5000	Continued From page 8	A5000		

and the pharmacy for clarification. E2 then said she reported the incident to IDPH on 06/24/2025.

On 09/13/2025 at 12:12 PM, E3 (Licensed Practical Nurse) said on the night of Monday, 06/23/2025, she was working on the fourth floor but had to count narcotics on the second floor in preparation for the oncoming nurse. E3 added that she was counting narcotics by herself and when she got to R2's narcotic sheet, there was a "sticky note" on the sheet that indicated R2's loratadine/pse was missing. E3 said that she didn't know who wrote the note but thought it was E6, and after confirming the medication was indeed missing, she informed E10 (Registered Nurse/Wellness Nurse) right away. E3 said she also called the previous nurse E5 (Licensed Practical Nurse) and asked her about R2's missing medication but was told by E5 that the medication was present during E5's narcotic count, which she did by herself prior to leaving, and E5 did not see any note on the narcotic sheet. E3 added that she works second shift and normally nurses are to count narcotics at the end and beginning of each shift with two nurses but at times, there isn't always an outgoing nurse present because four nurses work day shift, and two of them leave at 08:00 PM. E3 then said there was an emergency meeting help and nursing were told that narcotics have to be counted with two nurses before handing off keys and both nurses have to sign the narcotic sheet.

On 09/13/2025 at 01:58 PM, E5 (Licensed Practical Nurse) said she works from 7:00 AM to 8:00 PM and normally the third shift nurse is gone so she "counts the narcotics by [herself]". E5 said she was not aware that R2 had any medications missing and does not recall seeing a note indicating R2's medication was missing. E5 then

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	ASL510354	A. BUILDING: _____ B. WING _____	C 09/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF PARK RIDGE	1725 BALLARD RD PARK RIDGE, IL 60068

(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
A5000	Continued From page 9	A5000		

said when she left at 08:00 PM on 06/23, she had counted how many cards were present and reconciled counts by herself before leaving then indicated that all meds were accounted for. E5 informed E3 of this when E3 called her that same night around 09:00 PM. E3 asked E5 how many boxes were there for R2 and E5 said she didn't recall how many boxes were present but indicated that there was a medication present for R2 before she left. E5 said that she did not know why there was a discrepancy with R2's med then indicated that she may have miscounted, or the sheets may have been stuck together. E5 added that by rule, "we are supposed to count with two nurses and any discrepancies are reported to the supervisor".

On 09/13/2025 at 02:44 PM, E8 (Licensed Practical Nurse) said E6 (LPN) was counting the narcotics for second floor and found that R2 had a medication missing so he asked E8 to come double check the count. She added that when she arrived on the unit, no other nurse was there counting with E6. At 02:56 PM, E8 said she and E6 counted the narcotics and reconciled the meds with the control log counts and found that R2 had a sheet for loratadine/pse 10-240mg but no medication. E6 then notified the nurse manager, E9 (Registered Nurse). E8 added that someone put a sticky note on the narcotic sheet indicating that the med was missing after that night but wasn't sure if it was E6 or not and a mass text was sent out a couple days after incident from E2 asking for statements from everyone. E8 then said, "we've been counting shift to shift with two nurses since this incident, but prior to, that wasn't always being done". E8 indicated that the medication was never found nor who removed the medication from the med cart.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510354	A. BUILDING: _____ B. WING _____	C 09/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF PARK RIDGE	1725 BALLARD RD PARK RIDGE, IL 60068

(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
A5000	Continued From page 10 On 09/13/2025 at 04:03 PM, E9 (Registered Nurse) said he believes E6 had informed him that R2's med was missing and E9 had then informed E2 who started an investigation. E9 then indicated that best practice when counting narcotics is to have 2 two nurses present so that any discrepancies can be dealt with at that time. E9 added that this is difficult at times when a nurse leaves prior to the next nurse coming in, there isn't always two nurses present so the oncoming nurse will have to count narcs by herself. E9 said when this occurs, the outgoing nurse will count narcotics by herself, secure the cart, and then secure the keys in a lock box in the wellness office. E9 then said the oncoming nurse will get the keys from the wellness office and count the narcotics by herself at the start of the shift. On 09/13/2025 at 02:28 PM 03:57 PM, E6 (LPN) was contacted with a detailed message left. No call back was received from E6 upon exiting survey. On 09/13/2025 at 02:31 PM and 04:00 PM, E7 (LPN) was contacted with a detailed message left. No call back was received from E7 upon exiting survey. On 09/13/2025 at 05:00 PM, E2 (Resident Care Director) indicated that E10 was on active military leave and provided E10's written statement from facility's investigation. Review of E10's statement of events dated 06/23/2025 documented he counted second floor narcotics on 06/21/2025 at 08:00 PM and all medications were present at shift change. On 09/13/2025 at 05:15 PM, E2 said since the incident, nurses are doing shift to shift counts at	A5000		

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SUNRISE OF PARK RIDGE	1725 BALLARD RD PARK RIDGE, IL 60068

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A5000	Continued From page 11	A5000		

the start and end of their shifts and must count each card/box and narcotic sheet before handing over keys. E2 added that she was told by this was previously being done.

Review of second floor "controlled substance inventory log" for June 2025 reads in part: controlled substances (certain Schedule I and all Schedule II) are counted at every shift change and/or change in team member administering/assisting with administration of medications (e.g., medication care managers, medication techs, medication aides, licensed nurses, and any team member trained to administer/assist with medications). Incoming team member counts the medications while the outgoing team member compares the declining inventory sheets with the count as provided by the incoming team member. State Board of Pharmacy regulations determine who can participate in counting controlled substances. Any discrepancy must be resolved/reported to the Resident Care Director (RCD) and Executive Director (ED) immediately ...Time must reflect actual time of count and not the shift ...

Medication Oversight Program dated 04/2023 reads in part: medication administration is one of the highest risk activities performed in long-term care ...We administer/assist with administering may high risk medications including but not limited to controlled substances ...The program's components include guidelines on the following ...proper medication handling, storage, and inventory ...The community follows all applicable state/province laws and regulations and accepted standards of practice related to medications and medication administration ... (p14) Controlled substances are stored in a double locked cabinet (locked box within a locked cabinet or medication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510354	A. BUILDING: _____ B. WING _____	C 09/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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
A5000	Continued From page 12 cart) ...Keys to locked boxes/carts/cabinets are kept with the individual team member responsible for maintaining security of these medications. Keys are not to be stored in a drawer, cabinet, or any other area and must always be in a team member's personal custody. Any time keys are transferred to another authorized team member, a full count of all controlled drugs must be done as outlined in section 3 below ...3. Counting: all controlled substances are counted at the beginning and ending of each shift (or any time there is a change of custody of the keys) by two authorized team members at the same time ...The incoming team member counts the controlled substances. The outgoing team member compares the declining inventory sheets with the medication count as provided by the team member, verifying the correct number of unit dose/blister packs, bottles, and syringes during the process. Both team members sign the controlled substance log after verifying accuracy of drug counts ...The keys are transferred to the oncoming team member when the count is complete ...	A5000		