STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145800	A. Building B. Wing	10/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunset Home	418 Washington Street Quincy, IL 62301

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure one resident (R1) was free from abuse of three residents reviewed for abuse in a total sample of nine. Based on V8's statement R1 acted scared and followed me around all night. I for sure think she was traumatized by the whole thing even if she couldn't say it., it can be determined that the reasonable person in this resident's position would have experienced psychosocial harm (e.g., embracement, humiliation, anxiety) as a result of this abuse. This failure resulted in an Immediate Jeopardy. Findings include: The Immediate Jeopardy began on 10/4/25 around 6:30 PM when R1 was forcibly moved down the hallway against her will while she was fighting and yelling. On 10/16/25 at 9:30 AM V1 (Administrator) and V2 (Director of Nursing) were notified of the Immediate Jeopardy on 10/4/25 around 6:30 PM. While the immediacy was removed on 10/17/25, the facility remains out of compliance at a severity Level 2 to evaluate the implementation and effectiveness of their removal plan. The Facility's Abuse and Neglect policy dated July 2023 documents It is the policy of (this facility) to provide each resident with an environment free from abuse, neglect, corporal punishment, involuntary seclusion, misappropriation of resident property, exploitation, and physical or chemical restraint not required to treat the resident's symptoms, as defined below. The Facility's Abuse and Neglect policy dated July 2023 documents Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm or pain or mental anguish. This includes deprivations by an individual, including a caretaker, of goods or services necessary to attain or maintain physical, mental, or psychosocial well-being. This presumes instances of abuse of all residents, even those in a coma, cause physical harm, or pain mental anguish. Physical Abuse- includes but not limited to, hitting, slapping, pinching, and corporal punishment. a. resident to resident abuse with or without injury b. staff to resident abuse with or without injury c. other (visitor, relative) to resident abuse with or without injury.R1's Medical Record documents that she was admitted to the facility on [DATE] with diagnosis to include but not limited to Alzheimer's Disease, Depression and Hypertension. R1's MDS (Minimum Data Set) dated 9/5/25 documents that she is rarely/never understood. R1's current undated care plan documents the resident is/has potential to demonstrate physical behaviors related to Dementia. R1's care plan documents the intervention for this this resident tolerates 1 to 2 people at a time. The resident needs personal space. The resident does not like to be touched by anybody. When resident becomes agitated: Intervene before agitation escalates; guide away from source of distress; engage calmly in conversation; if response is aggressive, staff to calmly walk away and approach later.On 10/14/25 at 11:00 AM V7 (R1's Health Care Power of Attorney) stated that he did not think the facility is used to having someone so mobile and confused. I don't think they know what they are doing with her. She can be difficult but their approach is a lot of the problem. When I get phone calls about (R1)'s behaviors staff say things like '(R1) has been off the chain today' or 'she's been crazy all day.' Throughout the survey R1 did not answer any questions appropriately and became verbally aggressive when spoken to.The Facility's Abuse Investigation dated 10/9/25 documents that on 10/4/25 around shift change/approximately 6:30 PM R1 was at the end of the hallway near a door and V3 (Registered Nurse) approached R1 and attempted to redirect her away from the door. The investigation documents that R1 was redirected from the door by V4 (Certified Nurse Aide). Staff Interviews dated from 10/4/25 through 10/9/25 document that R1 had been having combative behaviors and been resistive to cares for most of the day and became combative when V4 (Certified Nurse Aide) attempted to redirect her away from V3 (Registered Nurse) and the door. The Investigation dated 10/9/25 documents that the abuse allegation was unfounded and that it was believed that V4 (CNA) was intervening due to a behavior. On 10/14/25 at 10:00 AM V4 (CNA) stated that on 10/4/25 R1 had been crazy all day. V4 stated that at the end of her shift she saw R1 by the door with V3 (RN). V4 stated R1 was arguing with V3 (RN) and attempting to exit the door. V4 confirmed that she walked up behind R1 and hooked her arm up under R1's arm and turned her around and started walking towards (R1)'s room. V4 confirmed that R1 did not want to go. V4 repeatedly answered I do not recall to most other questions asked such as where any other staff members were at the time, how she knew that R1 did not want to go down the hallway and whether or not V4 cursed during this interaction as was documented in another interview.On 10/14/25 at 1:30 PM V9 (Licensed Practical Nurse) stated that on 10/4/25 during shift change around 6:30 PM she was waiting to get report from V3 (Registered Nurse) but V3 (RN) was at the door with R1 attempting to get R1 to go down the hall away from the door and R1 was resisting leaving the area. V9 (LPN)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to thoroughly investigate an allegation of abuse for one resident (R1) and determined it unsubstantiated and failed to protect R1 from further abuse. This failure resulted in an Immediate Jeopardy Findings IncludeThe Immediate Jeopardy began on 10/09/25 at 6 AM when V4 (Certified Nurse Aide) was allowed to return back to work with all residents and specifically R1. On 10/16/25 at 9:30 AM V1 (Administrator) and V2 (Director of Nursing) were notified of the Immediate Jeopardy on 10/4/25 around 6:30 PM. While the Immediacy was removed on 10/16/25 the facility remains out of compliance at a severity Level 2 as additional time is needed to evaluate the implementation and effectiveness of their removal plan. The Facility's Abuse and Neglect policy dated July 2023 documents It is the policy of (this facility) to provide each resident with an environment free from abuse, neglect, corporal punishment, involuntary seclusion, misappropriation of resident property, exploitation and physical or chemical restraint not required to treat the resident's symptom, as defined below. The Facility's Abuse and Neglect policy dated July 2023 documents should an incident or suspected incident of resident abuse, neglect, or injury of an unknown source be reported, the administrator, or his/her designee, will appoint a member of management to investigate the alleged incident. The person in charge of the investigation will be provided a completed copy of the abuse report form, witness statement, and or information regarding the alleged incident. The individual conducting the investigation will, at a minimum: i. review the resident's medical record to determine events leading up to the incident ii. interview the person reporting the incident iii. interview any witnesses to the incident iv. interview the resident (as medically appropriate) v. interview the resident's attending physician to determine the resident's current mental status vi. interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident vii. interview the resident's room mate, family members, and visitors viii. interview other residents to whom the accused employee provides care or services ix. review all events leading up to the alleged incident. The Facility's Abuse and Neglect policy dated July 2023 documents Employees accused of participating in the alleged abuse will be immediately suspended until the finding of the investigation have been reviewed by the administrator. If it is after regular office hours, the house supervisor will remove the accused employee from the facility immediately.R1's Medical Record documents that she was admitted to the facility on [DATE] with diagnosis to include but not limited to Alzheimer's Disease, Depression and Hypertension. R1's MDS (Minimum Data Set) dated 9/5/25 documents that she is rarely/never understood.Throughout the survey R1 became verbally aggressive when spoken to and did not answer any questions appropriately.On 10/14/25 at 10:00 AM V4 (CNA) stated that on 10/4/25 R1 had been crazy all day. V4 stated that at the end of her shift she saw R1 by the door with V3 (RN). V4 stated R1 was arguing with V3 (RN) and attempting to exit the door. V4 confirmed that she walked up behind R1 and hooked her arm up under R1's arm and turned her around and started walking towards (R1)'s room. V4 confirmed that R1 did not want to go. V4 repeatedly answered I do not recall to most other questions asked such as where any other staff members were at the time, how she knew that R1 did not want to go down the hallway and whether or not V4 cursed during this interaction as was documented in another interview.On 10/14/25 at 1:30 PM V9 (Licensed Practical Nurse) stated that on 10/4/25 during shift change around 6:30 PM she was waiting to get report from V3 (Registered Nurse) but V3 (RN) was at the door with R1 attempting to get R1 to go down the hall away from the door and R1 was resisting leaving the area. V9 (LPN) stated that V4 (CNA) walked up to V3 (RN) and R1 and said we aint doing this sh*t today and hooked her arm under R1's arm and marched her back up the hallway and yelled for help from another V5 (CNA) who was just walking out of another resident's room. V9 stated that both she and V3 (RN) felt very uncomfortable with V4 (CNA)'s actions.On 10/14/25 at 2:00 PM V3 (RN) stated on 10/4/25 during shift change R1 was by the doors that led out of the unit. V3 stated she was attempting to redirect R1 to back away from the doors. (R1) was slapping at my arms and yelling, but she does that all the time. She had been doing it all day. V3 stated that V4 (CNA) swooped in and hooked (R1) under the arm and dragged her down the hallway. V3 denied requesting help or needing help. (R1) had been having behaviors all day, it felt like (V4/CNA) just decided that (R1) was not going to be acting like that anymore. (V4/CNA) was visibly angry during this interaction. V3 (RN) stated that at the time of the incident both she and V9 (LPN) felt that the interaction was not appropriate and aggressive on V4 (CNA)'s part.On 10/14/25 at 3:00 PM V8 (Certified Nurse Aide) stated that on 10/4/25 he heard a commotion and turned the

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. Based on interview and record review the facility failed to ensure that Certified Nursing Assistant staff have had required 12 hours of in-service education. This failure has the potential to affect all 88 residents residing in the facility. Findings include: The facility policy titled, Abuse and Neglect, dated July 2023, documents not in its entirety, 3.) Aversion And Intervention of Abuse, a. Preventing resident abuse is a primary concern for Sunset Home. It is our goal to achieve and maintain an abuse free environment. B. Our abuse/intervention program may include but is not limited to: i. Conducting conflict resolution training classes for all staff. vii. Regularly scheduled in-service training programs designed to teach staff how to better understand the resident's abusive actions. Facility Town Hall meeting in-service sign in sheet for abuse training dated 3/13/25 documents V5, V6, V13, V15, and V16 (all Certified Nursing Assistants) attended, Town Hall meeting in-service sign in sheet for abuse training dated 4/17/25 documents V4, V5, V13, V17, V18, V19, V20, V21, V22, V23, V24, V25, V26, V27, and V28 (all Certified Nursing Assistants) attended, Town Hall meeting in-service sign in sheet for abuse training dated 9/18/25 documents V4, V5, V11, V12, V13, V14, V15, V19, V20, V21, V22, V23, V27, V29, V30, and V31 (all Certified Nursing Assistants) attended. On 10/15/25 at 1:10 PM V2 (Director of Nursing/DON) stated she is not sure about dementia training for the Certified Nursing Assistants/CNA, but the abuse training is done in the Town Hall meetings, and she (V2/DON) stated she does skills in-services on various topics at the monthly CNA meetings. On 10/15/25 at 1:15 PM V1 (Administrator) stated that she was not sure if there is proof that the CNAs (Certified Nursing Assistant) have had the required 12 hours of yearly in-servicing/education but will check with Human Resources. V1 also stated she does not think there has been any dementia training in the one and half years she has been with the facility. On 10/15/25 at 2:20 PM V1 (Administrator) stated, I'm going to be honest with you we do not have any proof to show that the CNA (Certified Nursing Assistant) staff have had their 12 hours of training and unable to prove they all have had abuse and dementia training.