STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146016	A. Building B. Wing	10/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunset Rehabilitation & Hlth C	129 South 1st Avenue Canton, IL 61520

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide post-fall assessments, identify injury, and thoroughly investigate incidents to identify the root cause and implement interventions to potentially prevent further events per policy for 2 of 3 residents (R1, R3) reviewed for falls in a sample of 6.Findings include:The Skilled Nurse Facility Post Fall Workflow policy, dated 5/2025, documents after a resident falls, they must be stabilized by the nursing staff. If the fall was unwitnessed, no matter their orientation status, the neuro (neurological) policy must be followed and completed. Staff must complete root cause analysis to determine why the resident fell and an appropriate immediate intervention must be placed and updated on the resident's care plan. The resident provider and representative must be notified of the resident's fall. A Fall Risk Assessment must be completed. A detailed Progress Note must be documented in the resident's record, including root cause analysis, resident provider notification, resident representative notification, details of injury and any other details surrounding the resident's fall. Post-fall documentation must be done every shift for 72 hours following the fall.The Skilled Fall Policy, dated 5/2025, documents every resident will receive a fall risk assessment after every fall. Each resident who experiences a fall will be treated and assessed adequately treat any current injuries and comprehensively assessed to determine causal effects of the fall to develop interventions to prevent further falls. After each fall, an occurrence report will be completed, root cause will be determined, and interventions will be implemented. A fall is defined as unintentional change in position coming to a rest on the ground, floor or next lower surface. An intercepted fall occurs when a resident would have fallen if the fall had not been intercepted by another person. This is still considered a fall.The Fall Investigation Guidelines for Quality Assurance only, dated 1/11/22, documents the step of the occurrence to review such as to review Progress Notes, were skin issues identified, were neuro checks initiated, anticoagulants, diagnostic test ordered, care plan interventions, fall assessments, pain assessment, responsible party and physician notification was conducted.The Neurological Assessment policy, dated 12/2024, documents Neurological assessments will be completed following an unwitnessed fall. Neurological assessments will be done every 15 minutes for the first hour, then every 30 minutes times two, every hour times six, every four hours times four, every eight hours times six for a total of 72 hours.The Charting and Documentation policy, reviewed 6/2020, documents to chart all pertinent changes in a resident's condition, as well as routine observations. Documents circumstances surrounding the accident/incident, where it took place, date and time it occurred, name of witnesses and their account of incident, residents account of incident, time physician was notified, date and time family was notified, condition of resident, pertinent observations and document every shift for 72 hours post-accident/incident. Document behaviors or change in behaviors using facts and describe symptoms. 1. R1 was admitted on [DATE], with diagnoses of Schizophrenia, Cystitis without Hematuria, Abnormal Liver function Studies, Rhabdomyolysis, and Sciatica. R1's current care plan documents R1 has impaired cognitive function and thought process related to Dementia and impaired decision making, at risk for falls related to physical status and poor safety awareness and is dependent on staff for Activities of Daily Living. R1's Minimum Data Set (MDS), dated [DATE] section C0500, documents R1 had a Brief Interview for Mental Status (BIMS) score of 04 (severe cognitive impairment).V3's (Licensed Practical Nurse) Progress Notes, dated 10/24/25 at 9:34 PM (fall occurred between 3:30 PM and 4:00 PM), documents V3 was notified by CNA (V11, CNA/Certified Nurse Aide) that R1 was found lying on the floor next to her bed. R1 complained of mild pain to her right leg and was noted to have a scratch to the back of her right thigh with scant amounts of blood noted. Full body assessment completed, neuro checks initiated and were within normal limits, range of motion intact, moves all extremities without difficulty. Transferred resident from floor to her bed by mechanical lift. New treatment orders were to apply skin prep to area every shift until healed. V3's Progress Note, dated 10/24/25 at 4:55 PM (documented as a late entry on 10/26/25 at 8:38 PM), documents R1 had a new skin tear on her rear right thigh that measured 0.02 centimeters (CM) in length, 0.5 cm in depth and 0.01 cm in width. A film/membrane dressing with dry dressing applied.V11's (Licensed Practical Nurse) Progress Note, dated 10/25/25 at 7:15 AM, documents R1's right leg had decreased range of motion, pain from previous fall (10/24/25), physician was notified and an order for a stat x-ray of right hip and leg was obtained. At 9:03 AM, V11 cancelled the stat x-ray and sent R1 to the hospital via ambulance due to rotation of right leg, hematoma to right leg and swelling. At 11:57 AM, R1 returned to the facility with a diagnosis of right tibia and fibula