

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146016	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/06/2025
NAME OF PROVIDER OR SUPPLIER Sunset Rehabilitation & Hlth C		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0555</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to choose his or her attending physician.</p> <p>Based on record review and interview, the facility failed to notify the resident and the resident's representative when the facility changed a resident's primary physician choice for one of three residents (R1) reviewed for Resident Rights in the sample of eight. Findings include: The facility's Resident Rights Policy, dated 12/24, documents, Each resident will have autonomy and choice, to the maximum extent possible, about how each resident wishes to live his/her everyday life and receipt of care, subject to the community's policies and procedures as long as those policies so not violate any requirement. Resident rights include but are not limited to: Choose a physician and treatment and participate in decisions and care planning. R1's admission Orders, dated 4/2/24, document V11 (Physician) was R1's Primary Care Physician on admission. R1's Electronic Health Record documents the facility switched R1's Primary Care Physician from V11 to V12 (Medical Director) in May 2025 (unknown day). R1's Electronic Health Record documents V12 continued to provide orders and/or physician visits in May, June, July, and August 2025. On 12/5/25 at 10:24 AM, V6 (R1's Family Member) stated, I was not notified, and neither was (V7/R1's Representative) that (R1's) physician was changed. I did not want (R1's) physician to be changed. (R1) had always had (V11) as his primary physician. On 12/5/25 at 10:50 AM, V9 (ADON/Assistant Director of Nursing) stated, (V12/Medical Director) took over cares for (R1) on May 19, 2025. On 12/5/25 at 11:00 AM, V1 (Administrator) verified R1's electronic health record does not include evidence of R1 or (V7/R1's Power of Attorney) being notified of R1's physician changing on 5/19/25 from V11 (R1's Primary Care Physician) to V12 (Medical Director). V1 also stated the facility hired V12 as their Medical Director in May 2025 and decided to switch all of the residents' physicians over to V12. On 12/6/25 at 10:00 AM, V7 (R1's Representative) stated, I was never informed in writing or verbally that (R1's) physician was changing. I would have never agreed to switch (R1) from V11 to V12.</p>

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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