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	06/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunset Rehabilitation and Health Care	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 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow therapeutic diet orders for one resident (R1) of 4 reviewed for therapeutic diets in a total sample of eight. Therapeutic Diet Policy, dated 12/2024, documents, Therapeutic diets shall be prescribed by the Attending Physician. The admission Policy, dated 12/2024, documents Prior to or at the time of admission, the resident's Attending Physician must provide the facility with information needed for the immediate care of the resident, including orders covering at least Type of diet. R1's Electronic Health Record documents R1 was admitted to the facility on [DATE] with diagnoses to include Diabetes Mellitus, Dementia, Chronic Obstructive Pulmonary Disease, and Hypertension. R1's Hospital Discharge orders, dated 4/20/26, documents R1's diet order as Carbohydrate Controlled Diet. R1's Physician's Order in the Electronic Health Record, dated 4/20/26, documents R1's diet order as Regular diet. R1's Physician's Order, dated 5/5/26, documents R1's diet was changed to Consistent Carbohydrate Diet. On 6/18/26 at 12:36 PM, V2 (Director of Nursing) reported the facility should follow the diet order on the hospital discharge orders. V2 verified R1's diet order was not put in the Physician's Orders correctly on 4/20/26 and R1 did not receive the correct diet until 5/5/26.

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