

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/15/2026
NAME OF PROVIDER OR SUPPLIER Sunset Rehabilitation and Health Care		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)		
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident was properly secured during transportation, conduct pre-trip safety inspections prior to transporting a resident in the facility van, conduct transportation van inspections, prevent staff from placing personal items on a resident's wheelchair, and ensure facility transportation staff were educated on driver safety training for one of three residents (R1) reviewed for accidents in a sample of 11. These failures resulted in R1's wheelchair tipping backward during transport on 7/3/26, requiring emergency hospital treatment, causing R1 excruciating pain, and R1 sustaining an acute nondisplaced fracture at the anterolateral aspect of the right ninth rib. Findings include: The facility's Rear Conversion Transportation Van Manual, undated, documents, Safety Precautions: All wheelchairs must be facing forward and be properly secured. Seating Securement: Instructions for Use- 1. Place wheelchair in the vehicle facing forward and in a suitable position. 2. Preselect a position on the wheelchair to attach the hook and a position on the floor to attach the floor latch end of the strap. 3. Release the buckle latch on the strap. With the buckle released, pull the webbing to create enough slack so that the restrain belt can be attached to the floor and the wheelchair. 4. Connect the floor latch to the pre-selected location on the floor track by pushing the fitting with even pressure into the track and slide the fitting in one direction until spring loaded latch drops into place. Pull on the strap to make sure it is secure. 5. Find the handhold strap and pull it to tighten the strap. Make sure there are no twists or knots in the strap. 6. Lock buckle by pushing down until the buckle latch locks into place. 7. Repeat the procedure for each of the four designated positions. The Facility's Dodge Grand Caravan 2019 Owner's Manual documents, Warning: A frayed or torn belt could rip apart in a collision and leave you with no protection. Inspect the belt system periodically, checking for cuts, frays, or loose parts. The facility's Driver Safety Training Form documents, Section 2. Rules and Responsibilities- All passengers, including wheelchair-bound residents, will always be secured and appropriately restrained in the vehicle, per the manufacturer's instructions and guidelines. R1's admission Record documents R1 is an [AGE] year-old female who admitted to the facility on [DATE] with the following, but not limited to, diagnoses: Dementia, Major Depressive Disorder, Age-Related Osteoporosis, Chronic Obstructive Pulmonary Disease, Anxiety Disorder, and Chronic Kidney Disease. R1's MDS (Minimum Data Set) Assessment, dated 6/18/26, documents R1 is moderately cognitively intact, and requires supervision or touching assistance with most ADLs (Activities of Daily Living). R1's Final State Reportable, dated 7/9/26, documents, Date and Location of Incident: 7/3/26 at 3:30 PM during transportation. Brief Description of Incident: (R1) complains of pain to right shoulder, neck and back during transportation following an appointment. (R1) sent to the emergency room for further evaluation noting non-displaced 9th right rib fracture. This same Reportable documents, Disposition: (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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F 0689 Level of Harm - Actual harm Residents Affected - Few	After thorough investigation it was determined that the root cause was the front strap disengaged during transportation. Upon initial nursing assessment, (R1) was compliant and reported pain to right shoulder, neck and back. R1's Progress Note, dated 7/3/26 and signed by V2/DON (Director of Nursing), documents, During transportation back to facility from appointment, (R1's) wheelchair unlatched in the front and (R1) rolled backwards in the van. (R1) stated she hit her right shoulder but did not hit her head. Upon returning to facility, full body assessment was completed and resident subsequently c/o neck and mid back pain. Pain medication administered. The decision was made to send (R1) to the Emergency Department for evaluation and treatment. R1's emergency room Note, dated 7/3/26, documents, History of Present Illness: Chief Complaint- Fall. Initial Comments- (R1) an [AGE] year-old female here via EMS (Emergency Medical Services) for injuries sustained from a fall. (R1) was in her wheelchair. (R1) was being wheeled up into wheelchair when (R1) fell from the wheelchair that accidentally tipped over. (R1) landed on her right side. (R1) has pain to the right rib cage and mid back. Hurts to move and hurts to breathe. Review of Systems: Musculoskeletal: Neck pain, Joint pain, and Joint Swelling. This same emergency room Note documents, Chest X-Ray interpretation: 2. Acute nondisplaced fracture at the anterolateral aspect of the ninth rib. Clinical Impression- Fall, Rib Fracture. R1's Order Summary Report, dated 7/3/26, documents R1 has the following Physician Order: Start date: Hydrocodone-Acetaminophen Tablet 5-325 milligrams give one tablet by mouth every eight hours as needed for pain due to fractured rib. R1's Physician Progress Note, dated 7/5/26 and signed by V12/R1's Nurse Practitioner, documents, Patient Name: (R1) Chief Complaint: My (R1's) ribs hurt when I breathe. History of Present Illness: (R1) is a female patient presenting after a fall from her wheelchair yesterday afternoon that resulted in a confirmed rib fracture on hospital X-ray. (R1) reports she is unsure if her wheelchair was strapped into the van prior to the incident and does not recall whether she was hooked up, which may be relevant for fall risk. She reports 10/10 pleuritic pain in the posterior rib region, worsened by deep inspiration. (R1) was given pain medication in the Emergency Department and requests additional analgesia today; current order is every 8 hours as needed. (R1) endorses subjective shortness of breath and states she must keep making myself breathe. (R1) has an incentive spirometer and was instructed today to perform 10 repetitions multiple times per day to prevent atelectasis. This same Progress Note documents, Review of Systems: Constitutional: No fevers, Respiratory: Positive for shortness of breath associated with rib pain, Musculoskeletal: Positive for severe rib pain rated 10/10, Gastrointestinal: Reports alternating diarrhea and constipation; currently passing hard pellet-like stools; rectal soreness. Objective- Physical Exam: General: Patient in obvious discomfort. R1's Progress Note, dated 7/13/26 and signed by V13/LPN (Licensed Practical Nurse), documents, Gave Tylenol as needed for comfort due rib fracture states it feels a little better. The facility's QAPI (Quality Assurance and Performance Improvement) Corrective Summary, dated 7/3/26, and prepared by V1/Administrator, documents, F689 Free of Accident Hazards/Supervision/Devices, F921 Safe/Functional/Sanitary/Comfortable Environment. Problem/Noncompliance Identified- The facility identified vulnerabilities in its Resident Transportation Safety. The facility identified a past noncompliance related to resident transportation safety after an incident in which a resident sustained an injury during transport in the facility van. During transport, (R1's) wheelchair restraint and/or occupant safety belt became unsecured, resulting in (R1) shifting from a safe position and sustaining an injury. Root Cause Analysis: Front strap disengaged and Improper wheelchair securement. The facility's Reeducation Memo, dated 7/6/26, documents, Employee Name: (V4/Transportation Driver). Date of incident: 7/3/26. Section 2. Areas of Concern- Resident safety while operating facility van. Section 3. Reeducation Topics Covered- V4 educated to overall resident (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	safety while operating facility van transporting residents to and from appointments/resident shopping trips and resident outings. On 7/13/26 at 12:44 PM, R1 stated, A few weeks ago, I was in an accident while being driven back from an appointment in the facility van. I was sitting in my wheelchair in the back of the van. The driver came to a stop, and when the van started moving again, I flipped completely backward in my chair. I started screaming for help. The driver, (V4/Transportation Aide), stopped, came to the back, and picked the wheelchair back up with me still in it. Once we got back to the facility, someone laid me down. I was in so much pain that they sent me to the hospital, where I found out I had a broken rib. Even now, my pain is sometimes a 10 out of 10 because of it. I don't know for sure if all four of the floor straps were hooked to my wheelchair, but I know that I didn't have a seatbelt over me or the chair. On 7/13/26 at 12:59 PM, V4/Transportation Aide, stated, While transporting (R1) back from a nearby medical appointment a few weeks ago, I secured the wheelchair in the facility van with two floor straps (one front, one rear) and locked the wheels. I did not place the lap belt on (R1) because it pinches residents at times. I thought, given the short distance, it would be ok. Upon accelerating from a complete stop at a stop sign, the front floor strap mount detached from the vehicle floor. This caused (R1's) wheelchair to tip backward completely. I immediately pulled over, picked (R1's) wheelchair back up with (R1) in it, and transported them directly back to the facility. (R1) was stating she was in pain. V4 stated he had hung his own heavy backpack on the handles of R1's wheelchair before loading R1 into the van. V4 noted if he had secured R1 with the lap belt, the wheelchair likely would not have flipped backward. V4 acknowledged the combination of the heavy backpack and securing only two of the four required floor straps allowed the front strap to detach from the floor, causing the wheelchair to tip backward. Additionally, V4 stated van safety checks were not being performed before trips-or at all-because he was managing all appointments and responsibilities by himself. On 7/13/26 at 1:25 PM, the facility's van was observed with V9/CNA (Certified Nursing Assistant) Supervisor. The van had four floor latches, two being in front of the wheelchair on the left and right side, and two being in the back of the wheelchair on the left and right. The floor latches each have a retractable hook that latches to the frame of the wheelchair. A lap belt was then observed that extends from the side of the van to the seat belt latch on the floor. During this observation, V9 stated all four floor latches should be secured to the wheelchair when transporting a resident along with the lap belt fastened through the wheelchair and out the other side of the wheelchair. V9 stated, If (R1's) wheelchair had been secured with the lap belt I do not believe the wheelchair could have tipped backwards. On 7/13/26 at 1:36 PM, V1/Administrator, stated prior to the 7/3/26 incident, no facility staff had been trained on properly securing wheelchairs in the facility's transport van. V1 noted her investigation revealed the right front floor latch had disengaged from the floor while secured to resident R1's wheelchair during transit. V1 stated V4/Transportation Aide failed to latch all four floor latches to R1's wheelchair, opting to latch only the front right and back left positions. V1 was also aware the van's lap belt was not fastened during R1's transport. V1 affirmed all four floor latches, alongside the lap belt, should have been fully secured to R1's wheelchair, that doing so likely would have prevented R1's wheelchair from tipping backward, even if a single latch had disengaged. V1 reported later it was discovered V4 had placed a personal bookbag on the back handle of R1's wheelchair, which was unauthorized, and may have caused a weight imbalance that contributed to the wheelchair tipping. V1 stated there was no record of any pre-trip safety checks being conducted and acknowledged there should have been.		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to prevent abuse for one resident (R8) of three residents reviewed for abuse in a sample of eleven. Findings include: The Abuse, Prevention and Prohibition Policy, dated 02/2026, documents, Each resident has the right to be free from abuse, corporal punishment, and involuntary seclusion. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, or other individuals. This facility prohibits mistreatment, neglect, or abuse of residents. This also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. This presumes that all instances of abuse, even those residents in a coma, can cause physical harm, pain, or mental anguish. The facility also prohibits misappropriation of resident property. The residents must not be subjected to abuse by anyone. Resident to Resident abuse includes the term willful. The word willful means that the individual's action was deliberate (not inadvertent or accidental), regardless of whether the individual intended to inflict injury or harm. An example of a deliberate (willful) action would be a cognitively impaired resident who strikes out at a resident within his/her reach, as opposed to a resident with a neurological disease who has involuntary movements and his/her body movements impact a resident who is nearby.The Initial State Report sent to Illinois Department of Public Health/IDPH prepared by V7/Prior Interim Administrator, dated 5/20/26, documents, Staff observed (R10) have physical contact with (R8).The Police Incident Report, dated 5/20/26 at 8:16 PM, documents the incident happened on 5/19/26 about 5:00 PM in the dining room. There was resident to resident physical abuse when R10 struck R8 with a closed fist in the jaw. R8's computerized Medical Record documents R8 is a [AGE] year-old that was admitted to the facility on [DATE] with diagnoses which included Unspecified Dementia, Heart Failure, Anxiety, and Seizures.R8's MDS (Minimum Data Set) assessment, dated 6/5/26, documents a BIMS (Brief Interview for Mental Status) of 6, indicating (severe cognitive impairment). R8 uses a wheelchair, is dependent on staff for activities of daily living, toileting, and transfers.On 7/13/26 at 1:40 PM, R8 was lying in bed. R8 was asked if he was ever hit by another resident. R8 stated he did not remember. R8 was asked if he would like to be hit by another resident and R8 stated, I wouldn't like that.R10's computerized Medical Record documents R10 is a [AGE] year-old that was admitted to the facility on [DATE] with diagnoses which included Alcohol Dependence with Withdrawal Delirium, Depression, and Anxiety. R10 was discharged on 7/2/26.R10's MDS (Minimum Data Set) assessment, dated 5/27/26, documents a BIMS (Brief Interview for Mental Status) of 13, indicating (cognition intact). R10 has no upper or lower extremity impairment, uses a wheelchair, requires supervision for ADLs, bed mobility, transfers, and partial assistance for toileting. R10 has verbal behaviors and behaviors directed towards others one to three times.On 7/15/26 at 1:11 PM, an attempt was made to contact R10. V16/R10's Family Member answered and stated R10 was not available to be interviewed. V16 also stated he did remember hearing R10 say he had got into a fight with someone at the facility but V16 had no other details.On 7/13/26 at 1:34 PM, V4/Certified Nursing Assistant/CNA stated she saw R10 hit R8 in the face but does not know the date. V4 stated it was in the dining room at supper time around 6:00 PM when R8 and R10 were arguing, then R10 punched R8 in the face. R10 hit R8 on the right side of R8's face with a closed fist. R8 said, Hey, he (R10) hit me. R8 did not like being hit. V4 stated, I took (R10) away from (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(R8) and told (V15/Registered Nurse) what happened. (R10) was yelling, Go ahead and arrest me. I would rather go to jail then be here. On 7/15/26 at 10:53 AM, V15/Registered Nurse stated she did not remember the date, but she heard R8 and R10 arguing during supper. V15 stated, I told them to stop arguing. (R10) said, I'm gonna (sic) beat the F*** out of him (R8). I told (R10) to go to his room. I did not know that (R10) hit (R8) so I didn't document it or do an assessment on either of the residents. The next day I got a call from work that (V4/CNA) had reported that (R10) hit (R8). On 7/15/26 at 12:50 PM, V9/CNA Supervisor stated on 5/20/26 around 1:30 PM, V4/CNA reported the day before (5/19/26) R10 punched R8 in the face. R8 kept saying, Coffee, coffee, coffee and R10 told R8 if R8 said coffee one more time I will punch you and R10 did hit R8.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility staff failed to report abuse immediately to the Administrator and the Administrator failed to report the abuse within two hours to the State Agency for 1 of 3 residents (R8) reviewed in the sample of eleven. Findings include: The Abuse, Prevention and Prohibition Policy, dated 02/2026, documents, Investigation: Resident abuse must be reported immediately to the Administrator. All alleged violations including abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property will be reported immediately to the administrator. The person made aware of allegations of abuse or neglect, or the administrator will report the allegations of abuse and neglect to the mandated state agency and law enforcement. The allegation will be reported no later than two hours, or per state regulation, after the allegation is made. Reporting/Response: The facility employee or agent, who becomes aware of abuse or neglect, including injuries of unknown origin or alleged misappropriation of resident property, shall immediately report the matter to the facility administrator or is her designated representative in the administrator's absence. Any employee or agent or any covered individual will make or cause a report to be made to law enforcement and the facility. The facility administrator, employee, or agent who is made aware of any allegation of abuse or neglect shall report or cause a report to be made to the mandated state agency per reporting criteria. Such reports may also be made to the local law enforcement agency in the same manner. The Police Incident Report, dated 5/20/26 at 8:16 PM, documents the incident happened on 5/19/26 about 5:00 PM in the dining room. There was resident to resident physical abuse when R10 struck R8 with a closed fist in the jaw. On 7/13/26 at 1:34 PM, V4/Certified Nursing Assistant/CNA stated she saw R10 hit R8 in the face but does not know the date. V4 stated it was in the dining room at supper time around 6:00 PM when R8 and R10 were arguing then R10 punched R8 in the face. R10 hit R8 on the right side of R8's face with a closed fist. R8 said, Hey, he (R10) hit me. R8 did not like being hit. V4 stated, I took (R10) away from (R8) and told (V15/Registered Nurse) what happened. (R10) was yelling, Go ahead and arrest me. I would rather go to jail then be here. (V15) did not assess (R8) but I looked at (R8's) face and did not see any injury. I was in the wrong because I forgot to call the Administrator to report the abuse. The next day when I came to work, I reported the abuse. On 7/14/26 at 10:26 AM, V14/Administrator stated the abuse should have been reported immediately to the Abuse Coordinator and reported to the State Agency within two hours. On 7/15/26 at 10:53 AM, V15/Registered Nurse stated she did not remember the date, but she heard R8 and R10 arguing during supper. V15 stated, I told them to stop arguing. (R10) said I'm gonna beat the F*** out of him (R8). I told (R10) to go to his room. I did not know that (R10) hit (R8) so I didn't document it or do an assessment on either of the residents. The next day I got a call from work that (V4/CNA) had reported that (R10) hit (R8). (V4) and I were both suspended while the investigation was done because we did not report it. On 7/15/26 at 12:43 PM, V7/Prior Interim Administrator stated he was told about the incident between R8 and R10 on 5/20/26. V4/CNA said it had happened on 5/19/26 but she did not report it until the following afternoon. V7 also stated, (V4) should have reported the abuse immediately. On 7/15/26 at 12:50 PM, V9/CNA Supervisor stated on 5/20/26 around 1:30 PM, V4/CNA reported the day before (5/19/26) R10 punched R8 in the face. R8 kept saying Coffee, coffee, coffee and R10 told R8 if R8 said coffee one more time I will punch you. and R10 did hit R8. V4 was suspended for not reporting the incident timely. V9 also stated, I was not with (V7/Prior Interim Administrator) when he interviewed (V4). The Time Report for the period of 5/17/26 to 5/23/26 documents V6/CNA and V15/RN both worked on 5/19/26. V15 did not work any (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	other days during that week. The Initial State Report sent to Illinois Department of Public Health/IDPH prepared by V7/Prior Interim Administrator, dated 5/20/26, documents, Staff observed (R10) have physical contact with (R8). Both residents were separated immediately, and a head-to-toe body assessment was completed on (R8). (R10) had been placed on 1:1 supervision. The Initial Report does not document the date or time that the abuse occurred.R8's Skin Check, dated 5/20/26, documents the skin check was completed on 5/20/26 at 5:40 PM.The Initial Report e (electronic) -mail sent to IDPH documents the report was sent on 5/20/26 at 8:29 PM.		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview and record review, the facility failed to implement their Abuse Policy to thoroughly investigate an allegation of resident-to-resident abuse and failed to update the Care Plan for two of three residents (R8 and R10) reviewed for investigating abuse in the sample of eleven. Findings include: The facility's Abuse Prevention and Reporting policy, dated 09/2024, documents, Any incident or allegation involving abuse, neglect, exploitation, mistreatment or misappropriation of resident property will result in an investigation. Witnesses will be asked to assist with completing statements if indicated. Complete a thorough investigation. Two management staff will conduct interviews with witnesses or other staff, residents or visitors who could have knowledge of the allegation. Witnesses will be asked to assist with completing statements if indicated. Every employee will be interviewed who was working on the specific hall/wing that the affected resident resides on. If the allegation occurred on a specific shift, all staff for the identified shift only will give a statement if indicated. The Police Incident Report, dated 5/20/26 at 8:16 PM, documents the incident happened on 5/19/26 about 5:00 PM in the dining room. There was resident to resident physical abuse when R10 struck R8 with a closed fist in the jaw. On 7/13/26 at 1:34 PM, V4/Certified Nursing Assistant/CNA stated she saw R10 hit R8 in the face but does not know the date. V4 stated it was in the dining room at supper time around 6:00 PM when R8 and R10 were arguing then R10 punched R8 in the face. R10 hit R8 on the right side of R8's face with a closed fist. R8 said, Hey, he (R10) hit me. R8 did not like being hit. V4 stated, I took (R10) away from (R8) and told (V15/Registered Nurse) what happened. (R10) was yelling, Go ahead and arrest me. I would rather go to jail then be here. (V15) did not assess (R8) but I looked at (R8's) face and did not see any injury. I was in the wrong because I forgot to call the Administrator to report the abuse. The next day when I came to work, I reported the abuse. On 7/14/26 at 10:26 AM, V14/Administrator stated she did not find a written statement from V6/CNA or V15/RN about the abuse incident between R8 and R10. V14 also stated the abuse should have been reported immediately to the Abuse Coordinator and reported to the State Agency within two hours. The incident should have been documented in the nursing notes, an assessment of the residents should have been made immediately on the day of the incident, and the care plan should have been updated. V14 stated there are to be two management staff during an interview for abuse. On 7/15/26 at 10:53 AM, V15/Registered Nurse stated she did not remember the date, but she heard R8 and R10 arguing during supper. V15 stated, I told them to stop arguing. (R10) said I'm gonna (sic) beat the F*** out of him (R8). I told (R10) to go to his room. I did not know that (R10) hit (R8) so I didn't document it or do an assessment on either of the residents. The next day I got a call from work that (V4/CNA) had reported that (R10) hit (R8). (V4) and I were both suspended while the investigation was done because we did not report it. On 7/15/26 at 12:43 PM, V7/Prior Interim Administrator, stated he was told about the incident between R8 and R10 on 5/20/26. V7 also stated, I did not have (V4/CNA) do a written statement, but I generally do. (V9/CNA Supervisor) was with me when I interviewed (V4). I did not know that (R10) hit (R8). I thought (R10) grabbed (R8's) face. On 7/15/26 at 12:50 PM, V9/CNA Supervisor stated on 5/20/26 around 1:30 PM, V4/CNA reported the day before (5/19/26) R10 punched R8 in the face. R8 kept saying, Coffee, coffee, coffee and R10 told R8 if R8 said coffee one more time I will punch you. and R10 did hit R8. V4 was suspended for not reporting the incident timely. V9 also stated, I was not with (V7/Prior Interim Administrator) when he interviewed (V4). The Initial Report sent to the State Agency, dated 5/20/2026, does not document the date or time that the abuse occurred. The same report documents, Staff observed (R10) have physical contact with (R8). Both residents were separated immediately, and a head-to-toe body assessment was completed on (R8). (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/15/2026
NAME OF PROVIDER OR SUPPLIER Sunset Rehabilitation and Health Care		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)		
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(R10) had been placed on 1:1 supervision. The Final Report sent to the State Agency, dated 5/27/26, documents the date of the incident as 5/21/26. The same report documents, (V6/Certified Nursing Assistant/CNA) states she was assisting another resident in the dining room. When (V6) saw (R10) reach out and grab the face of (R8), (V6) states she separated both residents immediately. Upon a thorough review of medical records and resident and staff interviews, the facility is unable to substantiate abuse towards (R8). Care plan will be revised and updated as needed. There was no documentation that V15/Registered Nurse was interviewed. R8's Care Plan does not include a plan of care for abuse and was not updated after the abuse incident between R8 and R10. R10's Care Plan does not include a plan of care for abuse and was not updated after the abuse incident between R8 and R10.		