STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0052993	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET REHABILITATION & HLTH C	129 SOUTH 1ST AVENUE , CANTON, Illinois, 61520

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S0000	Initial Comments Facility Reported Incident of October 20, 2025 / 2656943	S0000		11/13/2025
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.1210 d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:	S9999		11/13/2025

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

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S9999	Continued from page 1 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These requirements are not met as evidenced by: Based on observation, interview, and record review, the facility failed to adequately supervise a resident while handling a hot beverage and failed to have a policy regarding the use and supervision of hot beverages for one of three residents (R1) reviewed for accidents in the sample of three. These failures resulted in R1 sustaining a burn to the right thigh after spilling a hot beverage in his lap. This past noncompliance occurred on October 20, 2025 and was corrected on the same day. Findings include: R1's Admission Record documents R1's date of admission to the facility was 10/21/18, and his diagnoses on admission include Chronic Obstructive Pulmonary Disease, Seizures, Personal History of Transient Ischemic Attack, and Cerebral Infarction without Residual Deficits, and Unspecified Dementia without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, or Anxiety. R1’s Minimum Data Set Assessment, dated 9/5/25, documents R1 has moderately impaired cognition, requires a manual wheelchair for mobility, and is dependent with bathing, grooming, transfers, and mobility throughout the facility in his wheelchair. R1’s care plan documents R1 can move self around the facility with supervision only, and prior to 10/20/25, had no intervention for a cup with lid for coffee. The facility's report to the local State Agency for R1, dated 10/20/25, documents R1 “experienced a potential burn to bilateral thighs and R (right) knee after spilling coffee on his lap.”	S9999		

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S9999	Continued from page 2 R1's "Final Report", dated 10/21/25, documents R1 "inadvertently spilled his coffee onto his lap due to unsteadiness while attempting to self-propel in his wheelchair, Tx (treatment) orders to be followed and areas to be monitored for any new changes. (R1) to be seen by Facility Wound Dr (Doctor) during next rounds", and "implemented a Hot Beverage Policy." R1's progress notes, dated 10/20/25 at 8:47am, document, "Resident given coffee by kitchen staff without lid. Order received to apply Silvadene topically to bilateral thighs BID (twice a day) and PRN (as needed). Resident (R1) will no longer receive hot beverages without a lid, and a cup holder will be added to his wheelchair." R1's progress notes also document on 10/21/25 at 9:44am documents, "Blisters have opened. Treatment orders have changed to apply nonadherent dressing and paper tape." R1's wound doctor note, "Wound Assessment and Plan", dated 1/22/25, documents right thigh burn, second degree measuring 2.5cm (centimeter) in length, 3 cm in width, and 0.1cm in depth with peri wound showing maceration. On 10/31/25 at 10:55 am, R1 was noted to be lying on his back in bed with covers pulled up to his bare chest watching television. R1 was in no distress. When asked about spilling coffee R1 stated, "I remember that. I burned myself." R1 pulled down blankets and points to two quarter sized pink areas on his inner right thigh and stated, "That's what happened." R1 denies discomfort to site and could not remember if he uses a cup with a lid. On 10/31/25 at 11:07 am, V3 (Dietary Manager) stated the facility initiated a new Hot Beverage and Soup Policy after R1's incident with spilled coffee. On 10/31/25 at 1:30 pm, V1 (Administrator) stated R1 had spilled coffee in his lap on 10/20/25, when he tried to hold onto the cup and wheel his wheelchair down the hallway, spilling coffee on his lap, causing a burn to his right thigh area. V1 (Administrator) also verified the facility did not have a Hot Beverage Policy in place prior to R1's incident.	S9999		

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S9999	Continued from page 3 On 10/31/25 at 3:10 pm, V7 (Assistant Director of Nursing/ADON) stated V7 was standing in the front foyer by the reception desk when R1 wheeled his wheelchair by her and started heading up the ramped hallway toward his room, when she heard R1 yell out an explicit word. V7 immediately went to him to see what was going on and noted he had spilled his coffee into his lap. V7 (ADON) immediately assisted R1 to his room where his pants were removed, and it was noted he had reddened area to his thighs and groin area. V7 (ADON) did not recall seeing R1 with coffee as he went by her. On 11/4/25 at 10:32 am, V1 (Administrator) confirmed she sees R1 with coffee frequently. V1 also confirmed R1 has impaired cognition and safety awareness. On 11/4/25, V14 (Certified Nursing Assistant/CNA) stated, "I do not feel he is safe to have coffee without a lid and staff should have carried it for him." V14 (CNA) also verified R1 has poor safety awareness. On 11/4/25 at 10:50 am, V6 (Licensed Practical Nurse/LPN) stated she feels R1 is not safe with coffee. "He tilts his cup in his lap when he is wheeling the halls in his wheelchair." On 11/4/25 at 11:00 am, V2 (Director of Nursing/DON) stated, "I don't think anyone is safe with an open cup of coffee." The following corrective actions for the past noncompliance were implemented for those residents found to have been affected by the alleged deficient practice. The facility Administrator made notification to the department per the regulations on 10/20/25. The facility adopted Hot Beverage Policy. R1 resides at the facility, and the facility QA Team reviewed/revised the care plan on 10/20/25. The Facility Administrator and Divisional VP of Clinical implemented an Ad Hoc QAPI tool on 10/20/25 to ensure Plan of Correction is effective and deficiency remains corrected.	S9999		

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S9999	Continued from page 4 The facility Administrator and DON In-Serviced staff regarding the facility's Hot Beverage Policy & Procedure. All beverages rechecked using food-safe thermometers to ensure serving at 130 degrees before being served to the residents. Dietary is responsible for ensuring coffee and hot water are not leaving the kitchen until the temperature is 130 degrees, this includes hot beverages for activities. All residents have the potential to be affected by the alleged deficient practice. However, due to the implementation of the above corrective action, alleged deficient practice will not recur. A systemic review of the facility systems, including Hot Beverage Policy & Procedure. This review found that all procedure(s) are in compliance with State and Federal guidelines. No further changes are required. The following Quality Assurance programs have been implemented to ensure continued compliance. The Quality Assurance Committee will ensure compliance through the internal Quality Assurance Process. The facility dietary manager is to record daily temperature checks for beverages and maintain logs for review in addition to daily checklist. The facility DON is to complete weekly observation audits for 4 weeks and then monthly for 3 months to ensure compliance with beverage temperature policy. Noncompliance findings to be discussed in QAPI meetings monthly until sustained compliance for 90 days. Concerns about the progress of the implementation of the Hot Beverage Policy & Procedure will be discussed in the QA Morning meetings for immediate resolution. The ongoing progress will be reviewed quarterly during the QA meetings. The DON or Designee will educate newly hired dietary staff on Hot Beverage Policy & Procedures. (B)	S9999		