

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3001117		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/18/2026	
NAME OF PROVIDER OR SUPPLIER Sunset Rehabilitation and Health Care				STREET ADDRESS, CITY, STATE, ZIP CODE 129 SOUTH 1ST AVENUE , CANTON, Illinois, 61520			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
S0000	Initial Comments		S0000				
	First Probationary Licensure Survey						
S9999	Final Observations		S9999				
	Statement of Licensure Violations:						
	1 of 6						
	300.610a)						
	300.661						
	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 300.661 Health Care Worker Background Check						
	A facility shall comply with the Health Care Worker Background Check Act and the Health Care Worker Background Check Code.						
	(225 ILCS 46/15)						
	Sec. 15. Definitions. In this Act:"Initiate" means obtaining from a student, applicant, or employee his or her social security number, demographics, a disclosure statement, and an authorization for the Department of Public Health or its designee to request a fingerprint-based criminal history records check; transmitting this information electronically to the Department of Public Health; conducting Internet searches on certain web sites, including without limitation the Illinois Sex Offender Registry, the Department of Corrections' Sex Offender Search						

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 Engine, the Department of Corrections' Inmate Search Engine, the Department of Corrections Wanted Fugitives Search Engine, the National Sex Offender Public Registry, and the List of Excluded Individuals and Entities database on the website of the Health and Human Services Office of Inspector General to determine if the applicant has been adjudicated a sex offender, has been a prison inmate, or has committed Medicare or Medicaid fraud, or conducting similar searches as defined by rule; and having the student, applicant, or employee's fingerprints collected and transmitted electronically to the Illinois State Police. Sec. 33. Fingerprint-based criminal history records check. (e) When initiating a background check requested by the Department of Public Health, an educational entity, health care employer, workforce intermediary, or organization that provides pro bono legal services shall electronically submit to the Department of Public Health the student's, applicant's, or employee's social security number, demographics, disclosure, and authorization information in a format prescribed by the Department of Public Health within 2 working days after the authorization is secured. The student, applicant, or employee shall have his or her fingerprints collected electronically and transmitted to the Illinois State Police within 10 working days. The educational entity, health care employer, workforce intermediary, or organization that provides pro bono legal services shall transmit all necessary information and fees to the livescan vendor and Illinois State Police within 10 working days after receipt of the authorization. This information and the results of the criminal history record checks shall be maintained by the Department of Public Health's Health Care Worker Registry. These requirements were not met as evidenced by: Based on record review and interview, the facility failed to ensure required background and registry checks were completed prior to or upon hire for three of 10 employees (V12/CNA/Certified Nursing Assistant, V13/Social Service Director, and V14/Housekeeper) reviewed for employee background checks in the sample of 10. This has the potential to affect all 70 residents in the building. Findings include: The facility's Abuse Policy, dated 11/25, documents, "Abuse Prohibition Program: The facility's abuse prohibition program includes the following seven components: Screening, Training, Prevention,			S9999			

Illinois Department of Public Health

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S9999	Continued from page 2 Identification, Investigation, Protection, and Reporting/Response. The facility Administrator will be designated as the facility Abuse Coordinator and will be responsible for overseeing the Abuse Prevention and Prohibition Program and directing any abuse investigation. If the Administrator is not available to address this role, the Administrator will designate a person "in charge" in their absence to fulfill the role. This person would normally be the Director of Nursing. Screening: The facility will not knowingly employ individuals who have been found guilty of abusing, neglecting, or mistreating residents or misappropriating properties. A person at a supervisory level will interview potential employees. All employees will have criminal background checks, state and federal required checks, employment reference checks (previous and current), and license/certification confirmation." The facility's Midnight Census Report, dated 3/17/26, documents 70 residents reside within the facility. The facility Employee Roster indicates V12/CNA was hired on 02/05/25. V12's Employee File revealed V12's Illinois Department of Public Health (IDPH) Health Care Worker Registry, Illinois Sex Offender Registry, Department of Corrections (DOC) Sex Offender, DOC Inmate Search, and DOC Wanted Fugitives checks were all undated. V12's National Sex Offender Registry and the Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) checks were dated 03/17/26, representing a delay of 406 days after V12's hire date. The facility Employee Roster indicates V13/Social Service Director was hired on 07/07/25. V13's Employee File revealed all V13's required registry checks (IDPH, Illinois and National Sex Offender, DOC registries, and OIG LEIE) were dated 08/14/25, representing a delay of 38 days after the hire date. The facility Employee Roster indicates V14/Housekeeper was hired on 02/19/26. V14's Employee File revealed all V14's required registry checks (IDPH, Illinois and National Sex Offender, DOC registries, and OIG LEIE) were dated 02/25/26, representing a delay of 6 days after the hire date. On 3/18/26 at 10:35 AM, V1/Administrator in	S9999					

Illinois Department of Public Health

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S9999	Continued from page 3 Training/AIT confirmed V12's employee file lacked documentation of the required background and registry checks at the time of hire. V1 noted the facility conducted V12's screenings on 3/17/26 only after discovering they were missing. Furthermore, V1 confirmed required screenings for V13 and V14 were completed after their hire dates. (C) 2 of 6 300.670a) 300.670c)1)2)3) 300.670d) Section 300.670 Disaster Preparedness a) For the purpose of this Section only, "disaster" means an occurrence, as a result of a natural force or mechanical failure such as water, wind or fire, or a lack of essential resources such as electrical power, that poses a threat to the safety and welfare of residents, personnel, and others present in the facility. c) Fire drills shall be held at least quarterly for each shift of facility personnel. Disaster drills other than fire shall be held twice annually for each shift of facility personnel. Drills shall be held under varied conditions to: 1) Ensure that all personnel on all shifts are trained to perform assigned tasks; 2) Ensure that all personnel on all shifts are familiar with the use of the fire-fighting equipment in the facility; and 3) Evaluate the effectiveness of disaster plans and procedures. d) Fire drills shall include simulation of the evacuation of residents to safe areas during at least one drill each year on each shift. These requirements were not met as evidenced by: Based on interview and record review, the facility failed to conduct bi-annual disaster drills for each shift of facility personnel and failed to include a required annual simulation of resident evacuation to designated safe areas during at least one fire drill per shift. This failure has the potential to affect all 70 residents residing within the facility.	S9999					

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S9999	Continued from page 4 Findings include: The facility's Disaster Drill records were reviewed from 03/14/25 through 03/17/26 and revealed only one disaster drill was conducted during this entire period (on 12/08/25). This single drill was the only recorded instance of disaster preparedness training for all shifts within a 12-month timeframe. The facility's Fire Drills were reviewed from 1/22/25 through 3/16/26 and revealed the fire drills consisted only of alarm activation and staff response. The fire drills did not contain evidence of a simulation of resident evacuation to designated areas. On 3/17/26 at 11:24 AM, V1/AIT confirmed only one disaster drill was completed during the past year on 12/8/26 on all shifts. On 3/18/26 at 11:08 AM, V1/AIT verified an evacuation simulation fire drill had not been completed within the last year on any shift. The facility's Midnight Census Report, dated 3/17/26, documents 70 residents reside within the facility. (C) 3 of 6 300.700b)2)3) Section 300.700 Testing for Legionella Bacteria b) The policy shall be based on the ASHRAE Guideline "Managing the Risk of Legionellosis Associated with Building Water Systems" and the Centers for Disease Control and Prevention's "Toolkit for Controlling Legionella in Common Sources of Exposure". The policy shall include, at a minimum: 2) A water management program that identifies specific testing protocols and acceptable ranges for control measures; and 3) A system to document the results of testing and corrective actions taken.			S9999			

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S9999	Continued from page 5 These requirements were not met as evidenced by: Based on interview and record review, the facility failed to provide a water management program that identifies specific testing protocols with acceptable ranges and control measures and a system that documents results of testing's with corrective actions. Findings include: During this investigation, the facility was unable to provide any documentation with specific testing protocols for legionella with specific ranges and control measures. Further, the facility could not provide a system that documents results of any testing that was completed in the past and any possible corrective actions. On 3/18/2026 at 9:30 AM, V1 (Administrator) confirmed she did not have any specific testing protocols for legionella with specific ranges and control measures, and she did not have a system that documents past or future results from testing's. (C) 4 of 6 300.610a) 300.1610a)1) 300.1640a) 300.1640i) 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			S9999			

Illinois Department of Public Health

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S9999	Continued from page 6 operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1610 Medication Policies and Procedures a) Development of Medication Policies 1) Every facility shall adopt written policies and procedures for properly and promptly obtaining, dispensing, administering, returning, and disposing of drugs and medications. These policies and procedures shall be consistent with the Act and this Part and shall be followed by the facility. These policies and procedures shall be in compliance with all applicable federal, State and local laws. Section 300.1640 Labeling and Storage of Medications a) All medications for all residents shall be properly labeled and stored at, or near, the nurses' station, in a locked cabinet, a locked medication room, or one or more locked mobile medication carts of satisfactory design for such storage. i) The medications of each resident shall be kept and stored in their originally received containers. Medications shall not be transferred between containers, except that a licensed nurse, acting as the agent of the resident, may remove previously dispensed medication from original containers and place it in other containers to be sent with a resident when the resident will be out of the facility at the time of scheduled administration of medication. When medication is sent out of the facility with the resident, it shall be labeled by the nurse with the name of the resident, name and strength of the medication, instructions for administration and any other appropriate information. These requirements were not met as evidenced by: Based on observation, interview, and record review, the facility failed to properly label medications and ensure timely administration for two residents (R11 and R12) and failed to appropriately discard medications or maintain them in their original container in a sample of ten residents. Findings Include: The facility's Critical Care Pharmacy Policy and Procedure Manual, dated 4/2021, documents, "Drug Labeling, a., the label of each individual container shall clearly indicate the resident's full name,		S9999				

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S9999	Continued from page 7 physician's name, prescription number, name and strength of drug, directions for administration, date of issue, the initials of the pharmacist filling the prescription, and the amount of medication contained in each individual prescription. In addition, the pharmacy's name, address, and telephone number shall be on all prescription labels. Storage and Return of Drugs, b, resident's medications shall be properly labeled and stored at or near the nurse's station in a locked cabinet, locked medication room, or in one or more located mobile medication carts of satisfactory design for such storage. All medication mobile medication carts shall be under the visual control of the responsible nurse at all times when not stored either in a locked room or otherwise made immobile. C, the medications of each resident shall be kept and stored in their originally received containers. Medications shall not be transferred between containers." On 3/17/2026 at 9:25 AM, V15 (Registered Nurse) was the assigned nurse for C Hall. V15 opened the top drawer of the medication mobile cart for C Hall and R11 and R12's medications were in a cup, with their names labeled on the clear cup. R11 had the medications sertraline (antidepressant), hydroxychloroquine (anti-rheumatic), and hydrocodone/acetaminophen (pain medication). R12 had the medications sertraline (2) (antidepressant), carbamazepine (anti-seizure), docusate sodium (laxative), sucralfate (gastroduodenal cytoprotective agent), omeprazole (proton pump inhibitor), hydrochlorothiazide (thiazide diuretic), and aspirin (pain medication, fever reducer, and anti-inflammatory). R11's Physicians Order sheet, dated 3/18/2026, documents sertraline 100 mg (milligrams) two tablets, once a day, hydroxychloroquine 50mg, 1 tablet, one time a day, and hydrocodone/acetaminophen 5-325 mg, every six hours as needed. R12's Physicians Order sheet, dated 3/18/2026, documents sertraline 100mg, two tablets, two times a day, carbamazepine 200mg, two tablets, two time a day, docusate sodium 100mg, 1 capsule, one time a day, sucralfate, omeprazole 20mg, one time a day, hydrochlorothiazide 50mg, one time a day, and aspirin 81mg, one time a day. On 3/17/2026 at 9:27 AM, V15 (Registered Nurse) stated she should have passed R11 and R12's medications immediately or discarded them when they refused, and not saved them in the medication mobile cart for later with their names on cups containing their medications.			S9999			

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S9999	Continued from page 8 On 3/17/2026 at 9:30 AM, C Hall medication mobile medication cart contained a Lantus (Insulin Glargine) 100 units/mL flexpen with no resident label. R8's Physicians Order sheet, dated 3/18/2026, documents, "Insulin Glargine Subcutaneous Solution 100 UNIT/ML (milliliter) (Insulin Glargine) Inject 20 units subcutaneously two times a day for DM (Diabetes Mellitus)". R9's Physicians Order sheet, dated 3/18/2026, documents, "Lantus Subcutaneous Solution 100 UNIT/ML (Insulin Glargine) Inject 44 unit subcutaneously as needed for DM when insulin pump is not working". On 3/18/2026 at 2:15 PM, V2 (Director of Nursing) confirmed all medications need to be administered one at a time and not ahead of time with resident names on cups. V2 confirmed V15 should have discarded medications if residents were asleep or refused. V2 also confirmed all medications need to be always labeled per facility policy. (B) 5 of 6 300.340c)3)C)iii) 300.610a) 300.2100 Section 300.340 Incorporated and Referenced Materials c) The following statutes and State regulations are referenced in this Part: 3) State of Illinois rules: C) Department of Public Health: iii) Food Code (77 Ill. Adm. Code 750)- 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			S9999			

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S9999	Continued from page 9 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 300.2100 Food Handling Sanitation Every facility shall comply with the Department's rules entitled "Food Code." (77 Ill. Adm. Code 750) Section 750.110 Incorporated and Referenced Materials c) The following materials are incorporated in this Part: 1) The 2022 FDA Food Code, Chapters 1 through 7 (except the terms "food employee" and "food establishment" in Sections 1-201.10), U.S. Department of Health and Human Services, Public Health Service, Food and Drug Administration, College Park MD 20740, available at https://www.fda.gov/media/164194/download?attachment The 2022 FDA Food Code 3-501.14 Cooling (A) Cooked time/temperature control for safety food shall be cooled: (1) Within 2 hours from 57°C (135°F) to 21°C (70°F); and (2) Within a total of 6 hours from 57°C (135°F) to 5°C (41°F) or less. (A) Cooked time/temperature control for safety food shall be cooled: (1) Within 2 hours from 57°C (135°F) to 21°C (70°F); P and (2) Within a total of 6 hours from 57°C (135°F) to 5°C (41°F) or less. P (B) TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be cooled within 4 hours to 5°C (41°F) or less if prepared from ingredients at ambient temperature, such as reconstituted FOODS and canned tuna.			S9999			

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S9999	Continued from page 10 (C) Except as specified under ¶ (D) of this section, a TIME/TEMPERATURE CONTROL FOR SAFETY FOOD received in compliance with LAWS allowing a temperature above 5 °C (41 °F) during shipment from the supplier as specified in ¶ 3-202.11(B), shall be cooled within 4 hours to 5oC (41 °F) or less. (D) Raw EGGS shall be received as specified under 3-202.11(C) and immediately placed in refrigerated EQUIPMENT that maintains an ambient air temperature of 7oC (45 °F) or less. These requirements were not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure cool down temperatures were taken for food items cooked ahead and then stored in the refrigerator. This has the potential to affect all 70 residents in the building. Findings include: The facility's Handling Leftover Food, undated, documents, "Guideline: Leftover foods will be properly handled, cooled, and stored to ensure minimal waste. Procedure: 2. Leftover food items to be reused at the end of meal service to ensure they are less than 41 degrees F (Fahrenheit) for cold food and greater than 135 degrees F, or per state specific regulations, for hot food. Foods that are outside the correct range shall be discarded for food safety. Foods are inspected to ensure they are of good quality. Any food that is dry, burnt or appears to be in poor condition is discarded. Hot foods shall be checked to ensure they have not been hot held for greater than two hours. Food held for greater than two hours are discarded to ensure food safety and quality. 3. All leftover food that meets these safety and quality parameters shall be immediately started in the cooling process. The cooling item is monitored to ensure that the food reaches 70 degrees F within two hours and 41 degrees F or less in four more hours and not to exceed six hours total. Food is loosely covered and placed in the refrigerator or on ice bath. The temperatures are recorded and documented on the food cover. Once the food has correctly cooled to 41 degrees F or less it is sealed tightly and labeled to identify the contents and has a use by date that is clearly visible. Food (s) that are removed from hot service during evening shift and cannot be monitored during the cooling process before staff close the department are discarded to ensure food safety."			S9999			

Illinois Department of Public Health

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S9999	Continued from page 11 On 3/17/26 at 9:25 AM, a tour of the kitchen with the Dietary Manager (V7) revealed three items in the walk-in refrigerator—cooked ground sausage (3/16/26), cooked chicken (3/12/26), and meat ravioli (3/14/26)—that lacked recorded cooling temperatures. The facility's Cool Down Temperature Log, dated January 1st, 2026, through March 17th, 2026, does not include cool down temperatures for cooked ground sausage, dated 3/16/26, cooked chicken dated 3/12/26, and cooked meat ravioli dated 3/14/26. On 3/17/26 at 9:35 AM, V7/Dietary Manager stated the cooked ground sausage, cooked chicken, and cooked meat ravioli were not recorded on the cool down log when prepped and should have been. V7 stated, "We have some new cooks on second shift, so I am guessing that's why the cool down temperatures weren't recorded." The facility's Midnight Census Report, dated 3/17/26, documents 70 residents reside within the facility. (C) 6 of 6 300.610a) 300.3220 k) 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 300.3220 Medical Care		S9999				

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3001117		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/18/2026	
NAME OF PROVIDER OR SUPPLIER Sunset Rehabilitation and Health Care				STREET ADDRESS, CITY, STATE, ZIP CODE 129 SOUTH 1ST AVENUE , CANTON, Illinois, 61520			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
S9999	Continued from page 12 k) A resident shall be permitted respect and privacy in his or her medical and personal care program. Every resident's case discussion, consultation, examination and treatment shall be confidential and shall be conducted discreetly, and those persons not directly involved in the resident's care must have his or her permission to be present. (Section 2-105 of the Act) These requirements were not met as evidenced by: Based on observation, interview, and record review, the facility failed to administer insulin in a private setting for one of four residents (R10) reviewed for medication administration in a sample of ten. Findings include: The facility's Resident Rights Policy, dated 12/2024, documents, "resident rights include but are not limited to, privacy and confidentiality". The facility's Medication Pass Tips policy, dated 5/2019, documents, "miscellaneous, provide adequate privacy for treatments (injections, nebulizers, inhalers, patches, eye drops, nasal sprays, etc.)". On 3/18/2026 at 11:22 AM, V20 (Registered Nurse) prepared R10's insulin flexpen and entered the dining room during lunch time. V20 proceeded to uncover R10's right arm and administered insulin in dining room during lunch time, with other residents and staff present. On 3/18/2026 at 11:30 AM, V20 (Registered Nurse) stated she was never instructed to take a resident into a private setting to administer insulin. On 3/18/2026 at 11:45 AM, V2 (Director of Nursing) stated all nursing staff are to administer insulin in a private setting. V2 confirmed V20 should have taken R10 into a private setting to administer her insulin. (C)			S9999			