STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009302	A. BUILDING: _____ B. WING _____	C 03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET HOME	418 WASHINGTON STREET QUINCY, IL 62301

(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) COMPLETE DATE
S 000	Initial Comments Complaint Investigation 252148/IL186929 Complaint Investigation 2521674/IL187279	S 000		
S9999	Final Observations Statement of Licensure Violations: (1 of 2) 300.610a) 300.1010h) 300.1210b) 300.1210c) 300.1210d)4)A) 300.1220b)3) 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. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009302	A. BUILDING: _____ B. WING _____	C 03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET HOME	418 WASHINGTON STREET QUINCY, IL 62301

(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) COMPLETE DATE
S9999	Continued From page 1	S9999		

plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.

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.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

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:

4) Personal care shall be provided on a 24-hour, seven-day-a-week basis. This shall include, but not be limited to, the following:

A) Each resident shall have proper daily personal attention, including skin, nails, hair, and oral hygiene, in addition to treatment ordered by the physician.

300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009302	A. BUILDING: _____ B. WING _____	C 03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET HOME	418 WASHINGTON STREET QUINCY, IL 62301

(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) COMPLETE DATE
S9999	Continued From page 2 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. These regulations were not met as evidence by: Based on interview and record review the facility failed to follow treatments as ordered by the physician and failed to implement pressure relieving interventions for one resident (R5) of four residents reviewed for pressure ulcers in the sample of nine. These failures resulted in R5 developing a facility acquired stage 4 pressure ulcer to her coccyx that became infected and caused R5 pain. Findings include: The Prevention of Pressure Injuries policy dated 4/2020 documents "The purpose of this procedure is to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors. Review the resident's care plan and identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable. Mobility/Repositioning 1. Reposition all residents with or at risk of pressure injuries on an individualized schedule, as determined by the interdisciplinary care team. 2. Choose a frequency for repositioning based on the resident's risk factors and current clinical practice	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009302	A. BUILDING: _____ B. WING _____	C 03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET HOME	418 WASHINGTON STREET QUINCY, IL 62301

(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) COMPLETE DATE
S9999	Continued From page 3	S9999		

guidelines."

The Administering Medications policy not dated documents that medications shall be administered in a safe and timely manner, and as prescribed. "3. Medications must be administered in accordance with the orders, including any required time frame. 18. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR (Medication Administration Record) space provided for that drug and dose. 19. The individual administering the medication must initial the resident's MAR on the appropriate line after giving each medication and before administering the next ones. 21. Topical medications used in treatments must be recorded on the resident's treatment record (TAR) (Treatment Administration Record). 28. If a medication error is noted to have occurred, immediately assess the resident for adverse reactions and notify the physician for any additional orders. Place the resident on the 24-hour report book, notify the POA (Power of Attorney) and fill out a medication error form and turn into the nursing office."

R5's Face Sheet documents R5 was a 95-year-old female admitted to the facility on 6/8/20 with the diagnoses which included Spinal Stenosis, Lumbar Region without Neurogenic Claudication, Prolapsed Uterus, Essential (Primary) Hypertension, Unspecified Urinary Incontinence, Vitamin D Deficiency, Other Abnormalities of Gait and Mobility, Chronic Diastolic (Congestive) Heart Failure, Weakness, and Chronic Kidney Disease, Stage Three.

R5's Progress Notes dated 12/21/24 at 12:48 AM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009302	A. BUILDING: _____ B. WING _____	C 03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET HOME	418 WASHINGTON STREET QUINCY, IL 62301

(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) COMPLETE DATE
S9999	Continued From page 4	S9999		

document that R5 passed away on 12/20/24.

R5's Brief Interview for Mental Status/BIMS dated 11/20/24 documents a BIMS of 10 (moderate cognition). R5's MDS (Minimum Data Set) Assessment dated 11/20/24 documents R5 required substantial assist for bed mobility, was dependent on staff for toileting and transfers, R5 had an indwelling urinary catheter, and R5 was always incontinent of bowel.

R5's Care Plan dated 12/5/24 documents that R5 had impaired skin integrity related to Immobility and a Prolapsed Uterus and a Pressure Ulcer to the Coccyx dated 12/5/24. Interventions "Administer treatments as ordered and monitor for effectiveness. Avoid positioning (R5) on coccyx. Follow facility policies/protocols for the prevention and treatment of skin breakdown." This same Care Plan documents R5 had ADL (activities of daily living) self-care needs, was dependent on staff for bed mobility, and required one staff to turn and reposition R5 in bed.

R5's Nursing Note written by V2/Director of Nursing dated 9/18/24 at 3:00 PM, documents that R5 has two new pressure ulcers. Skin issue # (number) 1 is a stage one pressure injury on R5's left buttock that measures 0.7 cm/centimeters x 0.8 cm x 0.1 cm. Skin issue # 2 is a stage two pressure ulcer on R5's coccyx that measures 1.1 cm x 1 cm x 0.1 cm. There is no wound odor or tunneling on either wound.

R5's Physician Order dated 9/18/2024 documents "Cleanse coccyx open area with NS (Normal Saline) and apply calcium alginate and (absorbent foam dressing) daily." Start date 9/18/2024. "Cleanse open area to L (left) buttocks with NS and apply (moisture barrier ointment) TID

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009302	A. BUILDING: _____ B. WING _____	C 03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET HOME	418 WASHINGTON STREET QUINCY, IL 62301

(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) COMPLETE DATE
S9999	Continued From page 5	S9999		

(three times a day) and PRN (as needed)." Start date 9/18/24.

R5's Physician Order dated 10/19/2024 documents "Cleanse coccyx and R (right) buttock open areas with NS and apply calcium alginate four x (by) four gauze and (absorbent foam dressing) daily until healed." Start date 10/19/24.

R5's Braden Evaluation dated 11/20/24 at 3:52 PM, documents "Sensory Perception: very limited. Moisture: Constantly moist. Activity: Chair fast. Resident is Very Limited: Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently. Nutrition: Probably inadequate. Braden score of 10 (High Risk)."

R5's Progress Notes written by V4/Nurse Practitioner/NP for 12/2/24 service, documents R5 is a 91-year-old female who is seen today due to worsening wound to the coccyx. Last week the on-call NP was paged with concerns for progression of the wound. The wound measures 2.5 cm/centimeters by 3.5 cm by 1.2 cm with tunneling, sloth, and foul odor (indicates infection). Orders were given for Santyl, calcium alginate and dressing, change daily. "I (V4) am following up today. At my previous visit in early November, wounds to the coccyx and right buttocks were superficial without any slough tissue, depth, or tunneling. The area is painful for (R5). Wound care to coccyx: Cleanse with 1/4 (Diluted sodium hypochlorite solution) 0.125% (percent) solution. Apply Santyl to slough tissue in wound bed. Pack with (Diluted sodium hypochlorite solution) soaked four X four gauze, ensuring packing extends through the tunneling. When removing old dressings, MUST be sure old gauze is removed!!! This dressing must be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009302	A. BUILDING: _____ B. WING _____	C 03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET HOME	418 WASHINGTON STREET QUINCY, IL 62301

(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) COMPLETE DATE
S9999	Continued From page 6	S9999		

changed daily. Start Oxycodone 2.5 mg/milligrams oral daily; give 30 minutes prior to wound care in the AM. Turn every 2 (two) hours while in bed. (Pressure relieving) cushion at all times when in wheelchair."

R5's Physician Order dated 12/3/2024 documents "(Diluted sodium hypochlorite solution) (1/4 strength) External Solution 0.125 % (Sodium Hypochlorite) Apply to coccyx topically one time a day for wound care. Cleanse wound with (Diluted sodium hypochlorite solution), apply Santyl to slough tissue in wound bed. Pack with (Diluted sodium hypochlorite solution) soaked four X four gauze, ensure packing extends through tunneling. Upon removal make sure old gauze is removed. Dressing must be changed daily." Start date 12/4/24. "Oxycodone HCl Oral Tablet 5 MG (milligrams) Give 0.5 tablet by mouth every night shift for wound prior to wound care." Start date 12/3/24.

R5's Nursing Note written by V6/LPN dated 12/3/24 at 1:57 PM, documents Per (V4/Nurse Practitioner) on 12/3/24 at 1:00 PM: Orders for wound care as follows: Cleanse with 1/4 (Diluted sodium hypochlorite solution) 0.125% solution. Apply SANTYL to slough tissue in wound bed. Pack with (Diluted sodium hypochlorite solution) soaked 4x4 gauze, ensuring packing extends through the tunneling. When removing old dressings, MUST be sure old gauze is removed!!! This dressing must be changed daily. Currently waiting on (Diluted sodium hypochlorite solution) from the pharmacy. Faxed pharmacy to ensure (Diluted sodium hypochlorite solution) is delivered tonight."

R5's Medication Administration Note written by V6/Licensed Practical Nurse/LPN dated 12/3/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009302	A. BUILDING: _____ B. WING _____	C 03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET HOME	418 WASHINGTON STREET QUINCY, IL 62301

(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) COMPLETE DATE
S9999	Continued From page 7	S9999		

at 2:41 PM, documents "(Diluted sodium hypochlorite solution) (1/4 strength) External Solution 0.125 % Apply to coccyx topically one time only for Wound care for 1 (one) Day 1 dose No supplies available from pharmacy at this time."

R5's Physician Order dated 12/5/2024 documents "(Diluted sodium hypochlorite solution) (1/4 strength) External Solution 0.125 % (Sodium Hypochlorite) Apply to coccyx topically every day and night shift for wound care. Cleanse wound with (Diluted sodium hypochlorite solution), apply Santyl to slough tissue in wound bed. Pack with (Diluted sodium hypochlorite solution) soaked four x four gauze, ensure packing extends through tunneling. Upon removal make sure old gauze is removed. Dressing must be changed daily." Start date 12/5/24. "Turn every two hours while in bed, side to side, avoid laying on back. Must use pillows between knees. Every shift to prevent further breakdown." Start 12/5/24.

R5's Progress Notes written by V4/NP for 12/13/24 service, documents that R5 is a 91-year-old female who is seen today for follow up wound care to the coccyx. Physical Exam "Stage four, now with deep tissue injury to surrounding tissue at 12 O'clock. Wound bed: 2.5 cm x 3.5 cm x 1.2 cm with slough/foul odor (indicated infection) and tunneling at 5-6 O'clock, approx. 3 of tunneling. Cleanse with 1/4 (Diluted sodium hypochlorite solution) 0.125% solution. Apply Santyl to slough tissue in wound bed. Pack with (Diluted sodium hypochlorite solution) soaked 4 x 4 gauze, ensuring packing extends through the tunneling. When removing old dressings, MUST be sure old gauze is removed!!! Changed dressings twice daily. Turn every two hours while in bed, side to side, avoid laying on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009302	A. BUILDING: _____ B. WING _____	C 03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET HOME	418 WASHINGTON STREET QUINCY, IL 62301

(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) COMPLETE DATE
S9999	Continued From page 8	S9999		

back. Must use pillows between knees to prevent further breakdown."

R5's Medication Administration Note written by V17/Licensed Practical Nurse dated 12/17/24 at 4:52 AM, documents "(Diluted sodium hypochlorite solution) (1/4 strength) External Solution 0.125 % Apply to coccyx topically every day and night shift for wound care Cleanse wound with (Diluted sodium hypochlorite solution), apply Santyl to slough tissue in wound bed. Pack with (Diluted sodium hypochlorite solution) soaked 4x4 gauze, ensure packing extends through tunneling. Upon removal make sure old gauze is removed. Dressing must be changed daily. Unable to complete due to there being no (Diluted sodium hypochlorite solution) available to complete this treatment."

R5's Skin Check dated 12/18/24 at 5:38 AM, documents that R5 has a Stage four Pressure Ulcer, full thickness skin and tissue loss on her right coccyx that was "acquired in-house." R5 is unable to describe pain. R5 says "It hurts" during dressing change. Length 7 cm/centimeters, width 5.5 cm, depth 3 cm, with undermining and tunneling. Granulation 50 % (percent), slough 50 %, with purulent heavy exudate and moderate odor after cleansing. Skin issue 2, left breast "Excoriation Pressure ulcer staging: Stage 2 Pressure ulcer/injury - partial thickness skin loss with exposed dermis. Wound acquired in-house. Length 6 cm, Width 1.3 cm, Depth 1.2 cm. Skin issue 3, Right medial forefoot, "Eschar Pressure ulcer staging: Stage 2 Pressure ulcer/injury - partial thickness skin loss with exposed dermis. Wound acquired in-house." "Other pain description: Unable to describe, says "It hurts" when doing dressing change." Length 1.5 cm, Width 1.6 cm, Depth 1.2 cm, Area 9.3 cm."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009302	A. BUILDING: _____ B. WING _____	C 03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET HOME	418 WASHINGTON STREET QUINCY, IL 62301

(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) COMPLETE DATE
S9999	Continued From page 9 R5's Treatment Administration Records/TAR for September 2024 through December 2024 documents "Cleanse coccyx open area with NS (normal saline) and apply calcium alginate and (absorbent foam dressing) daily." This same TAR documents R5's treatment was not signed as being done on 9/22, 9/23, 9/24/24. "Cleanse open area to L (left) buttocks with NS and apply (moisture barrier ointment) TID (three times a day) and PRN (as needed) every shift for Wound care." This same TAR documents R5's treatment was not signed as being done on day shift 10/5, 10/20, 11/7, evening shift 9/20, 9/21, 9/24, 9/29, 11/6, 11/12, 11/26, 11/27, 11/28/24, and night shift 9/22, 9/23, and 9/24, 10/21, 10/23, 11/22, 11/24 "Cleanse coccyx and R (right) buttock open area with NS and apply calcium alginate four x four gauze and (absorbent wound dressing) daily until healed." This same TAR documents R5's treatment was not signed as being done on 11/6, 11/22, and 11/24/24. "(Diluted sodium hypochlorite solution) (1/4 strength) External Solution 0.125 % (Sodium Hypochlorite) Apply to coccyx topically every day and night shift for wound care. Cleanse wound with (Diluted sodium hypochlorite solution), apply Santyl to slough tissue in wound bed. Pack with (Diluted sodium hypochlorite solution) soaked 4 X 4 gauze, ensure packing extends through tunneling. Upon removal make sure old gauze is removed. Dressing must be changed daily." This same TAR documents R5's treatment was not signed as being done on days 12/10/24 and nights 12/11/24. "Turn every 2 (two) hours while in bed, side to side, avoid laying on back. Must use pillows between knees. Every shift to prevent further breakdown." This same TAR documents R5's treatment was not signed as being done on the evening of 12/12/24.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009302	A. BUILDING: _____ B. WING _____	C 03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET HOME	418 WASHINGTON STREET QUINCY, IL 62301

(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) COMPLETE DATE
S9999	Continued From page 10	S9999		

On 3/13/25 at 11:20 AM, V4/NP stated, "I took care of (R5) for five years. For most of that time (R5) was stable with advanced Dementia. (R5) was up to activities then started having age related decline that led to her being bed bound. (R5) was not getting up at all at that time. (R5's) wound were caused by pressure. (R5's) wounds started out simple and treatments were ordered. From what I knew the treatments were working for (R5's) wounds and they were getting better. Then I was notified that I needed to look at (R5's) wound. I was totally floored by how huge it was. It was foul smelling and infected. It looked like there was also a deep tissue injury. I told (R5's) family that unfortunately this wound is bad, and we can't do surgery and all we can do is to try to manage pain and odor because the odor was so bad. We were doing symptom control until the end of (R5's) life. Once bed bound, (R5) should have been turned, and I should not have to explain it to staff and put that in the orders. It is nursing 101 that a resident should be turned and repositioned. (R5's) wound was nasty. I don't think (R5's) wound care was being done as ordered. I do the treatments at times and the supplies are not always available. I have had to request that they (the facility) get supplies that I have ordered. If treatments are not done as ordered the wound will get worse."

On 3/13/25 at 4:51 PM V3/Previous MDS Coordinator stated "There are a lot of reasons that (R5's) pressure ulcer got worse. (R5) was not turned like she should have been. The staff are not good about turning and repositioning the residents. (R5) had a small pressure ulcer that healed then (R5) got another one. The dressings were not changed like it should have been either because we would run out of supplies."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009302	A. BUILDING: _____ B. WING _____	C 03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET HOME	418 WASHINGTON STREET QUINCY, IL 62301

(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) COMPLETE DATE
S9999	Continued From page 11	S9999		

On 3/14/25 at 11:34 AM, V16/R5's Power of Attorney/POA stated "I came to the facility about once a week and talk to (R5) every day. (R5) had dementia but she knew what was going on. I went in more once (R5) was moved to the fourth floor from the first floor. The care just wasn't as good on the fourth floor. Most of the time (R5) was laying on her back. There was a sign in her room that (R5) was to be on her side. (V4/NP) made it known that (R5) should be on her side. I am putting the blame on the aids not all of them but some. (R5) had no use of her legs and could not move herself. (R5) was dependent on staff. I saw the wound and it was disgusting. I wish I had never seen it. It had a bad smell and was nasty. (V4/NP) had been brought in to take care of it. (V4) told me that inside the wound was bigger than the outside. It was on (R5's) lower back towards the buttock."

On 3/15/25 at 1:23 PM, V12/LPN stated that she took care of R5. R5 did have a pressure ulcer that got worse and had a bad odor to it. There were times there were no supplies to do the dressing. R5 was supposed to be kept off her back while in bed but that didn't always happen."

On 3/15/25 at 1:36 PM, V13/LPN stated "I am not at the facility often because I work as needed. The first time I saw the skin issue on (R5) it looked like a bruise. About a week later the area had opened and had a foul smell to it."

On 3/15/25 at 3:59 PM, V15/Registered Nurse/RN stated "(R5) had a pressure ulcer that got worse from laying on her back. The CNAs (Certified Nursing Assistants) don't turn the residents like they are supposed to."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009302	A. BUILDING: _____ B. WING _____	C 03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET HOME	418 WASHINGTON STREET QUINCY, IL 62301

(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) COMPLETE DATE
S9999	Continued From page 12	S9999		

On 3/17/25 at 1:43 PM, V1/Administrator verified that according to R5's TAR, R5's dressings were not done daily as ordered. V1 stated "If it is not marked it is not done."

On 3/18/25 at 10:18 AM, V4/NP stated "R5 was a high risk for developing a pressure ulcer but the severity of the wound did not need to happen. Better care would have minimalized the severity of it."

(B)
(2 of 2)
300.610a)
300.1210b)
300.1210d)1)2)
300.1220b)3)
300.1630d)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009302	A. BUILDING: _____ B. WING _____	C 03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET HOME	418 WASHINGTON STREET QUINCY, IL 62301

(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) COMPLETE DATE
S9999	Continued From page 13	S9999		

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:

1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.

2) All treatments and procedures shall be administered as ordered by the physician.

Section 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition.

Section 300.1630 Administration of Medication

d) If, for any reason, a licensed prescriber's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009302	A. BUILDING: _____ B. WING _____	C 03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET HOME	418 WASHINGTON STREET QUINCY, IL 62301

(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) COMPLETE DATE
S9999	Continued From page 14	S9999		

medication order cannot be followed, the licensed prescriber shall be notified as soon as is reasonable, depending upon the situation, and a notation made in the resident's record.

These regulations were not met as evidence by:

Based on interview and record review the facility failed to send the correct medication on a home visit for one resident of three residents (R2) reviewed for home medications in the sample of 9.

Findings include:

The Administering Medications policy (not dated) documents "Medications shall be administered in a safe and timely manner, and as prescribed. 3. Medications must be administered in accordance with the orders, including any required time frame."

The Dispensing Medications to Residents on Leave/Pass dated 4/2007, documents "The facility shall provide residents with necessary medication(s) when they leave the facility temporarily. 1. Residents who are away from the facility during medication passes will be given scheduled and essential PRN (as needed) medication(s) to take with them. They will only be given the amounts and dosages needed for the length of the anticipated absence."

R2's current computerized medical record documents R2 is a 69-year-old female admitted to the facility on 6/20/19 with diagnoses which include Essential (Primary) Hypertension, Fibromyalgia, Spondylosis, Chronic Obstructive Pulmonary Disease, Hyperlipidemia, Unspecified Atrial Fibrillation, Hypertensive Chronic Kidney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009302	A. BUILDING: _____ B. WING _____	C 03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET HOME	418 WASHINGTON STREET QUINCY, IL 62301

(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) COMPLETE DATE
S9999	Continued From page 15	S9999		

Disease, Type 2 Diabetes Mellitus with Diabetic Polyneuropathy, and Peripheral Vascular Disease.

R2's MDS (Minimum Data Set) Assessment dated 2/12/25 documents R2 has a Brief Interview for Mental Status/BIMS of 15 (cognition intact). R2 requires set up help for eating, supervision for bed mobility, and is dependent on staff for transfers.

R2's Care Plan documents "I have Diabetes Mellitus." Intervention "Administer diabetes medication as ordered by doctor."

R2's Nursing Note written by V8/Unit Coordinator dated 12/21/24 at 10:49 AM, documents "(R2) went out with family Noon meds and 7 PM med's sent with (R2). (R2) is planning to return around 7 PM this evening."

On 3/13/25 at 10:56 AM, V1/Administrator stated that she remembers a conversation about R2 going on a home visit and having the wrong insulin with her. Either R2 or her family were called and told it was the wrong insulin and for R2 not to take it. V1 does not know whose medication it was or why R2 was given it.

On 3/13/25 at 4:51 PM V3/Previous MDS Coordinator stated "(R2) was going on a home visit and (V7/Unit Coordinator) got (R2's) medication ready to send with (R2). When it was time for (R2) to leave (V6/Previous Licensed Practical Nurse/LPN) gave the medication to (R2). Later (V7) said that (V6) gave (R2) the wrong insulin. (R2) and her family were called and told the insulin was wrong and not to take it."

On 3/14/25 at 1:42 PM, V1 stated "(V7/Previous

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009302	A. BUILDING: _____ B. WING _____	C 03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET HOME	418 WASHINGTON STREET QUINCY, IL 62301

(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) COMPLETE DATE
S9999	Continued From page 16	S9999		

Unit Coordinator) got (R2's) medication ready for (R2) to take on her home visit and had them in the medication cart. (V7) then left the floor. While (V7) was gone (R2) was ready to leave the facility. (V6/Previous LPN) gave (R2) the insulin syringe that was in the cart with (R2's) other med's that were ready. Then (V7) returned to the floor and (V6) told (V7) that (R2) had left with her insulin and medication. (V7) told (V6) that was not (R2's) insulin." V1 also stated "I have no idea of whose insulin that was. I don't know who it would have been for."

On 3/14/25 at 1:50 PM, V2/Director of Nursing stated, "There was no insulin that was supposed to go home with (R2). I don't know why the nurse had a syringe with insulin in it laying in the med cart. That shouldn't have happened."

On 3/14/25 at 3:07 PM, R2 stated "I went on a home visit on 12/21/24. I was gone from about 10:30 AM to 6:30 PM. Shortly after leaving the facility, I got a call and was told not to take the insulin the facility had sent with me because it was not my insulin."

On 3/19/25 at 12:44 PM, V1/Administrator stated "We do not have a policy on medication storage that I can find. I know the insulin should not have been left in the drawer like that."

(B)