STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0011643	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET HOME	418 WASHINGTON STREET , QUINCY, Illinois, 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) COMPLETION DATE
S0000	Initial Comments Investigation of Facility Reported Incident of October 14, 2025/2639135	S0000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.3210t) 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 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. Section 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property.	S9999		

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

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S9999	Continued from page 1 These regulations were not met as evidence by: Based on interview and record review the facility failed to ensure one resident (R1) was free from abuse of three residents reviewed for abuse in a total sample of nine. The facility also failed to thoroughly investigate an allegation of abuse. Based on V8's statement R1 acted “scared” and “followed me around all night.” “I for sure think she was traumatized by the whole thing even if she couldn’t say it.”, it can be determined that the reasonable person in this resident's position would have experienced psychosocial harm (e.g., embracement, humiliation, anxiety") as a result of this abuse. Findings Include: The Facility's "Abuse and Neglect" policy dated July 2023 documents "It is the policy of (this facility) to provide each resident with an environment free from abuse, neglect, corporal punishment, involuntary seclusion, misappropriation of resident property, exploitation and physical or chemical restraint not required to treat the resident's symptom, as defined below." The Facility's "Abuse and Neglect" policy dated July 2023 documents "Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm or pain or mental anguish. This includes deprivations by an individual, including a caretaker, of goods or services necessary to attain or maintain physical, mental, or psychosocial well-being. This presumes instances of abuse of all residents, even those in a coma, cause physical harm, or pain mental anguish. Physical Abuse- includes but not limited to, hitting, slapping, pinching, and corporal punishment. a. resident to resident abuse with or without injury b. staff to resident abuse with or without injury c. other (visitor, relative) to resident abuse with or without injury." The Facility's "Abuse and Neglect" policy dated July 2023 documents "should an incident or suspected incident of resident abuse, neglect, or injury of an unknown source be reported, the administrator, or his/her designee, will appoint a member of management to investigate the alleged incident. The person in charge of the investigation will be provided a completed copy of the abuse report form, witness statement, and or information regarding the alleged incident. The individual conducting the investigation	S9999		

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S9999	Continued from page 2 will, at a minimum: I. review the resident's medical record to determine events leading up to the incident ii. interview the person reporting the incident iii. interview any witnesses to the incident iv. interview the resident (as medically appropriate) v. interview the resident's attending physician to determine the resident's current mental status vi. interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident vii. interview the resident's roommate, family members, and visitors viii. interview other residents to whom the accused employee provides care or services ix. review all events leading up to the alleged incident." The Facility's "Abuse and Neglect" policy dated July 2023 documents "Employees accused of participating in the alleged abuse will be immediately suspended until the finding of the investigation have been reviewed by the administrator. If it is after regular office hours, the house supervisor will remove the accused employee from the facility immediately." R1's current undated care plan documents "the resident is/has potential to demonstrate physical behaviors related to Dementia." R1's care plan documents the intervention for this "this resident tolerates 1 to 2 people at a time. The resident needs personal space. The resident does not like to be touched by anybody." "When resident becomes agitated: Intervene before agitation escalates; guide away from source of distress; engage calmly in conversation; if response is aggressive, staff to calmly walk away and approach later." R1's Medical Record documents that she was admitted to the facility on 12/16/24 with diagnosis to include but not limited to Alzheimer's Disease, Depression and Hypertension. R1's MDS (Minimum Data Set) dated 9/5/25 documents that she is rarely/never understood. Throughout the survey R1 became verbally aggressive when spoken to and did not answer any questions appropriately. On 10/14/25 at 10:00 AM V4 (CNA) stated that on 10/4/25 R1 had been "crazy all day." V4 stated that at the end of her shift she saw R1 by the door with V3 (RN). V4 stated R1 was arguing with V3 (RN) and attempting to exit the door. V4 confirmed that she walked up behind R1 and "hooked" her arm up under R1's arm and turned her around and started "walking towards (R1)'s room."	S9999		

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S9999	Continued from page 3 V4 confirmed that R1 "did not want to go." V4 repeatedly answered "I do not recall" to most other questions asked such as where any other staff members were at the time, how she knew that R1 did not want to go down the hallway and whether or not V4 cursed during this interaction as was documented in another interview. 10/14/25 at 11:00 AM V7 (R1's Health Care Power of Attorney) stated that he did not think the facility "is used to having someone so mobile and confused." "I don't think they know what they are doing with her. She can be difficult, but their approach is a lot of the problem." "When I get phone calls about (R1)'s behaviors staff say things like '(R1) has been off the chain today' or 'she's been crazy all day.' " On 10/14/25 at 1:30 PM V9 (Licensed Practical Nurse) stated that on 10/4/25 during shift change around 6:30 PM she was waiting to get report from V3 (Registered Nurse) but V3 (RN) was at the door with R1 attempting to get R1 to go down the hall away from the door and R1 was resisting leaving the area. V9 (LPN) stated that V4 (CNA) walked up to V3 (RN) and R1 and said "we aint doing this sh*t today" and hooked her arm under R1's arm and "marched her" back up the hallway and yelled for help from another V5 (CNA) who was just walking out of another resident's room. V9 stated that both she and V3 (RN) felt "very uncomfortable" with V4 (CNA)'s actions. On 10/14/25 at 2:00 PM V3 (RN) stated on 10/4/25 during shift change R1 was by the doors that led out of the unit. V3 stated she was attempting to redirect R1 to back away from the doors. "(R1) was slapping at my arms and yelling, but she does that all the time. She had been doing it all day." V3 stated that V4 (CNA) "swooped in" and "hooked (R1) under the arm and dragged her down the hallway." V3 denied requesting help or needing help. "(R1) had been having behaviors all day, it felt like (V4/CNA) just decided that (R1) was not going to be acting like that anymore." "(V4/CNA) was visibly angry during this interaction." V3 (RN) stated that at the time of the incident both she and V9 (LPN) felt that the interaction was "not appropriate" and "aggressive" on V4 (CNA)'s part. On 10/14/25 at 3:00 PM V8 (Certified Nurse Aide) stated that on 10/4/25 he “heard a commotion” and turned the corner to see R1 “being dragged” down the hallway while she was fighting and yelling. V8 stated that V4 stated “here you take her.” V8 stated he was able to hold his hand out to R1 and she took it calmly and was	S9999		

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S9999	Continued from page 4 cooperative once let go. “That is not the way we should be treating a confused person.” “(V4/CNA) was noticeably upset and frustrated with (R1)." R1 acted “scared” and “followed me around all night.” “I for sure think she was traumatized by the whole thing even if she couldn’t say it.” The Facility's Abuse Investigation dated 10/9/25 documents that on 10/4/25 V4 (CNA) was immediately suspended. The Abuse Investigation dated 10/9/25 documents that the allegation was considered unsubstantiated as of 10/9/25 and V4 was allowed to return to work. The Facility's schedule documents that V4 (CNA) worked on 10/09/25 and 10/14/25. On 10/14/25 V4 (CNA) was the staff member responsible for R1's direct care. On 10/14/25 at 1:30 PM V1 (Administrator) confirmed that all statements from staff members on 10/4/25 indicated that V8 (CNA) was the staff member who took R1 from V4 (CNA) during the incident. V1 confirmed that she had not interviewed or spoken with V8 as of 10/14/25. "I just haven't had problems with (V4/CNA)" "I wasn't that worried about it." On 10/14/25 at 2:30 PM V1 (Administrator) stated "I am now hearing more of the story about the incident on 10/4/25 with (R1) and (V4/CNA). I am reopening the investigation and interviewing more staff." On 10/16/25 V1 (Administrator) provided an amended "Abuse Investigation" dated 10/15/25 that declared the abuse allegation on 10/4/25 as "substantiated abuse." The facility's schedule for 10/4/25 documents that 3 staff members that were present on the hallway that incident took place on and V2 confirmed she has not interviewed them: V8 (CNA), V11 (CNA) and V12 (CNA). On 10/16/25 V1 (Administrator) provided an amended "Abuse Investigation" dated 10/15/25 that declared the abuse allegation on 10/4/25 as "substantiated abuse." The Facility's "Resident Bedsheet" census form dated 10/4/25 documents that 88 residents reside in the facility. (B)	S9999		