STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510359	A. BUILDING: _____ B. WING _____	C 09/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE GARDENS	442 COMFORT DRIVE MARION, IL 62959

(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
A 000	Initial Comment COI #2557676 / IL196978 295.2000 a) 3) 5) Residency Requriements 295.6000 a) 1) 5) 8) 11) Resident Rights .	A 000		
A2000	Section 295.2000 Residency Requirements This Regulation is not met as evidenced by: Type 2 Violation Section 295.2000 Residency Requirements a) No individual shall be accepted for residency or remain in residence if the establishment cannot provide or secure appropriate services, if the individual requires a level of service or type of service for which the establishment is not licensed or which the establishment does not provide, or if the establishment does not have the staff appropriate in numbers and with appropriate skill to provide such services. (Section 75(a) of the Act) 3) The person requires total assistance with 2 or more activities of daily living; 5) The person requires more than minimal assistance in moving to a safe area in an emergency. For the purpose of this Section, minimal assistance means that the resident is able to respond, with or without assistance, in an emergency to protect himself/herself, given the staffing and construction of the building; Based on interview and record review, the facility failed to ensure that residency requirements were	A2000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510359	A. BUILDING: _____ B. WING _____	C 09/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE GARDENS	442 COMFORT DRIVE MARION, IL 62959

(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
A2000	Continued From page 1	A2000		

met
for (R1) who required total assistance with 2 or more activities of daily living as well as maximum assist in moving to a safe are in an emergency. This failure had the substantial probability of harm to R1. This failure creates a substantial probability of harm to a resident or residents.

Findings include:

The Individual Service Plan, ISP, dated 12/01/24, identifies R1 as a female resident who was born on 10/21/52. The ISP for R1 has documented under 'Activities of Daily Living', under Bathing is circled Yes and hand written 'total'. Under 'Transferring / Mobility Assistance is circled Yes and wheelchair is circled and then handwritten is 'unable to walk total transfer'. Then under 'Continence is circled Yes and handwritten 'incont of urine, has cath., total assist if BM.'

During observation on 08/19/25, R1 was awake and alert up in her bed, and unable to remove herself from her bed. During this observation it was noted that R1 was wearing an attend, had a catheter, no wheelchair present, and her transferring equipment was not present either.

During interview with R1 in her room on 08/19/25, R1 stated that E1/Administrator stated R1 was too big and R1 would be staying in her room from now on. Furthermore E1 told staff not to get me out of her bed. When asked R1 when this started, R1 replied 'The first of this month." R1 went on to say that R1 is not able to go to the dining area for meals, activities to play Bingo, and to the restroom and shower room for personal use. R1 then stated R1's has a indwelling Foley and an attend for her toileting needs. R1 stated that the staff have to clean her up in her bed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510359	A. BUILDING: _____ B. WING _____	C 09/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE GARDENS	442 COMFORT DRIVE MARION, IL 62959

(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
A2000	Continued From page 2 when she has a BM (bowel movement). My wheelchair is not in here and neither is my transfer equipment, its all next door.	A2000		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: Type 2 Violation Section 295.6000 Resident Rights a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of his or her status as a resident of an establishment, nor shall a resident forfeit any of the following rights: 1) The right to live in an environment that promotes and supports each resident's dignity, individuality, independence, self-determination, privacy, and choice and to be treated with consideration and respect; 5) The right to receive the services specified in the service plan, to review and renegotiate the service plan at any time; and to be informed of the cost of the changes; 8) The right to exercise free choice in selected activities, schedules, and daily routine; 11) The right to the free exercise of religion and to participate or refuse to participate in religious, social, recreational, rehabilitative, political or community activities;	A6000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510359	A. BUILDING: _____ B. WING _____	C 09/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE GARDENS	442 COMFORT DRIVE MARION, IL 62959

(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
A6000	Continued From page 3	A6000		

Based on interview, record review, and observation, the Establishment failed to ensure that R1 did not have her rights altered by being left isolated in her bed. This failure resulted in R1 confined to her bed, no assistance to to the restroom for showers or toileting, the inability to attend meals in the dining area, or to participate in activities at the Establishment. In addition, this failure by the Establishment has the probability for all residents at the Establishment to confined to there bed/rooms.

The Individual Service Plan, ISP, dated 12/01/24, identifies R1 as a female resident who was born on 10/21/52. The ISP for R1 has documented under 'Activities of Daily Living', under Bathing is circled Yes and hand written 'total'. Under 'Transferring / Mobility Assistance is circled Yes and wheelchair is circled and then handwritten is 'unable to walk total transfer'. Then under 'Continence is circled Yes and handwritten 'incont of urine, has cath., total assist if BM.'

During observation on 08/19/25, R1 was awake and alert up in her bed, and unable to remove herself from her bed. During this observation it was noted that R1 was wearing an attend, had a catheter, no wheelchair present, and her transferring equipment was not present either.

During interview with R1 in her room on 08/19/25, R1 stated that E1/Administrator stated R1 was too big and R1 would be staying in her room from now on. Furthermore E1 told staff not to get me out of her bed. When asked R1 when this started, R1 replied 'The first of this month." R1 went on to say that R1 is not able to go to the dining area for meals, activities to play Bingo, and to the restroom and shower room for personal use. R1 then stated R1's has a indwelling Foley

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510359	A. BUILDING: _____ B. WING _____	C 09/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE GARDENS	442 COMFORT DRIVE MARION, IL 62959

(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
A6000	Continued From page 4 and an attend for her toileting needs. R1 stated that the staff have to clean her up in her bed when she has a BM (bowel movement). My wheelchair is not in here and neither is my transfer equipment, its all next door. During record review, no documentation was present regarding R1 attending any activities. During record review regarding showers, R1 had the following documentation for showers on 06/06/25, 06/25/25, 07/01/25, & 07/23/25. On R1 was offered a bed bath instead of a shower, on 08/13/25 & 08/19/25, states R1 refused a bed bath due to the fact that R1 wanted a shower. The Establishment document stated Sunshine Gardens Abuse Neglect Policy Mental abuse including humiliation, harassment, threats of punishment or deprivation directed toward a resident Corporal punishment Involuntary seclusion of a resident for convenience of staff or discipline.	A6000		