STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145892	A. Building B. Wing	06/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunny Hill Nursing Home of Will County	421 Doris Avenue Joliet, IL 60433

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview and record review, the facility failed to follow the care plan interventions of two-person care and as a result, R1 fell from the bed during personal care and sustained a fracture. This applies to 1 of 3 residents (R1) reviewed for accidents. The findings include:The facility's 06/05/26 Initial Report to the State Agency showed Resident-R1 had a fall incident this morning, complained of pain to left hip and right knee. She (R1) was sent out to the hospital and was admitted with bilateral distal femoral fractures. Full report to follow. On 06/27/26 at 9:30 AM, R1 was in bed. R1 had a left-hand contracture. R1 stated a few weeks ago, she was receiving a bed bath, being done by V4 (CNA/Certified Nursing Assistant). R1 stated V4 did not have any other staff assisting her with the bed bath. R1 stated she was in bed, lying on her left side. R1 stated V4 rolled her too far away from her, causing her to fall from the bed, onto the floor. R1 stated she was not holding on to the side rail for support. R1 stated while on the floor, her feet, hips, leg, and head were hurting. R1 stated she was sent to the hospital, where she had to undergo surgery. V4's written statement was reviewed. V4 stated, To Whom it May Concern: I, (V4's Name) CNA was giving R1 a bed bath as usual, she had a very large bowel movement. She was on her left side facing the window. R1 was holding on to the right bed rail with her right hand. while I was cleaning her backside with my right hand while my left hand was holding her. R1's left foot slid off the bed causing her to fall forward. I tried to grab her to pull her backwards, but she was naked, and her weight was too much. I had on gloves, so her body was slippery she slid off the bed. Everything happened so fast. This is our normal routine, as I reflect on what happened, the only thing that could have changed what has occurred was another person CNA.R1's ADL (Activities of Daily Living) self-care performance deficit related to weakness and limitations in ROM (Range of Motion) related to contracture of bilateral ankles, foot drop, CVA (Cerebral Vascular Accident) with left hemi care plan showed: Interventions-Bathing/Showering: I am totally dependent on two staff for bathing. I prefer to have a bed bath only dated 12/20/13. Bed Mobility: I need a two person assist for turning and repositioning in bed dated 12/20/13. Risk for falls care plan dated 12/20/13 showed Ensure that I am always positioned in the middle of the bed, dated 05/10/22. On 06/27/26 at 12:40 PM, V3 (Assistant Director of Nursing/Restorative Nurse) stated she was the restorative nurse for R1. V3 stated R1 requires two persons assist with bed mobility, transfers, and bathing. V3 stated on 06/05/26, V4 was the only one person assisting R1 with bathing and bed mobility when she rolled out of bed onto the floor. V3 stated if V4 had read R1's care plan, she would have known that she requires two people to provide care. V3 stated R1 had been a two person assist since 2014 which was documented in the care plan.On 06/27/26 at 4:00 PM, V1 (Administrator) stated V4 was alone, giving R1 a bed bath when she slid out of bed and fell onto the floor. V1 stated she looked at R1's care plan after the fall and saw that R1 required two people to assist with bed mobility, transfers, and showers since 2013. V1 stated V4 was placed on paid administrative leave pending the investigation. V1 stated V4 was subsequently terminated for failure to follow the care plan for R1.On 06/27/26 at 2:00 PM, V2 (Director of Nursing) stated she expects the staff to go over the care plan before a resident is touched for the day. V2 stated she expects the staff to follow what the care plan says. R1's MDS (Minimum Data Set) dated 06/23/26 showed R1 (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	was dependent upon staff for bathing, toileting, and transferring. The same MDS showed R1 required substantial to maximal assistance with rolling from left to right and returning to back while in bed. R1's Emergency Department Physician Report dated 06/05/26 showed, (R1's age) female presents with a fall out of bed; she said she was at the nursing home; they were changing her. Stated when they rolled her, she rolled out of bed. [NAME] abrasion present, she says both femurs and both knees hurt her. Diagnosis bilateral distal femur fractures. R1's Diagnostic Imaging Report from (Hospital) dated 06/05/26 showed Radiology/Xray Femur Right, there is impacted comminuted distal femoral fracture at the meta diaphysis. No angulation or displacement. Diagnostic Imaging Report dated 06/05/26 showed, Radiology/Xray Femur left, Xray knee left, there is comminuted impacted distal femoral shaft fracture at the meta diaphysis. Impression: Distal Femoral Fracture. R1's Operative Report dated 06/07/26 showed, Open treatment right distal femur fracture with retrograde femoral rod without intra-articular extension. Open treatment left distal femur fracture with intercondylar extension with headless compression screws and retrograde rod.On 06/27/26 at 3:00 PM, V9 (Medical Doctor) stated he was the doctor for R1. V9 stated R1 had a fall and sustained fractures to both her legs due to the fall. V9 stated the fall, and fractures could have been avoided if V4 had followed the care plan and had two staff members giving the bed bath and repositioning R1 instead on one person. V9 stated he expects the staff to follow the care plans. The facility's Care Plans, Comprehensive Person-Centered Policy, dated 03/08/26, showed Policy: It is the policy of (Facility Name) to develop and implement a person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs for each resident at periodic intervals. The Nursing-CNA Assignments Policy, dated 02/24/03, showed Policy: It is the policy of (Facility Name) to assure CNA functional duties are based on residents assessed needs as identified in the resident's Care Plan and additional duties as assigned/directed are completed. D) Review the resident care plan on PCC (Point Click Care) daily. E) Follow care plan and assure all resident needs are met. The Fall Prevention and Management Policy, dated 09/12/05, showed Policy: It is the policy of (Facility Name) to ensure that (1) The resident environment remains as free from accident hazards as is possible; and (2) each resident receives adequate supervision and assistive devices to prevent accidents. Procedure: 4) Residents that are to be determined to be a high risk of falling will be alerted to staff. 7) All staff is responsible to review and follow all individualized resident care plan approaches and interventions.