| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 146068 | A. Building<br>B. Wing | 01/27/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Sunny Acres Nursing Home | 19130 Sunny Acres Road<br>Petersburg, IL 62675 |

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 0580<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>50430<br><br>Based on record review and interview the facility failed to notify the physician of decreased/absent urinary output, resident having a urinary tract infection with no antibiotic medication orders, and urinalysis labwork being collected four days after ordered for one (R1) of five residents reviewed for physician notification in the total sample of six. These failures resulted in R1 being transferred to the emergency room for evaluation and subsequent hospitalization and treatment for an UTI (Urinary Tract Infection) receiving intravenous fluid and antibiotic medication. These failures also resulted in a repeated hospitalization for R1 where again she was diagnosed with a UTI as well as encephalopathy (brain disease that alters brain function or structure, common cause includes infections and can be life threatening if left untreated).<br><br>Findings include:<br><br>The Facilities Guidelines for Physician Notification of Change in Resident Condition revised 4/2019 documents it is the responsibility of each nurse to notify the physician of a significant change in condition before the end of each shift.<br><br>R1's Nurse Progress Notes dated 12/23/2024 at 12:48, documents the facility received a call that R1's urine was positive for ESBL (Extended-Spectrum Beta-Lactamase an antibiotic resistant urinary tract infection) and E. coli (Escherichia coli bacteria that is a common cause of UTI), Faxed results to V9 Medical Director.<br><br>R1's current medical record has no documentation of the physician being notified to follow up regarding R1's abnormal urinalysis results from 12/23/24-12/28/24.<br><br>R1's Nurse progress Note dated 12/28/24 at 9:18 PM, documents R1 had no urinary output in indwelling urinary catheter for two days. R1 was sent to emergency room by ambulance for evaluation.<br><br>R1's Emergency Department progress notes, dated 12/28/24, document R1 was kept in the hospital overnight and received IV fluids and antibiotics. R1 was noted to have a UTI due to urinary retention and evidence of cystitis (bladder inflammation) and hydronephrosis (excess fluid in kidney due to a backup of urine) secondary to urinary retention. The physician documents in R1's Emergency Department progress note, At presentation: the differential diagnosis considered could potentially be life threatening or risk to bodily function.<br><br>(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 0580<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | On 1/7/25 at 1:00 PM, V6 emergency room Nurse, stated V6 was working in emergency room when R1 arrived on 12/28/24 and provided her care. V6 stated the facility nurse reported to V6 that R1 had not urinated in her indwelling urinary catheter drainage bag in two days. V6 stated the emergency room placed a new indwelling catheter in R1 and had dark gold urine return. V6 further stated that he felt it was concerning that R1 had not voided in two days before R1 was sent to the emergency room .<br><br>On 1/22/25 at 9:05AM, V9 Medical Director stated V9 would expect the facility to call and notify V9 if a resident with a catheter has not voided in an eight-hour shift. V9 stated my office, nor I received a phone call from the facility that they did not receive antibiotic orders for R1. V9 stated she reviewed all phone calls with her office which are documented, and none were received from the facility from 12/23/24-12/28/24. V9 further stated the facility also has my personal cell phone and I was not notified on my cell phone either. V9 stated R1 could have become very sick because of the facility not notifying V9 of urine output. V9 stated R1 could have developed sepsis and had to be admitted to hospital and receive IV antibiotics. V9 stated the facility has not made V9 aware of low or no urine output for R1. V9 stated there are a couple of good nurses here but the facility uses a lot of agency staff, and it scares me what kind of care they are providing when they work because it's not the same.<br><br>On 1/22/25 at 10:04 AM, V16 Physician stated V16 was on call while V9 was on vacation from 12/25-12/31. V16 stated he did not receive any phone calls from facility regarding R1. V16 stated he checked with office staff who also have no record of facility contacting office during that time frame regarding R1.<br><br>R1's Nurse Progress Notes dated 1/9/2025 at 1:06 PM, documents that R1's urinary output was 75 milliliters and urine is thick with foul smell. V9 informed through fax, awaiting reply.<br><br>R1's Physician Orders dated 1/9/25 contains an order for a urinalysis to be completed.<br><br>R1's current medical record has no documentation of R1's urinalysis being collected until 1/13/25 nor of V9 being notified of the delay in the collecting of R1's urinalysis.<br><br>R1's Nurse Progress Note signed by V3, dated 1/13/25 at 11:45 AM, documents R1 straight catheterized to get urine sample. R1 fought with staff the whole time and stated it hurt. R1's urine sample is green, thick, and has a foul odor so R1 will be sent out to hospital.<br><br>R1's hospital records dated 1/13/25 documents R1 was admitted to local hospital to receive intravenous antibiotics with a diagnosis of urinary tract infection and encephalopathy (Brain disease that alters brain function or structure. Common cause includes infections and can be life threatening if left untreated).<br><br>On 1/21/25 at 10:00 AM, V2 Director of Nursing confirmed there was no documentation of a urinalysis being obtained on 1/9/25. V2 stated that urinalysis should have been collected the same day it was ordered.<br><br>On 1/22/25 at 9:30 AM, V9 stated she was not notified R1s urinalysis was not collected on 1/9/25. V9 stated she expects labs to be collected the same day as ordered unless indicated otherwise. |

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| F 0690<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>50430<br><br>Based on observation, interview, and record review the facility failed to ensure a resident's indwelling urinary catheter maintained patency, monitor a resident's urinary output, notify the physician of no/decreased urinary output, obtain physician ordered urinalysis results, and follow up with the physician in regards to abnormal urinalysis results, for two of three residents (R1 and R5) reviewed for indwelling urinary catheters and has the potential to affect all five residents (R1, R3, R4,R5, R6) with indwelling urinary catheter out of a total sample of six. These failures resulted in R1 not having urinary output documented for two days, without physician notification or medical intervention, resulting in R1 being sent to the emergency room (ER) for evaluation and subsequent hospitalization and treatment receiving intravenous fluid and antibiotic medication for the diagnosis of a UTI (Urinary Tract Infection) positive for ESBL (Extended-Spectrum Beta-Lactamase an antibiotic resistant urinary tract infection) and E. coli (Escherichia coli bacteria that is a common cause of UTI), as well as cystitis (bladder inflammation) and hydronephrosis (excess fluid in kidney due to a backup of urine). These failures also resulted in a repeated hospitalization for R1 where again she was diagnosed with a UTI as well as encephalopathy (brain disease that alters brain function or structure, common cause includes infections and can be life threatening if left untreated).<br><br>These failures resulted in an Immediate Jeopardy.<br><br>While the immediacy was removed on 1/27/25, the facility remained out of compliance at a Severity Level 2 as additional time is needed to evaluate the implementation and effectiveness of the facility's removal plan and quality assurance monitoring.<br><br>Findings include:<br><br>The Facility Assessment, revised 7/30/24, documents that the facility provides bladder training programs, urinary catheter maintenance, prevention of infections, and management of medical conditions such as urinary tract infections.<br><br>The facility's Guidelines for Physician Notification of Change in Resident Condition policy, revised 4/2019, documents Certified Nursing Assistants (CNA) are responsible for reporting any changes they observe to their charge nurse and it's the responsibility of the charge nurse to notify the physician of a significant change in condition before the end of the shift.<br><br>The facility's Catheter Protocol Policy, dated 2/1/10, documents when monitoring for accurate intake and output, the clinical record shall reflect the intake and output for each 24-hour period. Observations of abnormal amounts of urine, color, clarity, or odor shall be documented in the clinical record and notification shall be made to the attending physician and Power of attorney as indicated. Orders shall be followed.<br><br>1.) On 1/7/25 at 9:05 AM, R1 was sitting in a manual wheelchair in R1's room with an indwelling urinary catheter. The catheter drainage bag contained yellow urine with sediment in the catheter tubing.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | R1's Nurse progress notes document on 12/19/24 a fax was sent to V9 Medical Director that R1's urine was dark and slimy with a foul odor.<br><br>R1's Physician Orders, dated 12/19/24, document V9 gave an order for the facility to obtain a urinalysis for R1.<br><br>R1's Nurse Progress Notes, dated 12/23/24, document the facility was notified R1's urinalysis indicated a UTI positive for ESBL and E. coli.<br><br>R1's Point of Care Response History documented on 12/25/24 R1 had no documentation of urine output for second shift (3PM-11PM). On 12/26/24 there was no urine output documentation for third shift (11pm-7AM) or dayshift (7AM-3PM) and 50 milliliters of urine output on second shift. On 12/27/24 third shift and dayshift documented R1's urine output as zero and there was no documentation on second shift. R1's medical record did not contain notification to V9 Medical Director of R1's absent/decreased urine output.<br><br>R1's current medical chart has no documentation of a physician being notified regarding R1's abnormal urinalysis on 12/23/25 or a follow up with a physician order to treat R1's UTI from 12/23-12/28/24.<br><br>On 1/7/24 at 10:30 AM, V2 Director of Nursing confirmed nursing staff did not document follow up regarding R1's decreased/absent urinary output and did not document notification of the physician from 12/23/24-12/28/24. V1 stated I tell the staff all the time to document it, or it didn't happen.<br><br>On 1/16/25 at 9:08 AM, V13 CNA stated V13 came into work on the 12/28/24 at 6:00 AM, and V13 noticed R1 had no urine in her indwelling catheter bag. V13 stated she reported to V10 Registered Nurse on 12/28/24 in the afternoon that R1 had no urinary output on dayshift. V13 stated V13 and V10 laid R1 in bed after being notified from dining room staff that R1 was throwing up in dining room and was more confused. V13 stated she noticed brown urine in R1's depend, but not in R1's indwelling catheter bag. V13 stated V10 told V13 she was going to irrigate R1's indwelling catheter, but V13 was not successful.<br><br>R1's Nurse's note, dated 12/28/24 at 9:18 PM, document, R1 complains of pain at the indwelling urinary catheter site, brown mucus discharge coming from vagina. R1 hasn't voided in two days per CNA and documentation. Tried to flush indwelling urinary catheter unable to flush. Took indwelling urinary catheter out and R1 urinated large amount in adult incontinent brief two times. R1 is positive for ESBL and E. coli per urinalysis culture. R1 is more confused than normal. Notified V9 ordered to take indwelling urinary catheter out and send to ER.<br><br>On 1/8/24 at 11:35 AM, V10 Registered Nurse stated after V13 made her aware that R1 had no urine output in R1's indwelling catheter. V10 called V8 R1's Family Member who requested R1 be sent to emergency room since R1 had not urinated in two days. V10 stated she called 911 and sent R1 to the local emergency room for evaluation.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | R1's Emergency Department progress notes, dated 12/28/24, document R1 was kept in the hospital overnight and received IV fluids and antibiotics. R1 was noted to have a UTI due to urinary retention and evidence of cystitis and hydronephrosis secondary to urinary retention. The physician documents in R1's Emergency Department/Room progress note, At presentation: the differential diagnosis considered could potentially be life threatening or risk to bodily function.<br><br>On 1/7/25 at 1:00 PM, V6 emergency room Nurse, stated V6 was working in emergency room when R1 arrived on 12/28/24 and provided her care. V6 stated the facility nurse reported to V6 that R1 had not urinated in her indwelling urinary catheter drainage bag in two days. V6 stated the emergency room placed a new indwelling catheter in R1 and had dark gold urine return. V6 further stated that he felt it was concerning that R1 had not voided in two days before R1 was sent to the emergency room .<br><br>R1's Nurse Progress note, dated 12/29/24 documents R1 came back from emergency room with orders for Cephalexin (antibiotic) 5 milligrams by mouth, three times a day for seven days for the treatment of a UTI.<br><br>R1's Point of Care Response History, dated 1/2/25 to 1/23/25, documents that R1's urinary output should be documented every shift. However, there is no documentation of R1's urinary output being obtained on the following dates: 1/2/25 day shift and second shift; 1/3/25 day shift; 1/4/25 day shift; 1/5/25 day shift and second shift; 1/6/25 day shift and third shift; 1/7/25 day shift; 1/9/25 day shift. The Point of Care Response History also documents the following decreased urinary outputs: 1/5/25 100 milliliters on third shift; 1/6/25 15 milliliters on second shift; 1/9/25 50 milliliters on second shift. R1's medical chart has no documentation of V9 being notified of R1's decreased urinary output until 1/9/25.<br><br>R1's Nurse Progress Note, dated 1/9/25 at 1:06 PM, documents, This nurse was informed that R1's output was 75 milliliters and urine is thick with foul smell. V9 informed through fax, awaiting reply.<br><br>R1's Nurse progress Note signed by V3 Licensed Practical Nurse, dated 1/9/25 at 2:40 PM, documents Received orders from V9 to recheck R1's urinalysis.<br><br>On 1/16/25 at 12:31 PM, V3 stated that V3 worked on 1/9/25 and received the order for R1's urinalysis on 1/9/25 because R1 was having decreased urinary output. V3 stated she didn't obtain R1's urinalysis on 1/9/25 because she didn't have time and she passed it on to the oncoming nurse. V3 further stated she returned to work on 1/13/25 and R1's urinalysis was still in the refrigerator at the nurse's station. V3 stated V3 obtained a new urinalysis after finding the lab was not processed on 1/10/25.<br><br>On 1/16/25 at 1:13 PM, V14 Registered Nurse stated that V14 worked third shift the night on 1/9-1/10. V14 stated V3 asked V14 to obtain the urinalysis for R1. V14 stated R1's urine was dark yellow, contained sediment and was murky. V14 stated she made V3 aware that V14 collected R1's urine early Friday morning (1/10/25) and gave R1's urine sample to V3 on 1/10/25 at shift change. V3 placed R1's urinalysis in refrigerator and stated she would take care of it.<br><br>R1's medical record has no documentation of R1's urinalysis being obtained from 1/9/25 thru 1/13/25.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | R1's Point of Care Response History, dated 1/2/25 to 1/23/25, lacks documentation on 1/12/25 of R1's urinary output being obtained on 2nd shift.<br><br>R1's Nurse Progress Note signed by V3, dated 1/13/25 at 11:45 AM, documents R1 straight catheterized to get urine sample. R1 fought with staff the whole time and stated it hurt. R1's urine sample is green, thick, and has a foul odor so R1 will be sent out to hospital.<br><br>R1's hospital records dated 1/13/25, documents R1 was admitted to hospital to receive intravenous antibiotics for treatment of a Urinary Tract Infection (UTI) and encephalopathy (brain disease that alters brain function or structure, common cause includes infections and can be life threatening if left untreated).<br><br>R1's Point of Care Response History, dated 1/2/25 to 1/23/25, documents decreased or absent urinary output on the following days: 1/17/25 zero urine output on third shift, 150 milliliters on day shift; 1/18/25 125 milliliters on second shift. There is no documentation of urinary outputs being obtained on 1/18/25 day shift and third shift. R1's medical record does not contain documentation of physician notification of R1's absent/decreased urine output.<br><br>On 1/21/25 at 10:00 AM, V2 Director of Nursing confirms there is no documentation of a urinalysis being obtained on 1/9/25. V2 stated that urinalysis should have been collected the same day it was ordered. V2 further stated she was not aware R1's medical chart had days with absent or decreased urinary output.<br><br>On 1/22/25 at 9:05AM, V9 Medical Director stated V9 would expect the facility to call and notify V9 if a resident with a catheter has not voided in an eight-hour shift. V9 stated my office, nor I received a phone call from the facility that they did not receive antibiotic orders for R1 on 12/23/24. V9 stated she reviewed all phone calls with her office which are documented, and none were received from the facility from 12/23/24-12/28/24. V9 further stated the facility also has my personal cell phone and I was not notified on my cell phone either. V9 stated R1 could have become very sick because of the facility not notifying V9 of absent or low urine output. V9 stated R1 could have developed sepsis (life threatening complication of an infection) and had to be admitted to hospital and receive IV antibiotics. V9 stated the facility has not made V9 aware of low or no urine output for R1. V9 confirms she was not notified R1s urinalysis was not collected on 1/9/25. V9 stated I was not made aware until sometime after. V9 stated there are a couple of good nurses here but the facility uses a lot of agency staff, and it scares me what kind of care they are providing when they work because it's not the same.<br><br>2.) R5's Point of Care Response History, documents R5 has a suprapubic indwelling catheter and on 12/31/24, no urine output documented on second shift. On 1/3/25 no urine output documented on dayshift, and second shift documented 100 milliliters. On 1/5/25 200 milliliters of urine output on dayshift and there was no documentation on second shift. On 1/8/25 zero urine output was documented on second shift. On 1/9/25, zero output was documented on third shift, dayshift 150 milliliters of urine output and second shift 50 milliliters. On 1/10/25, 250 milliliters of urine output on third shift, zero output on dayshift, and 250 milliliters on second shift. 1/11/25 175 milliliters on third shift, zero output on day shift and no documentation for second shift. On 1/12/25 zero output documented on third shift and zero on day shift. There is no documentation in R5's medical record that an MD (Medical Doctor) was notified of absent/decreased urine output.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | An immediate Jeopardy situation was identified to have started on 12/23/24 when the physician wasn't notified regarding R1's 12/23/24 abnormal urinalysis results indicating a UTI positive for ESBL and E. coli, or a follow up with a physician regarding R1's decreased/absent urinary output from 12/23/24-12/28/24.<br><br>On 1/23/25 at 9:00 AM, the V1 administrator and V2 Director of Nursing were notified of the immediate Jeopardy.<br><br>The facility submitted an abatement plan on 1/23/25 and was advised by the regional office to make revisions before it would be accepted. The final abatement plan was submitted and accepted on 1/23/25.<br><br>On 1/27/25, the Removal plan was confirmed through observation, interview, and record review that the facility took the following actions to remove the Immediate Jeopardy:<br><br>1. QA Tool Urinary Status Report. Utilizing Urinary Status Report Tool was implemented 1/23/25 by V2 Director of Nursing and V22 Infection Preventionist. This is a new process for shift-to-shift communication and medical provider notification and follow up to ensure physician orders and labs are obtained timely and physician is notified of results. This is a practice to exchange the information related to urinary output on each shift verbally with a signature from the CNA and the nurse they are giving report to.<br><br>2. All clinical staff were in-serviced on monitoring outputs for residents with indwelling catheters which includes completing, monitoring, reporting, and documenting by V22/Infection Preventionist, V2 Director of Nursing, and V1 Administrator on 1/23/25<br><br>3. All licensed staff were in-serviced on physician orders and labs being obtained timely and the notification of the physician timely by V22/Infection Preventionist, V2 Director of Nursing on 1/23/25.<br><br>4. All licensed staff were in-serviced on physician notification of change in urinary status or any change in condition by V22/Infection Preventionist, V2 Director of Nursing on 1/23/25.<br><br>5. New staff will be educated during onboarding and will have an in-service sign off sheet to show the education has been completed. This will be completed by V22 IP Nurse.<br><br>4. A binder was created for agency staff with the educational documents of the same information all of the in-house staff was educated on, and they are to read and sign off on prior to starting their next shift. This binder was created on 1/23/25 by V2.<br><br>5. V2 Director of Nursing or designee will monitor for compliance to ensure compliance of intervention by auditing three times a week for four weeks. |

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| F 0713<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide or arrange emergency care by a doctor 24 hours a day.<br><br>50430<br><br>Based on interview, and record review the facility failed to ensure a Physician was available for emergency calls related to changes in condition for one (R1) out of six residents reviewed for physician services in the total sample of six.<br><br>Findings include:<br><br>The facilities Resident Care Policy and Procedure revised 4/2019 documents it is the responsibility of each nurse to notify the physician of a significant change in condition before the end of their shift. If the nurse is unable to contact the physician, the nurse may use judgement to send resident to the hospital for evaluation and treatment.<br><br>R1's Nurse Progress Note dated 12/28/24 at 9:18 PM, documents R1 had a rash covering R1's body, brown mucous and brown discharge was coming from R1's vagina, and R1 had not urinated in her indwelling catheter for two days. The same Nurse Progress note documents R1's urine culture obtained 12/23/24 contained ESBL (Extended-Spectrum Beta-Lactamase an antibiotic resistant urinary tract infection) and E Coli (Escherichia coli bacteria that is a common cause of UTI). R1's electronic medical chart did not contain new orders for treatment or documentation of a physician response.<br><br>On 1/7/25 at 10:00 AM, V1 Administrator stated nursing staff had issues reaching a Physician on call while V9 Medical Director was on vacation from12/23/24 through 12/28/24. V1 stated V1 told nursing staff if there is an issue, and they can't reach a physician for orders then send the resident to the emergency room for evaluation. V1 confirmed the Medical Director or a Physician covering the facility needs to be available by phone for emergencies.<br><br>On 1/7/25 at 1:00 PM, V6 emergency room / Registered Nurse, stated V6 was working in local emergency room when R1 arrived from facility by ambulance. V6 stated the facility reported to emergency room staff they were unable to reach V9 by phone or fax for three days.<br><br>On 1/7/25 at 1:30 PM, V8 Family Member stated on 12/28/24 V10 called and told me R1 had not voided in two days and had a rash on her body. V8 stated V10 asked if I would like R1 sent to the local emergency room to be evaluated since she could not reach a physician by phone. V8 stated he requested R1 be sent to emergency room .<br><br>1/8/24 at 11:35 AM, V10 Registered Nurse stated V10 was the nurse who worked on 12/28/24 and V10 stated she noticed another nurse had faxed V9 several times during the week about the results of R1's urine culture with no response. V10 stated she called V9 several times on 12/28/24 and received no call back from a physician. V10 stated the Certified Nursing Assistants kept telling me R1 was not voiding and was more confused than normal. V10 stated she finally called V8 Family Member about R1's situation and V8 agreed R1 should be sent to emergency room for evaluation. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 146068 | A. Building<br>B. Wing | 01/27/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Sunny Acres Nursing Home | 19130 Sunny Acres Road<br>Petersburg, IL 62675 |

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 0770<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide timely, quality laboratory services/tests to meet the needs of residents.<br><br>50430<br><br>Based on interview and record review, the facility failed to obtain a physician ordered urinalysis result timely for one (R1) of four residents reviewed for laboratory services in a total sample of six.<br><br>Findings include:<br><br>The Facilities Physician Orders policy revised 5/2022 documents if for any reason, a physician's order cannot be followed, the physician shall be notified, and notification shall be documented in the medical record.<br><br>R1's Nurse Progress Notes dated 1/9/2025 at 1:06 PM, documents that R1's urinary output was 75 milliliters and urine is thick with foul smell. V9 informed through fax, awaiting reply.<br><br>R1's Physician Orders dated 1/9/25 contains an order for a urinalysis to be completed.<br><br>On 1/16/25 at 12:31 PM, V3 Licensed Practical Nurse stated V3 worked on 1/9/25 and received the order for R1's urinalysis on 1/9/25 because R1 was having decreased urinary output. V3 stated she didn't obtain R1's urinalysis on 1/9/25 because she didn't have time and she passed it on to the oncoming nurse. V3 further stated she returned to work on 1/13/25 and R1's urinalysis was still in the refrigerator at the nurse's station. V3 stated V3 obtained a new urinalysis after finding the lab was not processed on 1/10/25.<br><br>On 1/16/25 at 1:13 PM, V14 Registered Nurse stated that V14 worked third shift the night on 1/9-1/10. V14 stated V3 asked V14 to obtain the urinalysis for R1. V14 stated R1's urine was dark yellow, contained sediment and was murky. V14 stated she made V3 aware that V14 collected R1's urine early Friday morning (1/10/25) and gave R1's urine sample to V3 on 1/10/25 at shift change. V3 placed R1's urinalysis in refrigerator and stated she would take care of it.<br><br>R1's current medical record has no documentation of R1's urinalysis being collected until 1/13/25 nor of V9 being notified of the delay in the collecting of R1's urinalysis.<br><br>R1's Nurse Progress Note signed by V3, dated 1/13/25 at 11:45 AM, documents R1 straight catheterized to get urine sample. R1 fought with staff the whole time and stated it hurt. R1's urine sample is green, thick, and has a foul odor so R1 will be sent out to hospital.<br><br>R1's hospital records dated 1/13/25 documents R1 was admitted to local hospital to receive intravenous antibiotics with a diagnosis of urinary tract infection and encephalopathy (brain disease that alters brain function or structure, common cause includes infections and can be life threatening if left untreated).<br><br>On 1/21/25 at 10:00 AM, V2 Director of Nursing confirmed there was no documentation of a urinalysis being obtained on 1/9/25. V2 stated that urinalysis should have been collected the same day it was ordered.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 146068 | A. Building<br>B. Wing | 01/27/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Sunny Acres Nursing Home | 19130 Sunny Acres Road<br>Petersburg, IL 62675 |

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

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| F 0770<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 1/22/25 at 9:30 AM, V9 Medical Director stated she was not notified R1s urinalysis was not collected on 1/9/25. V9 stated she expects lab tests to be completed the same day as ordered unless told otherwise. |