STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146068	A. Building B. Wing	07/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunny Acres Nursing Home	19130 Sunny Acres Road 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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview, and record review the facility failed to ensure residents' room walls, restroom floors, toilets, and sinks were clean, maintained, and in good repair, failed to ensure the facility was free of odor, failed to ensure waste receptacles were lined, and failed to properly dispose of soiled washcloths for ten of ten residents (R2, R4, R5, R10, R11, R12, R13, R15, R16, and R17) reviewed for clean/comfortable/homelike environment in the sample of 17.Findings include:The facility's Maintenance Supervisor Job Description dated 5/30/24 documents, Job Summary: Provide necessary maintenance for the facility, equipment in every department, and do maintenance and repairs as requested by staff and residents. Essential Job Functions: Replace float units in facility toilets and washers and unclog drains and remove sink traps for cleaning. Replace ceiling and floor tile. Paint walls, ceilings, doors, window and door frames, tables, chairs, shelves, racks, and parking-space stripes.The facility Housekeeping/Laundry Supervisor Job Description dated 3/4/24 documents, Ensure the facility is maintained in a clean, safe, and comfortable manner. Supervise day-to-day housekeeping/laundry functions of assigned personnel. Assure that refuse is disposed of daily and in accordance with the established sanitation procedures.The facility's Resident Council Minute Meetings dated 7/3/25 document, Some agency staff are throwing soiled (adult briefs) onto floor. Housekeeping: Weekends the trash is not being taken out.On 7/23/25 from 10:15 AM through 10:30 AM a tour of the facility was done. During this tour it was noted R4, R11, and R16 all share a restroom. R4, R11, and R16's restroom sink drain was not working and the entire sink was full of standing water and the restroom smelled strongly of urine. R4, R11, and R16's toilet was full of urine and stool and would not flush. The floor tiles surrounding R4, R11, and R16's stool, were stained with an orangish-brownish substance. The wall behind R16's recliner had a baseball sized area of missing drywall and had multiple linear lines of missing paint. R10, R12, and R17's restroom floor tiles surrounding the toilet had a dark black stain and the entire sink had a brownish-greenish stain. R2, R5, R13, and R15 all share a restroom. R2, R5, R13, and R15's floor tiles surrounding the stool had a dark black stain and the lid to the top of the toilet tank was missing. Three used washcloths were sitting on the top of R2, R5, R13 and R15's sink and there was trash in the waste can with no liner.On 7/23/25 at 10:20 AM V6 (CNA/Certified Nursing Assistant) stated, (R4, R11, and R16's) sink drain has not drained, and their toilet has not flushed right for over a year. (R4, R11, and R16's) bathroom sink and the floor is stained.On 7/23/25 at 10:30 AM both R11 and R16 both verified their toilet has never flushed right and their sink does not drain. R11 and R16 also verified their restroom floor has been stained for quite some time and the housekeepers could not do a better job.On 7/23/25 at 10:45 AM R17 stated, My bathroom needs to be deep cleaned. The floor is stained and the sink.On 7/25/25 at 1:45 PM V1 (Administrator-in-Training) did a tour of the facility with this surveyor and verified R4, R11, and R16's restroom sink drain and toilet were not working, the bathroom floor was stained, and the wall behind R16's recliner had missing drywall. V1 also verified R2, R5, R10, R12, R13, and R15's and R17's floor tiles surrounding their toilets had dark black stains and the lid to the top of the toilet tank was missing.

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to protect a resident from staff-to-resident mental and verbal abuse for two of three residents (R4 and R9) reviewed for abuse in the sample of 17. These findings resulted in V5 (CNA/Certified Nursing Assistant) yelling at R4 and causing R4 to feel belittled, to feel like a child, and feel verbally abused.Findings include:The facility's Abuse Prohibition Policy, dated 3/15/2018, documents Abuse and Neglect Prohibited: 1. All residents have the right to be free of from verbal, sexual, physical, mental abuse, corporal punishment, involuntary seclusion, neglect, misappropriation of property, and exploitation. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting in physical harm, pain, or mental anguish. Abuse includes deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, or psychosocial well-being. Mental Abuse includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation, or offensive physical contact by an employee or agent. Verbal Abuse means the use by an employee or agent of oral, written, or gestured language that includes disparaging and derogatory terms to a resident or within his or her hearing or seeing distance, regardless of the resident's age, ability to comprehend, or disability. All staff are trained that a facility will treat all residents with respect and dignity, promote and protect the rights of all residents and recognize their individuality.1.R9's Compliment/Complaint From dated 5/15/25 and signed by V17 (Prior Director of Nursing) documents, Care Concern: (R9) stated he has the same (CNA/V5) last night as the night before and (V5) was rude again about (R9's) cares. Investigation: Spoke with (R9) and (R9) stated that (V5) appeared to be frustrated with providing (R9) cares.V5's Employee Disciplinary Action Form dated 5/15/25 and signed by V17 (Prior Director of Nursing) and V5 documents V5 received a verbal warning due to V5's code of conduct for having rude/discourteous behavior toward R9. This same form documents, Plan for improvement: Treat all residents with dignity and respect.R9's Progress Notes dated 5/22/25 document R9 was discharged from the facility.2. R8's admission Record documents R8 is a [AGE] year-old admitted to the facility on [DATE].R8's MDS (Minimum Data Set) dated 7/3/25 document R8 is cognitively intact and has no behaviors.R8's current Care Plan documents R8 has a history of abuse as a very young child and will maintain current level of functioning through next review dated 10/19/25.R8's Compliment/Complaint form dated 7/11/25 and signed by V3 (Speech Language Pathologist/SLP) documents, Reported by (R8) to (V3). Last night (7/10/25), (R8) used her call light to ask for assistance to the restroom. (CNA/Certified Nursing Assistant/V5) answered the light. (R8) states (V5/CNA) was mean to (R8) and yelled at (R8) for using (R8's) call light. (V5/CNA) stated that (R8) has always transferred on her own before and didn't understand why (R8) needed help now.On 7/23/25 at 11:52 AM V3 (SLP) stated, On 7/11/25 (R8) reported to me that (V5/CNA) was mean and yelled at (R8) the night before and did not want to assist (R8) to the restroom. It seemed like it really bothered (R8). I immediately wrote the statement and gave the statement to (V2/DON). I did not report this to (V1/Administrator in Training) as I felt like (V2) would report the allegation to (V1).On 7/23/25 at 12:15 PM R8 was lying in bed. R8 stated with her eyebrows raised and drawn together, (V5/CNA) came into her room (7/10/25) at night and said in a loud voice What do you want? I (R8) told (V5) that I needed to go to the restroom and (V5) stated, You (R8) have been going on your own all along. I do not know why you need my help! I (R8) explained to (V5) that I have been declining and feeling sick lately and needed help. (V5) then helped me to my wheelchair and the restroom and (V5) yelled at me I am not going to wipe your butt either. I felt belittled and verbally abused and felt like (V5) was treating me like a child.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review the facility failed to implement their Abuse Policy to immediately report an allegation of abuse to the Administrator and the State Agency for one of three residents (R4) reviewed for Abuse in the sample of 17.Findings include:The facility's Abuse Prohibition Policy, dated 3/15/2018, documents, A facility employee or agent or covered individual who becomes aware of alleged abuse or neglect of a resident shall immediately report the matter to the facility administrator. A facility administrator who becomes aware of alleged abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative. The administrator shall provide the Illinois Department of Public Health (IDPH) with initial notice of the alleged abuse, neglect, or incident of unknown origin by telefaxing the Department a copy of a report of the incident completed immediately after the incident becomes known. R8's Compliment/Complaint form dated 7/11/25 and signed by V3 (Speech Language Pathologist/SLP) documents, Reported by (R8) to (V3). Last night (7/10/25), (R8) used her call light to ask for assistance to the restroom. (CNA/Certified Nursing Assistant/V5) answered the light. (R8) states (V5/CNA) was mean to (R8) and yelled at (R8) for using (R8's) call light. (V5/CNA) stated that (R8) has always transferred on her own before and didn't understand why (R8) needed help now.The facility's Abuse Investigations and R8's Electronic Medical Record dated 7-11-25 through 7/24/25 were reviewed and do not include evidence of R8's abuse allegation being reported to the State Agency.On 7/23/25 at 11:30 AM V1 (Administrator-In-Training) stated, No one reported to me that (R8) reported to (V3/SLP) on 7/11/25 that (R8) felt like (V5/CNA) was mean or yelled at (R8).On 7/23/25 at 11:40 AM V2 (Director of Nursing/DON) stated, I was not aware of (R8) reporting to (V3/SLP) that she felt like (V5/CNA) was mean and yelled at her. I just saw (R8's) statement today when I was pulling the grievances from (V9's/Social Service Director's) grievance book. After I saw (R8's) written statement about (R8) reporting (V5) was mean and yelled at her, I did not report this to (V1).On 7/23/25 at 11:52 AM V3 (SLP) stated, On 7/11/25 (R8) reported to me that (V5/CNA) was mean and yelled at (R8) the night before and did not want to assist (R8) to the restroom. It seemed like it really bothered (R8). I immediately wrote the statement and gave the statement to (V2/DON). I did not report this to (V1/Administrator in Training) as I felt like (V2) would report the allegation to (V1).On 7/25/25 at 9:45 AM V1 (Administrator-In-Training) stated the facility still has not reported R8's allegation of V5/CNA yelling at R8 and being mean to R8 to the state agency. (V1) stated, After collaboration with the IDT (Inter-Disciplinary Team) we felt like the report was already late, so it did not matter if I reported the allegation now.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Respond appropriately to all alleged violations. Based on interview and record review the facility failed to implement their Abuse Policy to thoroughly investigate an allegation of abuse and protect residents from the alleged perpetrator (V5/CNA/Certified Nursing Assistant) after an allegation of staff-to-resident abuse was made. These failures have the potential to affect all 78 residents residing within the facility.Findings include:The facility's Daily Census Report dated 7/23/25 documents the facility currently has 78 residents residing within the facility.The facility's Abuse Prohibition Policy, dated 3/15/2018, documents, The administrator or designee shall investigate all allegations of abuse or neglect. The administrator shall be responsible for resident's protection from retaliation during and after the investigation. When an allegation of suspected abuse is received that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution, or disciplinary action against the employee. If the incident involves alleged abuse by an employee as the perpetrator of the abuse, then the administrator shall immediately the employee suspected to be involved in the alleged abuse without pay pending investigation of the incident. If an employee is suspected perpetrator of the abuse, then the employee shall be kept separate from all residents until further orders.R8's MDS (Minimum Data Set) dated 7/3/25 document R8 is cognitively intact and has no behaviors. R8's Compliment/Complaint form dated 7/11/25 and signed by V3 (Speech Language Pathologist/SLP) documents, Reported by (R8) to (V3). Last night (7/10/25), (R8) used her call light to ask for assistance to the restroom. (CNA/Certified Nursing Assistant/V5) answered the light. (R8) states (V5/CNA) was mean to (R8) and yelled at (R8) for using (R8's) call light. (V5/CNA) stated that (R8) has always transferred on her own before and didn't understand why (R8) needed help now.On 7/23/25 at 12:15 PM R8 stated, (V5/CNA) came into her room (7/10/25) at night and said in a loud voice What do you want? I (R8) told (V5) that I needed to go to the restroom and (V5) stated, You (R8) have been going on your own all along. I do not know why you need my help! I (R8) explained to (V5) that I have been declining and feeling sick lately and needed help. (V5) then helped me to my wheelchair and the restroom and (V5) yelled at me I am not going to wipe your butt either. I felt belittled and verbally abused and felt like (V5) was treating me like a child. On 7/23/25 at 11:30 AM V1 (Administrator-In-Training) stated, (V5/CNA) has never been suspended pending investigation regarding (R8's) allegation of (V5) yelling at (R8) and being mean to (R8) and an investigation has not been done.On 7/25/25 at 9:45 AM V1 (Administrator-In-Training) stated V5/CNA has never been suspended pending investigation regarding R8's allegation of V5 yelling at R8 and being mean to R8 and an investigation has not been done. V1 confirmed V5 was not suspended even after this surveyor confirmed V1 was aware of R8's allegation on 7/23/25 at 11:30 AM. V1 stated V5 has worked in the facility since 7/11/25 and helps take care of all residents within the facility.V5's Timecard dated 7/11/25 through 7/24/25 documents V5 has worked 11 days/shifts, with the most recent shift being on 7/24/25 from 10:05 PM through 6:06 AM.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to prevent resident injury during transfer in a wheelchair, failed to investigate the cause of the injury, and failed to develop interventions after the injury to prevent future injuries for one of three residents (R4) reviewed for accidents in the sample of 17.Findings include:The facility's Occurrence Reporting to (local State Agency) Policy and Procedure dated 10/3/11 documents, The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. Procedure: Provide immediate care to the resident. Initiate the appropriate monitoring of the resident. Notify the physician and family of the occurrence. If the occurrence requires it, complete a Risk Watch Occurrence Report form. Staff will document specific information relating to the occurrence including the exact description of facts surrounding the occurrence. Include statements by the resident or any witnesses.R4's admission Record documents R4 is a [AGE] year-old admitted to the facility on [DATE].R4's MDS (Minimum Data Set) assessment dated [DATE] documents R4 is severely cognitively impaired.R4's Progress Notes dated 7/14/25 at 10:14 AM and signed by V13 (MDS Coordinator) documents, Therapy staff reported left ring finger bruised. Noted left ring finger with bruise to first and second knuckles. Dark purple and approximately dime sized. Report from (CNA//Certified Nursing Assistant/V6) that finger was pinched between wheelchair ad table in dining room on 7/11/25 which may have resulted in the bruises. (R4) able to move fingers without issues. Grasp is ok. Denies pain when asked.R4's Medical Record does not include a Risk Watch Occurrence Form with an investigation as to how the bruises occurred to R4's left hand fingers, or an intervention and update to R4's care plan to prevent R4 from further injuries.On 7/23/25 at 10:15 AM R4 was sitting in a wheelchair. R4's left third and fourth fingers both had a dime-sized purple bruise. On 7/23/25 at 10:20 AM V6 (CNA) stated, (R4's) bruises were my fault. On (7/11/25) when I was moving (R4) in her wheelchair from the dining room table I did not make sure (R4's) hand was inside the wheelchair and I pinched (R4's) finger between the table and the wheelchair.On 7/23/25 at 11:30 AM (V1/Administrator) stated, There was no investigation done or Risk Watch Occurrence Form completed after (R4) got the bruises to her left fingers. V1 verified at this time that there should have been an investigation done and (R4's) care plan should have been updated with an intervention to prevent further injuries.