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	09/19/2025

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 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. (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

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	09/19/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow its hot liquids policy; failed to identify potential hazards relating to hot liquids; and failed to provide staff supervision to prevent hot liquid incident/accident for one (R1) resident of three residents reviewed for accidents/incidents in a sample of three. This failure resulted in R1 sustaining blisters from the spilled hot liquid. Findings include: The facility's (State) Long-Term Care Ombudsman Program Residents' Rights for People in Long-Term Care Facilities, dated 11/28/18 documents: Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life; and, Your facility must provide services to keep your physical and mental health, at their highest practical levels. The facility's Hot Liquids Policy dated 3/7/25 documents: It is the policy of this facility to maintain protocols to assist in preventing injuries related to hot liquids and develop an individualized plan of care to address resident risk. 1. A Hot Beverage Use Assessment will be performed upon admission, quarterly and with a significant change in condition. 4. Residents identified through the assessment process as at risk for injury related to exposure to hot liquids shall not be left unsupervised during meal service. R1's Minimum Data Set (MDS) dated [DATE] documents R1 has a BIMS (Brief Interview of Mental Status) score of 7. (MDS indicates that on a scale of 0 - 15, 13 to 15 cognitively intact; 8 to 12 moderate impairment; and 0 to 7 severe impairment.) R1's diagnoses include: Major depressive disorder, anxiety, chronic pulmonary embolism, repeated falls, chronic embolism and thrombosis of unspecified deep veins of right proximal lower extremity, hallucinations, peripheral vascular disease, dementia with other behavioral disturbance, unspecified lack of coordination. R1's current Care Plan documents: (R1) is at risk for impaired cognitive function or impaired thought processes related to dementia. R1's Final Report to (State) Department of Public Health dated 8/31/25 documents: Interviews with staff revealed that incident (hot liquid spill on R1) was not witnessed by staff members. Resident sits in the independent dining room per her normal routine. The date of the occurrence was 8/24/25. R1's Progress Note dated 8/24/25 documents: Resident spilled her hot coffee during lunch. Resident stated, I burnt myself. Can you help me? Left upper thigh assessed; small area of redness noted. (Documentation and Staff interviews indicated that (R1) refers to her hot chocolate as hot coffee and only drinks hot chocolate.)R1's medical record documents on 8/26/25 at 3:07PM resident has three blisters (second degree-partial thickness) on L (left) upper thigh. Both she (R1) and the CNA (certified nursing assistant) stated that she spilled coffee on her.R1's Wound documentation report form documents, date wound identified: 8/26/25, Site: Left Thigh (front) Blister. Comments: 3 different blisters noted- 3x1, 2x1, 0.5x 0.5. R1's Progress Note and Wound Documentation Note dated 8/26/25 indicated that R1 had two open areas and one closed area (blisters) to (R1's) left thigh, one measuring 2.1cm/centimeters, one 3x1cm and the third measuring 0.5 x 0.5 cm. On 9/18/25 at 12:35pm, R1 stated that when she spilled the hot liquid (hot chocolate) on her left thigh, that she completed her lunch meal and then went to inform the staff. R1 stated, No CNAs (Certified Nursing Assistants) or staff around when this happened; and all I got is a little scar left. There was probably no one around except the people I was sitting with (at table); I did not see any staff around. On 9/19/25 at 12:08pm, V2 Director of Nursing/DON stated that a Hot Liquids Risk Assessment had not been done for R1 per their policy and did not know why this was not completed. V2 stated there were no hot liquid burn interventions in place for R1 until after the 8/24/25 incident, and confirmed that the facility had not been following it policy regarding hot liquids. On 9/19/25 at 12:08pm, V2 also stated: No one was supervising residents in the dining on 8/24/25 or prior to (R1's) hot chocolate incident; Management does do supervision in the dining room with residents now.