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	12/18/2025

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview the facility failed to follow all fall management safety protocols by manually lifting a resident from the floor after a fall and transferring them to a wheelchair without utilizing a mechanical lift for one (R1) of three residents reviewed for falls in the total sample of 11.Findings include:R1's medical record documents R1 was a [AGE] year old admitted to the facility on [DATE] with diagnoses including: Type 2 Diabetes, Hypertensive Heart Disease with Heart Failure, Bradycardia; Atherosclerotic Heart Disease of Coronary Arteries and Anemia. R1's diagnoses include a recent diagnosis dated 10/21/25 of Non-displaced fracture of the greater trochanter of the Left Femur, Closed Fracture with Routine Healing.Facility record reviews included the following: admission packet; Fall Assessment and Management policy dated 6/2024 and the Reports to the state agency by the facility dated 10/21/25. Other facility records reviewed included the past 3 months of: Facility Staffing data, Direct Care Staff Schedules, Daily Staffing Assignments and postings; Resident Council Meeting Minutes; Resident Shower Sheets, Grievance Logs, Incident Logs and Falls logs.Resident records were reviewed for Physicians Orders; Care Plans; MDSs/Minimum Data Sets; Progress Notes; and Fall Risk Assessments.R1's Progress Notes dated 10/21/25 by V10 prior DON/Director of Nursing documents the following: Unwitnessed fall in (R1's) room on 10/20/25 at 10:15am. The initial Report to the state agency dated 10/21/25 by V10 the facility's prior DON, (no longer employed by the facility), documents R1's fall occurred at 10:15am on 10/20/25. R1 was assessed by the nurse on duty (V4 RN/Registered Nurse) at that time, and R1 denied having any pain. At that time V4 and V5 (CNA-Certified Nursing Assistant) assisted (R1) off the ground and into his wheelchair.V1/Administrator provided V4 and V5's employee records and including Disciplinary Action forms for improper resident transfer after a fall dated, respectively, 10/29/25 and 10/27/25. On 12/16/25 at approximately 11:25am V1 stated V4 and V5 improperly transferred R1 from the floor after R1's fall and should have utilized a mechanical lift to safely transfer R1. V4 and V5 received written disciplinary actions identifying and addressing the improper transfer of R1 from the floor into a wheelchair without utilizing a mechanical lift. V1 stated V4 and V5 lifted R1 off the floor with their arms under R1's arms on either side of R1. V4 RN was no longer employed by the facility and was unavailable for comment.On 12/17/25 at 12:20pm V5 stated she and V4 did not use a mechanical lift as directed by facility policy to transfer the resident after a fall.On 12/17/25 at approximately 2:45pm, V2 DON verified fall management protocol calls for the use of a mechanical lift to safely lift residents after a fall.

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	12/18/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (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 B. Wing	12/18/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 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 observation, interview and record review the facility failed to follow infection control standards for Enhanced Barrier Precautions during wound cares for two of three residents (R4, R5) reviewed for wound care in the total sample of 14 residents.Findings include:The facility's undated Enhanced Barrier Precautions Protocol documents: Enhanced Barrier Precautions are indicated for residents with the following: Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with MDRO (Multi-Drug-Resistant Organisms).The facility was unable to provide a wound care policy outlining Standard Precautions to be followed when providing wound care. Published and accepted Standard Precautions guidelines document: Always work on a disinfected surface; For opened dressing supplies, standard precautions mean discarding unused portions of dressing supplies, or retain them in a clean sealed bag (if non-sterile) in a clean, dry area in the residents room avoiding the bathroom, and Never reuse dressings or supplies after they've been opened; Never return opened items to supply carts.R4 is a [AGE] year-old resident admitted to the facility on [DATE] with diagnoses including: Malignant Neoplasm of the Tongue; Cerebral Vascular Accident with Right-sided hemiparesis and Hemiplegia; Dysphagia; Severe Protein-Calorie Malnutrition and Aphasia. R4 has an indwelling enteral feeding device in use.R4's Physicians Orders for wound care documents the following: Cleanse left neck with normal saline and gauze, apply skin prep to perimeter; pack with iodoform ensuring to leave a wick; gauze and medipore tape every day and evening shift.A sign declaring R4 was in Enhanced Barrier Precautions and identifying infection control measures and PPE/Personal Protective Equipment required when providing certain cares to the resident including wound care visible on R4's room door frame.On 12/17/25 at 12:35pm V12 LPN/Licensed Practical Nurse performed wound care for R4's left neck wound. V12 gathered wound care supplies, donned personal protective equipment and entered R4's room. V12 removed the neck dressing and packing. V12 cleansed the wound and applied skin prep to the intact skin around the wound. V12 then realized she had no scissors to cut the packing gauze and asked another staff member to bring a pair to the room. V12 received the bandage scissors without cleansing them and cut a length of packing gauze, packed the wound and placed the bandage scissors in her pocket. V12 then tore a piece of medipore tape and covered the wound with no gauze over the wound. Later, when asked if gauze was needed over the wound, V12 removed the tape and placed gauze over the wound and covered it with a new piece of medipore tape.V12 did not sanitize/cleanse the bandage scissors before or after using them for R4's wound care.2. R5 is a [AGE] year-old resident admitted to the facility on [DATE] with diagnoses including: Left-sided Hemiplegia; Cerebral Infarction with resulting Aphasia; Type 2 Diabetes. R5 also has an indwelling enteral feeding device in use.The facility's Wound Care Report dated 12/15/25 includes the following order for R5's wound care treatment: Cleanse left lateral thigh with wound cleanser and pat dry. Silver Silvadene (a medicated cream), cover with telfa (a non-stick dressing) and Kerlix (a roll of fluffy gauze). On 12/17/25 at 1:20pm V13 LPN performed wound care for R5's left thigh burn site with subsequent skin grafting. V13 gathered R5's wound care supplies including wound cleanser, a pack of 4 by 4 gauze pads, A sealed multi-pack of large absorbent dressings, and tape. V13 then donned appropriate PPE/Personal Protective Equipment and entered R5's room. V13 placed the wound care supplies directly onto R5's overbed table without sanitizing it or placing a clean barrier on the surface of the table prior to setting down the wound supplies on it. V13 removed R5's dressing, cleansed the wound with wound cleanser. R5's left thigh wound measured approximately 5 inches by 7 inches with scattered fluid-filled blisters noted on an otherwise pink granulating wound base. V13 patted the wound dry with gauze, applied a white medicated cream to the wound. V13 opened the roll of gauze and placed the roll directly onto the surface of the overbed table and opened the multi-pack of absorbent dressing and removed one, placing it over R5's wound. V13 picked up the large gauze roll and wrapped it around R5's thigh, securing the dressing. V13 then gathered the remaining portion of the open roll of gauze and the unsealed, open pack of absorbent dressings and carried them out of R5's room, stating I usually put a towel down to put the supplies on. V13 then placed the opened gauze roll and absorbent dressings in a drawer on the multi-use wound cart with other dressing supplies. V13 stated the partially used roll of gauze and opened multi-pack of dressings were stock items and would be used for other resident's wound cares. On 12/17/25 at approximately 3:00pm, V2 Interim DON/Director of Nursing verified V12 and V13 did not follow standard precautions for wound care or infection control measures during R4 and R5's wound care.