

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146068	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/20/2026
NAME OF PROVIDER OR SUPPLIER Sunny Acres Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** A. Based on observation, interview, and record review, the facility failed to ensure wound treatments were completed as ordered, appropriate infection control practices were followed during wound care, a readmission assessment was completed, physician ordered pressure relieving interventions were implemented, and worsening wound conditions were monitored and reported to the physician for one (R66) of six residents reviewed for wound care in the sample list of 32. This failure resulted in worsening wound conditions with development of osteomyelitis to R66's right foot requiring hospitalization, surgical debridement, and intravenous antibiotic therapy B. Based on observation, interview and record review the Facility failed to follow physician orders and monitor a resident's blood sugar for one of 18 Residents reviewed for following physician orders (R33) and failed to communicate a resident's change of condition with a physician office for one of 18 Residents reviewed for physician communication (R50) in a sample of 32. Findings include: A) The facility's Wound and Ulcer Policy and Procedure revised 3/28/24 documents residents will receive wound assessments upon admission, weekly for four weeks, quarterly, and with any significant change in condition. Licensed nurses are responsible for wound assessment, initiation of ordered treatments, documentation of care, and physician notification of changes in condition. R66's Hospital Discharge Orders dated 3/18/26 document an order for negative pressure wound therapy (Wound Vac) to R66's right foot at 125 mmHg (millimeters of mercury) continuously with dressing changes every Monday, Wednesday, and Friday. R66's Nurse Progress Note dated 3/19/26 documents R66 was admitted to the facility on [DATE] with a negative pressure therapy (wound vac) device to the right great toe amputation site. This note further documents the surgical site to R66's right foot was approximately five centimeters (cm) deep with black tissue and granulation tissue present. R66's Nurse Progress Note dated 3/25/26 at 12:34 AM, documents that R66's wound vac remained in place with intermittent suction noted and spots of dried sanguineous drainage present in the tubing. Documentation further noted redness surrounding the wound site. The note indicated nursing would continue to monitor the resident. There is no documentation in R66's medical record that R66's physician was notified of the change in R66's wound. R66's Nurse Progress Note dated 3/25/26 documents R66's wound vac dressing change scheduled for that date was unable to be completed and was reported off to the next shift nurse. R66's electronic medical record does not contain documentation that this treatment was completed or that R66's physician was notified that the treatment was not completed. R66's Census line documents R66 was transferred out of the facility on 4/3/26 to the hospital and (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 0684 Level of Harm - Actual harm Residents Affected - Few	readmitted to the facility from the hospital on 4/22/26. R66's Hospital Records dated 4/3/26 documents R66 presented to the emergency room from a wound clinic appointment with yellow and green drainage surrounding the right great toe amputation site and black eschar (dead tissue) present in the wound bed. Blood cultures were obtained due to suspected osteomyelitis. R66's Hospital Records documents on 4/5/26 blood cultures confirmed osteomyelitis to right foot. R66 started on intravenous antibiotics in the hospital for treatment of infection. R66s Physician Orders dated 4/24/26, documents an order for Metronidazole 500 milligrams (mg) by mouth twice daily for osteomyelitis through 5/28/26. R66s Physician Orders dated 5/1/26, documents an order for Daptomycin 400 mg intravenously every 24 hours for treatment of osteomyelitis through 5/30/26. R66s Physician Orders dated 5/10/26, documents an order for Cefepime two grams intravenously twice daily for osteomyelitis of the left calcaneus through 5/30/26. R66's electronic medical record revealed no documented readmission assessment or a skin assessment on 4/22/26 following R66's return from hospitalization. R66's Minimum Data Set (MDS) assessment dated [DATE] documents R66 is cognitively intact and is dependent on staff for transfers, bathing and needs substantial/maximum assistance with toileting. R66s current care plan documents 4/30/26, an order for placement of an air overlay mattress to help decrease pressure risks. On 5/18/26 at 9:16 AM, observation of R66's bed revealed the ordered low air loss mattress overlay was not in place on R66's bed. On 5/18/26 at 11:45 AM, R66 was sitting in his wheelchair in his room with a large undated bandage on R66's right leg. Observation revealed the bandage did not cover the entire wound area to the inner calf and approximately four inches of dried black scabbed area was left uncovered. R66 stated he was unsure when the bandage had last been changed. R66 stated nursing staff often did not complete treatments to his right leg and foot because staff did not have time or agency nurses were unfamiliar with his care. R66 stated he wanted to improve so he could return home, however that had not occurred. R66 further stated the care in the facility was not great and residents were not always cared for appropriately. On 5/18/26 at 12:12 PM, V11 (Licensed Practical Nurse/LPN) stated R66 came to the facility after toe amputations with a wound vac to the right foot and the wound vac was not being changed correctly, resulting in worsening of the wound. V11 stated the resident was sent to the wound clinic and subsequently transferred to the hospital due to worsening wound condition and returned with a surgical incision to the leg following surgical debridement. On 5/18/26 at 1:00 PM, V11 (LPN) performed wound treatment to R66's leg without applying appropriate personal protective equipment (PPE). Observation further revealed V10 (Certified Nursing Assistant/CNA) and V11 transferred R66 utilizing a mechanical lift from wheelchair to bed without (continued on next page)		

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F 0684 Level of Harm - Actual harm Residents Affected - Few	use of isolation gown despite Enhanced Barrier Precaution signage posted on R66's door. V11 and V10 did not perform hand hygiene before or after wound care and resident contact. R66's wound dressing revealed Xeroform dressing (medicated gauze dressing used to keep wound bed moist) was not applied to the entire wound area as ordered. Black eschar was observed extending from the lower extremity above and below the knee. V11 stated the dressing removed from the wound was not dated and she was unable to determine when the dressing had last been changed. On 5/20/26 at 10:00 AM, V2 (Director of Nursing) stated a readmission assessment should have been completed upon R66's return to the facility. V2 further stated weekly wound assessments should have been completed when R66 originally admitted to the facility on [DATE] and R66's Physician should have been notified of any changes to R66's surgical wound. V2 confirmed there was no further documented skin assessments for R66 after 3/19/25 until the R66 was sent to the hospital on 4/3/26 for wound infection and osteomyelitis. On 5/20/26 at 9:15 AM, V24 (Medical Director) stated R66's dressing should have been changed as ordered and the physician should have been notified when the wound appeared to worsen. B) 1. The Facility Care Policy and Procedure, revised 8/2024, documents blood glucose levels will be monitored and obtained per licensed health care practitioner's orders and will be performed by a licensed nurse. The Facility Registered Nurse Job Description, revised 7/1/25, documents: prepare and administer medications and treatments; maintain charts; and responsible for nursing care of assigned residents. R33's Medication Administration Record/MAR, dated 5/1/26 through 5/31/26, documents a physician's order for a blood glucose monitoring test and sliding scale insulin injection to be performed prior to mealtime, every day at 6:00 am. The MAR does not document V15's blood glucose test result (215) that V31 (Agency Registered Nurse) performed. On 5/18/26 at 8:58 am, V31 (Agency Registered Nurse) entered R33's room and performed R33's 6:00 am scheduled blood glucose monitoring test. V31 stated, (R33) just got back from breakfast. I am the night shift nurse, and I am so far behind on my medication pass, I know (R33) already ate but I must get this test done. On 5/19/26 at 10:40 am, V1 (Administrator) stated, Our agency staff gets training on our policies, but any nurse should know how to perform basic nursing duties and not do blood sugar monitoring right after someone eats, they should be done prior to eating. 2. The Facility Guidelines for Physician Notification of Change in Resident Condition Policy, revised 4/2019, documents: to define resident care situations that require physician notification; staff observe, document and communicate to the physician changes in resident condition properly; change in condition includes accidents or occurrences; physician notification is based on the Physician Notification Protocols from the American Medical Directors Association on Assessing and Collecting Data on Nursing Facility Patients; a facility must consult with the resident's physician; and the facility must ensure that all pertinent information is available and provided upon request to the physician. The Facility Registered Nurse Job Description, revised 7/1/25, documents responsible for nursing care of assigned residents; transcribe physicians orders; and personally receive or place phone calls (continued on next page)		

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F 0684 Level of Harm - Actual harm Residents Affected - Few	to physicians. R50's admission Record/Resident Information Sheet, dated 5/20/26, documents V29 (Attending Physician) as R50's primary doctor. R50's Nursing Notes, dated 4/20/26, documents R50 went to doctor appointment accompanied by family, no new orders received from visit. On 5/28/26 at 10:43 am, V32 (R50s daughter/emergency contact) stated, On 4/20/26, I had to take my mom (R50) to a doctor appointment because (R50) had fallen. (R50) is not seen by the Facility doctor because we take (R50) to her general practitioner (V29). (V29) recommended some wheelchair modifications to the arms on her wheelchair because she had fallen out of the wheelchair and we thought it would be safer for her to have higher arms on it. I have had phone calls with (V29's) office because they keep telling me that they cannot get through to the Facility. They have called the Facility multiple times, and no one answers, and they have also left messages, but no one has returned the phone calls. They (V29) is trying to get new orders called in for (R50). On 5/20/26 at 11:22 am, V29 (R50's Attending Physician stated), We have made so many attempts to get ahold of someone at the Facility. When we call, the phone rings for eight to ten minutes and no one answers it. When we have gotten through and left messages (with V1/Administrator and V2/Director of Nursing), no one returns our phone calls. I started getting frustrated, so I started documenting all of our attempts to contact that Facility. We are working on getting higher arms on (R50's) wheelchair because (R50) has fallen out of the wheelchair, but no one from the Facility is contacting us. On 5/20/26 at 10:05 am, V1 (Administrator) stated, Our phone system does allow for messages to be left directly in management in boxes. I am not sure why the phone calls are not getting answered or returned. I do know that we have had a change in management and maybe the calls got lost in that transition. We do need to work on a better phone answering system.		