

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/23/2026
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 0580 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to notify a resident's family of a hospitalization for one (R1) of three residents reviewed for quality of care in the sample of four. Findings include: The Resident Care Policy and Procedure dated 4/2019 documents Notification of changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority the resident's representative(s) when there is (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility. Even when a resident is mentally competent, his or her designated resident representative or family, as appropriate, should be notified of significant changes in the resident's health status because the resident may not be able to notify them personally, especially in the case of sudden illness or accident. The resident is not capable of making decisions, facility staff must contact the designated resident representative, consistent with his or her authority, to make any required decisions, but the resident must still be told what is happening to him or her. On 7/21/26 at 10:35 AM, V13 (R1's Family Member) stated that the facility did not call to report that R1 was going to the hospital. The hospital called V13 on 7/4/26 at 6:19 AM to request permission to treat R1. On 7/23/26 at 9:48 AM, V15 (Agency Registered Nurse/RN) stated that she was working on 7/4/26 when a Certified Nursing Assistant/CNA told V15 that R1 was complaining about his toe hurting. V15 went to check R1's toe. There was some of the bandage from the top of R1's foot that was tangled to R1's toenail. When V15 removed the bandage from the toenail V15 thought she saw some movement under R1's toenail. V15 looked closely and thought she saw some larva. V15 called V7 (R1's Primary Care Physician/PCP) and was told to send R1 to the hospital. V15 also stated that she did not call V13 (R1's Family Member) before sending R1 to the hospital. On 7/23/26 at 11:01 AM, V1 (Administrator) stated that V15 (Agency RN) should have called V13 (R1's Family Member) before R1 was sent to the hospital. R1's admission Record printed 7/22/26 at 9:52 AM, documents that R1 was admitted to the facility on [DATE]. R1's Nursing Note written by V15 (Agency RN) dated 7/4/26 at 5:16 AM, documents that bug larvae were found inside R1's big toenail. V15 notified V7 (R1's PCP) and was given the order to send R1 to the hospital. R1 left the facility by ambulance at 5:15 AM. R1's Emergency Department Triage Note dated 7/4/26 at 5:52 AM, documents that R1 arrived at the hospital by ambulance from the facility with complaints of big toe pain. R1's Hospital Consultation Note dated 7/4/26 at 11:45 AM, documents that R1 was admitted to the hospital for a foot infection with maggots in the wound.		

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to properly store medication for one (R2) of three residents reviewed for quality of care in the sample of four. Findings include: The Medication Administration policy dated 1/11/10 documents Objective: To provide accuracy during medication pass to assure quality of care for residents. Policy: It is the policy of this facility to accurately administer medication following physician's orders. Procedure: 13. Make sure the resident takes the medication. Generally- Do not leave meds at bedside (may be exceptions after thorough assessment and care planning). On 7/20/26 at 4:52 PM, V8 (R2's Family Member) stated that R2's prescription eye drops have been left on R2's bedside several times. R2 is not able to self-administer the eye drops. V8 also stated that she has told Administration about the eye drops left at the bedside and the problem has not been corrected. V8 stated that she had filled out a grievance form and taken pictures of the bottle left sitting by the bed. On 7/21/26 at 8:45 AM, R2 was sitting in her room in her wheelchair watching television. R2 stated that she gets eye drops several times a day. R2 also stated that she cannot administer the drops herself. On 7/21/26 at 9:25 AM, V2 (Director of Nursing/DON) stated It was told to me that there were some eye drops that were left in (R2's) room. I got a grievance form about the eye drops and did education with the staff about not leaving the drops in the room. On 7/21/26 at 10:03 AM, V2 (DON) stated, I got an E (electronic)-mail from (V8 R2's Family Member) with a picture of the eye drops at (R2's) bedside. On 7/23/26 at 11:01 AM, V1 (Administrator) stated that medication including eye drops should not be left at the bedside. R2's admission Record printed 7/23/26 at 11:04 AM, documents that R2 was admitted to the facility on [DATE]. R2's Order Summary Report documents, Systane Balance Ophthalmic Solution - Instill one drop in both eyes two times a day for dry eyes. Order date 11/13/24. An In-Service dated 6/29/26 presented by V2 (DON) documents Do not leave medications at bedside including pills, eye gtts (drops), powders, creams. R2's Complaint Form dated 7/5/26 reported by V8 (R2's Family Member) documents, On Sunday, July 5 at 3 (three) PM I visited (R2). (R2's) prescription eyedrops were on (R2's) table. This same situation has been reported to (V1 Administrator) previously on 5/27/26 by my (family member). Investigation: I (V2 DON) have not personally witnessed eye gtts on table in room but am aware they get forgotten in room at times. Findings: On-going education (with) staff. Signed by V2 DON dated 7/14/26. An E-mail sent to V2 (DON) by V8 (R2's Family Member) dated 7/6/26 at 8:21 AM, documents On Sunday, July 5 (2026), I visited (R2) at approximately 3 (three) PM. (R2's) prescription eyedrops were on (R2's) table. This same situation has been reported to (V1 Administrator), by my (family) on 5/27/26. Shouldn't these be on the medicine cart and administered by the nurse as prescribed? They could be cross contaminated or thrown away, etc. (etcetera). I left them on the table but took the picture to document the incident. I will follow up doing the grievance form, so the appropriate paper trail is followed according to protocol. (Attached was a picture of a bottle of eye drops on R2's bedside table.) An In-Service dated 7/14/26 presented by V2 (DON) documents Please, make sure all medications including eye gtts are placed back on med carts after use.		