	Department of Public					
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION 3:	(X3) DATE SURVEY COMPLETED		
IL6009252		B. WING		C 04/26/2022		
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY	STATE, ZIP CODE		12022
SUNNY	HILL NURSING HOME	404 DOD	S AVENUE	, Some, Eli Gobe		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED DEFICIENCY)	TIVE ACTION SHOULD BE COMPLET COMPLET DATE	
S 000	Initial Comments	<u> </u>	S 000			
	Investigation of Fac 04-11-2022/IL14612	ility Reported Incident of			5	
S9999	Final Observations		S9999			
	Statement of Licens	ure Violation:				9
	300.610a) 300.1010h) 300.1210a) 300.1210b) 300.1210c) 300.1210d)6)					
	Section 300.610 Re	sident Care Policies	-			
	procedures governin facility. The written p be formulated by a R Committee consisting administrator, the ad medical advisory con of nursing and other	hall have written policies and g all services provided by the policies and procedures shall desident Care Policy g of at least the visory physician or the nmittee, and representatives services in the facility. The with the Act and this Part.				
	The written policies s the facility and shall t	chall be followed in operating be reviewed at least annually becomented by written, signed				
	Section 300.1010 M	edical Care Policies			· .	
	physician of any acci- change in a resident's health, safety or welfa but not limited to, the	nall notify the resident's dent, injury, or significant s condition that threatens the are of a resident, including, presence of incipient or cers or a weight loss or gain		Attachment A Statement of Licensure Violati	ons	

nois Department of Public Health BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: _ COMPLETED C IL6009252 B. WING 04/26/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **421 DORIS AVENUE** SUNNY HILL NURSING HOME OF WILL COUNT **JOLIET, IL 60433** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) S9999 Continued From page 1 S9999 of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each

resident to meet the total nursing and personal

Each direct care-giving staff shall review and be knowledgeable about his or her residents'

care needs of the resident.

respective resident care plan.

Illinois Department of Public Health				15. 414	FORM APPROVED		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTII A. BUILDING	PLE CONSTRUCTION 3:		E SURVEY		
IL6009252			B. WING			C 04/26/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY	, STATE, ZIP CODE	1 04/	20/2022	
SUNNY	HILL NURSING HOM	404 505	S AVENUE	,			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
S9999	Continued From pa	ige 2	S9999				
	nursing care shall i	subsection (a), general nclude, at a minimum, the practiced on a 24-hour, basis:		inc.			
	to assure that the re as free of accident nursing personnel s	ry precautions shall be taken esidents' environment remains hazards as possible. All shall evaluate residents to see eceives adequate supervision revent accidents.					
	These Regulations	are not met as evidenced by:					
12	review the facility st	on, interview, and record aff failed to follow their policy ident transfer using a total	:9	Na ed			
	This failure resulted lift falling during use Left Femur Fracture	in the total body mechanical and the resident sustaining a requiring surgery.		7 2			
	This applies to 1 of 3 with a mechanical life	3 (R1) reviewed for transfers t in the sample of 3.					
	The findings include	:	3				
	R1 had diagnoses in Comminuted Fracture Cardiomyopathy, Act Obesity, Polyneuropathy, Amputation of Toes, of Left Lower Leg, Die Hemiparesis, Anemia Hyperlipidemia, Perip Hypertension, Depre	re of Left Femur Shaft, ute Osteomyelitis, Morbid athy, history of falling, Non-Pressure Chronic Ulcer abetes, Hemiplegia and					

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Illinois Department of Public Health			<u> </u>			FORM APPROVED	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COI	COMPLETED		
		l				_	
	•	IL6009252	B. WING			С	
						/26/2022	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
SUNNY	HILL NURSING HOME	OF WILL COUNT	IS AVENUE				
		JOLIET, I	L 60433				
(X4) ID PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T	ION SHOULD BE	COMPLETE	
			1,70	DEFICIENC	Y)	DATE	
S9999	Continued From pa	70 3	50000			 	
- 1		•	S9999			1	
	Malignant Breast C	ancer, age-related	1			1.	
	Osteoporosis.		J				
	The Minimum Date	C-4/MDO\		Ť		1 1	
	showed P1 peeded	Set (MDS) dated 02/14/2022 extensive assistance of two					
	neonle for hed moh	ility; was totally dependent on					
	two people for trans	fers and toilet use. R1 was 5					
	feet 4 inches tall and	d weighed 240 pounds. The				· •	
1	MDS showed R1's o	ognition was intact.					
				52			
	A care plan showed	R1 was a high risk for falls				1	
	due to Left Sided W					***	
	Cerebrovascular Ac	cident with interventions				1 1	
1.5	had and make sure	people for repositioning in bed was locked prior to					
9	transfers.	bed was locked prior to					
- /	il director of					1 1	
	On 04/25/2022 at 1:	18 PM, R1 was awake,					
· ·	lying-in bed watching	g television wearing a left leg				1	
	immobilizer. R1 had	a splint on her left hand				1 I	
	which she stated she	e wore due to a stroke 20					
	years ago and she o	ontinued to have weakness	1	H2 (H2		1	
.	on ner lett side. R1 s	stated a CNA (Certified	1			1 I	
22.0	hed to the wheelcha	as transferring her from the ir approximately eight feet				1 1	
1	away from the hed	The CNA was the only person					
	in the room, she didr	n't have anyone else helping					
1	her. R1 stated once	she was up in the total body					
	mechanical lift and the	ne CNA was starting to move	1				
- 1	it, the CNA seemed t	to be having some trouble			-	1	
	moving the lift, "it wa	s like stuttering when she		35		ļ 1 .	
	was moving it" then t	he whole machine tipped					
1	denied hitting her had	landed on her back but					
	are two neonle who !	ad. R1 stated usually there nelp me get up using the total					
	body mechanical lift	R1 stated she was in a lot of					
	pain. R1 stated she r	needed surgery to place a					
	rod in her leg. R1 sta	ted she hasn't been able to				. f	
	get out of bed since s	surgery, not even to get into				ŀ	
	her chair. Prior to the	fall. R1 would go to the			İ		

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	Department of Public	Health		25	FORM	APPROVED
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION 5:		(X3) DATE SURVEY COMPLETED	
		IL6009252	B. WING	·		C 26/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY	STATE, ZIP CODE		20/2022
		404 DOD!	S AVENUE	STATE, ZIP CODE	•	
	HILL NURSING HOME	JOLIET, II				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 4	S9999			
	of the facility activiti participate in any of her legs are hurting pain medication abo	als and would participate in all es but was unable to it right now. R1 stated both of all the time and she needs but twice a day. According to and surgery she hardly ever ication.				
20	stated she was tran the wheelchair after for a bowel moveme have assistance froi incontinence care of wheelchair to the be help a little bit to roll didn't ask anyone el or the incontinence	s43 PM, V6 (CNA agency) sferring R1 from the bed to providing incontinence care ent. V6 stated she did not m anyone else during with the transfer from the d. V6 stated R1 was able to during incontinence care and se to assist with the transfer care. V6 stated after placing				
i e	mechanical lift, she is began to turn it towa the lift seemed to stifell over". V6 did not the floor in the way on think the lift or R was moving it. V6 stiand R1 fell on the floor in the floor in the floor in the floor in the stifell on the	hooking it to the total body raised R1 off the bed and and ard the wheelchair. V6 stated atter a bit before it "bent and think there was anything on of the mechanical lift and did 1 had hit anything while she ated it happened very fast for with the mechanical lift efore she was able to lower				
	Nurse/RN) stated she to a resident across that called her to R1' lying on top of the methe floor and the total lying next to R1. V7 stwo-person assistance total body mechanical	2:10 AM, V7 (Registered e was passing medications the hallway when V6 (CNA) is room. V7 stated R1 was echanical lift body sling on I body mechanical lift was stated R1 needed a se with transfers using the all lift. V7 stated the total mately 22 or 23 residents and				

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	Department of Public	Health		Sec. 12.	FOR	MAPPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	-	IL6009252	B. WING		.	C
NAME	F PROVIDER OR SUPPLIER	STREET AD	DDESS CIT	Y, STATE, ZIP CODE	1 04	1/26/2022
SHAM	HILL NURSING HOME		S AVENUE			
3014/	THE NORSING HOME	JOLIET, I		_		
(X4) ID PREFI TAG	((EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERNCED TO THE APPRO DEFICIENCY)	DRE	(X5) COMPLETE DATE
S999	Continued From pa	ge 5	\$9999			
	stated the CNAs reconstruction continuous and the nurse usually have the research well as a card on a bed. V7 stated "I do ask someone else f had kept R1 comfor paramedics arrived stretcher. On 04/25/2022 at 1: (CNA) stated reside transferred using an always need to have During the transfer to CNAs should always while one person used the conthe resident's back. was on should also to secure it to the me V9 stated the CNAs residents are to be trof care in the compuwall above the reside On 04/25/2022 at 4:00 Director) stated he hamechanical lift after the find anything physica and he could not replover. The total body rethe incident was obsesservice for the reside.	y kind of mechanical lift to two people present to assist. Ising a mechanical lift, the skeep a hand on the resident, ides the legs, the other troller and placed a hand on The body sling the resident use the same-colored loops echanical lift hooks. V8 and should determine how the ansferred by the Kardex/plan ter as well as the sign on the ent's head of the bed. 14 PM, V5 (Maintenance and inspected the total body the incident and could not lift wrong with the machine icate the machine to tip mechanical lift used during erved and was back in ints. R1's body weight was bund maximum capacity of				
	On 04/25/2022 at 4:2	5 PM, V4 (Restorative d tried recreating how the				

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FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: COMPLETED C IL6009252 B. WING 04/26/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **421 DORIS AVENUE** SUNNY HILL NURSING HOME OF WILL COUNT JOLIET, IL 60433 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 6 S9999 mechanical lift could have tipped over. V4 stated during testing the mechanical lift, V5 had accidentally dropped a washcloth onto the floor and when V4 was moving the mechanical lift, the machine had started to tip when the wheels hit the washcloth. V4 could not recall any linens being on R1's floor after the incident. On 04/26/2022 at 11:32 AM, V3 (Director of Nursing/DON) stated during the investigation both V6 (CNA) and R1 stated the sling started swinging prior to the total body mechanical lift falling. V3 stated V6 (CNA) had plenty of help available to her since they were not short staffed that day. The large blue full body sling was inspected, and no tears, frays, or rips were found. The sling was from the same manufacturer as the total body mechanical lift and the weight limit listed was the same as the mechanical lift. Ahospital X-Ray of the Left Femur and Pelvis dated 4/11/2022 showed R1 had a Comminuted Fracture involving the Distal Left Femoral Shaft. A hospital physician note dated 04/17/2022 showed a Magnetic Resonance Imaging (MRI) was negative for Osteomyelitis in R1's left leg. A hospital Physician Note dated 04/13/2022 showed a Computerized Tomography revealed R1 had a Fracture of the Distal Left Femoral Metaphysis. The hospital Discharge Instructions showed R1 had a Hip Fracture requiring an Open Reduction and Internal Fixation (ORIF). The facility's Transfer Electric Lift policy dated 12/31/2021 included "At least two (2) people are

present during transferring the resident. You

	Department of Public		- 10		ronn	MAFFROVED	
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION IG:	(X3) DAT	(X3) DATE SURVEY COMPLETED	
		IL6009252	B. WING _	<u> </u>		C	
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY	/, STATE, ZIP CODE		26/2022	
SUNNY	HILL NURSING HOME	OF WILL COUN? 421 DORI JOLIET, II	S AVENUE				
(X4) ID PREFIX TAG	(EACH DEFINIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE	
S9999	Continued From pag	ge 7	S9999				
	during the transfer. (have HANDS ON Coduring the ENTIRE)	ON the resident at ALL times One of the persons MUST ONTACT with the resident transfer." The policy also				#C	
	lifting a resident.	rt to not lock the wheels when			***	100	
-							
	¥	470					
		(A)		i s			
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70							
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