STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009252	A. BUILDING: _____ B. WING _____	C 12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNY HILL NURSING HOME OF WILL COUNT	421 DORIS AVENUE JOLIET, IL 60433

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S 000	Initial Comments Complaint Investigation: 24710280/IL182712	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 300.1210d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) 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	S9999		

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care needs of the resident.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

These Regulations are not met as evidenced by:

Based on observation, interview, and record review the facility failed to assist and supervise a resident (R1) who was dependent on staff for feeding. As a result of this failure, R1 spilled a hot beverage on himself and sustained four percent of full thickness (third-degree) burns to his inner thighs which required surgical intervention.

This applies to 1 of 3 (R1) residents reviewed for accidents.

The findings include:

R1's EMR (Electronic Medical Record) showed R1 was admitted to the facility on 12/29/2023 with multiple diagnoses including spinal stenosis, a spinal fusion of the cervical region, muscle weakness, lack of coordination, abnormal posture, cervicalgia, right shoulder osteoarthritis,

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right-hand limitations, loss of sensation his lower extremities, and unspecified vision loss.

On 12/19/2024 at 11:40 AM, R1 was in bed with non-removable dressings to his thighs. R1 stated on 11/23/2024 he sustained burns to his posterior-inner thighs after he spilled coffee. R1 stated V3 (Agency Certified Nurse Assistant/CNA) had left him unsupervised after she set his breakfast on the tray table while he was in bed. R1 stated when he tried to reach out for the cup of coffee with his hand it tilted and spilled on his lap. R1 stated he was transferred to the hospital and had surgery.

On 12/19/2024 at 3:15 AM, V3 (Agency CNA) stated on 11/23/2024 she prepared R1's coffee and placed it in front of him. V3 stated that before she left R1 unsupervised with his breakfast, she used his hand to guide him on the location of his breakfast items. V3 stated she did not assist R1 with his breakfast because she was unsure how much assistance he needed. V3 stated a few minutes later R1 called for help because he had spilled his coffee on his lap.

On 12/19/2024 at 11:55 AM, V14 (Registered Nurse/RN) stated on 11/23/2024 R1 was transferred to the hospital after he spilled coffee on his lap. V14 stated R1 had always required to be fed by staff as indicated in his plan of care. V14 stated R1 was readmitted back to the facility on 12/3/2024 with burns to his bilateral thighs which required wound care.

On 12/20/2024 at 2:00 PM, V5 (Burn Nurse Practitioner/NP) stated R1 had sustained approximately 4% full-thickness third-degree burns to his inner-posterior thighs after he accidentally spilled hot coffee on his lap. V5

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stated R1's burns had required a surgical excisional and autograft skin procedure on 11/29/2024. V5 stated the severity of burns varied based on multiple factors, and for R1, those additionally included decreased motor function and sensation to his bilateral lower and right upper extremities. V5 stated burns can occur due to accidents but they should be avoided when possible.

On 12/19/2024 at 2:10 PM, V10 (Restorative Nurse) stated R1 was last assessed for feeding assistance on 9/20/2024. V10 stated it was determined that R1 required full staff assistance with feeding because of his vision limitations and right-hand weakness. V10 stated R1's care plan indicated the level of assistance R1 required with feeding.

On 12/20/2024 at 1:25 PM, V2 (Director of Nursing/DON) stated the facility expects nursing staff to review residents' care plan profiles before providing care because they indicate the level of assistance residents need with their ADLs (Activities of Daily Living), including feeding. V2 stated residents who require assistance with feeding should be assisted accordingly and should not be left unsupervised to ensure their safety with meals. V2 stated V3 (Agency CNA) had failed to remain and assist R1 with his breakfast on 11/23/2024 and as a result, R1 was left unsupervised with a hot beverage that accidentally spilled on his lap causing him to sustain severe burns.

R1's Hospital Notes dated 11/23/2024 stated R1 "sustained a 4% full thickness scald burn to bilateral/BL posterior thighs on 11/23/2024 after he spilled coffee on himself" and "underwent excision and debridement with autograft

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placement to bilateral posterior thighs on 11/29."

R1's Wound Progress Notes dated 12/19/2024 stated R1's left anterior thigh donor site was healed, and the left and right posterior thigh wounds were still open, and the dressings were to remain in place until 12/21/2024.

R1's Wound-Weekly Observation Tool form dated 12/17/2024 stated R1's left posterior thigh wound measured 18 cm x 6 cm x 0.2 cm (centimeters) with 60% epithelial and 40% granulation tissues. The form also stated the right posterior thigh wound measured 8.5 cm x 5.5 cm x 0.1 cm with 85% epithelial and 15% granulation tissues.

R1's Care Plan reviewed on 12/19/2024, stated R1 had an "ADL self-care performance deficit r/t recent C3-6 laminectomy, severe spinal stenosis ...impaired vision." The Care Plan had an active eating intervention of "I need to be fed by staff" initiated on 12/29/2023.

R1's ADL Functional/Restorative Assessment and Progress form dated 9/20/2024, stated R1's eating/feeding status was total staff assistance. The form said, R1 "Needs to be fed by staff, unable to use rt. arm but won't try to use left."

R1's Facility Incident report dated 12/3/2024 states "The Agency CNA had full access to the resident's Kardex and care plan which included the resident's meal assistance and equipment needs; facility staff further reinforced components of the resident's care plan and Kardex. Despite the fact that facility ensured that all the necessary information was readily available to the Agency CNA, the resident was provided with a different level of assistance."

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S9999	Continued From page 5 The facility's policy titled Activities of Daily Living (ADLs), Supporting dated 1/202/2024, states "It is the policy of Sunny Hill Nursing Home to provide residents with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs) ...Appropriate care and services will be provided for residents who are unable to carry out ADLs independently ...in accordance with the plan of care, including appropriate support and assistance with: e. Dining (meals and snacks) ...Interventions to improve or minimize a resident's functional abilities will be in accordance with the resident's' assessed needs, preferences, stated goals and recognized standards of practice ..." The facility's policy titled Feeding the Resident dated 12/6/2023, states "It is the policy of Sunny Hill Nursing Home to provide adequate nutrition to resident unable to do for self. Procedure: Residents unable to feed self will be encouraged, instructed, assisted and/or fed by a qualified staff member ...3. To feed liquids, be sure that the liquid is the proper temperature. If in bed, place your hand under the pillow and raise the resident's head slightly. Hold the glass or cup with your other hand and let the resident guide it if resident can. Always feed the liquids slowly ...9. Care plan reflects feeding needs of resident and should be reviewed prior to feeding ..." (A)	S9999		