

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0005009		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/28/2026	
NAME OF PROVIDER OR SUPPLIER SUNNY ACRES NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 19130 SUNNY ACRES ROAD , PETERSBURG, Illinois, 62675			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
S0000	Initial Comments		S0000			03/20/2026	
	Complaint Investigation #2622462/2789634						
S9999	Final Observations		S9999			03/20/2026	
	Statement of Licensure Violations:						
	300.610a)						
	300.1210b)						
	300.3210t)						
	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 care needs of the resident.						
	Section 300.3210 General						
	t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of						

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 property. These requirements were not met as evidenced by: Based on observation, interview, and record review the facility failed to provide adequate supervision to prevent verbal and physical resident-to-resident abuse for two of four residents (R1 and R2) reviewed for abuse in the sample of seven. These findings resulted in R1 physically assaulting R2 causing R2 pain, a laceration to the left cheek, and two large hematomas to the bilateral shins which required emergency room services. Findings include: The facility's Abuse Prohibition Policy, dated 1/29/2026, documents "Abuse and Neglect Prohibited: 1. All residents have the right to be free from verbal, sexual, physical, mental abuse, corporal punishment, involuntary seclusion, neglect, misappropriation of property, and exploitation. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting in physical harm, pain, or mental anguish. Abuse includes deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, or psychosocial well-being. Physical Abuse means the infliction of injury on a resident that occurs other than by accidental means and that requires medical attention. Physical abuse may include, but it is not limited to such acts as hitting, slapping, kicking, hair pulling, and pinching. Verbal Abuse means the use of oral, written, or gestured language that includes disparaging and derogatory terms to a resident or within his or her hearing or seeing distance, regardless of the resident's age, ability to comprehend, or disability. R1's Admission Record documents R1 is an 84-year-old admitted to the facility on 3/27/21 with diagnoses of Alzheimer's Disease, Dementia with Agitation, Major Depressive Disorder, and Anxiety Disorder. R1's MDS (Minimum Data Set) Assessment documents R1 is moderately cognitively impaired and has behaviors every one to three days. R1's current Care Plan documents R1 has behaviors of yelling out, being demanding, making inappropriate sexual comments, touching on staff, and most recently (2/13/26) having physical behavioral symptoms. R2's Admission Record documents R2 is an 86-year-old		S9999				

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S9999	Continued from page 2 that was admitted to the facility on 8/12/25 with diagnoses of Osteoarthritis, Cardiomyopathy, Aortic Aneurysm, Hypertensive Heart Disease with Heart Failures, and Idiopathic Peripheral Autonomic Neuropathy. R2's MDS Assessment dated 2/11/26 documents R2 is cognitively intact and self-propels in a wheelchair. R1 and R2's Final Abuse Report dated 2/12/26 and signed by V1 (Administrator-In-Training) documents that on 2/7/26 at 8:45 PM R1 and R2 had a verbal altercation while in the bathroom that turned into a physical altercation when R1 hit R2 in the face and R1's walker hit R2's leg. This same Abuse Report documents R2 was sent to the hospital for treatment of left cheek abrasion and lower leg bruising. R1's Progress Notes dated 2/7/26 at 10:22 PM document R1 had a physical altercation with another resident (R2). R2's Emergency Department Notes dated 2/7/25 at 8:30 PM document, "Chief Complaint: (R2) arrives via EMS (Emergency Medical Services) from (the facility) for assault by another resident (R1). (R2) arrives with abrasion to left side of face and bilateral hematomas to shins from being hit with (R1's) walker multiple times. (R2) punched in head then struck by walker in shins. Left temporal pain and Tramadol 50 mg (milligrams) administered for pain." R1 and R2's Police Report dated 2/7/26 and signed by V4 (Police Officer) documents, "Offense: Battery. Offender: (R1). On 2/7/26 (V4) was dispatched to (the facility) for a battery report. The incident took place at (the facility). I spoke to (V7/RN/Registered Nurse). (V7) explained that (R2) and (R1) had gotten into a verbal and physical altercation inside the common bathroom (R2) and (R1) shared. (V7) said both (R2) and (R1) are separated now. (V7) stated that (R2) needed to go to the hospital to get his injuries checked after I was done speaking with (R2). (V7) briefly explained the situation to me, stating that both (R1) and (R2) were arguing and (R1) struck (R2) in the face with (R1's) fists and struck (R2) in the face several times, and hit (R2) with (R1's) walker. (R2) was unable to provide a written statement and wanted to go to the hospital to be checked out. I requested dispatch to send EMS to my location for transport to (ED/Emergency Department). I took photographs of the injuries too (R2). I then went to speak to (R1) inside (R1's) room. I asked (R1) what happened tonight. (R1) stated that he beat (R2) up because (R2) had called (R1) a "Son of a bi**h." (R1)		S9999				

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S9999	Continued from page 3 stated that he hit (R2) several times and may have hit (R2) with the walker. I photographed (R1's) hands and (R1's) right hand did appear to possibly have some bruising and (R1) stated it hurt. I asked (V7) if any staff witnessed the incident. (V7) stated (Certified Nursing Assistant/CNA/V3) did. (V3's) statement is attached to the report." The Police Report Photos printed 2/9/26 were observed. In the photos R2 had a laceration to the left upper cheek and a softball sized, dark purple hematoma to the right lower leg, and R1 had reddish discoloration to the top of his right hand and end of his right fingers. On 2/27/26 at 9:30 AM R2 was sitting in his room in a wheelchair. R2 had a 2-inch by 2-inch dressing with brownish drainage covering an open area to the top of the left shin. R2 had a baseball sized dark red hematoma to the right shin. R2 stated, "Several weeks ago I had a friend visiting me and (R1) was in the bathroom singing a song repeatedly, "It's bare a** time." What (R1) was singing was embarrassing and (R1) does it just to aggravate me. I went into the bathroom and told (R1), "Shut the h**l up you son of a bi**h!" (R1) took his walker and slammed it into my legs over and over and when I grabbed ahold of the walker to get (R1) to stop, (R1) started to punch me in the face. Both of my shins are really swollen and sore and my cheek got busted open. It hurt really badly, and I asked to go to the hospital to make sure my cheek wasn't broken. I definitely felt abused and should not have to deal with (R1). My shins are still swollen and are painful every day." On 2/27/26 at 2:12 PM V3 (CNA) stated, "On 2/7/26 around 8:30 at night I heard someone yelling help. I went into (R2's) room and (R2) was in the doorway of the bathroom and (R1) was in the bathroom. I saw (R1) punching (R2) in the chin with closed fists. I yelled at (R1) to stop, and (R1) had ahold of (R2's) wheelchair. I removed (R1's) hands from (R2's) wheelchair and separated (R1) and (R2). (R2) had a bloody mouth and a soft-ball sized bruise to the right shin. (R2's) left cheek was busted open. (R2) told me that (R1) was singing its bare a** time, so (R2) yelled at (R1) and called (R1) a son of a bi**h. (R2) stated (R1) hit him multiple times in the face and hitting (R2) in the shins with (R1's) walker. (R2) was hurting and wanted to go to the hospital." (B)			S9999			