STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145892	A. Building B. Wing	02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunny Hill Nursing Home of Will County	421 Doris Avenue Joliet, IL 60433

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16746 Based on observation, interview and record review the facility failed to assess and provide adaptive device to residents, to prevent further reduction in ROM (range of motion). This applies to 2 of 6 residents (R83 and R129) reviewed for range of motion in the sample of 30. The findings include: 1. R129 face sheet indicates multiple diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. R129's quarterly MDS (minimum data set) dated January 4, 2024, showed that the resident was severely impaired with cognition. R129's MDS showed that the resident had functional limitation in ROM on one side of both upper and lower extremities. The same MDS showed that R129 required maximum to total assistance from the staff with most of his ADLs (activities of daily living). On February 20, 2024, at 12:34 PM, R129 was in bed, alert and verbally responsive. R129's left hand and wrist were contracted. R129 was not able to extend his left-hand fingers without the assistance of his right hand, and even with the assistance of his right hand, R129 was still having difficulty, extending his left-hand fingers. According to R129, he does not use any device or splint on his left hand/wrist. On February 21, 2024, at 1:56 PM, R129 was in bed, alert and verbally responsive. R129's left hand and wrist were contracted. R129 was not able to extend his left-hand fingers without the assistance of V3 (Assistant Director of Nursing/Restorative Nurse). R129 had no device or splint on his left hand/wrist. V3 stated that she was not aware of R129's left hand contracture because the last time she had assessed the resident his left hand was flaccid. V3 was prompted to request the therapy department to screen and/or evaluated R129 to determine the need for a device or a hand splint and any therapy services. R129's skilled therapy screening form dated February 21, 2024, created by V19 (Occupational Therapist) showed, [Patient] presents [with] increased tone in [left] hand/wrist. [Patient's] wrist presents in flexed position [with] digits 1-5 in extension position. [Patient] can benefit from [left upper extremity] resting hand splint to improve ROM in [left] hand and in prep for overnight wear. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145892	A. Building B. Wing	02/23/2024

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On February 21, 2024, at 3:39 PM with V20 (Rehab Director), V19 stated that she had screened R129 that day at around 2:30 PM per physician's order and V3's request. Upon screening, R129's left wrist was in a flexed position and his left fingers were extended and was not able to bend. R129's left wrist was tight and was not able to move his left wrist and left fingers with staff assistance, and even with staff assistance, R129 was not able to have a full range of motion. V19 stated that she recommended a left resting hand splint for R129 to prevent contracture and further decline of the left hand/wrist, to improve the resident's ROM on the left hand and for the staff to provide hand hygiene and monitor the skin on the hand. According to V19, R129 definitely needed the left resting hand splint because the resident's left hand/wrist ROM had declined. During the same interview, R129 stated that on February 22, 2024, R129 will be evaluated to determine the need for therapy services. R129's OT (occupational therapy) evaluation dated February 22, 2024, showed that the resident will be receiving occupational therapy services to increase the resident's functional level of independence and improve quality of life. The same OT evaluation showed in-part, [Patient] can benefit from LUE (left upper extremity) resting hand splint to improve ROM in [left] hand/wrist and prevention of contractures. On February 22, 2024, at 9:50 AM, V3 (Assistant Director of Nursing/Restorative Nurse) stated that she last assessed R129's left hand sometime in December 2023 and during that time the resident's left hand was flaccid. According to V3 she was not notified by the staff about the decline in R129's left hand ROM. V3 stated, I would have thought the CNA (Certified Nursing Assistant) would have caught it. On February 22, 2024, at 12:34 PM, V2 (Director of Nursing) stated that the nursing staff are expected to inform the nurses, Director of Nursing, Assistant Director of Nursing and/or restorative nurse when a resident's ROM changed or declined to ensure that proper assessment could be done and appropriate device, splint or any adaptive equipment can be used to improve, maintain or prevent further decline in ROM. 36567 2. R83's face sheet included diagnoses of C5-C7 incomplete quadriplegia and right-hand contracture. R83's quarterly MDS dated [DATE], showed that R83 was cognitively intact. The same MDS showed that R83 has impairment on one side for functional limited range of motions with upper extremity. On February 20, 2024, at 10:32 AM, R83 was lying in bed and noted to have his right-hand fingers (except thumb) curled into his palm. When prompted, R83 was unable to open his fingers. R83 stated My right hand is not real good. R83 also stated that he does not recall wearing any devices to his right hand. On February 20, 2024, at 2:39 PM, R83 was seated upright in a wheelchair in his room with V12 (Certified Nursing Assistant) seated by his side. R83 received two hot dogs per request and did not touch his meal. R83 stated that he is mostly right-handed but able to use left hand to feed self. No devices seen on both hands. V12 was not aware of R83 using any devices and stated that she is not familiar with R83. (continued on next page)

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	145892	A. Building B. Wing	02/23/2024

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On February 21, 2024, at 10:38 AM, V7 (Restorative Nurse) stated He should have a splint on while he is up in chair. It can be applied by the CNAs or CRA/Certified Restorative Aides. (V12) was from agency and that was the problem. R83's care plan revised November 6, 2023, showed that R83 has an ADL/activities of daily living self-care performance deficit related to generalized weakness, history of seizures, osteoarthritis, and incomplete quadriplegia due to lesion of C5-C7 level. The goal for this focus included that R83 will wear right resting hand splint daily without complications through next review target date March 27, 2024.

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	145892	A. Building B. Wing	02/23/2024

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 16746 Based on observation, interview and record review, the facility failed to provide urinary catheter care and services, and failed to provide incontinence care in a manner that would prevent the potential development of infection and to maintain hygiene. This applies to 4 of 6 residents (R20, R36, R42 and R130) reviewed for catheter and incontinence care in the sample of 30. The findings include: 1. R20 had multiple diagnoses including neuromuscular dysfunction of the bladder, hydronephrosis and calculus of the kidney, based on the face sheet. R20's electronic records showed that R20 had history of UTI (urinary tract infection). R20's quarterly MDS (minimum data set) dated January 23, 2024, showed that the resident was cognitively intact. R20's MDS showed that the resident required total assistance from the staff with regards to toileting hygiene. The same MDS showed that R20 had an indwelling urinary catheter and was always incontinent of bowel function. On February 20, 2024, at 11:17 AM, R20 was in bed, alert, oriented and verbally responsive. R20 had a urinary catheter and the catheter tubing had white sediments. R20 stated that the nurses kept on flushing her urinary catheter because of the sediments and also stated that there are times that her urine would leak. R20 had a strong urine odor. On February 21, 2024, at 11:08 AM, R20 was in bed, alert, oriented and verbally responsive. R20's urinary catheter bag and tubing was directly on the floor under her bed, which was visible from the hallway and door. On the same location where the urinary catheter bag and tubing were, multiple tissue papers were on the floor beside the trash container. At 11:14 PM, V24 (Certified Nursing Assistant) went inside R20's room to open the window per resident's request and then left the room without picking up the catheter drainage bag and catheter tubing to keep it off the floor. On February 21, 2024, at 11:16 AM, V28 (Licensed Practical Nurse) went inside R20's room per resident's request to open the other window per resident's request. After opening the other window, V28 picked up the multiple tissue papers on the floor that were beside the urinary catheter bag and tubing. However, V28 did not pick up the catheter drainage bag and the catheter tubing that was on the floor to keep it off the floor. At 11:26 AM, V28 again went inside R20's room to give the resident cups of water. It was only during that time that V28 picked up the catheter drainage bag and tubing off the floor and hung it under R20's bed frame. (continued on next page)

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	145892	A. Building B. Wing	02/23/2024

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On February 21, 2024, at 11:28 PM, V29 (Certified Nursing Assistant) emptied R20's urinary catheter bag and obtained 500 ml of yellow cloudy urine. At 11:29 AM, R20 stated that her disposable brief was wet. While R20 was on her back, V29 unfastened R20's disposable brief. R20 had an indwelling urinary catheter and V29 stated that R20's brief was slightly wet with urine. With her gloved hands, V29 used disposable wet cloths and cleaned R20's pubic area and bilateral groin area. V29 then cleaned the visible part of R20's urinary catheter (portion away from the insertion site) but did not separate the resident's labial folds to clean the area and also did not clean the urinary opening/catheter insertion site and the catheter tubing closer to the opening. On February 22, 2024, at 12:37 PM, V2 (Director of Nursing) stated that a resident's urinary catheter bag and urinary catheter tubing should never be directly resting on the floor to prevent potential UTI. V2 stated that during incontinence and catheter care, the Certified Nursing Assistant and/or nurses should make sure to open the female labial folds to clean the area and make sure to also clean from the urinary opening to the catheter tube for good hygiene and to prevent UTI. The facility's urinary catheter policy and procedure last reviewed by the facility on December 13, 2023, showed that it is the policy of the facility to prevent catheter-associated urinary tract infections. The procedure showed in-part, under infection control, 2. Maintain clean techniques when handling or manipulating the catheter, tubing, or drainage bag b. Be sure the catheter tubing and drainage beg are kept off the floor. The same policy under steps in the procedure showed in-part, 13. With nondominant hand separate the labia of the female resident or retract the foreskin of the uncircumcised male resident. Maintain the position of this hand throughout the procedure. 14. Assess the urethral meatus. 15. For a female resident. Use a washcloth with warm water and soap to cleanse the labia . and cleanse around the urethral meatus .17. Use a clean washcloth with warm water and soap to cleanse and rinse the catheter from insertion site to approximately four inches outward. 36567 2. R36's face sheet included diagnoses of neuromuscular dysfunction of bladder, urinary tract infection, site not specified, presence of urogenital implants. R36's Physician Order Sheet showed an order for indwelling urinary catheter change as needed based on clinical indications such as infection, obstruction or when closed system is compromised (revised December 18, 2023). R36's care plan revised January 2, 2024, included that R36 was admitted back with Indwelling Catheter related to Neurogenic bladder with potential for complications. The same care plan included that urine culture done on December 20, 2023, showed evidence of urinary tract infection. On February 21, 2024, at 1:35 PM, R36 was in her room with urinary catheter bag in privacy bag that was hooked on to her wheelchair. The tubing of the catheter was noted almost touching the floor and had yellow colored urine that was cloudy with thick sediments. (continued on next page)

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	145892	A. Building B. Wing	02/23/2024

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On February 21, 2024, at 1:52 PM, R36 was seen wheeled down the hallway by V8 (R36's family). R36's catheter tubing which contained cloudy urine with thick sediments was seen dragging on the floor. V8 then stopped to ask questions to V6 (Licensed Practical Nurse). Other staff were noted to be around R36. After the conversation with V6, V8 resumed wheeling R36 down the hallway and V6 was notified about the catheter tubing dragging on the floor. V6 agreed that the catheter should be off the floor and proceeded to put it back in the privacy bag. On February 22, 2024, at 12:06 PM, V2 (Director of Nursing) stated that urinary catheter bag and tubing should be kept below the bladder but above the floor for infection prevention. 29562 3. On February 21, 2024, at 12:17 PM, R130 was in his bedroom, sitting in his wheelchair. R130's urinary catheter bag and tubing was touching the floor. On February 21, 2024, at 1:35 PM, V18 (Certified Nursing Assistant/CNA) assisted R130 to the bathroom. After R130 used the toilet, V18 wiped his back perineum and pulled his pants back up without cleaning his frontal perineum and catheter. Then R130 propelled back to the bedroom, his urinary catheter tube and bag was observed touching/dragging on the floor. 4. On February 21, 2024, at 1:25 PM, V17 (CNA) provided incontinence care to R42 who was heavily saturated with urine which overflowed to her (R42's) pants and wheelchair cushion. V17 used wet wipes to clean R42's pubic area. V17 turned R42 on her left side and proceeded to clean the back perineum. V17 did not clean the labia and the rest of the frontal perineum and applied a new incontinence brief. Facility's Policy and Procedure for Perineal Care with review date of December 20, 2023 shows: Policy: It is the policy of this facility to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition. Procedure: For a female resident: b. Wash perineal area, wiping from front to back. (1) Separate labia and wash area downward from front to back. (2) Continue to wash the perineum moving from inside outward to the thighs. Rinse perineum thoroughly in same direction, using fresh water and clean washcloth. For a male resident: b. Wash perineal area starting with urethra and working outward. c. If the resident has an indwelling catheter, gently wash the juncture of the tubing from the urethra down the catheter about 3 inches. Gently rinse and dry the area.

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	145892	A. Building B. Wing	02/23/2024

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 29562 Based on observation, interview, and record review, the facility failed to ensure that a resident who was receiving gastrostomy tube (g-tube) feeding was not lying flat in bed while tube feeding was being administered. This applies to 1 of 3 residents (R54) reviewed for enteral feeding in the sample of 30. The findings include: On February 21, 2024, at around 11:25 AM, R54 was lying in bed with Jevity infusing at 40 ccs (cubic centimeters) per hour through the g-tube. R54's head of bed was elevated less than 30 degrees. On February 21, 2024, at 11:34 AM, V14 and V15 (Both Certified Nursing Assistants/CNA) rendered incontinence care to R54 who had a bowel movement. R54 was lying flat in bed and the g-tube feeding was running while R54 was being cleaned. During the care R54 was turned to her right side and left side flat while the g-tube feeding was still running. After completing the incontinence care, V15 and V16 elevated R54's head of the bed (HOB) to about 25 to 30 degrees. On February 21, 2024, at 11:49 AM, V16 (Wound Care) stated that HOB/head of bed should be 45 degrees and the g-tube feeding should be put into pause prior to care to prevent potential aspiration. On February 22, 2024, at 12:07 PM, V2 (Director of Nursing/DON) stated that staff should turn off the g-tube for 30 minutes prior to provision of care to avoid aspiration. The head of bed should be elevated to 45 degrees and up. Care plan shows that R54 has gastrostomy tube feeding, and she requires the head of bed elevated to 45 degrees during and thirty minutes after tube feeding.

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	145892	A. Building B. Wing	02/23/2024

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 36567 Based on observation, interview and record review, the facility failed to serve pureed meat portions and pureed soup and garlic bread as shown on the menu spreadsheet for the lunch meal. This applies to 4 of 4 residents (R37, R47, R140 and R145) observed for dining in the sample of 30. The findings include: Facility Fall/Winter 2023-2024 daily spreadsheet for Week 4 Wednesday lunch meal for the pureed meal included as follows: Pureed Beef Vegetable Soup (6 oz/ounce), pureed Veal Parmesan #6 scoop +1 oz/ounce sauce), pureed Linguini (#8 scoop) OR pasta of choice (#8 scoop), Italian Beans (#12 scoop, swirl pudding 1/2 cup, pureed garlic bread (#16 scoop). An alternate lunch choice of pureed pork (#8 scoop) was also shown on the menu. Facility scoop/disher and portion control charts showed that #6=5+1/3 oz, #8 =4 oz, #12 =2.875 oz, #16=2 oz. On February 21, 2024, at 9:35 AM, V10 (Cook) stated that the pureed items she prepared for the lunch meal included pureed Veal Parmesan, pureed pasta, and pureed Italian beans. On February 21, 2024, at 12:03 PM, during lunch meal service, V9 (Dietary Aide) was observed platting the food on the 1st Avenue steam table. V9 used a #8 scoop (4 oz/ounce per scoop) to serve the pureed meat (Veal Parmesan). When asked what the meat was, V9 stated that he thinks its turkey or pork. The other menu items on the steam table for the pureed meal included pureed green beans, pureed pasta, and a pre-plated pudding in a bowl for dessert. No pureed soup or pureed garlic bread was seen on the steam table. R37, R47 and R140 received the 4-ounce scoop of pureed meat along with a serving as shown on menu spreadsheet of pureed green beans and pureed pasta for lunch meal in the dining room. R145 also received the same serving portions in his room. The same residents were also offered a bowl of pre-plated pudding in a bowl for dessert. On February 22, 2024, at 9:26 AM, V10 stated that she prepared only two pureed soups for the residents on the 6th avenue, and she did not prepare the garlic bread for pureed diets as she ran out of time. On February 21, 2024, at 2:14 PM, and February 22, 2024, at 9:56 AM, V4 (Director of Food and Nutrition Services) stated that she spoke to the Dietitian Consultant who oversees the menus and she (Dietitian) stated that a 6 oz portion of veal =3 oz portion of protein which was the serving portion for the lunch meal. V4 stated that since the veal had breading and thickening/liquid added in pureed preparation, a 6 oz portion for the pureed should be served to get the 3 oz protein. V4 stated that the residents on pureed should also receive the additional planned menu of pureed soup and pureed garlic bread. (continued on next page)

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	145892	A. Building B. Wing	02/23/2024

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Facility Diet Type Report showed that R37, R47, R140 and R145 were on pureed diets.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 36567 Based on observation, interview and record review, the facility failed to maintain a unit refrigerator under sanitary conditions. This applies to 7 of 7 (R45, R67, R68, R83, R87, R107, R121) observed for dining in the sample of 30. The findings include: On February 20, 2024, at 12:28 PM, during lunch meal service, the refrigerator in the 2nd Avenue was noted to have smears and smudges of food debris and other miscellaneous substance on and around the handle of the refrigerator door. V11 (Dietary Aide) was seen wearing gloves and opening and closing the refrigerator to take items out for meal service in between handling plates to plate the food. V11 was notified of the cross contamination related to the same. On February 20, 2024, at 3:32 PM, the same refrigerator was monitored in presence of V12 (Certified Nursing Assistant). All the storage shelving (on the inside of the refrigerator) had areas of rust like substance along with multiple blackish colored spots of unknown substance. Multiple food items consisting of thickened juice containers, regular juices and prepared juices including closed packages of unknown items were stored on the top shelves. V12 stated that the packaged items belonged to residents in the unit. The leftover bowls of fruit cocktails from the lunch meal service were placed on the refrigerator on one of the middle shelves covered with a saran wrap. The bottom shelf had multiple individual milk and juice containers stored over a surface that had extensive debris/spills blackish and rust like substance. V12 added that this refrigerator stored foods that was distributed to the residents on the 2nd Avenue. V12 was not sure what the blackish and brown substance inside the refrigerator was. On February 20, 2024, at 3:40 PM, on inspection of the refrigerator, V4 (Director of Food and Nutrition Services) stated that the brownish substance is a lot of rust and the black substances looked like something exploded inside. When the black substance was wiped with a paper towel, smears of greyish powdery substance came off on the paper towel. V5 (Food Service Manager) who was also present, stated that the black substance could be related to the moisture in the refrigerator. V5 added that the refrigerator is old, and a work order is placed for replacement. V4 and V5 were notified that food in the refrigerator was not safe to serve with presence of unknown substance. On February 22, 2024, at 9:36 PM, V5 stated that the nursing department is responsible for the temperature monitoring and cleaning of the inside of the refrigerator. V5 added that the house keeping is responsible for cleaning the outside of the refrigerator. Residents that received the lunch meal served from the 2nd Avenue were identified as R45, R67, R68, R83, R87, R107 and R121.

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	145892	A. Building B. Wing	02/23/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 29562 Based on observation, interview, and record review, the facility failed to follow standard infection control practices with regards to hand hygiene and changing gloves during provisions of care. This applies to 4 of 6 residents (R20, R42, R54 and R84) reviewed for infection control during provisions of care in the sample of 30. The findings include: 1. On February 21, 2024, at 11:34 AM, V14 and V15 (Both Certified Nursing Assistants/CNA) rendered incontinence care to R54 who had a bowel movement. V14 cleaned R54's back peri-area, removed soiled items, applied new sheets and incontinence brief, and repositioned R54 while wearing the same soiled gloves. V14 removed her gloves and continued to straighten the clean bed linen and adjusted the bed position without hand hygiene. 2. On February 21, 2024, at 1:25 PM, V17 (CNA) provided incontinence care R42 who was heavily wet with urine. V17 cleaned R42 from the front to back and while wearing the same soiled gloves she applied barrier cream, placed new incontinence brief, and straightened the bed linens. After completing the incontinence care, while wearing same soiled gloves, V17 carried R42's soiled pants to the soiled linen cart in the hallway. V17 removed her gloves and without performing hand hygiene went to the clean linen cart to obtain some linens. 3. On February 21, 2024, at 1:50 PM, V14 and V15 (Both CNAs) rendered incontinence care to R84 who was wet with urine. V15 cleaned her from the front to back, applied new incontinence brief, removed soiled gloves and without performing hand hygiene straightened the bed sheet/linen and repositioned R84. On February 22, 2024, at 12:19 PM, V2 (Director of Nursing/DON) stated that staff must perform hand hygiene and change gloves, before and after care, in between task from dirty to clean tasks, to prevent spread of infection and cross contamination. Facility's Hand Washing Policy and Procedure with review date of December 20, 2023, shows: Policy: It is the policy of the facility to ensure that the proper handwashing technique is used for the prevention and transmission of infectious diseases and is the cornerstone of all infection control practices. Procedures: 6. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap and water for the following situations: h. Before moving from a contaminated body site to a clean body site during resident care. i. After contact with a resident's intact skin. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145892	A. Building B. Wing	02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunny Hill Nursing Home of Will County	421 Doris Avenue Joliet, IL 60433

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	j. After contact with blood or body fluids. m. After removing gloves. 7. Hand hygiene is the final step after removing and disposing of personal protective equipment. 8. The use of gloves does not replace hand washing/hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections. 16746 4. R20 had multiple diagnoses including neuromuscular dysfunction of the bladder, hydronephrosis and calculus of the kidney, based on the face sheet. R20's quarterly MDS (minimum data set) dated January 23, 2024, showed that the resident was cognitively intact. R20's MDS showed that the resident required total assistance from the staff with regards to toileting hygiene. The same MDS showed that R20 had an indwelling urinary catheter and was always incontinent of bowel function. On February 21, 2024, at 11:29 AM, R20 stated that her disposable brief was wet. While R20 was on her back, V29 (CNA/Certified Nursing Assistant) unfastened R20's disposable brief. R20 had an indwelling urinary catheter and V29 stated that R20's brief was slightly wet with urine. With her gloved hands, V29 used disposable wet cloths and cleaned R20's pubic area, bilateral groin area and the visible part of R20's urinary catheter. V29 then applied a new disposable brief to R20 using the same gloves that she used to clean R20. After applying the new disposable brief, V29 turned R20 on her left side (facing the window). R20 had pasty stool, using the same gloves, V29 cleaned R20's buttocks and anal area, then positioned R20 back on her back, fastened the resident's disposable brief, repositioned R20's left boot (was on the resident's left lower leg), fixed R20's gown and lines and used the bed remote to lower R20's bed, while using the same soiled gloves. During the entire catheter and incontinence care, V29 used only one gloves from dirty to clean procedure without changing gloves and performing hand hygiene. After the above procedure, V29 removed her soiled gloves inside R20's room, did not perform hand hygiene, went out of the resident's room to dispose of the soiled supplies. V29 had to be prompted to perform hand hygiene/wash her hands because V29 was about to go to another resident's room to provide care. On February 22, 2024, at 12:37 PM, V2 (Director of Nursing) stated that all the nursing staff are expected to remove their gloves, perform hand hygiene either hand wash or use of alcohol/sanitizer and re-gloved after performing dirty to a clean procedure. According to V2, the CNA should have removed her soiled gloves after providing incontinence care to R20, performed hand hygiene, and then put on a new pair of gloves, before applying new brief, before repositioning the resident and before touching any other supplies and/or equipment such as resident's gown, linens, and bed remote. V2 stated that performing hand hygiene and making sure that a clean glove is used after a dirty to a clean procedure should be performed to prevent cross contamination and prevent infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's policy and procedure regarding infection control-gloves last reviewed by the facility on January 20, 2024, showed that it is the policy of the facility for staff to use gloves for maintaining health and for monitoring infection control. Under the procedure it showed in-part, When wearing gloves, change or remove gloves in the following situations: during resident care if moving from a contaminated body site to another body site (including a mucous membrane, non-intact skin or a medical device within the same resident or the environment). Under the same procedure it showed in-part, Glove use and need for hand hygiene: When an indication for hand hygiene follows a contact that has required gloves, hand rubbing, or hand washing should occur after removing gloves. When an indication for hand hygiene applies while the health-care worker is wearing gloves, then gloves should be removed to perform hand rubbing or handwashing.