

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145370	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/25/2025
NAME OF PROVIDER OR SUPPLIER Sullivan Healthcare & Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE 11 Hawthorne Lane Sullivan, IL 61951	
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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to maintain the dignity of three (R10, R11, R12) residents by not providing Activities of Daily Living (ADL) timely out of six residents reviewed for ADL's in a sample list of 17 residents. Findings include: 1. R10's Minimum Data Set (MDS) dated [DATE] documents R10 as severely cognitively impaired. This same MDS documents R10 is dependent of staff for oral hygiene, toileting, dressing, personal hygiene, transfers and requires maximum assistance from staff for bathing and bed mobility. R10's Care Plan intervention dated 1/12/23 documents staff will provide hygiene and grooming per R10's preferences. Ensure hair is in place before meals. Keep facial hair trimmed/shaved per R10's usual style. Fingernail care is on shower days and as needed. On 11/25/25 at 9:15 AM R10 was sitting in the resident lounge with another resident present. R10 had overgrown, unkempt mustache and facial hair long stubble. R10 had a piece of egg on his shirt leftover from breakfast. R10 stated he prefers to be clean shaven. R10 stated he does not get any help cleaning himself up after breakfast and can't see if he has spilled any foods. R10 stated he prefers to wear clean clothes without any food spilled on them. On 11/24/25 at 12:00 PM R10 was sitting at the lunch table in the main dining room with multiple other residents present. R10 still had the overgrown, unkempt mustache and long facial hair stubble. R10's hair was not combed as it was sticking up on the top of his head in multiple places. 2. R11's Minimum Data Set (MDS) dated [DATE] documents R11 as moderately cognitively impaired. This same MDS documents R11 as dependent on staff for eating, oral hygiene, toileting, bathing, dressing, personal hygiene, bed mobility and transfers. R11's Care Plan intervention dated 3/22/23 documents staff will provide bathing hygiene, dressing and grooming per R11's preferences. Ensure hair is in place before meals, keep facial hair trimmed/shaved per R11's usual style. Fingernail care should be on shower days and as needed. On 11/23/25 at 1:45 PM R11 was sitting in her wheelchair. R11 had a half inch of chin hair showing. R11's fingernails showed dark grime underneath the ends of her nails. On 11/24/25 at 10:00 AM R11 was sitting in her wheelchair in the hallway with other residents present. R11 still had long chin hairs showing. R11's fingernails showed dark grime underneath the ends of her nails. 3. R12's Brief Interview for Mental Status (BIMS) dated 11/13/25 documents R12 as severely cognitively impaired. R12's Minimum Data Set (MDS) dated [DATE] documents R12 as moderately cognitively impaired. This same MDS documents R12 as dependent on staff for assistance with eating, oral hygiene, bathing, dressing, toileting, personal hygiene, bed mobility and transfers. R12's Care Plan intervention dated 11/17/24 documents staff will provide oral care with morning and evening cares. Staff will provide bathing, hygiene, dressing and grooming per R12's preference. Ensure hair is in place before meals. Keep facial hair trimmed/shaved per R12's usual style. Fingernail care will be on shower days and as needed. On 11/23/25 at 11:50 AM R12 was sitting in her wheelchair in the hallway with visitors passing by. R12 had multiple chin hairs approximately an inch long and several dark mustache hairs showing. R12's fingernails showed dark grime underneath the ends of her nails. On 11/24/25 at 3:00 PM R12 was sitting in the resident lounge with other residents with the same mustache and chin hair showing. R12's fingernails showed dark grime under the same nails as (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
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	previous observation. On 11/24/25 at 2:55 PM V13 Certified Nurse Aide (CNA) confirmed R11 and R12 had facial hair and grime underneath their fingernails. V13 stated residents should be shaved everyday if needed. V13 CNA stated she does not think R11 nor R12 would like to have long chin hairs. On 11/24/25 at 11:45 AM V24 Certified Nurse Aide (CNA) confirmed R10 likes to be clean shaven, in clean clothes and have his hair combed down. V24 CNA stated she was going to do that but haven't gotten around to it yet. On 11/25/25 at 11:45 AM V3 Director of Nurses (DON) stated all residents should be groomed per their preference. V3 DON stated she was aware the resident's personal hygiene was an issue with getting staff to ensure residents are clean and well groomed. V3 DON stated she has seen several female residents that need shaved, several residents that are in need of nail care and also some that need their hair brushed. V3 DON stated she is working on in servicing staff on Activities of Daily Living (ADL). The facility policy titled Dignity revised February 2021 documents each resident should be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life and feelings of self-worth and self-esteem. Staff are expected to treat cognitively impaired residents with dignity and sensitivity.		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to protect resident's right to be free from physical abuse by another resident for two of five residents (R2, R3) reviewed for abuse in the sample list of 17. This failure resulted in R2 obtaining lacerations to his Left Face, Left Upper Lip and Left Ear requiring treatment in the emergency room and experiencing pain and fear after R3 punched R2 in the face. Findings include: R2's Minimum Data Set (MDS) dated [DATE] documents R2 as moderately cognitively intact. This same MDS documents R2 requires moderate assistance with toileting, dressing, personally hygiene and transfers. R2's Physician Order Sheet (POS) dated November documents a physician order for Xarelto 20 milligrams (mg) daily (anticoagulant). R2's Nurse Progress Note dated 9/21/25 at 9:00 AM documents R2 was involved in an altercation with R3 on 9/21/25 at 9:12 AM. R2 was using his restroom when R3 came in and started punching R2 in the face. Both residents (R2, R3) were separated and evaluated for injuries. R2 obtained lacerations to his Left Ear, Left Face and Left Upper Lip. R2 was sent to the emergency room for further evaluation. R2's Assess, Intercommunicate, Manage (AIM) for Wellness dated 9/21/25 documents R2 received Left Ear, Left Face and Left Upper Lip Lacerations during a resident to resident altercation on 9/21/25. (R3) came in and started punching me (R2) in the face. R2's Hospital Record dated 9/21/25 documents R2's chief complaint as Assault and diagnoses listed as Assault and Abrasion. R2 was sitting on his toilet at his room at the facility and R3 had a behavioral outburst. R3 came into their shared bathroom and R3 punched R2 in his Left Jaw. R2 does have a laceration to his post Auricular region. R2 was treated with antibacterial ointment and administered Tramadol for pain. R3's Minimum Data Set (MDS) dated [DATE] documents R3 as severely cognitively impaired. This same MDS documents R3 requires maximum assistance from staff for bed mobility and transfers. R3's AIMS dated 9/21/25 documents R3 was separated (from R2) and administered as needed Haldol Intramuscularly (IM) for agitation and sent to the emergency room. On 11/24/25 at 2:05 PM R2 stated his room shares a bathroom with another resident room. R2 stated he was using the shared bathroom when R3 came charging in and hit me. R2 stated (R3) doubled up his fist and stated I am too good looking, and he needed to mess up my face because I have too many girlfriends. R2 stated he knew who R3 was prior to this incident but had never had any trouble with R3. R2 stated R3 hit him in the jaw causing R2 to be scared and shocked. R2 stated he did not know what R3 would do. R2 stated he yelled out and staff came in and dragged R3 off R2. R2 stated, Imagine you are on the toilet, and someone just comes barging in and punches you so hard you fall back. R2 stated he is very glad R3 is no longer in the facility. R2 stated he had to go the emergency room because R3 hurt him. On 11/24/25 at 9:20 AM V10 Licensed Practical Nurse (LPN) stated she and V11 LPN were in the facility medication room when she heard R3 yelling, (R2) thinks he can use my f***** (expletive) bathroom. V10 LPN stated another staff member tried to calm R3, but it didn't work. V10 LPN stated staff attempted several non-pharmacological methods such as a calm voice, no sudden movement, offering a change of atmosphere, etcetera with no positive response. V10 LPN stated R3 required an injection of Haldol to attempt to deescalate R3. V10 stated the Haldol kind of worked but (R3) was so angry even the Haldol was not enough to calm R3 down. V10 LPN stated emergency services (EMS) arrived and took both R2 and R3 to the emergency room. V10 LPN stated R3 left first because he was still yelling and cussing when EMS arrived so R3 left first so he wouldn't hurt anyone else. V10 LPN stated the staff tended to R2's lacerations. V10 LPN stated she thought that R2 would have a lot of bruising due to R3's level of anger and force when he hit R2. On 11/25/25 at 2:15 PM V1 Administrator confirmed the incident between R2 and R3 was definitely abuse. V1 Administrator stated the facility was aware this incident happened and fully expected to be cited for this resident-to-resident abuse that happened. V1 Administrator stated V1 wishes it didn't happen, but it did. The facility policy titled (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Abuse, Neglect, Exploitation and Misappropriation Prevention Program revised April 2021 documents residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. This same policy documents staff are to protect residents from abuse, neglect, exploitation or misappropriation of property by anyone including other residents.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to report a resident's allegation of staff to resident abuse for one of five residents (R1) reviewed for Abuse in a sample list of 17 residents. Findings include: R1's Minimum Data Set (MDS) dated [DATE] documents R1 as cognitively intact. R1's Care Plan initiated 1/9/2025 documents staff are to allow resident time and opportunity to express feelings, anger or frustration. Provide empathy and validation of feelings. Allow resident time and opportunity to express self and verbalize frustrations. Approach in a calm, non-threatening manner. R1's Nurse Progress Note dated 10/13/25 at 9:53 AM documents R1 has been cursing and throwing objects at staff. (R1) was asked to wait a couple of minutes until staff finished with another resident that staff was caring for. This same note documents when staff entered R1's room to care for R1, he started making accusations that they (staff) are abusing him. This same note documents R1 was administered pain medication and R1 started yelling and cursing at staff. This same note documents V28 LPN explained to R1, If (R1) keeps treating staff like this anymore, (V28) LPN will send (R1) to the hospital for behaviors. Then (R1) wants to take a gun and kill all of night shift. R1's Initial Report to the State Agency dated 11/23/25 documents R1 alleged abuse from staff on 10/13/25. On 11/25/25 at 10:30 AM V2 Administer in Training (AIT) stated she was aware R1 had alleged the staff abused him on 10/13/25. V2 AIT stated she did speak with R1 on 10/13/25 and he denied the allegation. V2 AIT stated she did not speak with any other cognitively intact residents or staff. V2 AIT stated she did not report R1's abuse allegation to the State Agency. V2 AIT stated anytime a resident alleges abuse it should be investigated and reported to the State Agency. On 11/25/25 at 1:20 PM V1 Administrator stated V2 Administrator in Training (AIT) should have reported this incident to the State Agency. V1 stated anytime a resident makes an allegation of abuse the facility abuse policy must be followed and that includes doing a full investigation and reporting the finding to the State Agency. The facility policy titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program revised April 2021 documents staff are to identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property. Staff are to investigate and report any allegations within timeframes required by federal requirements.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide timely and complete incontinence care for three residents (R9, R10, R13) out of six residents reviewed for Activities of Daily Living (ADL) in a sample list of 17 residents. Findings include: 1. R9's Minimum Data Set (MDS) dated [DATE] documents R9 as moderately cognitively impaired. This same MDS documents R9 is dependent on staff for assistance with oral hygiene, toileting, bathing, dressing and personal hygiene. R9's Care Plan intervention dated 10/27/25 instructs staff to check (R9) for incontinence and to wash, rinse and dry perineum. On 11/24/25 at 9:48 AM V19 Certified Nurse Aide (CNA) stated R9 was assisted up out of bed at 6:50 AM, brought to the nurses station until breakfast, then assisted to and from the dining room and sat in the resident lounge. V19 CNA stated residents are 'normally' provided incontinence care when they arise, before lunch and then again at the change of shifts at 2:00 PM. V19 CNA stated R9 will be provided incontinence care just before lunch. V19 CNA stated R9 is not cognitively intact and relies on staff for all cares. V19 CNA stated R9 is very compliant with cares and does not refuse cares. On 11/24/25 at 11:30 AM V19 and V23 Certified Nurse Aides (CNA) completed incontinence care for R9. V19 CNA did not provide complete incontinence care due to V19 CNA did not open R9's legs to be able to visualize R9's front perineal area. R9 was incontinent of bladder and bowel. R9's buttocks had multiple dark red lines from sitting on a total body mechanical lift sling. V19 CNA stated R9 had not been offered/assisted with incontinence care since she was gotten up at 6:50 AM. V19 CNA stated the heavy wetters are changed every two hours but since R9 is considered a light wetter she does not get incontinence care as often. V19 CNA stated she did not expect R9 to be incontinent of such a large amount of urine and soiled with stool. 2. R10's Minimum Data Set (MDS) dated [DATE] documents R10 as severely cognitively impaired. This same MDS documents R10 is dependent of staff for oral hygiene, toileting, dressing, personal hygiene, transfers and requires maximum assistance from staff for bathing and bed mobility. On 11/24/25 at 11:20 AM V24 and V25 Certified Nurse Aides (CNA) provided perineal care for R10. R10's buttocks had multiple dark red lines from the total body mechanical lift sling he had been sitting on. V25 CNA confirmed R10 had not been provided care since he got up before breakfast. V24 CNA stated, We (staff) know our residents. Residents should be changed (provided incontinence care) at least every two hours. We know our residents. (R10) doesn't like to be laid down until after lunch so there is no use in even asking him to get changed. We know what he wants. V24 CNA stated R10 is a light wetter and does not usually get incontinence care until after lunch. On 11/24/25 at 2:30 PM R10 stated he wants to be clean if he has an accident. R10 stated he does not want to sit for hours on end because it makes his back hurt. R10 stated he does not like to lay down all day but would like to be kept clean. 3. R13's Minimum Data Set (MDS) dated [DATE] documents R13 as severely cognitively impaired. This same MDS documents R13 is dependent on staff for toileting and personal hygiene and requires maximum assistance from staff with bathing, dressing and transfers. R13's Care Plan intervention dated 9/3/25 documents R13 requires total dependence of one staff member for toileting. On 11/24/25 continual observations were made from 7:45 AM to 11:15 AM. During this timeframe R9, R10, R13 were observed sitting in the dining room at 7:45 AM. R9, R10 and R13 were escorted out of the dining room from 8:35 AM-8:50 AM to the resident lounge area to watch television. R9, R10 and R13 all sat in the resident lounge area until 11:20 AM. R9, R10 and R13 were not offered drinks, toileting or had any assistance from any staff. Multiple staff were walking around the resident lounge area assisting other residents or standing at the nurses station talking amongst themselves. On 11/24/25 at 10:45 AM V10 Licensed Practical Nurse (LPN) was standing at the nurses station facing the resident lounge where R9, R10 and R13 were sitting. V10 LPN stated R9, R10 and R13 are all cognitively impaired, not able to determine or let staff know if they need to use the restroom and all are incontinent of bladder and (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bowel. On 11/25/25 at 2:40 PM V3 Director of Nurses (DON) stated all dependent residents should be provided incontinence care at least every two hours. V3 stated these same residents should be repositioned and well groomed. V3 stated staff should not assume they know the bladder and bowels habits of any resident as that can change day to day. V3 DON stated allowing residents to sit in the same position in a soiled incontinence brief could cause pressure ulcers and Urinary Tract Infections (UTI) among other clinical issues in addition to a negative psychosocial impact. D3 DON confirmed R9, R10 and R13 were all sitting in the resident lounge for four hours without any attention from staff. V3 DON stated she is not certain if there is a direct policy for this, but the expectation is to provide the standard of care which is to provide incontinence care at least every two hours.		

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on observation, interview and record review the facility failed to employ a Certified Dietary Manager (CDM). This failure has the potential to affect all 71 residents residing in the facility. Findings include: The Daily Midnight Census dated 11/23/25 documents 71 residents reside in the facility. The facility was unable to provide any documentation of employment of a CDM and/or Dietary Manager. Throughout the survey timeframe on 11/23/25-11/25/25 at various times on first and second shifts there was no CDM or Dietary Manager in the facility. On 11/23/25 at 9:00 AM, V9 [NAME] was providing verbal guidance to dietary staff. V9 [NAME] stated the facility does not have a CDM or Dietary Manager. On 11/24/25 at 12:15 PM V1 Administrator was serving resident meals from the kitchen. V1 Administrator stated she was helping due to a CDM was not onsite. On 11/25/25 at 3:25 PM V6 Regional Certified Dietary Manager (CDM) stated she splits her time in facilities with this facility and one other facility. V6 stated she had not been onsite at this facility for at least ten days. V6 stated prior to that time, she would have been onsite once a week on average. V6 stated she is not the interim Dietary Manager. V6 stated the facility has not had a Dietary Manager for six months or so.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review the facility failed to maintain kitchen sanitation, failed to obtain temperatures of cold stored foods and foods prepared for meal service. These failures have the potential to affect all 71 residents. Findings include: The facility Daily Midnight Census dated 11/23/25 documents 71 residents reside in the facility. The facility was unable to provide any temperature logs for meal service. The facility temperature logs dated, November 2025, document temperatures obtained on 11/8 and 11/10-14/25 for the facility walk in cooler, reach in vegetable freezer, third door reach in cooler and the reach in meat freezer. There were no other temperatures documented on the logs. On 11/23/25 at 12:15 PM V9 [NAME] did not obtain temperatures of country fried steak, mashed potatoes/gravy, mixed vegetables, spaghetti or green beans prior to meal service on 11/23/25. On 11/23/25 at 12:20 PM The facility reach in cooler, reach in vegetable freezer and reach in meat freezer had an unknown pink sticky liquid spilled on the bottom shelf along with dozens of pieces of food debris. On 11/24/25 at 12:35 PM V1 Administrator obtained food temperatures on a test tray of sliced pork, mashed potatoes and gravy, green beans and cornbread. The temperature of the sliced pork was 108 degrees Fahrenheit (F), mashed potatoes with gravy was 120 degrees F and the green beans were 86 degrees F. On 11/23/25 at 12:30 PM V9 [NAME] stated the kitchen is a mess because there are not enough staff. V9 [NAME] stated the staff that work in the kitchen do their best but can't keep up. V9 [NAME] stated the temperature logs posted on the coolers and freezers are not completed as they should be. V9 [NAME] stated the hot food service temperature logs have not been completed since she started a year ago. V9 [NAME] stated she is the main cook for all three meals served five to six days per week for the past year and has never checked food temperatures for food service. On 11/24/25 at 12:45 PM V1 Administrator confirmed the test tray of foods were not warm enough to be palatable. V1 Administrator stated she has her food handler's certificate and knows what the temperatures should be and these are not up to temp. On 11/25/25 at 3:25 PM V6 Regional Certified Dietary Manager (CDM) stated the facility should be checking the temperatures of all the coolers, freezers, dishwashing cycles and food service temperatures. V6 CDM stated not checking those temperatures could cause a food borne illness.		