STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145370	A. Building B. Wing	04/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sullivan Healthcare & Senior Living	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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to initiate and update fall care plans, failed to implement fall interventions, failed to thoroughly investigate falls for two (R3 and R7) residents out of four residents reviewed for Accidents in a sample list of eight residents.Findings include:1.R7's Minimum Data Set (MDS) dated [DATE] documents R7 as moderately cognitively impaired. This same MDS documents R7 requires supervision with transfers and toileting.R7's Care plan intervention dated 1/23/26 instructs staff to place a ?Call Don't Fall' sign in R7's room for visual reminder to allow staff to assist with Activities of Daily Living (ADL) to reduce the risk of falling. This same care plan documents an intervention dated 4/9/26 to place R7's urinal next to his chair. R7's Fall Risk Evaluation dated 2/12/26 documents R7 as a high fall risk.R7's Physician Order Sheet (POS) dated April 2026 documents a physician order for Aspirin 81 milligrams (mg) daily. R7's AIM for Wellness report dated 4/5/26 documents R7 had an unwitnessed fall on 4/5/26 after he had been in his recliner then stood up and fell backwards hitting his head. This same report documents R7 obtained a laceration to his posterior cranium due to this fall.R7's Fall Investigation dated 4/5/26 did not document when the last time staff offered toileting to R7 and what footwear R7 was wearing as he was trying to stand. R7's Hospital Record dated 4/5/26 documents R7's diagnoses as Fall, Closed head injury, Scalp Laceration. This same record documents R7 received four staples to his posterior skull due to a fall at the facility. On 4/15/26 at 11:10 AM V10 Advanced Practice Nurse (APN) removed four staples from R7's posterior scalp. Two urinals with R7's name on them were placed on a portable table out of reach of R7. R7's room did not have a ?Call Don't Fall' sign posted. R7's call light was attached to R5's (roommate) call light, out of reach of R7. On 4/15/27 at 11:30 AM R7 stated he could not reach his urinals the day he fell (4/5/26). R7 stated he had no way to call for help because he could not reach his call light. R7 attempted to stand to reach his urinal but could not unless he leaned forward approximately two feet. R7 stated, This is dangerous. I don't want to fall again.2.R3's Electronic Medical Record (EMR) documents R3 was admitted to the facility on [DATE] with medical diagnoses as Bacteremia, Metabolic Encephalopathy, Influenza, Malaise, Severe Dementia, Transient Ischemic Attack (TIA) and Cerebral Infarction. R3's Fall Risk Evaluation dated 2/25/26 documents R3 as a high fall risk.R3's Minimum Data Set (MDS) dated [DATE] documents R3 as severely cognitively impaired. This same MDS documents R3 requires maximum assistance with transfers.R3's Care Plan initiated 2/27/26 does not include a focus area, goal nor intervention for falls from admission on [DATE]-[DATE]. R3's Physician Order Sheet (POS) dated February 2026 documents a physician order starting 2/24/26 for Plavix 75 milligrams (mg) daily for stroke prevention.R3's AIM for Wellness report dated 2/26/26 documents R3 had an unwitnessed fall in his room after attempting to self-transfer from his wheelchair to his bed. R3 obtained a nasal fracture, and skin tears due to this fall. R3's Fall Investigation dated 2/26/26 did not document when the last time staff offered assistance to lay down to R3 and what footwear R3 was wearing as he was trying to stand. R3's Nurse Progress Note dated 2/26/26 at 2:37 PM documents R3 was self-transferring when he had a change of plane. This same note documents R3 was found on the floor and noted to have bruising on (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	his posterior head then sent to the emergency room.On 4/14/26 at 10:45 AM V7 Licensed Practical Nurse (LPN) stated R3 was found on his floor of his room by his bed after attempting to self-transfer from his wheelchair to his bed. V7 LPN stated R3's pull alarm was sounding. V7 LPN stated she had seen R3 approximately 1:45 PM-2:00 PM sitting in the sunroom. V7 LPN stated R3 ?must have' self-propelled into his room to lay himself down. V7 LPN stated R3 has Dementia and needs close supervision due to his poor cognition and lack of safety awareness. V7 LPN stated R3 had a cut to the bridge of his nose, bruising to the back of his head and a scrape on his Right Elbow. V7 LPN stated she sent R3 to the emergency room where he was diagnosed with a nasal fracture. On 4/15/26 at 11:35 AM V10 Advanced Practice Nurse (APN) stated R7 should have his urinals within reach to help prevent him from falling. V10 APN confirmed R7 could not reach his call light and there was not a precautionary sign posted in R7's room. V10 APN handed R7 his call light and R7 stated ?Oh thank you. I was looking for that'. V10 stated the facility is supposed to have a fall care plan in place for the staff to follow. V10 APN stated the staff will not know what to do for each individual resident if the care plan is not initiated/updated. V10 APN stated R3 and R7's falls may have been preventable but does not believe the facility caused the injuries. V10 APN stated the facility should train their staff on fall preventions/interventions/etc.On 4/15/26 at 2:35 PM V2 Director of Nurses (DON) stated all residents should have an at risk fall care plan in place from their admission. V2 DON stated residents who have had an actual fall should also have their fall care plan updated with an appropriate intervention for the fall the same day as the fall. V2 DON stated R3's fall could have been prevented if a fall care plan were initiated when R3 was admitted to the facility. V2 DON stated R7 should have had his urinal placed within his reach. V2 DON stated the staff were aware that R7 would use his urinal and should have known the urinal should have been in arms reach. V2 DON stated R7's fall could have been prevented. V2 DON stated the staff did not intentionally harm any resident but ?these two residents (R3, R7) injuries could have been prevented'. The facility policy titled Managing Falls and Fall Risk revised March 2018 documents staff will identify and implement relevant interventions.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to repeatedly prevent a significant medication error for one (R2) resident out of three residents reviewed for significant medication errors in a sample list of eight residents.Findings include:R2's Electronic Medical Record (EMR) documents medical diagnoses as Paroxysmal Atrial Fibrillation, Rapid Ventricular Rate (RVR) and Hypertension. R2's Minimum Data Set (MDS) dated [DATE] documents R2 as moderately cognitively impaired. R2's Provider progress note dated 2/23/26 documents a physician order to administer Warfarin Sodium (anticoagulant) 4 milligrams (mg) daily starting 2/18/26 with no end date for stroke prevention.R2's Physician Order Sheet (POS) dated February 2026 documents R2's Warfarin Sodium 4 mg was discontinued on 2/21/26. R2's Medication Administration Record (MAR) dated February 2026 does not document R2's Warfarin Sodium as being administered on 2/22/26-2/28/26.R2's Physician Order Sheet (POS) dated March 2026 documents R2's Warfarin Sodium was not documented as a Physician Order from 3/1-3/2/26.R2's Medication Administration Record (MAR) dated March 2026 does not document R2's Warfarin Sodium as being administered on 3/1/26 and 3/2/26. R2's Medication Error Report dated 4/15/26 documents R2 was readmitted to the facility on [DATE] and Warfarin was not transcribed into orders. (R2) missed doses until 3/2/26. On 4/15/26 at 10:00 AM V3 Regional Clinical Nurse (RCN) stated R2 admitted to the facility with physician orders for Warfarin (anticoagulant). V3 RCN stated R2 was sent to the hospital on 2/21/26 so the order was discontinued. V3 RCN stated R2 returned to the facility on 2/22/26 with orders from the hospital to continue Warfarin Sodium 4 milligrams (mg) daily. V3 RCN stated the readmission order for R2's Warfarin Sodium did not get transcribed nor double checked by the Interdisciplinary Team (IDT) or any other nurse. V3 RCN confirmed R2 was not administered her Warfarin Sodium from 2/22/26-3/2/26. V3 RCN stated R2's International Normalized Ratio (INR) was subtherapeutic prior to the significant medication error ?so it was a big error but did not harm (R2)'. The facility policy titled Adverse Consequences and Medication Errors revised February 2023 documents a medication error is defined as the preparation or administration of drugs and/or biologicals which are not in accordance with physician orders, manufacturers specifications or accepted professional standards and principles of the profession providing services. An example of a medication error includes a drug that is ordered but not administered.