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	08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sullivan Healthcare & Senior Living	11 Hawthorne Lane Sullivan, IL 61951

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 interview the facility failed to ensure the dignity of one (R7) resident out of three residents reviewed for dignity in a sample list of 35. R7's Minimum Data Set (MDS) dated [DATE] documents R7 as severely cognitively impaired. This same MDS documents R7 is dependent on staff for transferring, toileting, bathing, dressing, bed mobility, eating and personal hygiene. 08/13/2025 8:00 AM R7 was reclined in her wheelchair in the resident lounge with other residents and staff present. R7 had a thick line of white mucous hanging from her Right lower cheek to the Right corner of her mouth. On 8/14/25 at 9:00 AM R7 was laying in her recliner in the resident lounge with other residents present. R7 had dried, thick white mucous on her lips and corners of her mouth. On 8/15/25 at 3:00 PM V2 Director of Nurses (DON) stated the staff should provide oral care for all residents who need assistance at least daily and as needed. V2 DON stated R7 requires total assistance from staff.

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure a homelike environment for two (R7, R25) residents out of two residents reviewed for homelike environment in a sample list of 35 residents. 1). R25's Minimum Data Set (MDS) dated [DATE] documents R25 as cognitively intact. On 8/12/25 at 1:00 PM R25 was laying on her bed directly on the fitted sheet. R25's fitted sheet had several brown colored stains and was worn through so that the mattress could be seen. On 8/14/25 at 10:40 AM R25 was laying on her bed directly on her fitted sheet. R25's sheet was worn with three brown stains that were several inches in diameter. On 8/12/25 at 1:05 PM R25 stated the staff bring her clean sheets that are stained. R25 stated she would prefer to have sheets without 'someone else's stains' on them. On 8/14/25 at 11:30 AM V13 Certified Nurse Aide (CNA) stated most of the resident bed linens are stained and/or worn to the point you can almost see through them. V13 CNA stated she has had residents complain about them and has alerted management that the residents need new linens. 2.) R7's Minimum Data Set (MDS) dated [DATE] documents R7 as severely cognitively impaired. This same MDS documents R7 is dependent on staff for transferring, toileting, bathing, dressing, bed mobility, eating and personal hygiene. On 8/12/25 at 1:10 PM R7 was lying flat on her back with her bare legs showing. R7's legs were laying directly on a fitted sheet with several brown/grey stains. R7's fitted sheet was very worn with strings showing through and the mattress could be seen through sheet. On 8/13/25 at 1:25 PM R7 was lying flat on her back with her bare legs showing. R7's legs were laying directly on a fitted sheet with several brown/grey stains. R7's fitted sheet was very worn with strings showing through and the mattress could be seen through sheet. On 8/14/25 at 10:45 AM was lying flat on her back with her bare legs showing. R7's legs were laying directly on a fitted sheet with several brown/grey stains. R7's fitted sheet was very worn with strings showing through and the mattress could be seen through sheet. On 8/15/25 at 10:15 AM V21 Laundry Supervisor stated the facility does have linens with tears, stains and that are worn. V21 stated she tries to dispose of linens that are not adequate as they come through the laundry process. V21 stated she was off duty for the past week and there may be some linens being used by residents that do have stains and that look worn. V21 stated she will educate her laundry staff to pull the worn and stained linens. The undated facility pamphlet titled Resident's Rights for people in Long-Term Care Facilities documents the facility must provide services to keep the resident's physical and mental health and sense of satisfaction.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview and record review the facility failed to initiate a grievance report in a timely manner, resulting in a delay in resolving the resident grievance. This failure affects one of two residents (R37) reviewed for grievances on the sample list of 35.Findings include:On 08/08/2025 at 10:40 AM V5, Ombudsman stated she had concerns about R37's missing jacket. V5 said V5 spoke with V1 Administrator on 6/17/25 but did not know if the jacket had been found or replaced. On 8/12/25 at 1:30 pm V1, Administrator stated she did not have any grievances about R37's missing jacket. On 8/12/25 at 3:00 pm V1 stated V1 found a grievance regarding R37's jacket, that V1 had forgotten about. V1, Administrator stated she called the V6, Facility Owner and got permission to order two jacket tops for R37. V1 then provided a grievance dated 8/6/25 (50 days after V5 notified V1) and the order summary sheet defining that two jackets were ordered dated 8/12/25 (today). V1 again stated she had no grievance in June regarding R37's jacket that she could recall. On 8/13/25 at 10:45 am V5, Ombudsman pulled up her computer and reviewed V5's information after stating it was sometime in June. V5, confirmed a concern had been given to her from R37 regarding a missing purple jacket. V5 stated the grievance was given to her in person, by R37 on June 17, 2025. V5 stated V5 notified V1, Administrator the same day, (6/17/25) at 1:30 pm. I (V5) had called the facility repeatedly to follow-up with (V1) Administrator. She was never in the facility when I called. (V1) told me this morning that she tried to get ahold of me but was not able to leave a message. I have never had any problem with receiving messages on my phone. I gave her a new business card today. V5 stated V5 came into the facility today, and V1 Administrator told V5 that V1, Administrator has ordered new jackets for R37. On 8/13/25 at 11:25 am R37 became anxious and began to talk fast. R37 stated she was missing two winter coats soon after she admitted (5/29/25) to the facility. R37 stated she does not know exactly when they were missing because it was already summer weather when she noticed them gone. R37 stated she told everybody that would listen and does not believe her family took them out of the facility, but they may have. R37 stated the coats were not easily labeled due to the type of material. R37 stated, The jackets she reported missing were missing at least three or four weeks ago (6/17/25). I have been waiting for someone to do something to find it. I did tell the lady from an agency for the elderly. The ladies that work here said they looked in the laundry and couldn't find it. It was not until yesterday (8/12/25 while survey was in progress, (V1, Administrator)) came in and said they ordered me two new jackets. I won't believe it until I see them. I won't hold my breath. On 8/15/25 at 9:15 am V20, Social Service Director (SSD) stated V1 Administrator never reported R37's grievance to V20 until this week during survey.V19, Corporate Nurse provided the previous corporation policy, via email on 8/13/25 at 11:30 am. V19 stated the new facility owner is using many of the same policies as the previous company that owned the facility. The provided policy Resident Grievances/Complaint dated as revised April 2025 documents the following: Policy: It is the policy of (Previous Corporation Name) to actively encourage residents and their representatives to voice grievances and complaints on behalf of themselves or others without discrimination or reprisal. Grievances and/or complaints may be reported to the Administrator, any staff member, Resident Council and to State Agencies. All staff is required to report any and all grievances and complaints received from residents to the Social Service Director (SSD), who will serve as the grievance official. The grievance official will bring all grievances/complaints to the daily Quality Assurance meeting. The IDT will determine the best resolution. The Administrator is then responsible to ensure that resolution is carried out and the issue is resolved.The same policy documents: 7. The grievance official shall then investigate and take their findings to the morning Quality Assurance meeting on the next business day. The administrator will ensure the timely resolution.8. Grievance and complaint investigations shall be completed within 5 working days by the SSD who shall distribute copies of the report to the Administrator. The SSD shall keep complete forms on file.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to accurately encode a resident's health status on the Resident Assessment Instrument (Minimum Data Set) regarding falls. This failure affects one of two residents (R3) reviewed for falls/resident assessments on the sample of 30.Findings include:R3's Quarterly-Minimum Data Set (MDS) dated [DATE] documents R3 had a Brief Interview of Mental Status score of 10 out of a possible 15, indicating moderate cognitive impairment. R3's same MDS inaccurately documents R3 had no falls in the facility since the last quarterly MDS assessment.R3's A.I.M. (Assessment/Evaluation Intercommunicate Management/Intervention) for Wellness- Event Record dated 3/5/25 at 5:25 pm, documents the following: Note Text: Event Details: (R3) appears to have experienced an alleged Intentional Change in Plane; Witnessed w/o (without) head involvement. Event was first noted on 03/05/2025 5:00 PM. Evaluation of the resident and event occurred on or about 03/05/2025 at 5:00 PM. Just prior to/at the time of the event (R3) appears to have been sitting at dining room table. (R3's) account of the event is 'I just slide out (of the wheelchair) now get me up. The same event record documents R3's fall was witnessed by other residents, who confirmed R3 slid out of the wheelchair. R3 sustained a skin tear to his left elbow and non-skid material was placed in his wheelchair seat as the intervention.The facility fall log dated March 2025, documents R3 had a fall in the dining room on 3/5/25 at 5:00 pm.On 8/12/25 at 12:47 pm R3 was seated in his wheelchair next to the bed in his room. R3 stated he has had falls from his wheelchair a couple times but could not remember details.08/14/25 at 1:40 pm V2, Director of Nursing reviewed R3's electronic medical record and confirmed R3's most recent MDS dated [DATE] does not reflect R3's current resident status at the time of that assessment. V2, stated (R3) had a fall 3/5/25 as evidenced by the AIMS note (above), therefore that MDS is not encoded correctly. This was before my time. I did not start working for the facility until 5/27/25.On 8/14/25 at 1:50 pm V1, Administrator stated I am doing MDS right now. That fall documented on (R3's) 3/5/25 AIMS report may have been missed. I don't have experience doing the MDS, (V10, Licensed Practical Nurse/Previous MDS Coordinator) stopped doing them (MDS assessments). I took over.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide bathing and timely incontinence cares for a resident dependent on staff for hygiene. This failure affects one resident (R21) of two reviewed for Activities of Daily Living on the sample list of 35.Findings include: Resident Council meeting minutes (January 2025, February 2025, April 2025, May 2025, June 2025) document resident concerns with facility staff not answering resident call lights in a timely manner. The February 2025 minutes also document resident concerns with receiving showers in the facility.R21's Profile page (8/15/2025) documents R21 admitted to the facility on [DATE].R21's Medical Diagnosis page (8/13/2025) documents R21's diagnoses include Muscle Weakness, Parkinsonism (syndrome causing slowness of movement, muscle stiffness, tremor, and problems with balance and coordination), Left Femur Fracture, Severe Obesity, Chronic Obstructive Pulmonary Disease, Depression, and Anxiety Disorder.R21's Resident Assessment (7/6/2025) documents R21 does not have cognitive impairment, hallucinations, or delusions. The same record documents R21 has impaired upper and lower extremity range of motion, is always incontinent of bowel and bladder, utilizes a wheelchair, is dependent on staff for all mobility and transfers, and requires substantial/maximal staff assistance for both bathing and toileting hygiene. R21's admission Nursing Evaluation (7/3/2025) documents R21 has bladder incontinence at least once or more per shift.R21's Care Plan (8/13/2025) documents R21 is totally dependent on two staff to provide bathing as scheduled and as necessary. On 8/14/2025 at 10:14AM, V10 (Licensed Practical Nurse) reported R21 does not have a history of making false allegations related to care in the facility and R21's responses to interview questions are reliable. V10 reports R21 does have episodic bowel and bladder incontinence. V10 reports R21 will use R21's call light to request assistance with incontinence care. On 8/13/2025 at 10:50AM, R21 reported being incontinent and requiring staff assistance for incontinence care. R21 reported waiting a couple of hours several times after activating R21's call light to receive assistance from staff to change a wet or soiled brief. R21 reported facility staff tell R21 the staff are busy taking care of other residents and that is why they could not provide assistance to R21 sooner. R21 reported feeling irritated when staff do not provide a timely response to R21's call light. R21 also reported only receiving three showers since admission to the facility 55 days ago. R21 reported staff have told R21 that R21 is supposed to be receiving two showers per week. R21 stated R21 would be happy at this point to even receive one shower per week and this is ridiculous.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to identify, assess and provide treatment for pressure sores for one of one resident (R7) reviewed for pressure sores in a sample list of 35 residents. R7's Minimum Data Set (MDS) dated [DATE] documents R7 as severely cognitively impaired. This same MDS documents R7 is dependent on staff for transferring, toileting, bathing, dressing, bed mobility, eating and personal hygiene. R7's Care plan intervention dated 3/28/23 instructs staff to float R7's heels in bed as needed, use pillows /cushions between to prevent skin to skin contact legs/ankles and feet, avoid pressure off feet against footboard, and avoid pressure of toes against mattress, rails, or footboard. R7's Physician Order Set (POS) dated August 2025 documents a physician order starting 11/01/2022 to complete a daily skin check. This same POS documents a physician order starting 8/14/25 to monitor the red area on the back of R7's Left Leg and Right Inner Leg. There are no previous orders for R7's bilateral lower posterior calf Pressure Ulcers prior to 8/14/25.R7's Pressure Ulcer Risk assessment dated [DATE] documents R7 as a high risk for pressure ulcers.R7's Treatment Administration Record (TAR) dated August 2025 documents a physician order starting 8/14/25 to monitor the red area on the back of R7's Left Leg and Right Inner Leg. There are no previous orders for R7's bilateral lower posterior calf Pressure Ulcers prior to 8/14/25.R7's Skin Only Evaluation dated 8/14/25 documents R7's Right Inner Leg Stage II Pressure Ulcer as measuring 2.0 centimeter (cm) long by 3.0 cm wide with undetermined depth. This same Evaluation documents R7's Left Posterior Leg Stage I Pressure Ulcer as measuring 3.0 cm long by 1.0 cm wide with undetermined depth. R7's Nurse Progress Notes dated 8/14/25 at 2:28 PM document R7's Right lower inner leg wound as a Stage II Pressure Ulcer and Left Lower posterior Leg wound as a Stage I Pressure Ulcer. On 8/12/25 at 1:10 PM R7 was lying flat on her back with her bare legs showing. R7's legs were laying directly on a fitted sheet. There were no heel protectors, pillows or cushions within reach of R7. 08/12/2025 2:54 PM R7 was lying in bed on her back with both heels directly touching the mattress. There were no heel protectors, pillows or cushions within reach of R7. On 8/13/25 at 1:25 PM R7 was lying flat on her back with her bare legs showing. R7's legs were laying directly on a fitted sheet. There were no heel protectors, pillows or cushions within reach of R7. On 8/14/25 at 10:45 AM R7 was lying flat on her back with her bare legs showing. R7's legs were laying directly on a fitted sheet. R7's legs were laying directly on a fitted sheet. There were no heel protectors, pillows or cushions within reach of R7. On 8/14/25 at 2:20 PM V1 Administrator assessed R7's bilateral lower calf pressure areas. V1 confirmed R7 has Pressure Ulcers on her bilateral lower calves. 08/12/2025 at 2:56 PM V4 Licensed Practical Nurse (LPN) stated R7 does not have any physician orders to protect her skin, use heel protectors and/or use preventative skin measures. On 8/14/25 at 1:50 PM V1 Administrator stated any skin alteration should be assessed at least weekly, a skin evaluation should be completed and notifications made per the facility policy. V1 Administrator stated she was made aware of R7's reddened areas on the back of her lower calves today (8/14/25) after talking to V8 Assistant Director of Nurses (ADON)/Wound Nurse who reported to V1 that R7's bilateral posterior leg Pressure Ulcers were observed on 8/7/25 but there was no assessment, or any type of documentation completed. V1 Administrator stated the facility was aware of R7's Pressure Ulcers but ‘nothing was done about them and should have been.' The facility policy dated 2001 titled Prevention of Pressure Injuries documents staff are to inspect the skin on a daily basis when performing or assisting with personal care or Activities of Daily Living (ADL)'s. The staff are to position residents as indicated on the care plan.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review the facility failed to provide the services of a Registered Nurse (RN) eight consecutive hours a day, seven days a week. This failure has the potential to affect all 70 residents in the facility. Findings include:On 8/14/25 at 4:40 pm, V1 Administrator/Registered Nurse (RN) provided RN staff timecards. V1 stated she had given survey team the wrong nursing schedule, initially. V1 confirmed the wrong schedule reflected V23, Registered Nurse worked Saturday August 2, 2025, and Sunday August 3, 2025, was an error. V1 stated (V23, RN) had not worked due to illness. V1 stated the updated working schedule she now provided is accurate. V1 stated V8, Registered Nurse/Assistant Director of Nursing worked Saturday 8/2/25 from 2:00 am to 6:00 am, leaving the facility short four hours of RN coverage that day. V1 provided her own timecard which included hours worked on 8/2/25. V1 thought she may have worked the floor to cover the four RN hours short. V1, Administrator/RN stated she has regional responsibilities in other facilities and had been training V3, Administrator in Training. V1 verified she had no documentation in any resident's medical record to confirm V1 worked the floor as a nurse on 8/2/25.The updated facility Nursing Schedule provided by V1 as noted above, dated August 2025 documents the only Registered Nurse that was scheduled to work 8/2/25 was V8, Registered Nurse/ Assistant Director of Nursing. V8 was on the schedule to work from 2:00 am until 6:00 am (four hours). There was no corresponding timecard to confirm V8, RN worked those four hours. The same updated Nursing schedule documented V23 RN was scheduled but circled off to indicate she did not work on 8/2/25 or 8/3/25. On 8/15/25 at 9:15 am, V2 Director of Nursing confirmed there was no Registered Nurses working on 8/2/25 other than V8/ADON. V2 DON stated she has had a difficult time hiring nurses in the facility because the facility does not offer a competitive wage. V2 stated she has hired approximately eleven CNA's and has used agency staff to make sure she has direct care staff. V2 stated she had to worked one night shift herself and V1, RN/Administrator has worked approximately five shifts as floor nurse since V2, DON started May 27, 2025. V2, DON stated she cannot confirm V1 worked 8/2/25. V1 believes V8, ADON covered the four hours what she could and worked a second job at the hospital that day.The facility's Long Term Care Facility Application for Medicare and Medicaid (CMS-671) dated 08/13/25 documents 70 residents currently reside in the facility.

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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 clinically qualified Director of Food and Nutrition Services. This failure has the potential to affect all 70 residents in the facility. Findings include:On 8/12/2025 at 10:06AM, V16 (Cook) was actively supervising dietary operations in the facility kitchen. V16 reported the facility dietary service does not currently have a full-time designated manager. V16 reported not being a clinically qualified Certified Dietary Manager (also known as Certified Food Protection Professional) or having equivalent training. V16 denied meeting the State of Illinois standards to be a food service manager or dietary manager (required in states that have their own established standards to be a food service manager or dietary manager (483.60(a) (2)ii). V16 reported only completing a one-day course on food service sanitation which did not include any instruction on clinical nutrition. V16 denied:-being a dietician;-being a certified dietary manager;-having an associate's or higher degree in food service management or in hospitality;-being a graduate of a dietetic and nutrition school or program authorized by the Accreditation Council for Education in Nutrition and Dietetics, the Academy of Nutrition and Dietetics, or the American Board of Nutrition; -being a graduate, prior to July 1, 1990, of a Department (Illinois Department of Public Health) approved course that provided 90 or more hours of classroom instruction in food service supervision and having experience as a supervisor in a health care institution which included consultation from a dietician; -or having completed an Association of Nutrition & Foodservice Professionals approved Certified Dietary Manager or Certified Food Protection Professional course. On 8/14/2025 at 12:31PM, V15 (Cook) reported the facility dietician works in the facility one day per month and the food prepared in the facility kitchen is available for all residents to eat.Throughout the duration of the survey from 8/12/2025-8/14/2025 on first and second shifts, the facility failed to prevent the potential for physical cross-contamination of food by failing to utilize an approved food scoop in bulk food (flour), failed to maintain a can opener free of accumulated metal shavings, and failed to maintain sanitary floor surfaces in the facility walk-in-cooler. The facility Long-Term Care Facility Application for Medicare and Medicaid (8/13/2025) documents 70 residents reside in the facility.

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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 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 prevent the potential for physical cross-contamination of food and failed to maintain sanitary walk-in cooler floor surfaces. These failures have the potential to affect all 70 residents in the facility. Findings include: 1. On 8/12/2025 at 10:15AM, the kitchen walk-in cooler floor was soiled with food debris including a decomposed tomato, onion skins, and spilled beverages. On 8/14/2025 at 12:25PM, the cooler floor surfaces remained as above. 2. On 8/12/2025 at 10:25AM, the kitchen table-mounted can opener and receiver were soiled with dark and sticky food accumulations and metal shavings. On 8/14/2025 at 12:31PM, the above can opener remained soiled. V15 (Cook) was present and reported kitchen staff are supposed to clean the opener each time the opener is used. 3. On 8/12/2025 at 10:20AM, a bulk food storage container containing flour was located in the kitchen food pantry and contained a disposable foam cup being used as a food scoop. All portions of the foam cup were in direct contact with the flour. On 8/14/2025 at 12:31PM, V15 (Cook) reported the food prepared in the facility kitchen is available for all residents to eat.The facility Long-Term Care Facility Application for Medicare and Medicaid (8/13/2025) documents 70 residents reside in the facility.

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	08/15/2025

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 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on interview and record review the facility failed to ensure the Director of Nursing, (required personnel) attended the quarterly Quality Assessment and Assurance (QAA) committee meetings. This failure has the potential to affect all 70 residents residing in the facility. Findings Include:The facility QAPI (Quality Assurance and Performance Improvement) Plan for (the facility name) dated 5/19/24 documents, At minimum the Regional Team and Facility Management team, along with the QAPI Steering Committee, will conduct a facility-wide system evaluation utilizing QAPI Self-Assessment. The facility provided accompanying document states the QAA meeting is conducted every three months and includes Key Personnel. A second document was provided with a list of Key Personnel. This list included V2, Director of Nursing.The facility QA Meeting typed sign-in sheet documents key personnel. At the top of the sheet is a handwritten date of July 15, 2025. The sheet documents V2, Director of Nursing's (DON) signature.On 08/14/25 at 2:45 pm V2, DON reviewed the Quality Assurance Meeting signature page provided by V1, Administrator. V2 confirmed that it is her signature on the QA meeting sign in sheet. V2 stated she was given the sheet to sign, to indicate she was part of the QA meeting team. V2 stated the date 7/15/25, and April, May, June to indicate the quarter reviewed, were handwritten at the top of the page. V2 stated the handwritten information was not documented on the sheet V2 signed. V2 stated, I was not even here 7/15/25. I was on vacation in Hawaii. There has not been an official QA meeting since I started 5/27/25 as I mentioned before, morning daily meetings is all we do.On 8/14/25 at 2:55 pm V1, Administrator confirmed V2, DON was on vacation 7/15/25 and could not have attended that QA meeting. The facility's Long Term Care Facility Application for Medicare and Medicaid (CMS-671) dated 08/13/25 documents 70 residents currently reside in the facility.