

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146039	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/12/2025
NAME OF PROVIDER OR SUPPLIER Eastview Healthcare & Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Eastview Place 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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the right to be free from physical abuse for two (R1, R2) of three residents reviewed for physical abuse from a total sample list of three residents reviewed for abuse.</p> <p>Findings include:</p> <p>The facility provided, Abuse Policy dated 2001 documents that abuse of any kind against residents is strictly prohibited. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Physical abuse includes, but is not limited to hitting, slapping, biting, punching or kicking.</p> <p>1.) R1's undated diagnosis sheet documents the following diagnosis sheet includes: Unspecified Dementia with Agitation and Behavioral Disturbance, Anxiety, Alzheimer's Disease, Alcohol Abuse, Psychotic Disturbance, and Mood Disturbance.</p> <p>R1's Minimum Data Set, dated [DATE] documents that R1 is severely cognitively impaired.</p> <p>R1's care plan dated 11/8/24 documents impaired cognitive function and thought processes due to Dementia.</p> <p>R1's 4/22/25 progress note documents an altercation between R1 and another resident (R2) documents that R1 had hold of R2's collar and was punching him in th eback of the head while yelling, He was *expletive* with me.</p> <p>On 5/12/25 at 9:20AM, V3 Licensed Practical Nurse stated that she had gone to the kitchen to obtain juice for another resident and As I walked into the kitchen I saw (R1) holding the back of (R2's) shirt while hitting him on the back of his head and yelling at him.</p> <p>2.) R2's undated diagnosis sheet documents the following diagnosis sheet includes: Metabolic Encephalopathy, Paranoid Schizophrenia and Cerebral Infarction.</p> <p>R2's Minimum Data Set, dated [DATE] documents R2 as cognitively intact.</p> <p>R2's care plan dated 5/2/23 documents that R2 has the potential to be physically and verbally aggressive.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R2' progress notes dated 3/31/25 document that R2 displayed aggressive behavior toward staff and threatened other staff with physical harm.</p> <p>On 5/12/25 at 1:16PM, V9 Licensed Practical Nurse stated that she saw R1 punching R2 in the back of the head in the dining room on 4/22/25 at breakfast while yelling at R2.</p> <p>On 5/12/25 at 10:00AM, V1 Administrator stated that they did not know what caused the altercation but that it did occur.</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to thoroughly investigate an injury of unknown origin for one (R3) of three residents reviewed for injuries of unknown origin from a total sample list of four residents.</p> <p>Findings include:</p> <p>The facility provided Abuse Policy dated 2001 documents that bruising, including those found in unusual locations such as the head, neck, lateral locations on the arm, or posterior torso and trunk, or bruises in shapes such as finger prints are to be investigated.</p> <p>R3's undated diagnosis sheet documents the following diagnoses include: Unspecified Disorder of Psychological Development, Schizophrenia, Major Depressive Disorder, and Peripheral Vascular Disease.</p> <p>R3's care plan dated 3/7/24 documents that R3 will remain free of mistreatment or improper care and statements/allegations of mistreatment will be investigated including skin checks for physical marks or injury and interview persons assigned to R3's care.</p> <p>R3's Minimum Data Set, dated [DATE] documents that R3 is moderately cognitively intact.</p> <p>The facility provided final incident report dated 3/31/25 documents a (single) bruise due to care and that R3 is on an anti-coagulant causing her to bruise easily with updated care plan interventions.</p> <p>R3's ordered medications were reviewed and do not include an anticoagulant medication.</p> <p>On 5/12/25 at 1:55PM, V8 Certified Nursing Assistant stated that she found R3's multiple bruises on 3/25/25 and reported it. V8 stated that they looked like finger prints and stated that R3 is resistive to care.</p> <p>On 5/12/25 at 2:00PM, V8 and V9 Certified Nursing Assistants (CNA) provided R3 perineal care. Old bruising was observed on R3's inner thighs in a fingerprint pattern. Approximately 4 bruises were noted on the bilateral thighs. V8 confirmed that these were the same bruises that she reported on 3/25/25.</p> <p>R3's progress note dated 3/25/2025 documents that V13, R3's Family Member stated that R3 told her that It was Him who did it but would not tell (V13) who Him was. V13 Family Member stated that R3 was very upset on Sunday.</p> <p>The facility provided investigation of R3's bruising does not document interviews with male CNAs who provided care for R3 days prior to the discovery of R3's bruising.</p> <p>On 5/12/25 at 2:00PM, V3 LPN confirmed that V10 RN, V11 and V12 CNAs, and V14 CNA are all male employees.</p> <p>The facility provided nursing schedule dated 3/22/25 documents V11 CNA worked from 2:00PM-10:00PM.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility provided nursing schedule dated 3/23/25 documents V14 Licensed Practical Nurse (LPN) worked from 2:00PM-10:00PM and V11 CNA worked from 2:00PM-10:00PM.</p> <p>The facility provided nursing schedule dated 3/24/25 documents V10 Registered Nurse (RN) worked from 2:00PM-6:00AM, V11 CNA worked form 2:00PM-10:00PM and V12 CNA worked from 2:00AM-2:00PM.</p> <p>On 5/12/25 at 1:30PM, V1 Administrator stated that she didn't realize that Aspirin wasn't an anti-coagulant medication. V1 also stated that she didn't think that there weren't any men on the schedule that R3 could have been talking about. V1 stated that she thought it was from R1 resisting care that she received the fingerprint bruising, but that she did not interview any of the male caregivers in her investigation.</p>