STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146039	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eastview Healthcare & Senior Living	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interview and record review the facility failed to protect residents rights to be free from resident to resident physical abuse. This failure affects four of four residents (R3, R4, R5, R6) reviewed for abuse in the sample list of 13. Findings Include:Abuse, Neglect, Exploitation and Misappropriation Prevention Program dated 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.The facility reported incident final investigation dated July 25th, 2025, documents on July 18th, 2025, at 4:50pm was reported by R4 that R3 made contact with R4's right forearm. The same document documents: After a thorough investigation the facility has determined that the incident did occur.The facility reported incident final investigation dated August 13th, 2025, documents on August 7th, 2025, at 11:30pm it was reported to Nurse that R3 went into R4's room on the evening of the 6th. R3 entered R4's room through their adjoining bathrooms. R3 was going through R4's' things and R4 yelled to make R3 stop. R4 then reported on the morning of the 7th that R3 made contact with R4's hand.The facility reported incident final investigation dated July 29th, 2025, documents on July 26th, 2025, at 3:00pm it was reported to the Nurse that R3 made contact with R6's right wrist. The CNA reported to Nurse that R3 walked up to other residents playing cards. The other residents playing cards started yelling at R3 to get away. R3 then made contact with R6's right wrist.The facility reported incident final investigation dated August 12th, 2025, documents on August 6th, 2025, at 10:00am staff witnessed a resident-to-resident incident. As V12 License Practical Nurse (LPN), was doing a one-to-one with R3 when R3 made contact with the top of R6's hand. After a thorough investigation it was determined that R3 wanted the book that R6 had and R6 stopped her from taking it causing R3 to react.The facility reported incident final investigation dated July 29th, 2025, documents on July 26th, 2025, at 07:30am it was reported that R3 made contact with R5. The facility has determined that the incident did occur.On 8/25/25 at 1:20pm, V12 LPN, stated that R3 did make contact with R6 on 8/6/25 while V12 was providing one-to-one cares to R3.On 8/26/25 at 12:20pm, V1 Administrator confirmed that R3 has been investigated and had been involved in multiple incidents involving R4, R5, and R6 on various dates in which R3 has abused the other residents.On 8/26/25 at 1:04pm, V3 LPN confirmed that R3 has been investigated and known to make contact with R4, R5, and R6 on various dates.

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 - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to implement fall prevention measures for two of two residents (R2, R7) reviewed for falls on the sample list of 13. These failures resulted in R2 experiencing a displaced fracture of the right hand, and R7 a fractured nasal bone. Findings Include:Falls and Fall Risk Management policy dated March 2018 documents Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling.1. Facility Reported Incident Final Investigation dated August 19, 2025, documents on August 11th, 2025, the Certified Nursing Assistant (CNA) reported that while giving R7 a shower, R7 lunged forward out of the chair and onto the floor. Nurse assessed immediately and R7 was sent to the emergency room (ER). Conclusion: X-Ray found nasal bone fracture.R7's undated care plan documents diagnosis of Unspecified Dementia; Bipolar; Schizoaffective Disorder; Major Depressive Disorder; and Alzheimer's. The same document documents an admission date of 6/14/2021.R7's Minimum Data Set (MDS) documents on 08/19/2025 that R7 is severely cognitively impaired. The MDS documents R7 as dependent on staff for all cares including showers. R7's record review of progress notes documents a progress note dated 8/11/2025 at12:29pm stated the CNA yelled for a nurse from the shower room. The Nurse reported to the shower room to note resident face down on the floor with a pool of blood. The CNA stated that R7 thrashed herself forward and the CNA couldn't catch R7 in time before R7 hit the floor. Support provided for R7's head and 911 called. R7 was noted to have a possible fracture to nose and swelling to left eye. Both nurses remained with resident to monitor and keep her safe from further injury until Emergency Medical Services (EMS) arrived. All parties notified.R7's progress note dated 8/11/2025 at 5:00pm which stated R7 returned from ER via stretcher and EMT's. R7 was alert and had contusions on the left side of R7's face from eyebrow down to below cheek. Report states she has nasal bone fracture.R7's care plan documents under Falls section: educate staff on keeping chair in reclined position when R7 is in chair for proper positioning and comfort due to R7's strong thrusting body movements uncontrolled. Date Initiated: 04/07/2025R7's care plan documents the resident has a nasal bone fracture related to falling out of the shower chair. Date Initiated: 08/12/2025On 8/26/25 V12 License Practical Nurse (LPN) stated on 08/11/25 that R7 was getting a shower from V11 CNA, when V11 yelled out the shower room door for a nurse. V12 stated V12 ran to the shower room and observed R7 lying face down with a pool of blood coming from under R7's face. V11 stated she assessed R7 and rolled R7 over and noted that R7 had what looked like a nasal fracture with blood coming from the nares (nostrils). V11 stated EMS (Emergency Medical Services) was called to take R7 to the local hospital. V11 stated that all staff knew R7 rocks/lunges forward when seated and usually two nursing staff give R7 a shower. V11 stated there was only one CNA (V11) in the shower room at time of fall.On 08/27/25 at 10:10am, V11 Certified Nurse's Aide, stated that R7 lunged forward from the shower chair on 08/11/25. V11 stated that a second CNA had left the shower room to get R7 some clean clothing. V11 stated that R7 has a known history of lunging forward unexpectedly from chairs. V11 stated V11 was standing to the left side and behind the shower chair and was unable to reach the shower chair as R7 lunged forward falling from the shower chair and landing on the floor. V11 then stated that V11 opened the shower room door and yelled for a nurse.On 08/26/2025 at 12:45pm, V16 (R7's family) stated she was informed of R7 falling from the shower chair in the shower room. V16 stated the hospital told her that R7 had a broken nose. V16 stated that R7 has been known to be lunging/rocking when sitting up for as long as she can remember, and the staff know this.2. Facility Reported Incident Final Investigation dated July 9th, 2025, documents on July 5th, 2025, R2 was pushing on bed during care and rolled onto her right hand. Staff stated that as he (CNA) rolled R2 over to change her, R2 put her right hand down on the mattress and R2 rolled on top of R2's right hand. R2 was transferred to the ER for evaluation and the x-ray revealed a minimally displaced fracture involving the fifth proximal phalanx. R2 returned to the facility with a soft cast in place.Review of R2's hospital records dated 7/5/25 at 11:22 PM documents This is an [AGE] year-old female NHR (Nursing Home Resident) with a history of dementia who is nonverbal at baseline brought to the ED (Emergency Department) by EMS after her right hand became caught underneath her in bed with audible pop and subsequent swelling and bruising noted to the right little finger and hand. IMPRESSION: Obliquely oriented minimally displaced fracture involving the fifth proximal phalanx.R2's undated care plan documents diagnosis of: Unspecified Dementia; Type 2 Diabetes; Hypertensive Heart

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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 designate and maintain a full-time Director of Nursing (DON). This deficiency has the potential to affect all 50 residents in the facility by compromising the oversight and coordination of nursing services. Findings Include:Review of staffing schedules from 7/25/25 thru 8/25/25 confirmed that no licensed nurse was designated as Director of Nursing (DON) and no interim appointment was made.On 8/25/25 at 1:20pm, V12 Licensed Practical Nurse (LPN), confirmed there is no DON at this time and stated we haven't had a DON for a few weeks now.On 8/26/25 at 12:20pm, V1 Administrator stated, We've been trying to hire a Director of Nursing (DON), but we haven't been able to find anyone. We do have an interim DON starting soon.On 8/27/25 at 1:35pm, V2 Corporate Nurse stated the facility does not have a DON at this time, but we do have an interim DON starting soon.The Facility Census dated 8/21/25 documents there are 50 residents currently 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 upon interview and record review, the facility failed to employee a certified dietary manager for food services. This failure has the potential to affect all 50 residents currently residing in facility.Findings include:Facility Census dated 8/21/25 documents there are 50 residents currently residing in the facility. Dietary Services food certifications reviewed on 8/21/25. Certifications include food safety for all dietary staff. Certifications do not include Dietary Manager Certification.On 8/21/25 at 1:00pm, V4 Dietary Manager (DM) stated she is not certified for dietary management.On 8/27/25 at 11:57am, V5 Registered Dietician (RD), stated she consults for facility and primarily approves menus and completes dietary recommendations for residents. V5 stated V5 is at facility on average approximately 16 hours a month. V5 confirms the facility has a newer dietary manager that is not certified at this time. On 8/27/25 at 12:50pm, V1 Administrator and V2 Regional Nurse confirmed that V4 DM is not a certified dietary manager and that V4 is not currently enrolled in any certification courses.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based upon observation, interview and record review, the facility failed to ensure meals were palatable and at a safe and appetizing temperature. This failure has the potential to affect all 50 residents currently residing at facility. Facility Resident Census dated 8/21/25 documents that there are 50 residents currently residing in the facility.The Food Temperature Chart for August reviewed. Chart dated 8/10/25-8/16/25 documents food temperatures at meal service. Breakfast meal for dates 8/11 and 8/12 are missing documentation. Lunch meal for dates 8/10, 8/11, 8/12, and 8/13 are missing, and dinner meal for dates 8/15 and 8/16 are missing documentation. Vegetable temperatures are being documented at 200 degrees Fahrenheit (F) at time of service. Chart dated 8/17/25-8/23/25 missing documentation for the 8/17/25 dinner meal. Facility Food Temperature Chart for 8/21/25 lunch meal documented food temps as follows: meat 210 degrees F, ground meat 200 degrees F, pureed meat 192 degrees F, vegetables 185 degrees F, pureed vegetables 192 degrees F, fruit 31 degrees F, and milk 31 degrees F. No temperatures were documented for pasta.On 8/21/25, the lunch menu includes one piece of glazed meatloaf, four ounces of garlic buttered noodles, four ounces of broccoli. The recipes provided include holding temperature of food at time of service. Glazed meatloaf recipe documents to hold at 135 degrees F or above during the entire service period, noodles and broccoli are to hold at 135 degrees F for service.On 8/21/25 at 12:10pm, R5 stated very rarely do I get warm food, breakfast is always ice cold.On 8/21/25 at 12:15pm, R13's hospice aide was observed taking R13's lunch plate back to kitchen. R13 stated R13's food had just been delivered, and the food was cold. Meat temperature on the plate was 111.5 degrees Fahrenheit (F) and the pasta side temped at 98.4 degrees F.On 8/21/25 at 12:20pm, R11 stated food was cold today, the food is always cold.On 8/21/25 at 12:25pm, V4 Dietary Manager (DM) provided a test tray (photo attached) that included meat and pureed meat, noodles and vegetable. Regular texture meat temped at 194.6 degrees F, pureed meat was 120 degrees F, noodles temped at 110 degrees F and vegetable temped at 108 degrees F. The food was served on a Styrofoam plate, and a notable amount of liquid grease was pooling on the plate under the food. Regular texture meat was extremely hot to palate, flavor was palatable. Pureed meat had same flavor and was cold to palate. Noodles were cold to palate, very bland and very greasy. Vegetables were cool to the palate and had no flavor. The menu displayed on the whiteboard next to the kitchen entrance listed glazed meatloaf, garlic buttered noodles, broccoli, roll, and an apricot pie bar as mid-day meal. On 8/21/25 at 12:35pm, R12 stated the portions provided at lunch today did not reflect their normal portion sizes for protein. R12 stated they hardly get any protein and when they do its very small.On 8/21/25 at 12:45pm, V6 (R1's spouse) was at the lunch table with R1. V6 was feeding R1 pizza that V6 had brought into facility. V6 stated the food is always cold and the portion sizes are tiny. V6 stated they had pulled pork on a bun a few days ago and the portion of meat was so small that it wasn't visible on the bun until the top was removed. V6 stated that breakfast is the worst meal of the day. V6 stated the menu for breakfast never changes and consists of eggs, cereal, juice and maybe some fruit. V6 stated the eggs are always cold and the breakfast meal is always served on Styrofoam plates and bowls.On 8/25/25 at 12:02pm, V15 Dietary Aide was observed portioning out food onto resident plates for service. Resident meal cards containing diet type, restrictions, allergies and preferences listed on cards were utilized when plating food. Food observed included hamburger bun, ham salad, plain potato chips, melon, and chocolate cake. Portion sizes were not uniform, ham salad placed on bun was approximately size of half dollar, chips were placed by hand full, melon pieces varied from 3-5 pieces depending on what fit in small portion bowl, cake was cut in rectangular shape and approximately 1inch by 2inches in size. No observations were noted of food temping during service. Alternative options available included turkey burger and mashed potatoes. At 12:20pm, V4 was asked to perform temperature checks on hot food. No thermometer was available. This surveyor provided thermometer. Turkey burgers that were being held in steam table had internal temp of 117 degrees F, and mashed potatoes temped at 177 degrees F. 8/25/25 at 12:30pm, R11 stated the chips are stale, there never seems to be enough to eat, and they don't offer seconds anymore.8/25/25 at 12:35pm, V6 R1's spouse stated the chips are stale and you can't see the meat inside the bun. 8/26/25 at 1:35pm, R12 stated that often the meals provided contain meat that seems overcooked. R12 stated meat is rubbery and tough. R12 also stated that potato items such as tater tots and French fries are very undercooked.On 8/27/25 at 1:30pm, V4 Dietary Manager (DM) stated she has not been provided any education since the first day of employment and neither has the dietary aides. V4 stated that currently the left side of the oven doesn't get to temp, the flat top griddle is slow to warm and the steam table