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	12/30/2025

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 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 interview and record review the facility failed to ensure timely call light response for one of four residents (R6) reviewed for staffing in the sample list of eight residents. Findings include: On 12/29/25 at 11:17 AM R6 stated there aren't enough Certified Nursing Assistants (CNAs) on second and third shifts, R6 waits an hour for R6's call light on these shifts while needing incontinence cares, causing R6 to be left in urine/feces. R6 stated call lights are frequently brought up in resident council. The Grievance/Complaint Report dated 11/10/25 documents unidentified residents complain that third shift isn't answering call lights fast enough so residents can be changed. R6's Minimum Data Set, dated [DATE] documents R6 as cognitively intact, is dependent on staff for toileting and R6 is frequently incontinent or urine and always incontinent of bowel. On 12/29/25 at 1:06 PM, V9 Activity Director stated call lights were brought up in November's resident council meeting, but V9 could not recall which residents voiced the concerns. On 12/29/25 at 1:45 PM, V11 Certified Nursing Assistant (CNA) stated four CNAs is not enough for days/evenings, there are a lot of residents that require toileting assistance which affects call light response times. The facility's Residents Call System policy dated September 2022 documents calls for assistance should be answered as soon as possible, but no later than five minutes, with urgent requests for assistance immediately addressed.

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 showers as scheduled for one of four residents (R6) reviewed for staffing in the sample list of eight residents. Findings include: The facility's Shower/Tub Bath policy dated February 2018 documents the purpose of this procedure is to promote cleanliness, provide comfort and monitor skin condition. This policy documents to record if the resident refused showers/baths and notify the supervisor. On 12/29/25 at 11:17 AM, R6 stated R6 is supposed to get showers twice per week and R6 prefers to have them in the evenings after 7:00 PM. R6 stated her shower days used to be Mondays/Thursdays and then changed to Tuesdays/Fridays, and R6 goes two weeks without getting showers. R6's Grievance/Complaint Report dated 11/10/25 documents R6 stated R6 had not received a shower in two weeks. R6's Minimum Data Set, dated [DATE] documents R6 as cognitively intact and is dependent on staff for bathing. R6's active Care Plan documents R6 has activities of daily living self-care deficit related to above knee amputations and requires supervision/assistance to complete. This care plan includes an intervention that R6 will receive showers twice weekly.The facility's undated shower schedule documents R6's showers are scheduled on Tuesdays and Fridays on second shift. R6's November and December 2025 shower documentation, provided by V2 Director of Nursing, documents showers given on 11/10/25, 11/20/25, 11/25/25, 12/17/25, 12/29/25 and 12/26/25. R6's Shower/Abnormal Skin Report dated 12/2/25 documents R6 did not know that R6's shower day was changed and R6 would wait until Friday. R6's Response History for showers documents not applicable on 12/5/25. On 12/29/25 at 1:30 PM, V2 provided R6's shower documentation for November/December 2025. V2 stated that is all the documentation V2 was able to locate. V2 confirmed showers are scheduled twice per week and gaps in R6's shower documentation. V2 stated refusals would also be documented on the paper shower forms.

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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. Based on observation, interview, and record review the facility failed to implement interventions to prevent a fall for one resident (R1) who has a history of seizures and takes an anticoagulant of three residents reviewed for falls in a sample list of eight residents. This failure resulted in R1 falling from R1's bed while having a seizure and R1 sustaining a six centimeter scalp laceration requiring evacuation of a hematoma and sutures, and a subdural hematoma.R1's Care Plan updated 10/20/25 includes the following diagnoses: Epileptic Seizures, Peripheral Vascular Disease. Recent Femoral/Popliteal Bypass with Wound Dehiscence, Chronic Kidney Disease Stage III, Muscle Weakness, Difficulty Walking, Osteoarthritis, Major Depression, History of Subarachnoid Hemorrhage with Residual Hemiplegia and Hemiparesis of the Left Side.R1's Medication Administration Record (MAR) for December 2025 documents R1 has a current physician's order with the start date of 10/20/25 for Eliquis (anticoagulant) five Milligrams twice daily and Keppra (Anticonvulsant) 500 Milligrams twice daily. This MAR also documents R1 refused his morning Keppra on 12/3/25 and his evening Keppra on 12/2/25, 12/3/25, 12/7/25, 12/8/25, and 12/9/25. There is no documentation to support these refusals were reported to the physician or the Nurse Practitioner. There is no documentation to indicate new interventions were initiated to address R1's seizures. R1's Progress Note dated 12/10/25 at 6:41AM documents Certified Nurse's Assistant (CNA) noted R1 lying on floor in the prone position next to bed. This writer was summonsed to (R1's) room. (R1) was alert, Copious amount of blood noted from head. (R1) stated he thinks he had a seizure that caused him to roll out of bed onto the floor. Towel placed on the areas to head that were bleeding. Appeared to have large laceration to right orbital site and crown of skull. (R1) began to have absence Seizures lasting approximately 10-20 seconds, (R1) responded to this writer during the episode. (R1) then began to have a partial seizure that lasted approximately 20-30 seconds with no loss of consciousness. After these two seizures (R1) started to have grand mal seizures repeatedly with each one lasting approximately 5-10 seconds each. During these episodes (R1) unable to respond to verbal stimuli. Ambulance notified.R1's hospital discharge document dated 12/15/25 documents R1 sustained a six Centimeter scalp laceration requiring evacuation of a hematoma and sutures, and a subdural hematoma as a result of a ground level fall.On 12/29/25 at 3:11PM, V18 Licensed Practical Nurse (LPN) stated I was the nurse for (R1) when he had the seizures and fell. I saw the seizure activity. R1 had quite a bit of bleeding from the head wound. The CNA heard a noise from (R1's) room and went in. The bed was not in low position. We don't use fall mats because (R1) gets up on his own and we thought it would be a trip hazard. (R1) doesn't like side rails. (R1) does refuse his seizure meds at times. It's such a regular thing for him so I wouldn't notify the doctor or Nurse Practitioner.On 12/29/25 at 11:00AM, R1 was lying in bed. The bed was in low position. No rail or pads were in place. V11 Certified Nurse's Aide (CNA) was assisting R1. V11 stated before he fell, we had him in a regular bed. Now we keep the bed low. I don't think there's anything else we do. R1 stated I remember falling and going to the hospital. I think I had a seizure.On 12/30/25 at 11:30AM V6, Certified Nurse's Aide (CNA) stated When (R1) fell I was in another room, and I heard a moaning sound. I went to find (R1) lying face down on the floor with a lot of blood on his head. I called for the nurse, and she came right in. I went out and called 911. The ambulance was here pretty quick.On 12/30/25 at 1:00PM, R1 was in his bed, and the bed was in low position. No rail was present, and no pads were present.On 12/30/25 at 1:00PM, V1 Administrator verified the facility does not have a specific policy for seizure precautions.On 12/30/25 at 2:00PM, V20 Family Nurse Practitioner (FNP) stated The Nurse Practitioner should have been notified in a timely manner when (R1) was refusing his Keppra. V20 stated at a very minimum (R1's) bed should have been in low position prior to the seizure. V20 verified the refusal of the seizure medication caused the seizure which caused the fall which caused the subdural hematoma and the laceration.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 prevent cross contamination during incontinence care for one of four residents (R2) reviewed for incontinence in the sample list of eight residents. Findings include: The facility's Perineal Care policy dated February 2018 documents for female perineal care wash/dry from front to back, washing the labia and perineum followed by the rectal area/buttocks. On 12/29/25 at 1:34 PM, R2 was lying in bed. V11 and V12 Certified Nursing Assistants applied gloves and gowns and entered R2's room. V11 pulled down R2's brief which was wet with urine and had a small amount of soft bowel movement. V11 used wash cloths to clean R2's vaginal area in a front to back motion and then turned R2 on her side to cleanse buttocks. V11 did not change gloves and applied a clean brief. V11 then turned R2 onto R2's back and cleaned R2's vaginal area again while wearing the same gloves used to wash R2's buttocks. At 1:45 PM, V11 confirmed V11 used the same contaminated gloves to wash R2's vaginal area after washing R2's buttocks. V11 confirmed V11 should have changed her gloves. R2's Minimum Data Set, dated [DATE] documents R2 has moderate cognitive impairment, R2 is always incontinent of bowel and bladder, and is dependent on staff for toileting hygiene. R2's urine culture dated 12/3/25 documents greater than 100,000 colony forming units per milliliter (CFU/ml) of Klebsiella Oxytoca ESBL (Extended Spectrum Beta Lactamase) and Escherichia Coli, (E. Coli) indicating infection. R2's Provider Note dated 12/8/2025 at 12:49 PM documents persistent UTI / ESBL to start Tobramycin 80 milligram injection three times daily for 10 days. R2's Nursing Note dated 12/27/2025 at 2:35 PM documents R2's urine culture returned with E. Coli ESBL greater than 100,000 CFU/ml. Orders were received for Meropenem intravenous three times daily for seven days and contact isolation were implemented. On 12/29/25 at 3:00 PM, V13 Resident Care Coordinator stated during female incontinence care staff should change gloves when moving from soiled to clean areas and should cleanse from front to back.