

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

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 06/03/2026
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)		
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents were free from abuse for three residents (R2, R3, R6) reviewed for abuse, in a sample list of nine residents. Findings Include: 1. R3's Incident report dated 4/5/2026, documents the incident occurred in the lounge on 4/5/2026 at 6:15pm. It also documents that R3 came out of the dining room when R4 hit R3 on the left forearm. The incident reports that R3 had no redness, bruising, or swelling noted. R3 was interviewed and was documented as stating that R4 came toward R3 and hit R3's arm. The immediate action documented is that R3 and R4 were separated and assessed for injury. R3's Physician's Order Sheet documents diagnosis of: Dementia with Anxiety, Schizoaffective Disorder, Bipolar Disorder, and Repeated Falls. R3's Health status note dated 4/6/2026 documented, R3 was coming out of the dining room when another resident (R4) came at and hit R3's left forearm before staff could intervene. R3 and R4 were separated and R3 assessed for injury. No bruising, redness, or swelling noted to left forearm. R3's Care plan dated 1/8/2026 did not address interventions for the incident on 4/5/2026. R3's Minimum Data Set (MDS) dated [DATE] documents that R3 is not cognitively intact. On 6/1/2026 at 12:45pm, R3 was interviewed. R3 had no recollection of the incident on 4/5/2026. R4's Minimum Data Set (MDS) dated [DATE] documents that R4 is cognitively intact. R4's Physician Order Sheet dated 5/22/2026 documents diagnoses of: Metabolic Encephalopathy, Paranoid Schizophrenia, and Urinary Tract Infection. R4's Behavior note dated 4/4/2026, documented that R4 almost punched a Certified Nursing Assistant (CNA) in the face, missing by an inch or two. R4 stated the CNA called R4 a bastard, so R4 tried to punch the CNA and then threatened to get a knife and cut the CNA's lips off. Several witnesses stated the CNA did not call R4 a name but offered R4 a slice of pizza when R4 did that. R4 chased another CNA threatening to cut his b***s (expletive) off. R4 is currently in R4's room in R4's wheelchair. R4's Behavior note dated 4/5/2026 documents R4 was chasing another staff member yelling I hate you over and over. Staff went into the kitchen and shut the door. R4 then went into the lounge area in front of the nurse's station and spotted R3 and R4 went after R3 and hit R3 before staff could intervene. (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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R4's Progress note dated 4/6/2026 documented, Spoke to (Emergency Room) nurse at (local hospital) and (R4) will be admitted to the behavior unit once (R4) is medically clear as (R4) also has a (urinary tract infection). Nurse stated that resident has been very aggressive while there. R4 was interviewed on 6/1/2026 at 1:35pm. R4 did not recall the incident on 4/5/2026. R4 denied hitting other residents at any time. R4 denied any thoughts to harm others. R4 denied feeling sad, or angry. R4 stated I do see Bespoke Psychiatry and that they have made medication adjustments at times. R4 stated I used to get Electroconvulsive Therapy (ECT) at Local hospital. R4 stated I feel happy and safe here. On 6/1/2026 at 1:53pm, V7 Certified Nursing Assistant (CNA), stated, R4 approached R3 in the lobby and struck R3 in the left forearm before V7 Certified Nursing Assistant (CNA) could reach R3 and R4. V7 CNA also stated that prior to the incident R4 was being aggressive with staff and had chased V8 Dietary Aide, out of the dining room. V7 CNA also stated V7 has witnessed R4 be verbally abusive before, but not physical. That was the first time. On 6/1/2026 at 2:06pm, V8 Dietary Aide (DA) state that prior to the incident R4 was throwing punches at the air, but not connecting to anything. V8 DA also stated that V8 attempted to redirect R4 and R4 started chasing V8 around, so V8 secluded V8 in the kitchen. V8 DA stated V8 has seen R4 have behaviors like this before. R4 was mad because V8 intervened. On 6/2/2026 at 3:00pm, V9 CNA stated that after supper R4 was flinging R4's arms and legs around and V9 told R4 it was inappropriate and asked R4 to stop. V9 did not see any actual contact with R3. V9 has worked at the facility for two and a half years and R4 can be physical. 2. On 6/1/2026 at 11:20 AM, R2 stated that R1 came into R2's room and hit R2 in the left upper arm. R2 stated that R2 was not hurt, and that R2 did not bruise and that R2 went and reported it to the nurse. R2 stated that R1 thought it was R1's house, and R1 could do whatever R1 wanted. R2 stated that R1 was sent to the hospital and that R1 has been mean to a lot of residents and staff. R2 stated that R2 feels safe living in the facility if R1 stays in the hospital. R2's Progress note dated 5/25/2026 documented that R2 wheeled up to the nurse's station/lobby and reported that another resident came into R2's room and made contact with R2's left arm. R2 and R1 were kept separated from each other. R2's left arm was assessed with no bruising or open areas. R2's left arm had light redness to top of arm. Full ROM (Range of Motion). The State Agency, local police department, and Medical Doctor were all notified. R2's Physician's order sheet dated 6/2026 documented diagnosis of Unspecified Dementia. R2's MDS dated [DATE] documents that R2's cognition was intact. R2's Care plan dated 9/20/2023 documented, Staff to move between Resident and any dangers. On 6/3/2026 at 11:15 AM, R1 stated that R1 never went into anyone's room and hit them in the arm and that no one has hit R1 while at the facility. R1's Behavior note dated 5/25/2026 at 5:59am documented Note Text: R1 has been up since 0130 going into other residents room being physically and verbally abusive to staff has hit this writer in the face three (3) times this shift R1 has been in the lobby taking pictures off the wall throwing them in (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the floor taking cushions off the couches throwing them in the floor R1 went and hid in another residents room behind the door and when staff finally found R1 she said Oh did I make you look for me. R1 went into the dining room and threw another resident playing cards into the floor, threw bibs and other essentials in floor. R1 also came behind nurses' station and dumped a water pitcher all over the medication cart. R1 is not redirectable and when asking why R1 is doing all this R1 stated, So you dumb b*****s (expletive) can pick it up. R1 is currently sitting in lobby (at) this time. R1's Behavior Note dated 5/25/2026 at 12:10 PM documents, Note Text: Another resident came to nurses' station at 9:30am and reported that this resident (R1) was in her room and that made contact with her left arm. Staff went to room and (R1) was still in other resident's room and denied hitting anyone. (R1) was asked to go with staff to front office and resident followed staff to office. Resident unable to report anything on incident and continued to deny hitting. Resident was loudly telling staff to call her mom or her aunt. Resident repeatedly verbalized phone number for her aunt. Staff called (Medical Doctor) and (Power of Attorney) and (Medical Doctor) ordered her to be sent to hospital. (Emergency Medical Transportation) arrived shortly after incident and she was transported to (local hospital) per (Power of Attorney) request. Resident cooperated with (Emergency Medical Transportation) and was loudly telling and pointing to nursing staff that they needed to call her aunt right now. Bed hold policy sent with (Emergency Medical Transportation) /resident. R1's Hospital records dated 6/1/2026, documents, Discharge Diagnosis: 1. Dementia with Behavioral Disturbance; 2. Senile Dementia with Behavioral Disturbance It also documented, Hospital Course: [AGE] year-old female patient with a past medical history of Dementia, Hypothyroidism and tremors who presents to the emergency department 5/25/26 from (facility) for recent onset of combativeness at the nursing home. R1's Physician order sheet dated 6/2026 documents an admission date of 5/20/2026. On 6/2/2026 at 2:00 PM, V3 LPN/Resident Care Coordinator (RCC), stated that R2 came to V3 at the nurse's station and said that R1 hit R2 in the arm after R2 told R1 to leave R2's room. V3 continued to state that V3 assessed R2's arm and it was slightly red and then went to R2's room and assisted R1 out of R2's room and assessed R1. On 6/2/2026 at 11:30 AM, V5 LPN stated that R1's admission was an odd admission. R1 was discharged from the hospital and went home with R1's husband and then later that evening he brought R1 to the facility. There was no information, no medication list or heads up on what R1 needed. He also stated that he did not know the extent of R1's behavior. V5 LPN stated that R1 would wander in and out of other residents' rooms and use their bathrooms. On 6/2/2026 at 2:15 PM, V6 CNA stated that V6 was here the night R1 was admitted and R1 was starting to get upset when R1's husband left. V6 continued to state that R1 was wandering in and out of other residents' rooms and even ended up in the beauty shop and would not let them in. V6 stated that R1's family brought R1 into the facility and had R1 admitted but they, the staff, were not aware of R1's needs or any of R1's behaviors. V6 CNA stated that V6 feels like the staff do not get enough information about new residents and how to take care of them, especially the ones with behaviors issues. 3. On 6/1/2026 at 11:10 AM, R6 stated that no one hit R6 while R6 has been a resident at the facility. R6's Progress note, dated 5/11/26, documented, Resident had another resident make contact to the (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	right side of face by his ear. There is no redness or bruising and he denies pain at this time. Police, (administrator), (Power of Attorney), (Medical Doctor) all notified. R6's MDS, dated [DATE], documented that his cognition was intact. R6's Care Plan dated 3/11/2026 did not document any interventions for the risk of being abused. R6's Physician's Order Sheet dated 6/2026 documents diagnosis of Unspecified Dementia. On 6/1/2026 at 10:30 AM, R5 was asked if R5 had grabbed another resident (R6) by his face, R5 just smiled but did not answer. When asked more questions about what happened between R5 and R6, R5 was unable to answer and just smiled. R5's Progress Note dated 5/11/2026 V3 LPN/ RCC, documented, Resident made contact with another resident. (State Agency), (Medical Doctor), (administrator), (Power of Attorney), and Police notified. R5's MDS dated [DATE] documented that R5 was unable to answer the questions for the Brief Interview for Mental Status. R5's Physician's Order Sheet, dated 6/2026, documented a diagnosis of Unspecified Dementia, Severe, with Psychotic Disturbance. R5's Care Plan dated 6/14/2025 documents, Analyze times of day, places, circumstances, triggers, and what de-escalates behavior and document. There was no documentation presented during this investigation. It also documents, When the resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later. On 6/2/2026 at 11:30 AM, V5 LPN stated that R6 was coming down the hallway and R5 was blocking R6's doorway to R6's room. V5 stated that V5 heard R6 ask R5 to move out of R6's way. V5 continued to state that V5 did not see R5 smack R6 but V5 saw V6 CNA running that way and when V5 saw V6, V5 ran down the hallway and helped by deescalating R5 and help R5 down to R5's room and V6 took R6 into R6's room. V5 continued to state that V5 went and assessed R6 for injuries and there were none. V5 LPN stated that the facility has a lot of residents with behaviors, and they cycle. V5 stated that R5 is very territorial, and R5 thought R6's room was R5's and that night they moved R5 to the last room on the hallway away from R6. On 6/2/2026 at 2:15 PM, V6 CNA, stated that V6 was rounding the corner at the nurse's station and V6 saw R5 slap R6 on the side of the head. V6 continued to state that V6 ran down the hallway and so did V5 LPN. V6 moved R6 out of the way of R5 and V5 was trying to calm R5 down. V6 continued to state that R5 did not want to move, and R5 was very territorial of that part of the hallway because R5's room was right next to R6's room and they shared a bathroom. V6 continued to state that R5 was starting to get anxious prior to the incident because while they were getting resident up and ready for supper, R5 watches the staff go back and forth and that's when R5 starts to get anxious. The facility's policy, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, dated 4/2021, documented, Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. It continues, 1. Protect residents from abuse, neglect, exploitation or misappropriation of property by anyone including, a. facility staff; b. other residents.		