

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

Printed: 08/27/2026
Form Approved OMB
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 06/18/2026
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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide supervision for a resident in a resident's room to prevent falls for one resident (R2) and failed to implement fall prevention interventions to for one resident (R3). These failures affect two of four residents (R2, R3) reviewed for falls in the sample list of 19. These failures resulted in R2 sustaining a subarachnoid hemorrhage and a compression fracture of the T12 vertebral body from falling. Findings include: 1) R2's Medication Review Report dated 6/18/26 documents diagnoses including Unspecified Dementia with Other Behavioral Disturbance, Cognitive Communication Deficit, Other Lack of Coordination and Other Reduced Mobility. R2's Care Plan dated 11/4/25 documents R2 slid out of the wheelchair while in R2's room unsupervised. The intervention put into place was to educate staff to place R2 in the common area until available to assist R2. R2's Public Health Notification Form Dated 5/26/2026 documents R2 had a fall with injury. R2's incident report dated 5/25/2026 at 5:00pm documents (R2) had an unwitnessed and unintentional change of plane. (R2) was observed in (R2's) room lying on (R2's) right side in front of (R2's) wheelchair. (R2) had full range of motion and (R2) had a hematoma 5.0 cm x 5.0 cm on the right side of (R2's) forehead. R2 was sent to the local hospital. R2 demonstrated signs of pain. R2's hospital records dated 5/25/2026 documents R2 was admitted via the emergency room with a diagnosis of Subarachnoid Hemorrhage, and Acute-Subacute Compression Fracture of T12. V7's Certified Nursing Assistant (CNA) witness statement dated 5/25/2026 at 4:50 pm documents V7's statement as V8 CNA and I were getting residents up for supper. We got another resident up first and then got (R2)'s roommate up. V8 went on down the hall to the next resident's room, while I took another resident to the dining room. I was coming back for (R2) when I was informed that (R2) fell out of (R2) wheelchair. V8's CNA's witness statement dated 5/25/2026 at 4:50pm documents We got (R2) up around 4:45pm to 4:55pm for supper in (R2)'s wheelchair. After that we got (R2)'s roommate up. I went to the next resident while V7 took (R2)'s roommate to the dining room and was coming back to get (R2) as well. The undated final Report for the incident documents that on 5/25/26 at 4:50pm, V7 and V8 were getting residents ready for the evening meal. Upon returning to (R2)'s room (R2) was observed on the floor in front of her wheelchair. The conclusion documents a therapy evaluation, enhanced supervision, and monitor effectiveness of interventions. R2's fall risk evaluation dated 11/7/2025, 1/14/2026, and 2/6/2026 document R2 at risk for falls. On 6/18/2026 at 10:40am, V2 Director of Nursing stated R2 is a high fall risk. V2 stated V2 would expect that R2 would not be left alone in R2's room. 2) On 6/16/2026 at 12:35pm R3 stated I have not been here long. I am leaving tomorrow. R3's fall risk assessment dated [DATE], 4/16/2026 and 4/25/2026 documents that R3 is at a high risk for falls. R3's care plan dated 6/1/2026 documents the fall intervention of a left side rail on 4/19/2026 and documents that R3 is at risk for falls. R3's Fall Intervention dated 4/25/2026 documents unwitnessed fall in room due to bed rail not being in proper position with an intervention of place sign to ensure bed rail is up at all times. On 6/16/2026 at 12:35pm there are no bed rails on either side of either bed in R3's room. There is no signage posted in R3's room. R3 stated I was moved into this room from another room. They did not move my bed down (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 146039
		If continuation sheet Page 1 of 4

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F 0689 Level of Harm - Actual harm Residents Affected - Few	here that has side rails. I have not had side rails since I have been in this room. Facility census documents R3 was moved from on 5/18/2026 from R3's previous room. On 6/16/2026 at 11:30am and 3:00pm there were no bed rails noted on either of the two beds in R3's room. R3's Electronic Health Record documents R3 discharged from the facility on 6/16/2026 at 6:10pm. Facility Policy provided by V1 stated the staff and the physician will identify pertinent interventions to try to prevent subsequent falls and to address the risk of clinically significant consequences of falling.		

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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 perform adequate sanitation of residents' eating utensils, cutlery, and dishware. This failure has the potential to affect all 20 residents residing in the facility. Findings include: On 6/16/26 at 1:15 PM after the lunch meal, V16, Dietary Aide performed a temperature check using the manufacturer's provided temperature gauge on the dishwasher, and performed a chemical sanitization check with manufacturer approved litmus paper. The Litmus paper was read by V16 who stated the results were between 25-50 parts per million (ppm) when compared to provided scale on the bottle. V16 confirmed the temperature was read at 118 degrees Fahrenheit (F) during the wash cycle and 120 degrees F at the rinse cycle. On 6/17/26 at 9:20 AM V15, Dietary Aide was washing breakfast dishes and looked at the temperature gauge on side of the dishwasher and stated the water temperature during the wash cycle was 118 degrees F. On 6/17/26 at 9:51 AM V10, Maintenance Director, stated the water temperature in the dishwasher should be at least 120 to 145 degrees F when washing and rinsing the dishes, but at midday, the staff have to run the dishwasher three times before using it, to get up to the temperature needed. V10 stated that maintenance is done by the company that they lease the machine through. V10 referred to the poster on the wall behind the dishwasher which documents, Typical wash and rinse temperatures for a low temp (temperature) machine 120-145 degrees F. Temperatures should coincide with Manufacturer's label on machine. On 6/17/26 at 11:10 AM V17, Dietary Manager, first stated the dietary staff test the water temperatures and chemical sanitizer levels in the dishwasher once daily. V10 then walked over and looked at the clipboard on the wall where staff record the temperatures and V17 stated well, three times a day but we haven't been logging it as you can see, we just stopped. On 6/18/26 at 11:00 AM V1, Administrator, stated the dishwasher temps were low, and the machine is not functioning properly. V1 stated the company which leases them the dishwasher was notified and will be coming to repair it, and the kitchen is now using disposable utensils until the dishwasher is fixed. The facility's document, Dishwasher Temperature /Sanitizer Log, dated June 2026 documents temperatures and sanitizer levels are checked at breakfast, lunch and supper. Directions on this document read, Record temperature or test strip results before washing dishes after each meal. Report inappropriate temperatures or test strip results to the supervisor. There are no results of temperatures or sanitizer levels documented for supper on 6/7/26 through 6/10/26 and no temperatures or sanitizer checks for any meals on 6/11/26 through 6/14/26. On 6/15/26 and 6/16/26, the temperatures and sanitizer levels are recorded for breakfast and lunch, but not supper. On 6/18/26 at 11:00 AM, V1 stated the facility does not have a policy specific to testing water temperatures and sanitizer levels in the dishwasher. V1 stated the only thing the company that leases the dishwasher to the facility told V1 was to refer to the poster behind the dishwasher. The facility's MDS (Minimum Data Set) Resident Matrix dated 6/18/26 documents 20 residents reside in the facility.		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation and interview the facility failed to provide and maintain a safe, functional, and sanitary environment for three of five residents (R2, R5 and R6) reviewed for unsealed windows/environment in the sample list of 19. Findings Include: On 6/16/26 at 11:35 AM R5's window was observed with a window air conditioning unit sitting on the left side of the window opening and a piece of cardboard on the side right side which was taped loosely in place with white tape. There were openings around the cardboard where the tape was not sealed and outside light was observed through the gaps. There were dead gnats and other bugs and dirt on the sill of the window. R5 used her grabber to poke the cardboard, and it moved easily and the tape came apart. R5 stated the staff are aware her window is like this and she does not like it because she cannot see out of her window. R5 stated she asked if they could replace it with plexi-glass or something else, but stated, I still have the cardboard. On 6/16/2026 at 11:20 AM R6's window was observed with foam on both sides of the air conditioner unit secured loosely with white tape. The tape was not sealed all the way around the window, and outside light was observed through the cracks where the window was not sealed. On 6/17/2026 at 9:51 AM R2's previous room was observed with V10, Maintenance Director, and he acknowledged there were gaps where the tape was not sealed around the cardboard on each side of the window air conditioner unit and dead bugs on the window seal. There was outside light observed through the cracks where tape was not sealed. V10 stated the facility uses white tape around the air conditioning units because the board voted and does not want to use the metal tape on the new windows. V10 stated he is the president of the facility's board and stated this is acceptable. He stated the units are temporary and are removed in the winter On 6/18/2026 at 11:00 AM V1, Administrator, stated it is not acceptable to have cardboard taped around the window air conditioner units and agreed you could not see out the window with the cardboard there. She stated the windows were not adequately sealed with the tape.		