STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000400	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTVIEW HEALTHCARE & SENIOR LIVING	100 EASTVIEW PLACE , SULLIVAN, Illinois, 61951

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S0000	Initial Comments Investigation of Facility Reported Incident of 07/05/2025/IL2595567	S0000		09/17/2025
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210c) 300.1210d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.	S9999		09/11/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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S9999	Continued from page 1 d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These requirements were not met as evidenced by: 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	S9999		

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S9999	Continued from page 2 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: 04/07/2025 R7's care plan documents the resident has a nasal bone fracture related to falling out of the shower chair. Date Initiated: 08/12/2025 On 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	S9999		

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S9999	Continued from page 3 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 87-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 Disease; Generalized Anxiety Disorder; Major Depressive Disorder; and Cognitive Communication Deficit. The same document has an admission date 09/09/2019. R2's MDS (Minimum Data Set) dated 8/8/25 documents R2 as severely cognitively impaired. The same MDS documents R2 as dependent on staff for all cares. On 8/25/25 at 11:49am, call placed to V13, R2's Family, unanswered, Voicemail left. On 8/25/25 at 11:56am, V8 LPN stated V9 CNA was providing cares for R2 by pushing R2 over onto R2's side and R2 was pushing back. When R2 relaxed R2's body moved forward on to R2's right hand and V9 heard an audible pop. V9 noted the right 5th digit was pointed in the wrong direction so V9 came and got the nurse. On 8/25/25 at 12:50pm, V9 CNA stated R2 was being combative with cares after having a bowel movement. V9 stated V9 left the room to allow R2 to calm down and returned a few minutes later. V9 stated that R2 grabbed the side of the bed and was pushing against being turned but needed cleaned up. V9 was trying to clean R2 up when R2 relaxed R2's body moved forward onto R2	S9999		

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S9999	Continued from page 4 right hand. V9 stated he heard a pop and looked at R2 noting R2's pinky appeared dislocated and V9 got the nurse. V9 stated there was another agency CNA in the building and V9 could have asked her for help but did not want to scare her off on her first time working in the facility by asking her to help with a difficult resident so he chose to proceed on his own. "B"	S9999		