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 12/30/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S0000	Initial Comments Investigation of facility reported incident of 12/10/25 - 2698715 Complaint Investigation 25612183 / 2692011	S0000		
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	S9999		

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

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S9999	Continued from page 1 knowledgeable about his or her residents' respective resident care plan. 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 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. Findings include: 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	S9999		

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S9999	Continued from page 2 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.	S9999		

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S9999	Continued from page 3 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. "A"	S9999		