

Illinois State Department of Health

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 03/18/2026	
NAME OF PROVIDER OR SUPPLIER EASTVIEW HEALTHCARE & SENIOR LIVING				STREET ADDRESS, CITY, STATE, ZIP CODE 100 EASTVIEW PLACE , SULLIVAN, Illinois, 61951			
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S0000	Initial Comments	S0000					
	Annual Health Survey						
S9999	Final Observations	S9999					
	Statement of Licensure Violations						
	300.1010b)						
	300.1010h)						
	300.1210a)						
	300.1210b)						
	300.1210d)5)						
	Section 300.1010 Medical Care Policies						
	b) The facility shall have and follow a written program of medical services which sets forth the following: the philosophy of care and policies and procedures to implement it; the structure and function of the medical advisory committee, if the facility has one; the health services provided; arrangements for transfer when medically indicated; and procedures for securing the cooperation of residents' personal physicians. The medical program shall be approved in writing by the advisory physician or the medical advisory committee.						
	h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.						
	Section 300.1210 General Requirements for Nursing and Personal Care						
	a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's						

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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. 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: 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. These requirements were not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide ordered nutritional supplements needed to promote wound healing and maintain weight for one (R5) of three residents reviewed for pressure ulcers on a sample list of 23. These failures resulted in R5 experiencing significant weight loss and the progression of a pressure injury on her left heel to Stage 4, complicated by a recent Methicillin resistant Staphylococcus aureus (MRSA) infection that caused R5 severe pain and isolation. Findings include:	S9999					

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S9999	Continued from page 2 The facility's "Prevention of Pressure Injuries" Policy dated April 2020 documents that the purpose of this procedure is to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors. In preparation staff will: Review the resident's care plan and identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable. Risk Assessment 1. Assess the resident on admission (within eight hours) for existing pressure injury risk factors. Repeat the risk assessment weekly and upon any changes in condition. 2. Use a standardized pressure injury screening tool to determine and document risk factors. 3. Supplement the use of a risk assessment tool with assessment of additional risk factors. Skin Assessment 1. Conduct a comprehensive skin assessment upon (or soon after) admission, with each risk assessment, as indicated according to the resident's risk factors, and prior to discharge. 2. During the skin assessment, inspect: a. Presence of erythema; b. Temperature of skin and soft tissue; and c. Edema. 3. Inspect the skin on a daily basis when performing or assisting with personal care or ADLs. a. Identify any signs of developing pressure injuries (i.e., non-blanchable erythema). For darkly pigmented skin, inspect for changes in skin tone, temperature, and consistency. b. Inspect pressure points (sacrum, heels, buttocks, coccyx, elbows, ischium, trochanter, etc.). c. Wash the skin after any episodes of incontinence, using pH balanced skin cleanser. Moisturize dry skin daily; and		S9999				

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S9999	Continued from page 3 e. Reposition resident as indicated on the care plan Prevention Skin Care 1. Keep the skin clean and hydrated. 2. Clean promptly after episodes of incontinence. 3. Avoid alkaline soaps and cleansers. 4. Use a barrier product to protect skin from moisture. 5. Use incontinence products with high absorbency. 6. Do not rub or otherwise cause friction on skin that is at risk of pressure injuries. 7. Use facility-approved protective dressings for at risk individuals. Nutrition 1. Conduct nutritional screenings for residents at risk. 2. Conduct a comprehensive nutritional assessment for any resident at risk of pressure injury who is screened to be at risk for malnutrition; and for all adult residents with a pressure injury. 3. Establish and implement a nutrition care plan for any resident with or at risk of a pressure injury who is malnourished or at risk of malnutrition. 4. Provide optimal hydration, nutrient, protein and calorie requirements as established by current practice guidelines. 5. Monitor the resident for weight loss and intake of food and fluids. 6. Include nutritional supplements in the resident's diet to increase calories and protein, as indicated in the care plan. Mobility/Repositioning 1. Reposition all residents with or at risk of pressure injuries on an individualized schedule, as determined by the interdisciplinary care team. 2. Choose a frequency for repositioning based on the	S9999					

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S9999	Continued from page 4 resident's risk factors and current clinical practice guidelines. 3. Teach residents who can change positions independently the importance of repositioning. Provide support devices and assistance as needed. Remind and encourage residents to change positions. Support Surfaces and Pressure Redistribution 1. Select appropriate support surfaces based on the resident's risk factors, in accordance with current clinical practice. Device-Related Pressure Injuries 1. Review and select medical devices with consideration to the ability to minimize tissue damage, including size, shape, its application and ability to secure the device. 2. Monitor regularly for comfort and signs of pressure-related injury. 3. For prevention measures associated with specific devices, consult current clinical practice guidelines. Monitoring 1. Evaluate, report and document potential changes in the skin. 2. Review the interventions and strategies for effectiveness on an ongoing basis. The facility's "Weight Assessment and Intervention Policy" dated March 2022 documents that resident weights are monitored for undesirable or unintended weight loss or gain. Policy Interpretation and Implementation Weight Assessment: 1. Residents are weighed upon admission and at intervals established by the interdisciplinary team. 2. Weights are recorded in each unit's weight record chart and in the individual's medical record. 3. Any weight change of 5% or more since the last weight assessment is retaken the next day for confirmation. a. If the weight is verified, nursing will immediately		S9999				

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S9999	Continued from page 5 notify the dietitian in writing. 4. Unless notified of significant weight change, the dietitian will review the unit weight record monthly to follow individual weight trends over time. 5. The threshold for significant unplanned and undesired weight loss will be based on the following criteria [where percentage of body weight loss = (usual weight – actual weight)/(usual weight) x 100]: a. 1 month – 5% weight loss is significant; greater than 5% is severe. b. 3 months – 7.5% weight loss is significant; greater than 7.5% is severe. c. 6 months – 10% weight loss is significant; greater than 10% is severe. Evaluation 1. Undesirable weight change is evaluated by the treatment team whether or not the criteria for "significant" weight change has been met. The evaluation includes: a. the resident's target weight range (including rationale if different from ideal body weight). b. the resident's calorie protein, and other nutrient needs compared with the resident's current intake. c. the relationship between current medical condition or clinical situation and recent fluctuations in weight; and d. whether and to what extent weight stabilization or improvement can be anticipated. 2. The physician and the multidisciplinary team identify conditions and medications that may be causing anorexia, weight loss or increasing the risk of weight loss. For example: a. cognitive or functional decline. b. chewing or swallowing abnormalities. c. pain. d. medication-related adverse consequences. e. environmental factors (such as noise or distractions)		S9999				

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S9999	Continued from page 6 related to dining). f. increased need for calories and/or proprotein. poor digestion or absorption. h. fluid and nutrient loss; and/or i. inadequate availability of food or fluids. Care Planning 1. Care planning for weight loss or impaired nutrition is a multidisciplinary effort and includes the physician, nursing staff, the dietitian, the consultant pharmacist, and the resident or resident's legal surrogate. 2. Individualized care plans shall address to the extent possible: a. the identified causes of weight loss. goals and benchmarks for improvement; and c. time frames and parameters for monitoring and reassessment. Interventions 1. Interventions for undesirable weight loss are based on careful consideration of the following: b. Nutrition and hydration needs of the resident. c. Functional factors that may inhibit independent eating. d. Environmental factors that may inhibit appetite or desire to participate in meals. f. Medications that may interfere with appetite, chewing, swallowing, or digestion. 2. Interventions for undesired weight gain consider resident preferences and rights. A weight loss regimen will not be initiated for a cognitively capable resident without his/her approval and involvement. 3. If a resident declines to participate in a weight loss goal, the dietitian will document the resident's wishes, and those wishes will be respected. R5's Minimum Data Set (MDS) dated 03/10/26 showed that R5's active diagnoses included Cancer, Diabetes Mellitus, Malnutrition, Anemia, and a Stage 4 Pressure	S9999					

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S9999	Continued from page 7 Ulcer. The MDS also documented that R5 had moderate cognitive impairment and was dependent on staff for rolling left and right in bed. R5's Care Plan dated 06/28/25 documented that R5 had the potential for pressure ulcer development related to incontinence, cancer, Type 2 Diabetes Mellitus, Peripheral Vascular Disease, Depression, and Pain. The Care Plan included an intervention dated 12/01/25 documenting that R5 had developed a pressure sore on the bottom of the heel from pressure against the floor. The intervention stated to encourage R5 to get in bed between meals and to educate the resident, family, and caregivers on causes of skin breakdown, including transfer and positioning requirements, the importance of taking care during ambulation and mobility, good nutrition, and frequent repositioning. The Care Plan also directed staff to monitor nutritional status, serve the diet as ordered, monitor intake, and record findings. R5's Care Plan dated 06/28/25 identified unplanned weight loss related to endometrial cancer, Type 2 Diabetes Mellitus, and edema. Interventions included notifying the dietitian if intake was poor for more than 48 hours, providing ordered supplements, alerting nursing and dietary staff if intake declined, contacting the physician and dietitian if weight loss persisted, monitoring and evaluating weight loss per facility protocol, documenting meal intake, and weighing the resident per protocol. R5's Electronic Health Record (EHR) showed a wound care note dated 12/11/25 by V24, Medical Doctor (MD/Wound Care), documenting that R5 had a newly identified Stage 2 pressure wound on the left heel. V24 described the wound as partial thickness, measuring 5 cm by 6 cm, with the depth not measurable. A wound care note dated 02/26/26 documented that R5's left heel pressure injury had progressed to a Stage 4 pressure wound measuring 3 cm by 5.5 cm by 1.9 cm. The note indicated a suspected infection, and a wound culture was obtained; results were pending. Laboratory results dated 03/05/26 documented that a culture of R5's left heel wound identified Methicillin resistant Staphylococcus aureus (MRSA), confirming the presence of an infection. Record review showed a progress note dated 10/16/25 by V16, Registered Dietitian (RD), documenting that R5 had experienced a 13.8% weight loss over one month and had increased nutritional needs due to R5's cancer and	S9999					

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S9999	Continued from page 8 wounds. The RD documented the weight loss as severe and related to overall decline. Recommendations included adding malnutrition as a diagnosis, providing fortified, high protein, calorie dense frozen supplements at all meals, and obtaining weekly weights. R5's EHR documents that on 01/14/26, the resident weighed 214 pounds. On 02/16/26, the resident weighed 182 pounds, reflecting a 14.95% weight loss over one month. There are no weights documented for the month of March. A progress note dated 02/03/26 by V16, RD, documented that R5 had multiple factors affecting her nutritional needs, including recent oral intake ranging from 76–100%, and at times 51–100%. The note also identified a Stage 4 pressure wound on the left heel measuring 3.5 cm by 4.5 cm, exacerbated due to infection. V16 also documented that no wheelchair was visualized. On 03/15/26 at 8:08 a.m., R5 was observed lying flat on her back in bed with the breakfast tray positioned on the bedside table over the bed. The tray did not include the ordered fortified, high protein, calorie dense frozen supplement. No staff were present offering assistance or encouraging R5 to transfer out of bed. No Enhanced Barrier Precautions (EBP) signage was posted outside R5's room. On 03/16/26 at 12:23 p.m., R5 was observed with her lunch tray. The ordered fortified, high protein, calorie dense frozen supplement was not present. R5 stated she did not know what the supplement was and did not think she had been receiving it. On 03/16/26 at 12:40 p.m., R5's dietary card was observed in the kitchen after lunch service. The card listed her name, allergies, and diet order (Controlled Carbohydrates, Regular texture, thin liquids). No supplements were listed. On 03/16/26 at 12:45 p.m., V17, Dietary Manager, stated that all supplements must be written on a resident's dietary card and confirmed R5's card did not list any supplement. V17 denied knowing that R5 had an ordered supplement. On 03/16/26 at 2:00 p.m., V3, Regional Vice President, confirmed R5's dietary card did not list the ordered supplement and stated the card was updated. A facility document titled "Diet Type Report" dated 03/16/26 documented that R5 was ordered a Magic Cup at meals.			S9999			

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S9999	Continued from page 9 On 03/17/26 at 12:46 p.m., V16, RD, stated that she last saw R5 in February. V16 stated she recommended high calorie supplements and that the facility is "notorious" for failing to hand out supplements with meals, and she often has to remind staff to place supplements on trays. V16 stated the supplement "would for sure assist with wound healing" for R5. V16 also stated R5 should be weighed weekly and that missed weights do not trigger a dietitian visit. R5's wound care notes dated 03/12/26, documented by V24, MD, documents that R5 continues to have a full thickness pressure wound on R5's left heel. "B"			S9999			