STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009237	A. BUILDING: _____ B. WING _____	C 12/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTVIEW TERRACE	100 EASTVIEW PLACE SULLIVAN, IL 61951

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S 000	Initial Comments Investigation of Facility Reported Incident of 12/11/21/IL141690	S 000		
S9999	Final Observations Investigation of Facility Reported Incident of 12/11/21/IL141690 STATEMENT OF LICENSURE VIOLATIONS: 300.610a) 300.1210b) 300.1210d)6) 300.3240a) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

Section 300.1210 General Requirements for Nursing and Personal Care
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.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These regulations were not met as evidenced by:

Based on record review and interview the facility failed to ensure that one (R1) resident was free from abuse out of four residents reviewed for abuse. This failure resulted in R1 being physically abused by another resident (R2) causing harm resulting in Hyphema of Left Eye and Vitreous Hemorrhage of Left Eye for R1.

Findings include:

R1's Physician Order Sheet (POS) documented acute diagnoses of Hyphema of Left Eye, Vitreous Hemorrhage of Left Eye and history of Cerebral Vascular Accident, Pacemaker, Right Hemiparesis, History of Subdural Hematoma, Seizures. This same POS documents a

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S9999	Continued From page 2 Physician order for Xarelto 10 milligrams (mg) (anti-coagulant) one time daily. R1's Minimum Data Set (MDS) dated 10/19/21 documents modified independence in decision making skills and R1 requires extensive assistance of one person for personal hygiene and toileting. This same MDS documents R1 requires extensive assistance of two people for bed mobility, transfers and dressing. R1's Nurse Progress Noted dated 12/11/21 at 7:05 PM documents "(R1) came to the lobby very upset, had large swollen and bleeding Left eye. (R1) stated that another resident (R2) had come behind (R1) and hit (R1) in the back of the head and Left eye." R1's Hospital Emergency Room Progress Note dated 12/11/21 documents diagnoses of Hyphema of Left Eye, Left Ocular Hemorrhage and Periorbital Hematoma of Left eye. R1's Final Abuse Investigation Report to Illinois Department of Public Health (IDPH) dated 12/16/21 documents "After a thorough investigation the facility determined that the incident did occur." The facility Abuse Prevention Program Policy revised 11/28/2016 documents the following "The facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, and exploitation. The facility is committed to protecting residents from abuse including but not limited to facility staff, other residents, consultants, volunteers, staff from other agencies providing services to the individual family members or legal guardians, friends, or any other individuals. Abuse is the willful	S9999		

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infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, mental anguish or pain. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm."

On 12/2/21 at 3:45 PM V5 Maintenance Director stated had a good rapport with (R2). "(V5) had helped (R2) with (R2) television before and (R2) seemed to like (V5). (R2) had been sent into the hospital for health reasons and was released on 11/12/21. (R2) needed a ride back to facility so (V5) took the facility van to pick (R2) up at the hospital. (R2) was talking with (V5) pleasantly at the hospital and on the way back to the facility. We (V5 and R2) were making casual conversation. (V5) had to stop at at stop sign and when (V5) turned on to the highway, (R2) had unbuckled (R2) seatbelt and began to hit (V5) in the head from the back. (V5) pulled the van over at the first safe place (V5) could and got out of the van with the keys in hand. (R2) was inside the van. (R2) then unlocked the door and exited the van. (R2) was walking down the highway. (V5) was waving (V5) shirt around above head to vear off traffic so (R2) wouldn't get hit by another car. (V5) had already called the facility and 911. The 911 dispatcher called the sheriff's office also. As (R2) was walking down the highway and (V5) was walking a safe distance with (R2) when the county Sheriff arrived. The sheriff placed (R2) in the back of the police car. When the ambulance arrived, (R2) was assisted from the back of the police car into the ambulance per the Sheriff and ambulance crew. (V5) returned to facility. (V5) declined medical treatment and decided to not press charges against (R2). The ambulance took (R2) back to the hospital for evaluation." V5 stated "the next day (12/13/21) (R2) was released

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from the hospital again and again needed a ride back to the facility. (V5) and V2 Director of Nurses used facility van to pick (R2) up from the hospital. V2 was driving and (V5) was sitting up front in the passenger seat. (R2) was buckled in the back seat. As V2 was driving, (R2) reached from the back seat and grabbed V2 by the arm attempting to pull V2 out of the drivers seat. V5 was attempting to remove R2's hands from V2 while (V2) was driving. R2 began punching V5 in the face, bloodying V5 lip. V2 pulled the van over, the sheriff and the ambulance met us (R2, V2, V5) on the highway again and R2 was released to the ambulance crew. R2 was returned to the hospital and was admitted."

On 12/23/21 at 9:55 AM V2 Director of Nurses stated (R2) was released from the hospital on 11/13/21. (V2) was working that night and the hospital called to say (R2) needed a ride back to the facility. V5 Maintenance Director and (V2) drove the facility van to pick up (R2) from the hospital. On the way back, (R2) was sitting in the backseat and out of nowhere (R2) started pulling hard on (V2) right arm. (R2) was trying to pull (V2) out of the drivers seat as we (R2, V2, V5) were in motion. (V5) intervened, attempting to release (R2) grip on (V2) arm and (R2) then started punching (V5) in the face. (V2) think (R2) bloodied (V5) lip. (V2) was able to pull the van over and the sheriff picked up (R2). (R2) was delivered to the ambulance staff on the highway. (R2) was taken back to the hospital and then they (hospital) kept him (R2) this time. There didn't seem to be any reason (R2) became aggressive. It came out of nowhere." V2 Director of Nurses stated "I was the nurse on duty the day (12/11/21) (R2) hit (R1). (R2) was upset after supper time. (R2) kept looking for (R2) family and wanted to call family. (R2) was assisted in

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calling R2's wife and temporarily calmed down. V2 stated "we (staff) knew (R2) was agitated with (V2) so asked V8 Certified Nurse Aide (CNA) to assist (R2). (R2) likes (V8). (R2) allowed (V8) to assist (R2) to bed and (R2) was calm again for awhile. Then, (R2) walked out of (R2) room and sat in the lobby area. (R2) then became agitated again. (R2) walked over to V2 and attempted to hit V2 in face with R2 elbow. (R2) called (V2) names and yelled "F*** off". (R2) allowed V8 CNA to assist (R2) back to room to watch television and calmed again. A few minutes later, (R2) walked up to lobby and sat down again. (R1) wheeled self out to nurses station. (R1) was yelling at (R2) and seemed very distraught. (R1)'s left eye was bleeding, swollen and very bruised. (R2) stood up and started walking towards (R1), so (V2) intervened. (V8 CNA) stayed with (R2) and (V2 DON) assessed (R1) eye, applied ice to (R1) left eye and started making phone calls. The 911 dispatcher stated two ambulances would be dispatched, one for each resident. I (V2) would not have guessed (R2) would injure another resident. (R2) had behaviors with staff prior to this, but never with any other residents."

On 12/23/21 at 3:45 PM V1 Administrator stated "(R2) was agitated that evening (12/11/21) but that happens sometimes with Dementia. (R2) can get agitated in the evening, so the staff assist (R2) in calling family and (R2) calms down. The evening of 12/11/21, (R2) became agitated with staff and calmed after staff helped (R2) call family. We (staff) think (R2) became confused after using the bathroom and exited out the other resident (R1) door into (R1) room (R1 and R2 live in separate rooms that share a bathroom). (R2) must have thought (R1) was in (R2) room and started hitting (R1). As soon as the staff were

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S9999	Continued From page 6 made aware of the situation, (R1) and (R2) were both placed on 1:1 status until they were released to the ambulance crews. (R1) and (R2) left facility in two separate ambulances. The police were called, there was a police report made and they (police) came to facility and questioned both residents and staff. (R1), (R1)'s family and staff all declined to press charges against (R2). The other residents were never in any danger. (R2) had never had any behaviors towards other residents prior to this." On 12/23/21 at 3:30 PM V11 Medical Director stated "facility is not able to care for this resident due to unprovoked outbursts. (R2) has a long history of mental health issues, but nothing ever this violent. The facility should have sent R2 to emergency room after physical altercations with staff on evening of 12/11. They (facility) could have gotten an order for a one time dose of a medication to calm the resident, placed (R2) on 1:1's or just sent (R2) to Emergency Room (ER). They (facility) shouldn't wait for the Physician to call back. They (facility) should have just sent (R2) out. This is the worst resident to resident abuse I have ever seen in decades of being a Medical Director. This episode of violence came out of nowhere. It was an isolated event. This resident did not have any other behaviors towards other residents. I (V11) don't believe any other residents were ever in jeopardy. The facility couldn't have known (R2) was going to have this outburst." (B)	S9999		