Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		IL6009237	B. WING		10/24/2023
NAME OF SPOURSES OF SUSSIES					1 10/2-112-02-0
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE					
EASTVIEW TERRACE 100 EASTVIEW PLACE SULLIVAN, IL 61951					
(X4) ID				ID PROVIDER'S PLAN OF CORRECTION	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE COMPLETE CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)	
S 000	Initial Comments		S 000	***	
	Annual Licensure S	urvey			
	Investigation of Facility Reported Incident of 9/12/23/IL165215				
S 999 9	P99 Final Observations		S9999		
	Statement of Licensure Violations:				
	300.610a) 300.1210b)				
	Section 300.610 Resident Care Policies				
	procedures governi facility. The written be formulated by a Committee consisting administrator, the a medical advisory conformation of nursing and othe policies shall complete the facility and shall	dvisory physician or the immittee, and representatives in services in the facility. The y with the Act and this Part. shall be followed in operating be reviewed at least annually focumented by written, signed			
	Section 300.1210 (Nursing and Persor	General Requirements for al Care			
	care and services to practicable physical well-being of the res each resident's com plan. Adequate and care and personal of	shall provide the necessary attain or maintain the highest , mental, and psychological sident, in accordance with aprehensive resident care properly supervised nursing eare shall be provided to each		Attachment A Statement of Licensure Violati	ons
Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE					

STATE FORM

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If con inua ion sheet 1 of 3

PRINTED: 12/21/2023 FORM APPROVED Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ B. WING IL6009237 10/24/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **100 EASTVIEW PLACE EASTVIEW TERRACE** SULLIVAN, IL 61951 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (XS) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG **DEFICIENCY**) S9999 Continued From page 1 59999 resident to meet the total nursing and personal care needs of the resident. These requirements were not met as evidenced by: Based on interview and record review the facility failed to protect the resident's right to be free from physical abuse by another resident for two residents (R23, R46) of 16 residents reviewed for abuse on the sample list of 29. This failure resulted in R23 requiring emergency services for lacerations to the bridge and left side of the nose. Findings include: The facility's final report to Illinois Department of Public Health dated 9/18/23 documents on 9/12/23 at 2:00 PM, R46 was standing in the hallway at the end of the hall near R23's room. R23 wheeled himself to the door and then stood up and "went at" R46 screaming for R23 to not go in his room. R46 reacted by hitting R23 in the nose and R23 hit him back. R23 and R46 were immediately separated and assessed. R46 had no injuries but R23 had a laceration on the bridge of the nose. Both were sent to the Emergency room. R23's Hospital records dated 9/12/23 document R23 has a one centimeter laceration to the bridge and side of the nose. This record indicates the lacerations are caused from a resident to resident

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altercation that occurred in the facility.

On 10/24/23 at 1:01 PM, V16 Housekeeper stated on 9/12/23 she witnessed the incident between R23 and R46. V16 stated: R23 was in his room and R46 was out in the hallway. R23

PRINTED: 12/21/2023 FORM APPROVED Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ____ IL6009237 B. WING_ 10/24/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **100 EASTVIEW PLACE EASTVIEW TERRACE** SULLIVAN, IL 61951 **SUMMARY STATEMENT OF DEFICIENCIES** PROVIDER'S PLAN OF CORRECTION (XS) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE **DEFICIENCY**) S9999 Continued From page 2 59999 thought R46 was going to go into his room. R46 was just by the door. Then R23 started yelling at R46. V16 stated she got in between them and was really scared. V16 stated they were punching each other in the face. V16 stated several Certified Nursing Assistants came and separated them. R23 had to go to the hospital for a laceration on the nose. On 10/23/23 at 1:45 PM, V1 Administrator stated on 9/12/23, R23 and R46 were in a resident to resident altercation in which they struck each other. (B)

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