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 02/02/2023

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 Facility Reported Incident	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.3210t) 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. Section 300.3210 General	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. These regulations were not met as evidenced by: Based on observation, interview and record review the facility failed to ensure residents were not subjected to physical and mental abuse by another resident. This failure affects five (R1, R2, R3, R4, R5) of five residents in the sample list of five residents reviewed for abuse. These failures resuled in R4 being repeatedly struck in the head by another resident(R3), also R4 and R5 experiencing mental anguish caused by R3. Findings include: 1) On 1/21/23 at 10:30AM, the facility provided investigation documents that R3 struck R4 on the head and face repetitively until V8 Certified Nursing Assistant (CNA) pulled R3 off of R4. R4's nurse's notes dated 1/21/23 document, "R4 was walking back to his room after getting a shower and passed another resident in the hall, by R4's door. R3 started to walk past and turned around and punched R4 in the back of the head and on the right side of the face and kept swinging until (V8 CNA) separated them. Nurse's notes of the same date document the physician orders to monitor R4 closely due to R4's history of stroke and use of blood thinners, post head injury. On 2/1/23 at 2:50PM, R4 stated, "I remember walking down the hall and all of a sudden I felt a	S9999		

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S9999	Continued From page 2 blow to my head from behind and he kept hitting me until (V8CNA) got him off of me. I have seen him hit staff and come close to hitting other residents and I am very fearful that he will come back to my room and I will have to defend myself. In the dining room, I won't sit anywhere but with my back to a wall because of him. I didn't used to do that, but I felt safer then. I have to be more alert because of him." R4's admission note dated 1/12/23 documents R4 as cognitively intact. R3's minimum data set dated 12/12/22 documents R3 as severely cognitively impaired and ambulatory. On 2/1/23 at 3:00PM, V7 Licensed Practical Nurse (LPN) stated, "I was the nurse the night that (R3) hit (R4). (R4) was walking down the hall and a CNA was coming out of another resident room and R3 just started hitting (R4). There was no provocation. R3 is definitely a hitter. I am concerned for the safety of the residents and staff. (R3) will come up behind you and you just never know what he is going to do." 2) R3's medical record documents that on 10/3/22, R3 was sent to a behavioral health hospital for an inpatient stay to address increasing aggression in the nursing home including punching, kicking, biting, hitting and exit seeking." R3's December 2022 and January 2023 behavior monitoring sheets document physical aggression and wandering. R3's nurse's notes dated 1/29/23 document at 10:00AM, "Consent received for haldol 1 milliliter intramuscularly for aggression to others, throwing over tables and agitation. Nurse's notes on the same date from 2-10PM document that R3 was agitated and attempted to go out the side doors several times and was combative with staff when redirected.	S9999		

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S9999	Continued From page 3 R3 was also documented as wandering into other resident rooms, getting into their beds and being resistive to all redirection and care. On 2/1/23 at 9:08AM, V1 Administrator stated, "He (R3) wanders in and out of other resident rooms. He is on 15 minute checks and we have tried to find alternative placement, but his family wants him to stay here." On 2/1/23 at 9:30AM, R3 was walking around the facility, wearing a wander guard going into and out of resident rooms. On 2/1/23 at 9:35AM, V5 Certified Nursing Assistant (CNA) stated, "R3 wanders in and out of resident rooms all day long. We just redirect him. On 2/1/23 at 9:36AM, V6 CNA stated, (R3) lays down in beds that aren't his but since he's on 15 minute checks, we find him pretty fast. He can be aggressive when we give care, sometimes it takes 3 people because he is strong and fast." On 2/1/23 at 10:00AM, R3 walked into R5's resident room and stayed there until R5 could be heard screaming, "Get out! This is a girl's room. Get out now!!!!" Staff entered the room at this time and redirected R3 out of the room. On 2/1/23 at 2:25PM, R5 stated, "(R3) comes in here all of the time and I don't like it. I yell at him and tell him that this is a girl's room. I have told the CNA's that I don't want him in here. Thank you for helping me." On 2/1/23 at 3:05PM, V7 LPN stated, "On Sunday night (1/29/23) I found (R3) trying to get into (R5's) bed while she was sleeping. He was trying to pull up the covers and I tried to redirect him but he fought me so I had to yell for help and thank god, two other staff came and helped me get him	S9999		

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S9999	Continued From page 4 out of her bed." 3) On 12/26/22 at 2:25PM, the facility provided investigation documents that R2 came out of the resident room that R1 and R2 shared and stated to a nurse that R1 had scratched his face. On 2/1/23 at 9:08AM, V1 Administrator stated, "I was the nurse that day and R2 came out of his room and said that R1 had scratched his face. He did have new scratches on his face and hand. I went down to talk to R1 and he said that R2 had started it. I immediately separated them and made all of the notifications." On 2/1/23 at 2:31PM, R1 was calmly lying in his bed, in a private room. R1 stated that he remembered arguing with his roommate and that he was glad that he didn't have one any longer. On 2/1/23 at 10:30AM, R2 stated that he liked the facility and that he did not remember being scratched by anyone however; old scratch marks were visualized on the right side of R2's face. R1's minimum data set dated 12/5/22 documents R1 as severely cognitively impaired and wheel chair bound. R2's minimum data set dated 1/5/23 documents R2 as severely cognitively impaired and wheel chair bound. On 2/1/23 at 9:15AM, V1 Administrator stated, "We separated them(R1,R2) into different rooms and they are both scheduled to see a psychologist. There have been no further issues between them, since this event." On 2/1/23 at 3:15PM, V9 Director of Nursing stated, "Both R1 and R2 dislike having roommates. We are just going to have to keep	S9999		

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S9999	Continued From page 5 them in their own rooms." The facility abuse policy dated 11/28/16 documents that this facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property and exploitation, as defined below. This includes, but is not limited to, freedom from corporal punishment, involuntary seclusion and any physical or chemical restraints not required to treat the resident's medical symptoms. This facility therefore prohibits mistreatment, exploitation, neglect or abuse of its residents, and has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of mistreatment, exploitation, neglect or abuse of our residents. This will be done by various means including dementia management and resident abuse prevention including, how to assess, prevent and manage aggressive, violent and/or catastrophic reactions of residents in a way that protects both residents and staff. (B)	S9999		