(X6) DATE

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION ( A. BUILDING:		(X3) DATE SURVEY COMPLETED		
IL6009211			B. WING		03/1	2/2025
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
SULLIVA	N HEALTHCARE & S	FNIOR I IVING	THORNE LAN AN, IL 61951	<b>E</b>		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
S 000	Initial Comments		S 000			
	First Probationary L	Licensure Survey				
S9999	Final Observations		S9999			
	Statement of Licens	sure Violations:				
	300.1210b)3)4) 300.1210 d)4)A)B)0	C)				
	Section 300.1210 ( Nursing and Person	General Requirements for nal 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. Restorative measures shall include, at a minimum, the following procedures:					
	3) All nursing personnel shall assist and encourage residents so that a resident who is incontinent of bowel and/or bladder receives the appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. All nursing personnel shall assist residents so that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary.		t			
		personnel shall assist and ts so that a resident's abilities				

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

04/05/25 **Electronically Signed** 

TITLE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			, Joseph G.			
IL6009211		B. WING		03/1	2/2025	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SULLIVA	N HEALTHCARE & S	FNIOR I IVING	HORNE LAN N, IL 61951	E		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETE DATE
S9999	Continued From pa	ige 1	S9999			
59999	in activities of daily circumstances of the demonstrate that don't have speed functional community who is unable to cashall receive the segood nutrition, ground of the physician.  B) Each residence of the demonstrate that don't have speed functional community who is unable to cashall receive the segood nutrition, ground of the pursuant to the nursing care shall infollowing and shall seven-day-a-week  4) Personal cast-hour, seven-day include, but not be  A) Each residence personal attention, oral hygiene, in additional baths and additional baths and additional baths and seven-day includes the physician.	living do not diminish unless ne individual's clinical condition iminution was unavoidable. esident's abilities to bathe, transfer and ambulate; toilet; th, language, or other ication systems. A resident arry out activities of daily living ervices necessary to maintain oming, and personal hygiene. Include, at a minimum, the be practiced on a 24-hour, basis:  The shall be provided on a deva-week basis. This shall limited to, the following:  The shall have proper daily including skin, nails, hair, and dition to treatment ordered by the shall have at least one hair wash weekly and as many did hair washes as necessary	29999			
	for satisfactory personal hygiene.  C) Each resident shall have clean, suitable clothing in order to be comfortable, sanitary, free of odors, and decent in appearance. Unless otherwise indicated by his/her physician, this should be street clothes and shoes.					
	These Requirements are NOT MET as evidenced by:					

Illinois Department of Public Health

Based on observation, interview, and record

STATE FORM 6899 XLSC11 If continuation sheet 2 of 6

NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  11 HAWTHORNE LANE		STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
SULLIVAN HEALTHCARE & SENIOR LIVING 11 HAWTHORNE LANE	IL6009211		B. WING		03/12/2025		
SULLIVAN, IL 61951	SULLIVAN HEALTHCARE & SENIOR LIVING 11 HAWTH			HORNE LAN	_		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CO	PRÉFIX	IX (EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETE DATE
Sepses  Continued From page 2 review the facility failed to provide showers, shaving, hair washing, face washing, clean clothes, assistance with eating and toileting to prevent odors for five (R1, R2, R3, R4, & R5) of seven residents reviewed for personal care from a total sample list of 11 residents.  Findings include:  The facility provided resident council minutes dated 2/6/25 document that residents were complaining that they are not getting showers as often as they would like.  The facility policy dated 3/20/23 documents that the facility is to ensure that adequate hygiene needs are met and that a bath/shower is scheduled for all residents at least weekly.  1.) R1's undated care plan documents R1 requires an assist of one for bathing as a result of right side hemiplegia.  R1's Minimum Data Set dated 2/26/25 documents that R1 is cognitively intact.  On 3/10/25 at 10:00AM, V1 Administrator stated R1 is the facility Resident Council President.  On 3/10/25 at 3:30PM, R1 was sitting in a chair watching television with a beard that was unkept, including food remnants in it.  On 3/10/25 at 3:30PM, R1 stated he does not always get a shower every week and he would really like them twice a week. R1 stated this issue has been brought up in resident council.  On 3/12/25 at 3:00PM, V1 Administrator stated,	\$9999	review the facility fashaving, hair wash clothes, assistance prevent odors for fiseven residents rea total sample list of Findings include:  The facility provide dated 2/6/25 docur complaining that the often as they would the facility is to ensineeds are met and scheduled for all reactions. All is undated or requires an assist or right side hemipleg. R1's Minimum Data that R1 is cognitive. On 3/10/25 at 10:0 R1 is the facility Reaction of the	failed to provide showers, hing, face washing, clean be with eating and toileting to five (R1, R2, R3, R4, & R5) of eviewed for personal care from a of 11 residents.  The desident council minutes ament that residents were they are not getting showers as all like.  Indicated 3/20/23 documents that assure that adequate hygiene did that a bath/shower is residents at least weekly.  The care plan documents R1 to of one for bathing as a result of egia.  The set dated 2/26/25 documents rely intact.  The documents R1 to one for bathing as a result of egia.  The set dated 2/26/25 documents rely intact.  The set dated 2/26/25 documents rely intact.	S9999			

Illinois Department of Public Health

STATE FORM 6899 XLSC11 If continuation sheet 3 of 6

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		R WING				
IL6009211			B. WING		03/1	2/2025
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S H <b>ORNE LAN</b>	STATE, ZIP CODE		
SULLIVA	N HEALTHCARE & S	FNIOR LIVING	I, IL 61951	_		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
S9999	Continued From pa	ige 3	S9999			
	down and take a shower and she didn't know why it wasn't being done.					
		are plan documents R2 of one for bathing and history of a stroke.				
	R2's Minimum Data Set dated 2/20/25 documents R2 is cognitively intact.					
	On 3/10/25 at 10:19 with greasy hair.	5AM, R2 was sitting up in bed				
	On 3/10/25 at 10:15AM, R2 stated, "We (residents) aren't getting our showers like we are supposed to. I told the staff that I wanted a shower today and they said I wouldn't be getting one. I am supposed to get a shower every Wednesday and Saturday and I didn't get either of them last week."					
	blind in the left eye	are plan documents that R3 is with low vision in the right eye sist of one for bathing and				
	R3 requires assista	a Set dated 2/20/25 documents ance for activities of daily living g and eating and R3 is vely impaired.				
	present include a 5	mented from admission to .5 percent weight loss over to intervention or assessment				
	reddened eyes. Us	OAM, R3 was lying in bed, with sed tissues were strewn about as wearing pajamas.				

Illinois Department of Public Health STATE FORM

6899 XLSC11 If continuation sheet 4 of 6

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				ATE SURVEY DMPLETED	
IL6009211		B. WING		03/12/2025			
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
SULLIVAN HEALTHCARE & SENIOR LIVING			IORNE LAN I, IL 61951	E			
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S9999	Continued From pa	ge 4	S9999				
		IAM, R3 stated, "I'm blind and ues). Can you help me?"					
	the tray table to her on it with no staff as down while trying to has food and drink	5PM, R3 was lying in bed with side with the lunch tray laying ssistance. R4 was laying eat and drink on her own and all over her pajamas. R4 had her lunch and stated that she					
	On 3/10/25 at 3:35F not know how often	PM, R3 stated that she does she gets showers.					
	with food on her clo	PM, R3 was sitting up in bed thing and tomato sauce on ttempting to eat chili in her sisting her.					
		dated 2/12/25 documents R4 with bathing/showering and					
		Set dated 2/26/25 documents act and requires assistance s.					
		PM, R4 stated that she cannot hat she had a shower, but that					
	dependent on staff daily living including	re plan documents R5 is to perform his activities of bathing, hygiene, eating, ng facial hair shaved.					
		5AM, R5 was hanging out of rly falling to the floor, while					

Illinois Department of Public Health STATE FORM

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1` '			(X3) DATE SURVEY COMPLETED	
AND I DAY OF CONTROL IS ENTIRED.			A. BUILDING:			
		IL6009211	B. WING		03/	12/2025
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
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\$9999	his wheelchair. R5 and in his wheelchair with an unshaven for to assist R5, they rewheelchair and the patty, smelling of unclothing, while still under the patty observed R5 and soleaned up and take been done.  On 3/11/25 at 9:40/2 that she would expand to a still under the patty of the patt	AM, R5 was laying sideways in had food on his face, clothing, air, smelling strongly of urine, ace. When staff were asked epositioned him in his n left him sitting on an eggrine, with food on his face and unshaven.  AM, V8 Registered Nurse tated that she would get him en care of because it had not AM, V1 Administrator stated ect R5 to be assisted with his	S9999			

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