

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105727	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/25/2025
NAME OF PROVIDER OR SUPPLIER Washington Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 879 Usery Road Chipley, FL 32428	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on record reviews and interviews, the facility failed to ensure allegations of neglect were reported timely for 2 of 2 sampled residents. (Residents #3 and #8) The findings include: Resident #8</p> <p>On 11/24/25, a record review was conducted for Resident #8. The review revealed the resident sustained a fracture of the right knee during a 1 person assist transfer from their bed to a wheelchair.</p> <p>On 11/24/25 at 11:00 AM, an interview was conducted with Staff B, a licensed practical nurse (LPN), who performed the transfer. The LPN stated he broke protocol when getting the resident up for a medical appointment. He stated that the resident needs a mechanical lift for all transfers but the lift could not be found, so he asked the resident if she could pivot and she agreed. He was the one who got the resident up and used a pivot turn to transfer the resident from the bed to the wheelchair. There did not seem to be any issues after the transfer so he did not think to say anything. It was not until later that the resident complained of knee pain.</p> <p>On 11/25/25 at 9:52 AM an interview was conducted with the Administrator, who stated she did file a state Adverse report for the fracture due to failure to follow the plan of care, but did not start an investigation into neglect as she believed the issue was limited to not following the plan of care.</p> <p>Resident #3</p> <p>An interview was conducted with the Social Services Director (SSD) and Director of Nursing (DON) on 11/24/25 at 2:30 PM concerning an issue where Resident #3 had an undetected broken hip which eventually led to hospitalization on 9/5/25 The SSD got a call on Labor Day that Resident #3 was at the hospital and had a fractured hip. The Risk Manager had a statement that another resident had rolled up to Resident #3 to speak to her and rolled too close to her leg, and the wheel of the wheelchair came between her legs, which caused Resident #3 to yell out. The next day the facility found a bruise in the same area. The DON stated they did not think it was hard enough to cause any injury.</p> <p>Further interview was conducted with the SSD and the Administrator on 11/24/25 at 2:45 PM. The Administrator was asked why the facility did not file a federal report with the state agency regarding the allegation of neglect for Resident #3; she stated they did not feel the incident rose to the level of neglect.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the undated facility policy for Abuse, Neglect, Exploitation, Misappropriation of Property, and Injury of Unknown Source revealed a definition of Neglect: Neglect means the failure of the facility, its employees or service providers to provide good and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Neglect occurs when the facility is aware of, or should have been aware of, goods or services that a resident(s) requires but the facility fails to provide them to the resident(s), that has resulted in or may result in physical harm, pain, mental anguish or emotional distress. Neglect includes cases where the facility's indifference or disregard for resident care, comfort or safety, resulted in or could have resulted in, physical harm, pain, mental anguish or emotional distress. Federal reporting requirements: immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, report to the Agency for Health Care Administration's Complaint Administration Unit.</p>		