STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145000	A. Building B. Wing	09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Washington Senior Living	1201 Newcastle Washington, IL 61571

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)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33973 Based on observation, interview, and record review, the facility failed to protect a resident (R2) from sexual abuse by another resident (R1) and failed to ensure a resident (R4) was free from physical abuse by another resident (R3) with a known history of verbal and physical aggression for two of four residents reviewed for abuse in a sample of six. This failure resulted in R3 verbally yelling and physically slamming his door on R4's hand. R4 sustained bleeding lacerations and fractures to three fingers on R4's right hand which required hospitalization evaluation where 12 sutures were placed to R4's fingers; further surgical intervention is pending. These failures have the potential to affect R4 and other dementia residents residing in the facility. This failure resulted in an Immediate Jeopardy. While the immediacy was removed on 9/24/24, the facility remains out of compliance at Severity Level 2 as additional time is needed to evaluate the implementation and effectiveness of the facility's removal plan and quality assurance monitoring. Findings include: 1. The facility's Abuse Prevention Program policy, dated 10/2022, documents, This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. In order to do so, the facility 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 abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff and mistreatment of residents. This policy continues with This facility is committed to protecting our residents from abuse, neglect, exploitation, misappropriation of property and mistreatment by anyone 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. This policy also states Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical hare, pain, or mental anguish to a resident .The term 'willful' in the definition of 'abuse' means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145000	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/25/2024
NAME OF PROVIDER OR SUPPLIER Washington Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 Newcastle Washington, IL 61571	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's undated Residents Rights Statement documents, All residents have a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. This facility will protect and promote the rights of each resident, including each of the following rights: 38. The resident has the right to be free from verbal, sexual, physical, or mental abuse, corporal punishment, and involuntary seclusion .47. The facility will provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. R3's current Face sheet documents diagnoses including but not limited to Restlessness and Agitation, Acute Kidney Failure, and Cognitive Communication Deficit R3's Minimum Data Set/MDS assessment, dated 7/15/24, documents R3 as cognitively intact with behaviors including physical symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually), verbal symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others), rejection of cares, and wandering. R3's Documentation Survey Reports for behavior tracking, dated August 2024 and September 2024, document R3 displayed behaviors including yelling/screaming, kicking/hitting, grabbing, pinching/scratching/spitting, wandering, abusive language, threatening behavior, sexually inappropriate and rejection of cares. R3 had one or more of these type of behaviors on one or more shifts on the following dates: 8/4, 8/9, 8/10 - 8/12, 8/14 - 8/16, 8/19 - 8/22, 8/24, 8/25, 8/28 - 8/30, 9/1, 9/3, and 9/8/24. Also documented is (R3's) response to staff interventions including any one or more of these responses: Increased activity/mobility/agitation, Combative (physically and/or verbally), and Unable to redirect/engage. R3's Progress Note, dated 8/1/24 by V11 Licensed Practical Nurse/LPN, documents, Resident became combative upon room entry. R3's Progress Note, dated 8/11/24 by V12 Registered Nurse/RN, documents, Describe behavior: Patient (R3) slammed peer's (R4's) hands into his (R3's) door when she (R4) was standing in his doorway. Patient (R3) was cursing at peer (R4) stating 'get out of my f***ing room or I will hurt you.' Before staff could diffuse situation patient (R3) did slam both (R4's) hands into his door. Environmental, Physiological, Psychosocial factors/triggers: Patient (R3) is easily agitated with aggressive tendencies and stated after slamming peer's (R3's) hands into the door, 'I don't f***ing care if I hurt her (R4) or not, damn b**ch does not need to be in here.' While assessing peer (R4) out in the hall patient (R3) came out of room shouting that he did not cause this harm but rather staff. Patient (R3) was making false accusations against staff stating that they slammed her (R4's) hands into the door. Intervention: Reviewed with patient (R3) that we needed to take care of peer (R4) involved and that they needed to go back into their room which he (R3) slammed the door and told all staff 'We can go f*** ourselves.' Resident response: did not come out of room. Notifications made: Director of Nursing notified. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Washington Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 Newcastle Washington, IL 61571	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R3's Progress Note, dated 8/22/24 by V3 Director of Nursing/DON, documents, Staff approached this nurse stating resident (R3) punched CNA (Certified Nursing Assistant/V11) in the stomach and the face. (V11) states when (V11) went into resident room to deliver room tray to resident (R3) when he (R3) punched her (V11) in the stomach and then the face. (V11) has notable red mark to her stomach where resident (R3) punched her. Police called and resident (R3) stated to police, 'I have told them I don't want their food.' Police took report. Report number 26-01054. Resident sent to (named hospital) for psych (psychiatric) eval (evaluation). R3's Nurse Practitioner Progress Note, dated 8/23/24, includes but is not limited to: Restlessness and agitation. Patient (R3) frequently having behaviors and agitation. He has made multiple attempts to harm staff and other residents. Staff injury reported today. Patient (R3) to be sent to the hospital for a psych evaluation. Patient (R3) is considered a threat to the safety of others and is not appropriate to reside in this long-term care setting. Patient refuses to see rounding mental health provider. HPI (History of Present Illness) Interval History: Staff report patient (R3) continues to have aggressive and harmful behaviors towards staff and other residents. Today, a staff member was providing patient with a meal tray and patient punched the staff member. He (R3) has had episodes of yelling while using profanity and hitting in the past. He often throws dishes in his room with the attempt to break them and subsequently poses risk to himself and staff members. Patient has previously slammed his door on another resident's fingers while yelling profanity at that resident. He has put other residents' safety at risk and vocalizes no remorse for injuring others. Patient is noncompliant with cares and medication orders despite frequent attempts to educate on the importance of bathing, eating, and taking medications as ordered. R4's current Face sheet documents diagnoses including but not limited to Unspecified Dementia, Unspecified severity, without Behavioral disturbance, Psychotic disturbance, Mood disturbance, and Anxiety; Chronic Kidney disease, stage 3; Displaced Fracture of middle phalanx of right middle, right ring, and right little finger; Presence of Cardiac Pacemaker; Syncope and collapse, and Weakness. R4's MDS assessment, dated 6/27/24, documents R4 is severely cognitively impaired and wanders. R4's current Care plan includes a focus of: (R4) has impaired cognitive function/dementia or impaired thought processes r/t (related to) Dementia with interventions including but not limited to (R4) requires approaches that maximize involvement in daily decision making and activity limit choices, use cueing, task segmentation, written lists, instructions. R4's Progress Note, dated 8/11/24 by V12 Registered Nurse/RN, documents Resident (R4) noted by staff walking into peers (R3's) room. Peer (R3) became immediately agitated and yelled 'get out of my f***ing room.' While staff was attempting to redirect resident (R4) out of peer's (R3's) room, Peer (R3) slammed the door and caught resident's (R4's) hands in the door. Immediate blood noted to right hand. Staff helped patient (R4) into chair and vitals started. Patient (R4) was found to be diaphoretic and very pale. Patient's (R4's) pulse ox (oximetry) was 76% upon assessment and patient (R4) was holding chest. Blood pressure was not palpable. Patient (R4) had head back in wheelchair .911 call placed for emergent transport to (named hospital). R4's Hospital After Visit Summary, dated 8/11/24, documents Reason for Visit: Loss of Consciousness; Diagnoses: Loss of consciousness, Crushing injury of right hand, initial encounter. (continued on next page)

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Washington Senior Living	1201 Newcastle Washington, IL 61571

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R4's Progress Note, dated 8/11/24, documents, Resident brought back to facility by daughter (POA/Power of Attorney) around (3:00pm), resident assessed and vitals WNL (within normal limits), x-ray done to right hand done by (named hospital) with no break/fractures, resident has no c/o (complaints of) pain, resident in wheelchair at nurses' station, no concerns at this time. R4's Progress note, dated 8/12/24 by V17 Facility Nurse Practitioner, documents: HPI (History of Present Illness) Interval History: Resident returns to the facility after being assessed by the ER (emergency room) after a hand injury. Patient had her hand shut in a door of another resident's room. The ER ruled out any fracture. Patient denies pain at this time but due to dementia is not an accurate historian. Bruising and scabbing noted on her right hand. She is able to move all finger and wrist joints without difficulty. Patient has PRN (as needed) Tylenol available for pain relief. R3 and R4's Progress Notes, dated 9/8/24 and 9/9/24 respectively, by V11 LPN, document, (V11) was at the north nurse's station and had just hung up the phone with doctor about another resident and had started making notes. (V11) heard resident yelling 'get the f*** away from here, get the f*** out now.' (V11) slid (V11's) chair back away from the computer so that she could see where the commotion was taking place, (R4) was standing up in front of (R4's) wheelchair at (R3's) door with her (R4's) hand on the doorframe. (V11) jumped up from (V11's) chair at the north nurse's station and ran towards (R4) while trying to yell to (R3) that (V11) would get (R3), but before (V11) could finish the sentence and intervene, (R3) slammed the door shut while still yelling at (R4) saying 'stupid bitch, get the f*** away from here.' (R4's) hand was caught in the door and a loud crunching sound was heard. (R4) sat back in wheelchair and looked down at her hand which was bleeding and stated, 'that really hurts.' (V11) moved (R4) away from (R3's) room door to the north nurse's station and inspected (R4's) hand. (V11) could see visible open bleeding wounds to (R4's) right hand digits 3, 4 and 5. (V11) wrapped (R4's) hand with a towel to try and stop the bleeding. (V11) went to take a look into (R3's) room and (R3) started yelling for (V11) to 'get the f*** away from here nigger.' (R3) also stated 'I didn't do anything to (R4), she shouldn't have brung (sic) her ass into my room.' (V11) called out for help and started giving orders for an aide to stay with (R3) and for an aide to stay with (R4) while (V11) made necessary phone calls to the proper authorities, management, Dr. (doctor), and POA (Power of Attorney), resident was transported to (named) ED (Emergency Department), (V16 Medical Director), (V3) DON (Director of Nursing) and POA notified of incident. R3's Progress note, dated 9/8/24 by V17 Facility Nurse Practitioner, includes but is not limited to: HPI (History of Present Illness) Interval History: Provider notified of a repeated incidence of patient significantly harming another resident while slamming his room door on another resident's hand and using profanity to call that resident names and for them to get away from the door. This is not the first time he has injured another resident at the facility. He continues to have aggressive and harmful behaviors towards staff and other residents, with noted episodes of striking staff members. He still has episodes of yelling while using profanity and striking out at staff and other residents. He will throw dishes in his room with the attempt to break them and subsequently poses risk to himself and staff members. He once again puts other residents' safety at risk and vocalizes no remorse for the significant hand injury that occurred. Patient is noncompliant with cares and medication orders despite frequent attempts to educate on the importance of bathing, eating, and taking medications as ordered. He is to be sent to the hospital for a psychiatric evaluation due to continued outbursts of anger and physical aggression towards staff and other residents. R4's X-ray report of right hand, dated 9/8/24, documents Impression: 1. Acute posttraumatic fractures of the third-fifth digit middle phalanges. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R4's Progress Note, dated 9/9/24 by V17 Facility Nurse Practitioner documents: HPI (History of Present Illness) Interval History: Patient returns to the facility after being evaluated at (named) ER (emergency room). Patient (R4) had her right hand slammed shut in the door of another resident's room. Per daughter, patient does have a fracture and is to follow up with ortho (orthopedics) tomorrow to discuss possible surgery. Patient denies any pain at this time but due to dementia, is not reliable with her ROS (Review of Systems). She does have noted stitches on the inside of her fingers. Multiple areas of dark bruising. Patient was started on a prophylactic antibiotic while at the ER to prevent infection. Patient also recently tested positive for COVID-19. She continues to have a clear runny nose, per baseline. No cough noted. On 9/18/24, at 12:04pm, R4 sat in her room then got up and walked over to the door entrance of her room. R4 showed this writer R4's right hand. R4's middle, index and pinky fingers are inflamed and purplish red in color with sutures noted across the first knuckle of all three fingers. R4 denies pain except when closes fist, R4 stated it doesn't feel too good. R4 is unable to recall how it happened and stated, did my family put me here? R4 then ambulated out of her room and wandered down the hall. On 9/19/24, at 9:28am, R4 sat in a wheelchair and self-propelled in the hallway. On 9/19/24, at 12:14pm, R4 stood in the hallway near the door of another resident's room. R4 ambulated a little further to the next resident's room and entered. On 9/20/24, at 9:59am, R4 self-propelled in her wheelchair up and down the hallway. R4 followed then caught up to this writer and stated, Did I go too fast? What's going on out there? while looking towards an exit door. On 9/19/24, at 9:31am, V13 Certified Nursing Assistant/CNA stated the following, (R4) is supposed to be in a wheelchair unless a CNA ambulates with her. She is a wanderer and has dementia. She wanders by self-propelling in her wheelchair. She goes in/out of resident rooms .She holds onto door frames as she peers into resident rooms looking, not always going in .She does it often and goes into a lot of rooms. After those two incidents we re-direct and try to keep her out of the center hallway especially if going towards his room in the center hallway. He usually left his door closed if he was in his room and leave it open when not in it. He was not a nice person .He was his own person, did not have dementia, refused cares and if we brought him water, he would bring it back out, slam it down and say I didn't want that. (R4) stops in doorways frequently every day. On 9/19/24, at 9:41am, V14 CNA stated the following, (R4) is a wanderer and has dementia. I was not working those days she got her hand caught in the door. She wanders in her wheelchair and sometimes leaves it and gets up to walk. I typically only work weekends so last weekend when I was working, I saw her hand with sore fingers. The nurse told me she got it slammed in the door and we were to keep her out of other peoples' rooms. I have seen (R4) go into resident rooms all the time. I kind of keep my eye on her and if she is going into another's room, I take her back to her room. She's got dementia so bad five minutes later she asks, 'where's my room.' When she walked, she braced herself by holding onto the doorframes. She does not get one on one supervision, but that would be a good idea. Can't have her in eyesight all the time. Keeping an eye on where she is all the time is impossible. She is here one minute and next minute she is down the hall. She's fast whether walking or in her wheelchair. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 9/19/24, at 10:29am, V11 LPN stated the following: I remember (R3 and R4's 9/8 incident). I was at nursing station on phone about another resident and hung up to write notes on the computer. I heard yelling so I swung my chair around and saw (R4) standing at (R3's) door but (R4) didn't go in. I could see (R4) peering into (R3's) room from the doorway standing up with (R4's) wheelchair behind (R4). I yelled out 'hey (R3)' but before I could finish the door went boom and I could hear (R4's) fingers crushing. Oh my god. (R4) sat down in her wheelchair and looked at her hand and said, 'wow that really hurts'. I don't think (R4) really understood. As I was going towards (R4) I could see the blood. I wheeled (R4) back towards the nurse's station while trying to call (V3 Director of Nursing/DON). The other nurse didn't know what to do. (R3) was still in his room yelling. He said, 'get away from here you nigger.' I said, 'you just smashed her fingers.' (R3) didn't care. (R3) said '(R4) shouldn't have brought her ass into my room.' (R4) is a wanderer and has dementia. She wanders in her wheelchair. (R4) likes to look around everywhere. We usually let her go about her business if she is in the wheelchair. She'll glide it around and look at things. (R4) just doesn't know what's going on. I thought (R4) would pass out or cry. (R3's) door is usually cracked open. I think (R4) may have gone into (R3's) room. (R4) was holding onto the doorframe when peering into (R3's) room. That is what (R4) would usually do and (R4) would do this when peering into other's rooms. I knew of their previous incident. I was on shift 8/11/24 and worked 2pm - 6:30am. That incident I did not see. I did see her fingers - her index finger and even more sore her thumb had skin torn off. We spoke with (R3) and explained (R4) doesn't know and is harmless so if (R4) comes to (R3's) door let us know and we will get (R4). (R3) is stuck in his ways. (R3) is aggressive and throws things and cusses. (R3) can be sweet when wants something. (R3) said, 'you keep (R4) out of here;' there is no reasoning with (R3). We try to keep an eye on (R4) as much as we can. There is only so much we can do while doing our job. It wasn't even five minutes that she had got away. (R4's) room is northeast and she was down the hallway and if there I know (R4) is okay down there and I show (R4) her room. (R4) had stopped at the nurses' station before I made the call then (R4) was gone .(R4) wanders into rooms often - she is looking for her room .(R3) punched a staff person in the stomach and (R3) has thrown things at staff. On 9/19/24, at 11:36am, V12 Registered Nurse/RN stated the following regarding R3 and R4's incident on 8/11/24: (R4) tends to wander and was in the doorway of (R3) and we heard yelling. Before we got there (R3) went to slam the door and (R4) had her hand in the door .Her hand was bleeding. We sent her out for chest pain, and we wanted her hand checked too. (R4) was on her feet from the minute she woke up and wandered a lot. There was constant redirection back to her hall. She had dementia .We were trying to redirect (R4) but it was difficult as she was going all over the place. I am not aware of anything (increased supervision/monitoring) in place. No increased supervision - I don't know how we would do that. We were already constantly going to get her .(R4) was not in eyesight 100% of the time but (R4) was never in her room. She was always staff asking, 'what do I do now.' It was so odd the way it happened because I was three doors down. (R3) is very vocal and (R4) was at (R3's) doorway. It happened so fast. (R3) is very private. (R3) is a strange character and knows more to what he plays on. (R3) is not nice. He may have arguments at times with residents but no other aggressive incidents that I know of. I stopped working about [DATE]th or so. I did not know it happened again. We didn't do anything different for (R4) or (R3). We asked (V18 Previous Administrator) about it and (V18) said 'this did not result in an injury and (V18) will handle it.' We felt (R3) needed a psychiatric evaluation to see if something was going on. I believe this was (R3's) first time it was an actual behavior harming someone. It is kind of hard to keep someone like (R4) safe. Breaks my heart that it happened again. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 9/19/24, at 12:54pm, V7 Social Service Director/SSD stated there was no increased supervision for (R4) or any care plan updates after the 8/11/24 for (R4's) wandering. V7 said, I wasn't in any discussion about it. I was in on discussion after the 9/9/24 incident and it happened so fast; the police were called. Everything was in place to get her out of that situation by redirecting. We don't usually have people in here that do things like slamming doors on others. V7 denies that any increased supervision or monitoring of (R4) was put into place. Confirmed that since a second similar incident occurred redirecting didn't really work. On 9/19/24, at 1:30pm, V3 Director of Nursing/DON stated the following: On the 8/11 incident I was not there. I received a call from (V12 RN) when it happened. (V12) said (R4) was by (R3's) room in the hallway. (R3) became angry and slammed (R4's) hand in the door. (R4) became diaphoretic and was pale so we sent (R4) out to see if any injury to her hand and there was not. As for (R4), we try to redirect her away and do our best and watching (R3) and staff approaching when (R3) is getting worked up. (R4) is a known wanderer and has dementia. (R4) hovers in a doorway, looks in, then keeps going. V3 confirmed redirecting was already in place for R4 prior to this incident. V3 stated, The 9/8 incident happened at night on 2nd shift. I got called by (V11 LPN). (V11) said (V11) was at the nurse's desk and could see (R3's) room. (V11) heard (R3) screaming and cussing at (R4). (V11) tried to get there but (R3) had slammed (R4's) hands on the door again. When (V11) got there (R4's) hand was visibly injured, cut open and bleeding. It appeared that (R4) had just used (R3s) doorframe to stand. (R4) sat right back down afterwards. We called the cops on (R3). (R4) was sent to a separate hospital for evaluation. (R4) had three fractured fingers and 12 sutures total to all three fingers, ring middle and pinky. (R4) has an ortho (orthopedic) referral for surgery. (R4) had COVID so will need to be rescheduled till clear of COVID. We sent (R3) for a psych (psychiatric) eval (evaluation). (R3) was deemed decisional. We called the hospital about (R3) being aggressive and noncompliant. (R3) has been sent out several times for psych evals and they send him back. I sent (R3) in once. (R3) became aggressive on staff when they went to change him. Cops were called and (R3) hit the cop . (R3) hit (V15 CNA) in the face and stomach when (V15) was taking his room tray in. We called the cops. All three incidents occurred within 30 days. We tried to reason with (R3). (R3) was mean on purpose. We don't have the staff to do one on one supervision. We are not a locked unit; no way to watch her every second. We do our best to keep our eye on her. It was a busy night, and everyone was busy right after dinner hour laying people down and the nurse was on the phone. There was a lot going on. Obviously, I want to protect (R4), but it could have been anybody. He was mean and impulsive all the time. I think (R3) was dangerous in general; not an (R4) thing. (R3) refused psych evals with our psych (psychiatric doctor) and refused meds (medications). On 9/20/24, at 1:36pm, V3 DON stated, (R3) was aggressive any chance he got. (R3) would break dishes, cuss us out or become aggressive. (R3) did this almost on a daily basis. It got to this point where (R3) started calling the cops. (R3) was decisional and knew what he was doing. (R3) was choosing these behaviors like threatening staff and residents so we started calling cops on him .(R3) refused a psychiatric evaluation and refused his medications frequently. The Facility Incident Report Form, regarding a Reportable Event, documents an abuse allegation occurred on 9/8/24 at 7:30pm involving R3 and R4. --- 32061 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145000	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/25/2024
NAME OF PROVIDER OR SUPPLIER Washington Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 Newcastle Washington, IL 61571	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. The facility policy, Abuse Prevention Program, dated 10/2022 directs staff, This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. This assumes that all instances of abuse of residents, even those in a coma, cause physical harm or pain or mental anguish. Sexual abuse includes, but is not limited to, sexual harassment, sexual coercion or sexual assault. The facility Incident Report Form, Date of Occurrence 8/19/24 at 7:30 P.M. Initial: Staff member (V6/Laundry Aide) reported to the Abuse Prevention Coordinator (V3/Director of Nurses) designee that R1 was allegedly touching R2 inappropriately in the dining room. R1 and R2 immediately separated. R2 assessed, no injuries noted. R1 being seen by psych (psychiatric services) and NP (Nurse Practitioner). Investigation initiated, final to follow. POA (Power of Attorney) of R2 notified. R1 is his own representative. MD (Medical Doctor) notified. Local Authorities notified. R1's facility Admission Record documents that R1 was admitted to the facility on [DATE] with the following diagnoses: Senile Degeneration of Brain, Chronic Kidney Disease and Adjustment Disorder. R1's Minimum Data Set Assessment, dated 6/12/2024 documents R1's cognitive status as 12 out of 15 (moderate cognitive impairment). R1's Nursing Progress Note, dated 8/20/2024 documents, Incident was reported to the writer by a staff member. Staff member reports seeing the resident in close proximity to a female resident in the dining room. Staff member saw resident's hand on the thigh of the female resident. R2's facility Admission Record documents that R2 was admitted to the facility on [DATE] with the following diagnosis: Alzheimer's Disease. R2's Minimum Data Set Assessment, dated 7/4/20204 documents R2's cognitive status as 3 out of 15 (cognitively impaired). R2's current Care Plan includes the following Focus Area: (R2) has impaired cognitive function/dementia or impaired thought processes related to Alzheimer's, Dementia, Delusional Disorders, Mood Disorder. Also included are the following Interventions: (R2) needs supervision and assistance with all decision making. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility Incident Report Form dated August 26, 2024, documents, Final: Investigation completed. Interviews with staff and resident completed. Per interview with R1, resident adamantly denies allegations stating he is [AGE] years old and has no sexual desires and would not touch anyone in an inappropriate manner. R1 has resided at the facility for a long time and has not had any behaviors or inappropriate interactions. This would be completely out of character for him. R1 states he might touch a resident on the hand to offer comfort or greeting but would never do anything inappropriate. It must be noted that R1 has impaired vision and is almost blind. It is highly likely that he could have made contact accidentally. R1 is alert and oriented X 2 with a BIMS (Brief Interview for Mental Status) of 12 and a hospice patient. R2 is not interviewable due to advanced dementia. (R2) is alert and oriented X 1 with a BIMS of 3. V1 the staff member who reported this incident states she was cleaning the dining room. R2 was sitting with her back to V1 as she walked further into the dining room, she observed R1 and R2 sitting across from each other knee to knee. V1 reports she observed R1's hand on R2's thigh. It appeared to be near the groin area of R2. R2's hands were positioned beside her in her wheelchair. V1 then told R1 to remove his hands and went and got the nurse who separated R1 and R2. V1 stated R2 was wearing long pants which were fully intact. V1 reports that no other staff or residents observed the incident. Peer reviews done with other women on the unit, none of which mentioned any sexual misconduct during their stays. R2 was assessed and no injury or evidence of sexual interaction was found. IDT (Interdisciplinary Team) met and reviewed plan of care for both R1 and R2 and updated accordingly. R1 UA (urinalysis) is negative, was seen by NP (Nurse Practitioner) who did med (medication) review. R1 refused to have psych (Psychiatric) eval (evaluation). R1 will continue to be monitored for any inappropriate conduct. The investigation determined insufficient evidence to substantiate abuse due to lack of intent, physical or mental distress. On 9/18/2024 at 1:24 P.M., V6/Laundry Aide stated, On (8/19/24) around 7:15 in the evening, I saw (R1) touching (R2) in her crotch. They were sitting side by side in the ADR (Activity Dining Room). They were the only two in the room. I happened to be walking through. Their wheelchairs were side by side. (R1's) left hand was on (R2's) inner right thigh and (R1's) right hand was in (R2's) crouch. It was on the outside of (R2's) gray sweatpants. I was able to see the position of his hands clearly. Her hands were down by her side. (R2) wasn't saying anything. (R1) was talking really low to (R2). I could not make out what (R1) was saying to (R2). (R1) was very angry when he saw me. He yelled at me and said, 'I am very offended of your presence.' (R1) immediately withdrew his hand. I went to the nurse; I don't know what her name is. She is an Agency nurse. She still works here. The nurse came into the ADR and separated them and told (R1) to keep his hands to himself. (R1) was still very angry with me, telling me that I was a dirty person and had a dirty mind. The nurse had me come to the nurse's station and write a statement. V8/CNA (Certified Nursing Assistant) was standing at the nurse's station talking to V3/DON (Director of Nurses) on the phone. He took a picture of my statement with his phone and sent it to (V3). (R1) likes to flirt with all the ladies. (R1) says he is looking for a lover. On 9/19/24 at 9:20 A.M., R1 stated, I have lived here for a few years. (R2) is my friend. I love her. I have touched (R2) many times, on the hand and face. I don't see (R2) much anymore. I miss (R2). On 9/19/24 at 10:00 A.M., V11/Agency Nurse stated, I recall the incident that happened (between R1 and R2 on 8/19/24). (R1) likes to think he's a ladies' man. (R1)'s always talking to the ladies and calling them his girlfriends. (R1) likes to say, 'I have everything I need, except a lover.' The Immediate Jeopardy was identified to have begun on 8/11/24 wh[TRUNCATED]

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 33973 Based on observation, interview, and record review the facility failed to implement their Abuse Prevention Program to protect residents from repeated physical abuse for one (R4) of four residents reviewed for abuse in the sample of six. Findings include: The facility's Abuse Prevention Program policy, dated 10/2022, documents, This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. In order to do so, the facility 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 abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff and mistreatment of residents. This policy continues to state VI. Protection of Residents. The facility will take steps to prevent potential abuse while the investigation is underway. Residents who allegedly abused another resident shall be immediately evaluated to determine the most suitable therapy, care approaches, and placement, considering his or her safety, as well as the safety of other residents and employees of the facility. In addition, the facility shall take all steps necessary to ensure the safety of residents including, but not limited to, the separation of the residents. This policy also states VII. Internal Investigation. 1. All incidents will be documented, whether or not abuse, neglect, exploitation, mistreatment or misappropriation of resident property occurred, was alleged or suspected. 2. Any incident or allegation involving abuse, neglect, exploitation, mistreatment or misappropriation of resident property will result in an investigation. The facility's undated Residents Rights Statement documents, All residents have a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. This facility will protect and promote the rights of each resident, including each of the following rights: 38. The resident has the right to be free from verbal, sexual, physical, or mental abuse, corporal punishment, and involuntary seclusion. On 9/18/24, at 12:04pm, R4 sat in her room then got up and walked over to the door entrance of her room. R4 showed this writer R4's right hand. R4's middle, index and pinky fingers are inflamed and purplish red in color with sutures noted across the first knuckle of all three fingers. R4 denies pain except when closes fist. R4 stated, it doesn't feel too good. R4 is unable to recall how it happened. R4 then ambulated out of her room and wandered down the hall. R4's Progress Note, dated 8/11/24, by V12 Registered Nurse/RN states, Resident (R4) noted by staff walking into peer's (R3's) room. (R3) became immediately agitated and yelled 'get out of my f***ing room.' While staff was attempting to redirect (R4) out of (R3's) room, (R3) slammed the door and caught (R4's) hands in the door. Immediate blood noted to right hand. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's Progress Note, dated 8/11/24 by V12 Registered Nurse/RN, documents, Describe Behavior: Patient (R3) slammed peer's (R4's) hands into his (R3's) door when she (R4) was standing in his doorway. Patient (R3) was cursing at peer (R4) stating 'get out of my f***ing room or I will hurt you.' Before staff could diffuse situation patient (R3) did slam both (R4's) hands into his door. Environmental, Physiological, Psychosocial factors/triggers: Patient (R3) is easily agitated with aggressive tendencies and stated after slamming peer's (R3's) hands into the door, 'I don't f***ing care if I hurt her (R4) or not, damn b**ch does not need to be in here.' R3's Progress Note, dated 8/23/24 by V17 Facility Nurse Practitioner, includes but is not limited to: Restlessness and agitation. Patient (R3) frequently having behaviors and agitation. He has made multiple attempts to harm staff and other residents. Staff injury reported today. Patient (R3) to be sent to the hospital for a psych evaluation. Patient (R3) is considered a threat to the safety of others and is not appropriate to reside in this long-term care setting. Patient refuses to see rounding mental health provider. HPI (History of Present Illness) Interval History: Staff report patient (R3) continues to have aggressive and harmful behaviors towards staff and other residents. Today, a staff member was providing patient with a meal tray and patient punched the staff member. He (R3) has had episodes of yelling while using profanity and hitting in the past. He often throws dishes in his room with the attempt to break them and subsequently poses risk to himself and staff members. Patient has previously slammed his door on another resident's fingers while yelling profanity at that resident. He has put other residents' safety at risk and vocalizes no remorse for injuring others. Patient is noncompliant with cares and medication orders despite frequent attempts to educate on the importance of bathing, eating, and taking medications as ordered. R3 and R4's Progress Notes, dated 9/8/24 and 9/9/24 respectively, by V11 LPN, document that on 9/8/24 (V11) was at the north nurse's station and had just hung up the phone with doctor about another resident and had started making notes. (V11) heard resident yelling 'get the f*** away from here, get the f*** out now.' (V11) slid (V11's) chair back away from the computer so that she could see where the commotion was taking place. (R4) was standing up in front of (R4's) wheelchair at (R3's) door with her (R4's) hand on the doorframe. (V11) jumped up from (V11's) chair at the north nurse's station and ran towards (R4) while trying to yell to (R3) that (V11) would get (R3), but before (V11) could finish the sentence and intervene, (R3) slammed the door shut while still yelling at (R4) saying 'stupid bitch, get the f*** away from here.' (R4's) hand was caught in the door and a loud crunching sound was heard. (R4) sat back in wheelchair and looked down at her hand which was bleeding and stated, 'that really hurts.' (V11) moved (R4) away from (R3's) room door to the north nurse's station and inspected (R4's) hand. (V11) could see visible open bleeding wounds to (R4's) right hand digits 3, 4 and 5. (V11) wrapped (R4's) hand with a towel to try and stop the bleeding, (V11) went to look into resident's (R3's) room and (R3) started yelling for (V11) to 'get the f*** away from here nigger.' (R3) also stated 'I didn't do anything to (R4), she shouldn't have brung (sic) her ass into my room.' R4's X-ray report of right hand, dated 9/8/24, documents Impression: 1. Acute posttraumatic fractures of the third-fifth digit middle phalanges. On 9/19/24, at 9:31am, V13 Certified Nursing Assistant/CNA stated the following: R4 wanders by self-propelling in her wheelchair. She goes in/out of resident rooms .She does it often and goes into a lot of rooms. After those two incidents we just continued to re-direct R4 and try to keep her out of the center hallway especially if going towards his room in the center hallway. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/19/24, at 9:41am, V14 CNA stated the following, I have seen (R4) go into resident rooms all the time. I kind of keep my eye on (R4) and if she is going into another's room, I take her back to her room .She does not get one on one supervision, but that would be a good idea. Can't have her in eyesight all the time. Keeping an eye on where she is all the time is impossible. She is here one minute and next minute she is down the hall. She's fast whether walking or in her wheelchair. On 9/19/24, at 10:29am, V11 LPN stated the following: (R4) is a wanderer and has dementia. She wanders in her wheelchair. (R4) likes to look around everywhere. We usually let her go about her business if she is in the wheelchair. She'll glide it around and look at things. (R4) just doesn't know what's going on .(R3) said 'you keep (R4) out of here;' there is no reasoning with (R3). We try to keep an eye on (R4) as much as we can. There is only so much we can do while doing our job. It wasn't even five minutes that she had got away . (R4) wanders into rooms often - she is looking for her room. On 9/19/24, at 11:36am, V12 Registered Nurse/RN stated the following: (R4) was on her feet from the minute she woke up and wandered a lot. There was constant redirection back to her hall. She had dementia . We were trying to redirect (R4) but it was difficult as she was going all over the place. I am not aware of anything (increased supervision/monitoring) put into place. No increased supervision - I don't know how we would do that. We were already constantly going to get her .(R4) was not in eyesight 100% of the time but (R4) was never in her room .I did not know it happened again. We didn't do anything different for (R4) or (R3) after the first incident .It is kind of hard to keep someone like (R4) safe. Breaks my heart that it happened again. On 9/19/24, at 12:54pm, V7 Social Service Director/SSD V7 confirmed there was no increased supervision or any Care plan updates to protect R4 while continuing to wander after the 8/11/24 incident. V7 confirmed that given that a second similar incident occurred, redirecting R4 didn't really work. On 9/20/24, at 1:36pm, V3 Director of Nursing/DON stated I think it was a behavior for (R3) because he was frequently aggressive. It was something (R3) did all the time. (R3) was aggressive any chance he got. V3 confirmed V3 did not put any interventions into place for keeping R4 safe from R3 after their first incident on 8/11/24.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 33973 Based on interview and record review the facility failed to report an allegation of resident-to-resident verbal and physical abuse for two (R3 and R4) of four residents reviewed for abuse in a sample of six. Findings include: The facility's Abuse Prevention Program policy, dated 10/2022, documents, This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. In order to do so, the facility 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 abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff and mistreatment of residents. This policy continues with V. Internal Reporting Requirements and Identification of Allegations: Employees are required to report any incident, allegation or suspicion of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property they observe, hear about, or suspect to the administrator immediately, to an immediate supervisor who must then immediately report it to the administrator or to a compliance hotline or compliance officer. In the absence of the administrator, reporting can be made to an individual who has been designated to act in the administrator's absence .Reports will be documented, and a record kept of the documentation. Supervisors shall immediately inform the administrator or person designated to act in the administrator's absence of all reports of incident, allegations or suspicion of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property. Upon learning of the report, the administrator or a designee shall initiate an incident investigation. Any allegation of abuse or any incident that results in serious bodily injury will be reported to the (State Agency) immediately, but not more than two hours of the allegation of abuse. Any incident that does not involve abuse and does not result in serious bodily injury shall be reported within 24 hours. R4's Progress Note, dated 8/11/24, by V12 Registered Nurse/RN documents, Resident (R4) noted by staff walking into peer's (R3's) room. (R3) became immediately agitated and yelled 'get out of my f***ing room.' While staff was attempting to redirect (R4) out of (R3's) room, (R3) slammed the door and caught (R4's) hands in the door. Immediate blood noted to right hand. R3's Progress Note, dated 8/23/24 by V17 Facility Nurse Practitioner, includes but is not limited to: Restlessness and agitation. (R3) frequently having behaviors and agitation. He has made multiple attempts to harm staff and other residents. Staff injury reported today .(R3) has previously slammed his door on another resident's fingers while yelling profanity at that resident. He has put other residents' safety at risk and vocalizes no remorse for injuring others. The facility's list of State Agency Reportables did not include any documentation for the incident on 8/11/24 between R3 and R4. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/18/24, at 11:35am, V5 Corporate Administrator was unable to produce any State Agency Reportable for the 8/11/24 incident between R3 and R4. V5 confirmed this incident should have been reported as a potential abuse allegation.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 33973 Based on interview and record review the facility failed to investigate a potential allegation of resident-to-resident verbal and physical abuse for two (R3 and R4) of four residents reviewed for abuse in a sample of six. Findings include: The facility's Abuse Prevention Program policy, dated 10/2022, documents, This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. In order to do so, the facility 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 abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff and mistreatment of residents. This policy continues with Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical hare, pain, or mental anguish to a resident .The term 'willful' in the definition of 'abuse' means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Physical Abuse is the infliction of injury on a resident that occurs other than by accidental means and that requires medical attention. Physical Abuse includes hitting, slapping, pinching, kicking, and controlling behavior though corporal punishment .Verbal Abuse is the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or families, or within their hearing distance, regardless of an individuals' age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to, threats of harm, saying things to frighten a resident, such as telling a resident that he/she will never be able to see his/her family again. This policy continues with VII. Internal Investigation. 1. All incidents will be documented, whether or not abuse, neglect, exploitation, mistreatment or misappropriation of resident property occurred, was alleged or suspected. 2. Any incident or allegation involving abuse, neglect, exploitation, mistreatment, or misappropriation of resident property will result in an investigation .4. Investigation Procedures: The appointed investigator will, at a minimum, attempt to interview the person who reported the incident, anyone likely to have direct knowledge of the incident and the resident, if interviewable. Any written statements that have been submitted will be reviewed, along with any pertinent medical records or other documents. Residents to whom the accused has regularly provided care, and employees with whom the accused has regularly worked, will be interviewed. R4's Progress Note, dated 8/11/24, by V12 Registered Nurse/RN documents, Resident (R4) noted by staff walking into peer's (R3's) room. (R3) became immediately agitated and yelled 'get out of my f***ing room.' While staff was attempting to redirect (R4) out of (R3's) room, (R3) slammed the door and caught (R4's) hands in the door. Immediate blood noted to right hand. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145000	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Washington Senior Living	1201 Newcastle Washington, IL 61571

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)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's Progress Note, dated 8/23/24 by V17 Facility Nurse Practitioner, includes but is not limited to: Restlessness and agitation. (R3) frequently having behaviors and agitation. He has made multiple attempts to harm staff and other residents. Staff injury reported today .(R3) has previously slammed his door on another resident's fingers while yelling profanity at that resident. He has put other residents' safety at risk and vocalizes no remorse for injuring others. On 9/18/24, at 11:35am, V5 Corporate Administrator was unable to produce any investigation for the 8/11/24 incident between R3 and R4. V5 confirmed this incident should have been investigated as a potential abuse allegation. On 9/19/24, at 11:36am, V12 Registered Nurse/RN stated We didn't do anything different for (R4) or (R3) after the first incident. We asked (V18 Previous Administrator) about it and (V18) said 'this did not result in an injury and (V18) will handle it.' On 9/20/24, at 1:36pm, V3 Director of Nursing/DON stated that regarding the 8/11/24 incident, I reported it to (V18 Previous Administrator) who at the time was the Administrator and obviously (V18) didn't do anything. I did not investigate it. I think it was a behavior for (R3) because he was frequently aggressive. It was something (R3) did all the time. (R3) was aggressive any chance he got. V3 confirmed V3 did not conduct any interviews or do any investigation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145000	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/25/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident’s representative in writing how long the nursing home will hold the resident’s bed in cases of transfer to a hospital or therapeutic leave. 33973 Based on interview and record review the facility failed to provide a copy of the bed hold policy for residents transferring to the hospital for one (R3) of three residents reviewed for bed holds in the sample of six. Findings Include: The facility's undated Bed Hold Policy documents, There may be instances when a Facility Resident leaves the Facility for medical or therapeutic reasons. If the Resident pays the Facility to hold the bed open, the Facility guarantees availability of a bed on Resident's return to the Facility. In such cases, Facility may be able to re-admit Resident to the same room and bed, but this is not assured. The facility's Transfer and Discharge Policy, dated March 2014, documents, Policy: To assure resident transfers and discharges will be conducted in accordance with residents' rights, physician's orders, and in such a manner as to maintain continuity of care for the resident. This policy continues with Policy Specifications: 4. Relocation rights including bed hold and readmission rights will be maintained in all transfers. R3's clinical record documents that R3 was transferred out to the hospital on 9/8/24. R3's clinical record does not contain documentation of written notice of the facility bed hold policy. On 9/24/24, at 12:28pm, V3 Director of Nursing/DON stated that the facility bed hold policy was not given to R3.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145000	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/25/2024
NAME OF PROVIDER OR SUPPLIER: Washington Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE: 1201 Newcastle Washington, IL 61571	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 33973 Based on interview and record review the facility failed to ensure the required in-service training was completed for Certified Nursing Assistants/CNA. This failure has the potential to affect all 61 residents residing in the facility. Findings include: The Facility Assessment for (named facility), signed and dated 8/8/24, documents, Required in-service training for nurse aides. In-service training must: Be sufficient to ensure the continuing competence of nurse aides but must be no less than 12 hours per year. Include dementia management training and resident abuse prevention training. Address areas of weakness as determined in nurse aides' performance reviews and facility assessment and may address the special needs of residents as determined by the facility staff. For nurse aids providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. The facility's Certified Nursing Assistant job description, revised October 2020, documents, Staff Development Functions: Attend and participate in facility in-service training programs as instructed including resident rights, prevention of abuse and neglect, dementia care, behavioral management and competencies for Certified Nursing Assistants (CNAs). Attend and participate in scheduled training and education classes to maintain current certification as a CNA. On 9/25/24, at 1:02pm, V3 Director of Nursing/DON could not produce proof of CNA trainings and stated that their (electronic) required training program is not up to date with CNAs' completed trainings for the past six months. V3 stated, It is hard to get them to come to in-services even though I mandate them. DON confirmed they have 32 CNAs on their roster and the recent in-services held (on 8/6/24 and 9/11/24) do not include signatures from all 32 CNAs' attendance. The facility's Resident Listing Report, dated 9/18/24, documents 61 residents are currently residing in the facility.