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	01/23/2025

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 - Actual harm 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** 38396 Based on Observation, Interview and Record Review the facility failed to prevent neglect of a cognitively impaired, high fall risk resident for one of three residents (R1) reviewed for neglect in the sample of five. This failure resulted in R1 lying on a cold, hard floor for an undetermined amount of time and was found to be cold with a shivering body appearance and chattering teeth in the early hours of the morning. Findings include: R1's current Care Plan, dated 1/21/25, documents R1 was admitted to the facility on [DATE] with diagnoses of Dementia, Agitation, Orthostatic Hypotension, Delirium, Chronic Obstructive Pulmonary Disorder, Heart Failure, Obstructive Sleep Apnea, Muscle Wasting and Atrophy, Difficulty in Walking, Abnormalities of Gait and Mobility and Lack of Coordination. This same care plan documents R1 is at risk for falls and injuries with an intervention, dated 1/15/25, to Keep bed in low position when resting in bed with mattress on right side of bed when resting in bed. R1's Fall Risk Assessment, dated 1/15/25, documents R1 is at a high risk of falling due to history of falling, diagnoses, chair bound incontinent status, disorientation at all times and recent changes in medications. On 1/22/25 at 1:00 PM, R1 was observed sleeping in his bed with blankets covering him. R1's bed was against the wall and in a low position and a mattress was on the floor to the side of R1's bed. R1's Nursing Progress Notes, dated 1/19/25 at 6:52 PM and completed by V5 (Licensed Practical Nurse, LPN), documents Patient fell on to floor no injury, denies hitting head, combative, assisted back to bed. Did not send out due to being care planned to floor. R1's Nursing Progress Notes, dated 1/20/25 at 2:29 AM and completed by V5, documents Patient on floor, will not stay in bed. Moving all around room and broke roommate's nightstand tabletop drawer. Pulling on room curtain divider, pushing staff hands away, will not stay in bed or on floor mat. R1's Facility Incident Report, dated 1/20/25, documents, Staff member (V4 Restorative Certified Nursing Assistant, CNA), reported to (V1) Administrator that she felt the nurse (V5) on duty neglected R1 during third shift. (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

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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 - Actual harm Residents Affected - Few	On 1/22/25 at 1:24 PM, V4 (Restorative CNA) stated, Monday (1/20/25) morning about 4:15 AM, my restorative aide (V10, Restorative CNA) and I were going down the hallway. (V10) said (R1) was on the floor. The nurse (V5, LPN) said he'd been there and that he was care planned to be on the floor. There was no mattress, he was lying on the hard floor. (R1) wasn't sleeping when I entered the room. (R1) was really cold, he was shivering, and his teeth were chattering. It was so sad. He had clothes on but no blankets and the floor was cold. Once (V10 and I) got him in the bed, he thanked us. We got him changed and got blankets on him. The area in his hall has been super cold since Saturday (1/18/25). Not dangerously cold, but below 70 degrees and lying on the floor with no blankets would be very cold. I went to the computer to see if he was care planned for being on the floor and he was not. I felt this was neglectful. This wasn't a case of (V5) not knowing he was on the floor, she knew, and she said he'd been there all night. V5's written statement, dated 1/21/25 and provided by V1 (Administrator), documents upon being interviewed V5 stated, I was made aware by a CNA (unknown) that (R1) had a fall at 6:52 PM. I notified the on-call nurse (unknown) and documented the incident. (R1) was combative but was able to be assisted back to bed. At 8:00 PM, 10:00 PM, between 1:00-2:00 AM and 4:00 AM, I noticed (R1) was on the floor and made sure he was placed back into bed. For the incidents at 8, 10, and between 1-2, I witnessed (R1) having a blanket around him. At some point I noticed that (R1) had rummaged with the roommate's nightstand and there were items on the floor. (R1) was off his mat and towards the other side of the room at this point. I believed that what was demonstrated throughout the night was behaviors but were redirectable. I did not notify the DON (V2, Director of Nursing) or Administrator regarding his behavior. I did not document the actions throughout the night, there was a lot going on that night. When (V4) came around 4:00 AM, she stated (R1) was on the floor. I stated he was care planned to be, that is what I was told. On 1/22/25 at 1:22 PM, V1 confirmed the facility has been working on getting a new part for the furnace/boiler system and it is affecting the heat output in some areas of the building. V1 stated while not in a dangerous temperature below 55 degrees Fahrenheit, the hall in which R1 resides has been cooler around 66 to 68 degrees Fahrenheit since the heat issues began on 1/18/24. On 1/22/25 at 2:58 PM, V2 (Director of Nursing) confirmed that R1 is very new to the facility with an admitted [DATE] and has had a couple falls prior to the night of 1/19/25. V2 confirmed R1's care plan does not include instructions or interventions to allow R1 to lay on the floor after a fall or anytime. V2 stated, (V5) quit employment via text message today. When I spoke with (V5) regarding the incident she did say that (R1) had fallen multiple times that night and I confirmed with her that none of it was charted. She didn't notify the doctor, family or anyone. (V5) didn't chart assessments of the resident, fall details or fill out risk management fall investigations. (R1) was supposed to have a mattress beside his bed and I don't know where it was. V5 told me There was no mattress that night. When someone has a fall the nurse conducts an immediate assessment, assists the resident back to a safe bed or chair and starts neurological checks, if it was unwitnessed. The nurse will complete risk management fall assessments and should notify the doctor and the family. Nothing was done to ensure (R1) was medically ok that night. After experiencing multiple falls that evening, (V5) let (R1) lay on the cold ground and she confirmed all of it. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The facility's Abuse Prevention 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 also documents Neglect means the failure to provide goods and services to a resident that are necessary to avoid physical harm, pain or mental anguish. Neglect means a facility's failure to provide, or willful withholding of, adequate medical care, mental health treatment, psychiatric rehabilitation, personal care, or assistance with activities of daily living that is necessary to avoid physical harm, mental anguish, or mental illness of a resident including deprivation of goods and services by staff. The facility's Fall Clinical Protocol policy, dated 5/2024, documents Fall Risk Assessment shall be completed on admission, quarterly, after a fall, and as clinically indicated. In addition, the nurse shall assess and document/report the following: Vital signs, Recent injury, especially fracture or head injury, Musculoskeletal function (observing for change in normal range of motion, weight bearing), Change in cognition or level of consciousness, Neurological status, Pain, Frequency and number of falls since last physician visit, Precipitating factors (details on how fall occurred), All current medications (especially those associated with dizziness or lethargy), All active diagnose. The staff will evaluate, and document falls that occur while the individual is in the facility; for example, when and where they happen, any observations of the events, etcetera. The staff, with the physician ' s guidance, will follow up on any fall with associated injury until the resident is stable and delayed complications such as late fracture or subdural hematoma have been ruled out or resolved. If a resident has an unwitnessed fall or hits their head initiate neurological checks. If a resident has an unwitnessed fall or hits their head and is on anticoagulation medication, then send resident to the ER (emergency room) for an evaluation.