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	03/05/2025

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 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. 30678 Based on observation, interview, and record review the facility failed to report a potential allegation of abuse to the State Agency for one (R1) of three residents reviewed for abuse in the sample of eight. Findings include: The facility's undated Abuse Prevention Training Program - Protocol documents Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. The objective of the Abuse Prevention Program is to comply with the seven-step approach to abuse and neglect detection and prevention. Employees are required to report any allegation 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. An initial report to the State licensing agency (Named Agency), shall be made immediately after the resident has been assessed and the alleged perpetrator has been removed. This same policy also documents A copy of this initial report shall be maintained. The facility Grievance Form for R1, dated 3/3/25, documents R1 feels some staff rush through care, poor attitude and discussed with DON, identified specific staff as agency, removed from schedule moving forward. There is no other information documented on this form. On 3/4/25 at 4:35 pm, V1 Administrator provided three abuse investigations for the last three months. These investigations do not include an allegation made by R1. V1 Administrator confirmed these are the only three investigations he has had. On 3/5/25 at 9:15 am, V2 DON (Director of Nursing) stated she was notified on the evening of 3/2/25 that R1 made an allegation of abuse by an Agency CNA who ripped his brief off him and left him naked in bed. V2 DON stated she reported immediately to V1 Administrator. On 3/5/25 at 1:50 pm, V1 Administrator stated he was made aware of a customer care concern on 3/2/25 regarding one of the Agency CNA's who allegedly ripped off R1's depend while he was in bed. V1 Administrator stated he did not investigate the allegation as potential abuse but rather treated the allegation as a customer service issue because R1 stated the CNA was rushing him and had a bad attitude. V1 Administrator confirmed he did not notify the State Agency of this incident.

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 30678 Based on observation, interview, and record review the facility failed to identify and investigate a potential allegation of abuse for one (R1) of three residents reviewed for abuse in the sample of eight. Findings include: The facility's undated Abuse Prevention Training Program - Protocol documents Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. The objective of the Abuse Prevention Program is to comply with the seven-step approach to abuse and neglect detection and prevention. The staff, with the physician's input (as needed), will investigate alleged occurrences of abuse and neglect to clarify what happened and identify possible causes. As soon as possible after an allegation of abuse, neglect, mistreatment, misappropriation of resident property, or exploitation, the administrator or designee will initiate an investigation into the allegation which may include the following elements: Interviewing all persons who may have knowledge of the alleged incident, including, but not limited to: All persons who reported the suspicion, allegation or incident; The alleged victim (if the victim is unable to be interviewed, this shall be documented); The alleged perpetrator (if alleged perpetrator is a resident who cannot be interviewed, this shall be documented); Any witnesses or potential witnesses to the alleged occurrence or incident; any staff having contact with the resident during the period of the alleged incident; Roommates, other residents, family or visitors; A review of the medical record, including care plan; a review of all circumstances surrounding the incident; and Physicians will be notified of any incident and any medical treatment will done as ordered. The investigation shall conclude whether the allegation of abuse, neglect, mistreatment, misappropriation of resident property, or exploitation can likely be sustained. Records of the investigation shall be maintained. The current Care Plan for R1 documents R1 is incontinent of bowel and bladder, has an ADL (activity of daily living) self-care deficiency, and potential impairment to skin integrity and has a stage three pressure ulcer to (R1's) coccyx. This Care Plan documents the following interventions as: Assist R1 with incontinence care; R1 Requires moderate to maximum assist with personal hygiene and dependent for toileting hygiene; and Keep skin clean and dry. The facility Grievance Form for R1, dated 3/3/25, documents Description feels some staff rush through care, poor attitude. Steps of the Investigation: discussed with DON, identified specific staff as agency, removed from schedule moving forward. Summary/findings: See above. There is no documentation as whether Grievance confirmed or Grievance Not confirmed. This form is signed by V1 Administrator on 3/3/25. On 3/4/25 at 4:35 pm, V1 Administrator provided three abuse allegations and confirmed he has only had three over the past three months and nothing new has been reported to him. The three abuse allegations provided did not include an allegation from R1. (continued on next page)

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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	On 3/5/25 at 12:45 pm, R1 was sitting up in a regular wheelchair, appeared clean and well kempt. Urinal was noted near R1's bed in a plastic bag. R1 stated one night, a few days ago, he put on his call light and asked one of the girl CNAs (Certified Nursing Assistants) to take off his pull up brief and put a tab brief on so that (R1) could use his urinal in bed. R1 stated I guess I made her mad. She ripped it right off of me and just left me there naked. R1 stated this same CNA didn't put another brief on R1 and was rude. R1 stated he did tell one of the other CNA's later that night and yesterday (3/4/25) V1 Administrator asked (R1) some questions about it. R1 stated that no one had talked to him (R1) prior to yesterday. On 3/5/25 at 10:41 am V5 CNA stated she worked second shift on 3/2/25 and R1's Family Member brought to (V5's) attention that the prior night R1 asked to have his pull up removed and a tab depend to be put on so he (R1) could use his urinal. R1 said CNA got upset and ripped the depend off R1 and left R1 naked in bed. V5 CNA stated she reported the incident to V2 DON. On 3/5/25 at 9:15 am, V2 DON stated V5 CNA reported R1 made an allegation of an Agency CNA ripping his brief off while he was in bed and left him lying in bed naked. V2 DON stated she immediately reported it to V1 Administrator and V1 stated he would take care of it. V2 DON stated she was able to determine who the Agency CNA was, removed the CNA from the schedule and DNR'd (do not return) her from the facility. V2 DON stated she does not know if V1 Administrator investigated it or not. On 3/5/25 at 1:50 pm, V1 stated V2 DON/Director of Nursing reported to (V1) on 3/3/25 that R1 complained about one of the Agency CNA's ripping his depend off while he was in bed. V1 Administrator stated he did not investigate the incident as potential abuse but treated the allegation as a customer service issue, filled out a Grievance form and put all the information on the form. V1 Administrator stated R1 verbalized the CNA was rushing him and had a bad attitude. V1 Administrator stated he spoke with V2 DON and the Agency CNA was DNR'd from the facility and has not been back.