

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 06/25/2025
NAME OF PROVIDER OR SUPPLIER Washington Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>Based on interview and record review the facility failed to promote an environment free of inappropriate staff behavior and failed to provide respect and dignity for residents. This failure has the potential to affect all 79 residents residing in the Facility.</p> <p>Findings include:</p> <p>The Facility Resident Census Roster, dated 6/19/25, documents 79 Residents residing in the Facility.</p> <p>The Facility Statement of Resident Rights, undated, documents: the Resident has a right to a dignified existence, self-determination and communication with and access to persons and services inside and outside the Facility; must treat each Resident with respect and dignity and care for each Resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each Resident's individuality; protect and promote the rights of the Resident; and has the right to be treated with respect and dignity; have a right to a safe and homelike environment including but not limited to treatment and supports for daily living safely; and a safe comfortable and homelike environment; ensuring the Resident receive care and services safely and that the physical layout of the Facility maximizes Resident independence and does not pose a safety risk.</p> <p>The Facility Administrator Job Description, revised 10/2020, documents: primary purpose of this position is to direct day-to-day functions of the Facility in accordance with current federal, state and local standards, guidelines and regulations; assume responsibility and accountability for all programs in the Facility; ensure each Resident receives care and services to attain/maintain the highest practical physical, mental and psychosocial well-being; ensure human resource management policies and programs are planned, implemented and evaluated in compliance with government laws and regulations; counsel/discipline personnel as requested or necessary in accordance with local, state and federal labor laws and implement facility policies; and terminate employment of personnel when necessary.</p> <p>The Facility Resident Council Meeting Minutes, dated 3/18/25, document issues that Residents hear CNAs (Certified Nursing Assistants) arguing.</p> <p>The Facility Resident Concern Form dated 3/18/25 and 6/10/25, documents concerns with staff approach.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 145000
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>The Facility Certified Nursing Assistant Job Description, revised 10/2020, documents: must attend and participate in Facility in-service training programs including Resident Rights, Abuse, Behavioral Management; must be a supportive team member, contribute to and be an example of team work and team concept; possess ability to deal tactfully with personnel, Residents, family members, visitors, government agencies/personnel and the general public; possess ability and willingness to work harmoniously with other personnel; have patience, tact and cheerful disposition and enthusiasm; and must be able to cope with the mental and emotional stress of the position.</p> <p>A typewritten investigation statement, unsigned and undated, documents that on (6/13/25) at 8:12 am, (V5/CNA) walks onto Southwest hallway and approaches (V6/CNA). They start to argue, V6 starts to walk away and points for V5 to return to (V5's) hallway. At this point V5 moves closer to V6 and is in her (V6) face at which point (V6) pushes (V5). The nurse breaks them up and at 8:13 am, (V11/Human Resource Director) and (V1/Administrator) walk down the hall to diffuse the situation and remove the parties from the floor.</p> <p>V5's (Certified Nursing Assistant/CNA) Employee Record, documents a Resignation/Discharge Form, dated 6/17/25, that V5 was hired on 2/25/25 and discharged on 6/13/25. V5's Disciplinary Report, dated 6/16/25, documents V5 had an incident on 6/13/25 of threatening or engaging in violence and was terminated. V5's Employee Record also documents an electronically signed Employee Handbook/Workplace Violence, dated 3/6/25 at 11:39 am, to commit to creating and maintaining a safe workplace and prohibits any physical, verbal or mental abuse or intimidation of co-workers and fighting threats violence or disorderly conduct on the job (including verbal or physical harassment); and behaviors not acceptable are physical, verbal or mental abuse of co-workers. V5's Employee Record also documents Disciplinary Reports, dated 4/17/25 and 5/16/25 for tardiness/attendance (3/10/25, 3/15/25, 3/16/25, 3/20/25, 3/21/25, 3/24/25, 3/30/25, 4/3/25, 4/7/25, 4/8/25, 4/12/25, 4/13/25, 4/20/25, 4/21/25, 4/22/25, 4/26/25, 4/27/25, 5/1/25, 5/2/25, 5/5/25, 5/6/25, 5/7/25, 5/10/25, 5/11/25, 5/15/25 and 5/16/25).</p> <p>V6's (Certified Nursing Assistant/CNA) Employee Record, documents a Resignation/Discharge Form, dated 6/17/25, that V6 was hired on 1/23/25 and discharged on 6/13/25. V6's Disciplinary Report, dated 6/17/25, documents V5 had an incident on 6/13/25 of threatening or engaging in violence and was terminated. The Employee Record also documents an electronically signed Employee Handbook/Workplace Violence, dated 1/22/25 at 7:02 pm, to commit to creating and maintaining a safe workplace and prohibits any physical, verbal or mental abuse or intimidation of co-workers and fighting threats violence or disorderly conduct on the job (including verbal or physical harassment); and behaviors not acceptable are physical, verbal or mental abuse of co-workers. V6's Employee Record also documents Disciplinary Reports, dated 3/21/25 and 3/24/25 for tardiness/attendance (1/27/25, 1/28/25, 1/29/25, 2/1/25, 2/8/25, 2/19/25, 2/22/25, 2/23/25, 2/26/25, 2/27/25, 3/1/25, 3/2/25, 3/3/25, 3/8/25 3/9/25, 3/10/25, 3/16/25, 3/17/25 and 3/21/25), 4/9/25 (out of uniform) and 4/18/25 (for improper Resident Transfer with a mechanical lift).</p> <p>On 6/19/25 at 11:38 am, R1 (Resident Council President/alert and oriented) stated, I hear the residents and other staff complain about the staff fighting with each other.</p> <p>On 6/19/25 at 12:50 pm, R2 (alert and oriented) stated, Some of the staff can be snotty with each other and unprofessional, it is uncomfortable sometimes.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 6/20/25 at 11:20 am, V2 (Director of Nursing/DON) stated, I was not there (on 6/13/25) but I did watch it on the camera. (V5/CNA) and (V6/CNA) got into an argument. (V5) was assigned to the North Hall and (V6) was assigned to the South Hall. I ended up having to keep them on opposite sides of the building because their personalities just clashed. What happened was, (V5) came over from the North Hall to the South Hall, where (V6) was assigned to and (V5) had no reason to be over there. I could see them arguing in the middle of the hallway. I think (V6) just got frustrated because (V5) kept interrogating (V6), and it appeared that (V6) finally pushed (V5) back to get out of her personal space. They had a personality conflict and there had been tension between them, so I ended up scheduling them on opposite sides of the building to keep them away from each other. (V1/Administrator) went and intervened. (V5) and (V6) both ended up getting terminated over it.</p> <p>On 6/19/25 at 8:03 am, V1 (Administrator) stated, I watched back the video tape of the fight that (V5 and V6) got into in the front South Hallway, (V5 and V6) were verbally arguing, then (V6) pushed (V5). I separated both of them and I had to terminate both (V5/CNA) and (V6/CNA) because we do not tolerate that behavior. V1 verified that (V5 and V6) were in the front lobby hallway (South Hallway) where residents reside when the incident occurred.</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>Based on interview and record review the Facility failed to notify Resident Physicians and Resident Representatives for an Abuse incident for two of four Residents (R1 and R2) reviewed for notification of change in a sample of four.</p> <p>Findings include:</p> <p>The Facility Abuse Prevention Program Policy, dated 10/2022, documents: the Facility must affirm the right of our residents to be free from abuse; prohibits abuse; facility has established a resident sensitive and resident secure environment; assures that the Facility is doing all that is within its control to prevent occurrences of abuse; implement systems to promptly and aggressively investigate all reports and allegations of abuse abuse is defined as physical or mental injury inflicted upon a resident other than by accidental means and is the willful infliction of injury resulting in physical harm, pain or mental anguish, physical abuse includes hitting, slapping, pinching, kicking and controlling behavior through corporal punishment; verbal abuse is a gestured language that willfully includes disparaging and derogatory terms to residents, within their hearing distance regardless of age, ability to comprehend or disability; resident concerns will be documented, reviewed, addressed and responded to using the Facility's concern identification and grievance procedures; residents and families will be informed of the facility's concern identification and grievance procedures.</p> <p>The Facility Administrator Job Description, revised 10/2020, documents: primary purpose of this position is to direct day-to-day functions of the Facility in accordance with current federal, state and local standards, guidelines and regulations; assume responsibility and accountability for all programs in the Facility; ensure each Resident receives care and services to attain/maintain the highest practical physical, mental and psychosocial well being; ensure the planning, development, implementation and monitoring of Facility policies and procedures; and ensure all employees and Residents follow the Facility's policies and procedures; develop and implement Facility compliance program that meets state and federal requirements.</p> <p>The Facility local State Agency Initial Report, dated 6/20/25, documents an altercation that occurred on 6/13/25 between R1 and R2. R2 hit R1 in the knees multiple times.</p> <p>On 6/19/25 at 8:29 am, R1 (alert and oriented/Resident Council President) stated, About a week ago, I was in the dining room and (R2) was trying to get through the tables and chairs and the area was not big enough and there was not enough room for his wheelchair, so I told him it would be easier for him to just go around. Then (R2) started yelling at me and kicked me a several times on my knees. It hurt because I have bad knees. (V1) talked to me and told me that (R2's) medication was going to get changed, but I never heard anything else. (R2) never hit me before, but (R2) always acts out and is loud and gets frustrated with everyone. It is just frustrating listening to him yell at people all the time. No one ever followed up with me or looked at me or my knees.</p> <p>R1's Physician Order Sheet/POS, Care Plan or Nursing Notes (dated 6/13/25 through 6/19/25) do not document the 6/13/25 abuse incident with R2 or notification to R1's Physician or Representative.</p> <p>R2's Physician Order Sheet/POS, Care Plan or Nursing Notes (dated 6/13/25 through 6/19/25) do not document the 6/13/25 abuse incident with R2 or notification to R1's Physician or Representative.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/19/25 at 8:03 am, V1 (Administrator/ADM) stated, I have not done an investigation on the 6/13/25 incident between (R1) and (R2), so I cannot provide an investigation report. I only interviewed (R1). I did not investigate this or report this to Public Health (local State Agency). I did not think this was abuse. I cannot provide any documentation that (R1's) or (R2's) Physicians or Representatives were notified.</p> <p>On 6/20/25 at 11:20 am, V2 (Director of Nursing/DON) stated, I did not hear a lot about the incident on 6/13/25 between (R1) and (R2). (V1/Administrator) handles everything and nothing was communicated with me and we did not discuss this incident in morning meeting either. Nursing has not done any follow-up assessments for this incident or notified (R1's) or (R2's) doctors or family.</p> <p>On 6/20/25 at 11:38 am, an interview was conducted with V1 (ADM) and R1 in the Facility Conference Room. R1 stated that on 6/13/25, R1 and R2 were in the Main Dining Room and R2 was trying to get through the tables. There was not enough room between the table and chairs for R2 to get to R2's table. R2 then kicked R1 in the knees multiple times and gave me the finger. All (R2) does is yell and scream. My knees did hurt me for a couple days after that and no one from nursing checked on me or looked me over.</p> <p>On 6/25/25 at 7:54 am, V1 (ADM) verified that on 6/20/25, an initial investigation was reported to the local State Agency for the 6/13/25 incident between R1 and R2. V1 also verified that the Facility had not notified R1's or R2's Physician or Representative.</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>Based on interview and record review the Facility failed to protect one of four Residents (R1) from a Resident Perpetrator (R2) reviewed for abuse in the sample of four.</p> <p>Findings include:</p> <p>The Facility Abuse Prevention Program Policy, dated 10/2022, documents: the Facility must affirm the right of our residents to be free from abuse; prohibits abuse; facility has established a resident sensitive and resident secure environment; assures that the Facility is doing all that is within its control to prevent occurrences of abuse; the Facility will establish an environment that promotes resident sensitivity and resident security; identify occurrences and patterns of potential mistreatment; immediately protect residents involved in identified reports of possible abuse; implement systems to promptly and aggressively investigate all reports and allegations of abuse and make necessary changes to prevent future occurrences; facility is committed to protecting residents from abuse from anyone including other residents; abuse is defined as physical or mental injury inflicted upon a resident other than by accidental means and is the willful infliction of injury resulting in physical harm, pain or mental anguish, physical abuse includes hitting, slapping, pinching, kicking and controlling behavior through corporal punishment; verbal abuse is a gestured language that willfully includes disparaging and derogatory terms to residents, within their hearing distance regardless of age, ability to comprehend or disability; resident concerns will be documented, reviewed, addressed and responded to using the Facility's concern identification and grievance procedures; residents and families will be informed of the facility's concern identification and grievance procedures; staff will identify residents with increased vulnerability for abuse; through the care planning process, staff will identify any problems, goals or approaches which would reduce the chances of abuse; and staff will continue to monitor the goals and approaches on a regular basis and update as necessary; all investigations will be reviewed and assessed for any corrective action while conducting investigations and assessments for patterns, like cases and changes in protocol will be done immediately and reviewed.</p> <p>R1's current Care Plan documents R1 struggles with not conversing with other residents at dining room table with interventions to monitor, intervene and document.</p> <p>R2's current Care Plan documents diagnoses including Dementia with aggressive behavior, Psychotic disturbance, Mood disturbance, Anxiety, Difficulty Walking, Abnormal Gait and Mobility and Lack of Coordination. R2's Care Plan also documents: R2's risk for psychosocial problems related to delirium, inattention, disorganized thinking, altered level of consciousness and when startled can become physical and aggressive; observed triggers at meals; and behavior symptoms including verbal and physical outbursts, attempting to strike staff. R2's Care Plan documents to redirect, monitor and document R2's behaviors.</p> <p>The Facility local State Agency Initial Report, dated 6/20/25, documents an altercation that occurred on 6/13/25 between R1 and R2. R2 hit R1 in the knees multiple times.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/19/25 at 8:29 am, R1 (alert and oriented/Resident Council President) stated, About a week ago, I was in the dining room and (R2) was trying to get through the tables and chairs and the area was not big enough and there was not enough room for his wheelchair, so I told him it would be easier for him to just go around. Then (R2) started yelling at me and kicked me several times on my knees. It hurt because I have bad knees. (V1) talked to me and told me that (R2's) medication was going to get changed, but I never heard anything else. (R2) never hit me before, but (R2) always acts out and is loud and gets frustrated with everyone. It is just frustrating listening to him yell at people all the time. No one ever followed up with me or looked at me or my knees.</p> <p>On 6/19/25 at 12:50 pm, R2 (alert) stated, I do not like when people get in my way, I have to defend myself.</p> <p>On 6/25/25 at 8:30 am, V12 (CNA) stated, (On/13/25) I was in the Assistive Dining Room and heading over to the Main Dining Room and I heard some commotion. I came in and saw (R1) and (R2) arguing. (R1) said that (R2) kicked her and tried hitting her. I guess (R2) was trying to come through the tables by (R1) and there was not enough room for his wheelchair and (R2) gets aggravated easily and was yelling. They were both upset so I separated them. At this time, V12 verified V12 reported R1 and R2's altercation to V1.</p>		

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<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 interview and record review the facility failed to report an allegation of abuse to the local State Agency for two of four residents (R1 and R2) reviewed for Abuse in a sample of four.</p> <p>Findings include:</p> <p>The Facility Abuse Prevention Program Policy, dated 10/2022, documents: the Facility must affirm the right of our residents to be free from abuse; prohibits abuse; facility has established a resident sensitive and resident secure environment; assures that the Facility is doing all that is within its control to prevent occurrences of abuse; the Facility will identify occurrences and patterns of potential mistreatment; immediately protect residents involved in identified reports of possible abuse; implement systems to promptly and aggressively investigate all reports and allegations of abuse and make necessary changes to prevent future occurrences; filing accurate and timely investigation reports; abuse is defined as physical or mental injury inflicted upon a resident other than by accidental means and is the willful infliction of injury resulting in physical harm, pain or mental anguish, physical abuse includes hitting, slapping, pinching, kicking and controlling behavior through corporal punishment; verbal abuse is a gestured language that willfully includes disparaging and derogatory terms to residents, within their hearing distance regardless of age, ability to comprehend or disability; resident concerns will be documented, reviewed, addressed and responded to using the Facility's concern identification and grievance procedures; all investigations will be reviewed and assessed for any corrective action while conducting investigations and assessments for patterns, like cases and changes in protocol will be done immediately and reviewed; employees are required to report any incident, allegation or suspicion of potential abuse to the Administrator or to the compliance hotline or officer; reports will be documented and a record kept of the documentation; upon learning of the abuse report, the administrator or designee shall initiate an incident investigation; the resident's physician and representative shall be notified of any incident or allegation of abuse; all incidents will be documented, whether or not abuse; any incident or allegation involving abuse will result in an investigation; the appointed investigator will, at a minimum attempt to interview the person who reported the incident, anyone likely to have direct knowledge and the Resident and any written statements that have been submitted will be reviewed, along with any pertinent medical records and Residents whom the accused has regularly provided care and employees, will be interviewed; the investigator will report the conclusions of the investigation in writing to the administrator or designee within five working days and the final investigation report shall include (name, age, diagnoses, mental status, original allegation day, time, specific allegation, perpetrator, witnesses and circumstances surround the occurrence, facts determined, police report if applicable, conclusion of investigation and the final written report will be sent to the Department of Public Health within five working days of the reported incident; initial reporting of allegations shall be sent immediately by fax/phone to the Department of Public Health.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/19/25 at 8:29 am, R1 (alert and oriented/Resident Council President) stated, About a week ago, I was in the dining room and (R2) was trying to get through the tables and chairs and the area was not big enough and there was not enough room for his wheelchair, so I told him it would be easier for him to just go around. Then (R2) started yelling at me and kicked me a several times on my knees. It hurt because I have bad knees. (V1/Administrator) talked to me and told me that (R2's) medication was going to get changed, but I never heard anything else. (R2) never hit me before, but (R2) always acts out and is loud and gets frustrated with everyone. It is just frustrating listening to him yell at people all the time. No one ever followed up with me or looked at me or my knees.</p> <p>On 6/19/25 at 12:50 pm, R2 (alert) stated, I do not like when people get in my way, I have to defend myself.</p> <p>On 6/25/25 at 8:30 am, V12 (CNA) stated, (On/13/25) I was in the Assistive Dining Room and heading over to the Main Dining Room and I heard some commotion. I came in and saw (R1) and (R2) arguing. (R1) said that (R2) kicked her and tried hitting her. I guess (R2) was trying to come through the tables by (R1) and there was not enough room for his wheelchair and (R2) gets aggravated easily and was yelling. They were both upset so I separated them. At this time, V12 verified V12 reported R1 and R2's altercation to V1.</p> <p>On 6/19/25 at 8:03 am, V1 (Administrator/ADM) stated, I have not done an investigation on the 6/13/25 incident between (R1) and (R2), so I cannot provide an investigation report. I only interviewed (R1). I did not investigate this or report this to Public Health (local State Agency).</p> <p>On 6/25/25 at 7:54 am, V1 (ADM) stated an initial investigation was not reported to the local State Agency for the 6/13/25 incident between R1 and R2 until 6/20/25.</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Respond appropriately to all alleged violations.</p> <p>Based on interview and record review the facility failed to conduct a thorough abuse investigation for two of four residents (R1 and R2) reviewed for abuse and failed to protect residents from further potential abuse. This failure has the potential to affect all 79 Residents residing in the Facility.</p> <p>Findings include:</p> <p>The Facility Abuse Prevention Program Policy, dated 10/2022, documents: the Facility must affirm the right of our residents to be free from abuse; prohibits abuse; facility has established a resident sensitive and resident secure environment; assures that the Facility is doing all that is within its control to prevent occurrences of abuse; the Facility will establish an environment that promotes resident sensitivity and resident security; identify occurrences and patterns of potential mistreatment; immediately protect residents involved in identified reports of possible abuse; implement systems to promptly and aggressively investigate all reports and allegations of abuse and make necessary changes to prevent future occurrences; filing accurate and timely investigation reports; abuse is defined as physical or mental injury inflicted upon a resident other than by accidental means and is the willful infliction of injury resulting in physical harm, pain or mental anguish, physical abuse includes hitting, slapping, pinching, kicking and controlling behavior through corporal punishment; verbal abuse is a gestured language that willfully includes disparaging and derogatory terms to residents, within their hearing distance regardless of age, ability to comprehend or disability; resident concerns will be documented, reviewed, addressed and responded to using the Facility's concern identification and grievance procedures; staff will identify residents with increased vulnerability for abuse; through the care planning process, staff will identify any problems, goals or approaches which would reduce the chances of abuse; staff will continue to monitor the goals and approaches on a regular basis and update as necessary; all investigations will be reviewed and assessed for any corrective action while conducting investigations and assessments for patterns, like cases and changes in protocol will be done immediately and reviewed; reports will be documented and a record kept of the documentation; upon learning of the abuse report, the administrator or designee shall initiate an incident investigation; the resident's physician and representative shall be notified of any incident or allegation of abuse; residents who allegedly abuse another resident shall be immediately evaluated to determine the most suitable therapy, care approaches and placement, considering his/her safety or safety of other residents; ensure the safety of residents including, but not limited to, the separation of residents; all incidents will be documented, whether or not abuse; any incident or allegation involving abuse will result in an investigation; the appointed investigator will, at a minimum attempt to interview the person who reported the incident, anyone likely to have direct knowledge and the Resident and any written statements that have been submitted will be reviewed, along with any pertinent medical records and Residents whom the accused has regularly provided care and employees, will be interviewed; the investigator will report the conclusions of the investigation in writing to the administrator or designee within five working days and the final investigation report shall include (name, age, diagnoses, mental status, original allegation day, time, specific allegation, perpetrator, witnesses and circumstances surround the occurrence, facts determined, police report if applicable, conclusion of investigation and the final written report will be sent to the Department of Public Health within five working days of the reported incident; initial reporting of allegations shall be sent immediately by fax/phone to the Department of Public Health.</p> <p>(continued on next page)</p>		

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 06/25/2025
NAME OF PROVIDER OR SUPPLIER Washington Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>The Facility Administrator Job Description, revised 10/2020, documents: primary purpose of this position is to direct day-to-day functions of the Facility in accordance with current federal, state and local standards, guidelines and regulations; assume responsibility and accountability for all programs in the Facility; ensure the planning, development, implementation and monitoring of Facility policies and procedures; ensure all employees and Residents follow the Facility's policies and procedures; and consult with department directors concerning the operation of their departments to assist in eliminating/correcting problem areas and/or improving services; develop and implement Facility compliance program that meets state and federal requirements.</p> <p>The Facility Resident Census Roster, dated 6/19/25, documents 79 Residents residing in the Facility.</p> <p>The Facility local State Agency Initial Report, dated 6/20/25, documents an altercation that occurred on 6/13/25 between R1 and R2. R2 hit R1 in the knees multiple times.</p> <p>On 6/19/25 at 8:29 am, R1 (alert and oriented/Resident Council President) stated, About a week ago, I was in the dining room and (R2) was trying to get through the tables and chairs and the area was not big enough and there was not enough room for his wheelchair, so I told him it would be easier for him to just go around. Then (R2) started yelling at me and kicked me a several times on my knees. It hurt because I have bad knees. (V1) talked to me and told me that (R2's) medication was going to get changed, but I never heard anything else. (R2) never hit me before, but (R2) always acts out and is loud and gets frustrated with everyone. It is just frustrating listening to him yell at people all the time. No one ever followed up with me or looked at me or my knees.</p> <p>On 6/19/25 at 12:50 pm, R2 (alert) stated, I do not like when people get in my way, I have to defend myself.</p> <p>On 6/25/25 at 8:30 am, V12 (CNA) stated, (On/13/25) I was in the Assistive Dining Room and heading over to the Main Dining Room and I heard some commotion. I came in and saw (R1) and (R2) arguing. (R1) said that (R2) kicked her and tried hitting her. I guess (R2) was trying to come through the tables by (R1) and there was not enough room for his wheelchair and (R2) gets aggravated easily and was yelling. They were both upset so I separated them. At this time, V12 verified V12 reported R1 and R2's altercation to V1.</p> <p>On 6/20/25 at 10:14 am, R5 (alert and oriented) stated, My room is real close to (R2's) and (R2) yells all the time, it gets scary and gets loud, I always wonder what could possibly happen one day down the road.</p> <p>On 6/19/25 at 1:20 pm, V4 (Activity Director) stated, (R2) has a lot of behaviors and can be verbally aggressive. Just today he tried to run my foot over. I did not know anything about (R2) kicking (R1) until today. It was never discussed in any of our meetings.</p> <p>On 6/20/25 at 9:59 am, V9 (Licensed Practical Nurse/LPN) stated (R2) does yell a lot and can be a little aggressive at times.</p> <p>On 6/20/25 at 11:20 am, V2 (Director of Nursing/DON) stated, I did not hear a lot about the incident on 6/13/25 between (R1) and (R2). (V1/Administrator) handles everything and nothing was communicated with me and we did not discuss this incident in morning meeting either.</p> <p>(continued on next page)</p>		

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 06/25/2025
NAME OF PROVIDER OR SUPPLIER Washington Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE 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.

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 6/20/25 at 11:38 am, an interview was conducted with V1 (ADM) and R1 in the Facility Conference Room. R1 stated that on 6/13/25, R1 and R2 were in the Main Dining Room and R2 was trying to get through the tables. There was not enough room between the table and chairs for R2 to get to R2's table. R2 then kicked R1 in the knees multiple times and gave me the finger. All (R2) does is yell and scream. My knees did hurt me for a couple days after that and no one from nursing checked on me or looked me over. My knees hurt and I did not get offered any pain medication.</p> <p>On 6/19/25 at 8:03 am, V1 (Administrator/ADM) stated, I have not done an investigation on the 6/13/25 incident between (R1) and (R2), so I cannot provide an investigation report. I only interviewed (R1). I did not investigate this.</p>