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	08/06/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145000	A. Building B. Wing	08/06/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review the facility failed to notify the Residents Family/Representative promptly of a change of condition for one of three residents (R1) reviewed for injury of unknown origin in the sample of three. Findings include: The Notification of Resident Change in Condition Policy (undated) documents Policy: It is the policy of this facility to promptly notify the resident, their legal representative(s) and attending physician of changes in the resident's health condition. Policy Specifications: To establish guidelines for assuring residents, their legal representatives and attending physicians are informed of changes in the resident's condition. Responsibility: Director of Nursing and Licensed Nurses. Standards: 1. A licensed nurse shall promptly inform the resident, consults with the resident's physician and if known, notify the residents legal representative or an interested family member of: a. An accident involving the resident in which there is a potential for an actual injury which could require nursing or medical intervention. b. A significant change in the resident's physical, mental or psychosocial status, i.e. (example) deterioration in health, mental or psychosocial status in either life threatening conditions or clinical complication. c. A need to alter treatment significantly i.e. need to discontinue an existing form of treatment. d. A decision to transfer or discharge the resident from the facility. 2. The licensed nurse is to use professional judgment in determining changes in condition based on assessment and findings or signs and symptoms of change which could lead to deterioration if not treated. 3. Clinical change in condition is determined by resident visualization, medical record review, clinical assessment findings and care plan review. Review of high-risk clinical issues such as skin breakdown, falls, weight loss, dehydration and others are conducted on a daily basis. 4. Following the assessment, observing signs and symptoms, and obtaining vital signs, the attending physician, family/guardian will be promptly notified of significant findings. 12. Resident representative(s) notifications and attempts will be made promptly and documented in the nurse's notes. In the event the licensed nurse is unable to contact the resident's representative, after a reasonable time period, the Director of Nursing will be notified. R1's Nursing Note written by V11/Licensed Practical Nurse dated 7/23/25 at 5:29 AM, documents that staff reported discoloration to R1's Left Lower Extremity from the knee down. R1 was guarding and facial grimacing when the leg was touched or moved. The knee was swollen and warm to the touch. No record of a fall. A message was left with Hospice. The Initial Facility Incident Report sent to the (State agency) dated 7/23/25 at 7:00 AM, documents that R1 has diagnoses which include Alzheimer's Disease with Late Onset, Type 2 Diabetes Mellitus with Diabetic Chronic Kidney Disease, Generalized Anxiety Disorder, Hyperlipidemia, and Delusional Disorder. R1 has confusion regarding time/place/person. Brief Interview of Mental Status 2/15 (severer cognitive impairment). R1 was noted with discoloration and swelling to the Left Lower Extremity. R1 noted guarded and unwilling or unable to extend her leg fully. R1's Family/Resident Representative was notified on 7/23/25 at 11:00 AM. On 8/4/25 at 5:50 PM, V17/R1's Power of Attorney/POA stated that she was upset that she was not notified immediately that R1 had bruising and swelling to R1's leg. I did not here from the facility about (R1's) injury. The first I knew of it was when I was told by hospice. I let (V2/Previous Director of Nursing) know that I was not happy about the lack of communication. On 8/5/25 at 1:55 PM, V15/Hospice Registered Nurse stated that on 7/23/25 at 10:59 AM V15 talked to V2/Previous Director of Nursing about R1's injury and what should be done. V13/Nurse Practitioner had come in to examine R1 and had decided that an x-ray of R1's leg needed done. V13 had said that R1 could be sent to the emergency room for the x-ray, or it could be ordered to be done in house. V13 said that V17/R1's Power of Attorney should make the final decision. That is when V15 found out that V17 was not notified of R1's injury by the facility. V15 called V17 to discuss R1's injury and V17 was upset that she had not been called earlier by the facility. V15 also stated Although (R1) is receiving hospice care (V17) should have been notified by the facility of (R1's) injury. I was told the injury was found around 5:45 AM on 7/23/25. I did not talk to (V17) until around 11:00 AM on 7/23/25. On 8/6/25 at 12:47 PM, V2/Previous Director of Nursing stated (V11/Licensed Practical Nurse/LPN) was the nurse that was working when (R1's) injury was noted on (R1's) leg. (V11) reported the injury to hospice, and (V18/Assistant Director of Nursing) but did not report the injury to (V17/R1's POA). When I ask (V11) why she did not call (V17), (V11) said that she was used to working in another state where hospice would contact the POA. I told (V11) that was not the protocol here. I told her that she should have notified the POA immediately.