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	11/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Washington Senior Living	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 0688 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30678 Based on observation, interview, and record review the facility failed to perform therapy recommended range of motion exercises and failed to place therapy recommended hand device for one (R1) of three residents reviewed for contractures in the sample of three. These failures resulted in R1 developing severe contractures of bilateral wrists and fingers causing R1's left thumb bone to protrude through the skin and R1 being scheduled for amputation of left thumb. Findings include: The facility's Rehabilitative Nursing Care policy and procedure, revised April 2007, documents Policy Interpretation and Implementation: 1. General rehabilitative nursing care is that which does not require the use of a Qualified Professional Therapist to render such care. 2. Nursing personnel are trained in rehabilitative nursing care. Our facility has an active program of rehabilitative nursing which is developed and coordinated through the resident's care plan. 3. The facility's rehabilitative nursing care program is designed to assist each resident to achieve and maintain an optimal level of self-care and independence. 4. Rehabilitative nursing care is performed for those residents who require such service. Such program includes but is not limited to: . b. Encouraging and assisting bedfast residents to change positions at least every two (2) hours (day and night) to stimulate circulation and to prevent decubitus ulcers, contractures, and deformities; . f. Assisting residents with their routine range of motion exercises . 5. Through the resident care plan, the goals of rehabilitative nursing care are reinforced in the Activities Program, Therapy Services, etc. The facility's Range of Motion Exercises policy and procedure, revised August 2008, documents The purpose of this procedure is to exercise the resident's joints and muscles .The following information should be recorded in the resident's medical record: 1. The date and time that the exercises were performed. 2. The name and title of the individual(s) who performed the procedure. 3. The type of ROM (range of motion) exercise given. 4. Whether the exercise was active or passive. 5. How long the exercise was conducted. 6. If and how the resident participated in the procedure or any changes in the resident's ability to participate in the procedure. 7. Any problems or complaints made by the resident related to the procedure. 8. If the resident refused the treatment, the reasons(s) why and the intervention taken. 9. The signature and title of the person recording the data. (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 0688 Level of Harm - Actual harm Residents Affected - Few	The Clinical Admission Evaluation for R1, dated 5/19/20, documents R1's initial admission assessment to the facility as R1's functional status being able to move all extremities with impairment to bilateral lower extremities. There is no documentation regarding upper extremities functional deficits or wounds to R1's hands. The Occupational Therapy Plan of Care for R1, dated 5/20/21, documents R1's initial therapy assessment Current Left UE (upper extremity) Completes up to 50% of normal range. Range of Motion Right UE completes up to 50% of normal range. Strength, Left UE 3-/5 (The muscle is able to contract and provide resistance, but when maximum resistance is exerted, the muscle is unable to maintain the contraction) and Strength, Right UE 3-/5. Tone, Left UE normal. Tone, Right UE normal. Gross Motor Control of LUE and RUE moderately impaired. Fine Motor Control LUE and RUE moderately impaired. Rehab potential Fair due to: Demonstrated higher functional level compared to current condition. The therapist Progress & Discharge Summary for R1, dated 5/29/20, documents Discharge: Goals not met - Program Complete. This Discharge Summary documents Completed caregiver training on ROM and positioning needs. The Occupational Therapy Plan of Care for R1, dated 10/29/20, documents a therapy screen was completed for R1 with the Treatment Diagnosis: Contracture, right hand .Reason for Referral: . due to worsening contracture of right hand - OT (Occupational therapy) to evaluate for use of splint to address development of contracture . Therapy Necessity: Skilled OT is necessary to develop a restorative/positioning program in order to maximize ROM/prevent worsening contracture. The Occupational Therapy Referral for Functional Maintenance Program for R1, dated 11/7/20, documents Range of Motion (Passive) as tolerated - Slow/rhythmic motor and Splint or Brace Assistance. Right hand palm protector - off for hygiene (wash/dry hand). Restorative Program to start on 11/7/20, to be done 6 to 7 times a week, one time daily, and ongoing. The Occupational Therapy Plan of Care (Evaluation Only) for R1, dated 8/26/21, documents Treatment Diagnosis: Contracture, right hand . Reason for Referral: . LTC (long term care) resident at (facility) referred to skilled OT for bilateral hand contractures resulting in significant pain, positioning deficits, and decreased functional use of hands. Pt's (patient's) L (left) hand contracture resulted in a significant L thumb wound warranting medical attention from orthopedic MD (medical doctor). Pt will be re-screened in order to develop a restorative nursing program for contracture management once wound has healed. This referral also documents Unable to assess due to pt refusing due to pain. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	On 11/5/21 at 11:25 am, V7 COTA/Therapy Program Manager stated R1 was initially screened for OT (Occupational Therapy) on 5/20/20 when she first came to the facility and V7 does not recall R1 having severe contractures at that time. V7 stated R1 and was picked up on therapy and discharged from OT on 5/29/20 due to inability to follow commands and resistive with treatment. V7 stated the Restorative Staff was educated on R1's positioning needs. V7 stated on 10/29/20 R1 was referred to OT because of worsening contracture of R1's right hand and we screened her and referred her to Restorative for Passive ROM (range of motion) for maintenance programing and for a palm protector for her right hand that should have started on 11/7/20. V7 stated (V7) received another referral for R1 on 8/26/21 for evaluation of R1's bilateral hand contractures, which caused a wound to R1's left hand and PT (Physical Therapy) also received a referral for R1 regarding contractures to R1's lower extremities. V7 stated at initial assessment in May of 2020 was completed for R1 and at that time R1 had 50% of movement in upper extremities and had normal tone and now does not and has significant contractures of her upper extremities, both arms, hands, and fingers. V7 stated the palm protector would have helped to keep R1's hand clean and fingernails from digging into her skin if it had been used or used correctly. V7 stated when a resident comes off of therapy, they will start a restorative program, the restorative nurse is educated on the program needed and the CNA's (Certified Nursing Assistants) are to do the programs. On 11/5/21 at 2:30 pm, V8 Restorative CNA stated she has been the restorative CNA for 2 years and does not recall any restorative programs coming through for R1. V8 stated no one is currently working with R1 and no one has in the past that she is aware of. On 11/5/21 at 2:40 pm, V9 LPN Restorative Nurse, stated she does not recall any restorative programs being done for R1 since she has worked at the facility and is unaware of R1 using a palm protector or any other type of device for contracture prevention. V9 stated when a resident is admitted the skilled therapy staff pick them up and when therapy discharges them I re-screen the resident for restorative programing and the Restorative CNA does the programs. The Care Plan for R1, created on 4/26/21, documents Alteration in musculoskeletal status r/t (related to) contractures of bilateral hands. The interventions include to Assist with use of applying rolled wash clothes to bilateral hands daily. Monitor and inspect daily for signs and symptoms of skin impairment daily. Report changes to nurse. The Care Plan for R1, created on 1/19/21, documents R1 has a ROM ADL (Activities of Daily Living) self-care performance deficit related to limited ROM and musculoskeletal impairment. The interventions include Explain all procedures/tasks before starting. Palm Protector to right hand daily. Right hand Palm protector - May remove for bathing and hygiene. The Care Plan for R1, created on 8/3/21, documents (R1) has actual skin impairment to left hand r/t contractures. The interventions include Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short. Educate resident/family/caregivers of causative factors and measures to prevent skin injury. Follow physician's orders for treatment of injury. Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, s/sx of infection, maceration etc. to MD. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	The POS (Physician Order Sheet) for R1, dated 8/2/21 documents a Physician Order Open area to palm L hand, thumb area. Cleanse with wound cleanser. Apply calcium alginate. Ensure palm protector is in place every day and evening shift for wound. Discontinued on 8/30/21. The POS, dated 8/19/21 documents Send to Methodist ER for evaluation and treatment of left thumb. The POS, dated 8/25/21, documents Refer to Ortho surgeon for left thumb. The POS, dated 8/30/21, document Open area to palm L hand, thumb area. Cleanse with wound cleanser. Apply calcium alginate. Ensure palm protector is in place every day shift for wound. The POS, dated 10/12/21 documents CBC (Complete Blood Count) with diff (differential), RCMP (Comprehensive Metabolic Profile), CRC (Chest X-ray), EKG (Electrocardiogram), clearance from PCP (Primary Care Physician) for amputation of L (left) thumb. On 11/4/21 at 9:30 am, R1 was lying in bed with her arms bent at the elbows with severe wrist and finger deformities. There are no washcloths or palm protectors visible in R1's hands. V3 LPN (Licensed Practical Nurse)/Wound Nurse was at R1's bedside performing wound care to R1's left thumb. R1 was screaming out loudly as V3 LPN/Wound Nurse was trying to clean and apply dressing to R1's left thumb wound. On 11/4/21 at 4:20 pm, R1 did not have a palm protector or washcloth in her hands. On 11/4/21 at 9:45 am, V3 LPN/Wound Nurse stated R1 has severe contractures to her hands and her thumb treatment is very difficult to do. On 11/4/21 at 2:40 pm, V2 DON stated R1 has severe contractures to both of her upper extremities and has a bone protruding through the skin of her left thumb. V2 stated a referral was made to an orthopedic surgeon who recommended amputation of her left thumb and the facility is trying to get Cardiac clearance so that R1 can have the surgery. On 11/5/21 at 9:30 am, V5 and V6 CNA's provided cares to R1 and transferred R1 into a reclining wheelchair. V5 and V6 did not place a palm protector or washcloth into R1 hands. On 11/5/21 at 9:32 am and 9:38 am, V5 and V6 CNA's respectively stated R1 is not able to move around, is unable to move her arms or open her hands, does not use a palm protector or washcloths because of her contractures and is total assist for all cares. On 11/5/21 at 9:20 am and 11/8/21 at 8:18 am, R1 did not have a palm protector or washcloth in her hands. The Nursing Note for R1, dated 8/2/21, documents Resident noted with dried blood and bleeding to inner left hand, cleansed hand with water softly. Open sore to inner left thumb. Area bleeding placed 4 x 4 gauze over the open sore. Wash cloth in place. Left hand is contracted. Notified wound nurse. Left hand noted with fungal odor, yeast. The Skin/Wound Note for R1, dated 8/2/21, documents Blood observed on towel in left hand. Upon assessment open area noted, however unable to examine full area d/t (due to) contractures. Area cleansed with wound cleanser and calcium alginate with silver applied. MD (Medical Doctor) made aware. The Transfer and Transfer to Hospital Summary Notes for R1, dated 8/19/21, document R1 was sent to the local hospital per Nurse Practitioner for an evaluation of left-hand wound. The Nursing Note for R1, dated 8/20/21, documents Resident returned to facility from (local hospital) via (transport company) stretcher. N.E. (new order) follow up with facility physician. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	The Nursing Note for R1, dated 8/23/21, documents Left hand x-ray back and shows mild soft tissue swelling with some flexion deformity of the fingers and wrist with no evidence of recent fracture or dislocation. Clinical correlation is requested. BAR (situation, background, assessment, and recommendation form) filled out and papers in doctor box. The Heath Status Note for R1, dated 8/25/21, documents Res (resident) continues on Reflex for infection in L (left) hand. Wound MD to follow . The Skin/Wound Note for R1, dated 8/25/21, documents Wound MD at facility for rounds. Resident is being seen for full thickness wound to L 4th finger. Orders received to continue calcium alginate as previously ordered. The Nursing Note for R1, dated 8/25/21, documents This writer spoke with PO (power of attorney) and informed PO that resident has a referral to see an Ortho (orthopedic) surgeon for her left thumb .on 9/3/21 at 8 am. The GNP (Nurse Practitioner) Progress Note for R1, dated 8/19/21 documents .She (R1) has severe contractures of hands, fingers, wrist. Her left thumb IP (intercalate - finger) joint is extending out abnormally to the point her anterior thumb surface has gotten an open area. It is covered with calcium alginate at present. (R1) per her baseline gets very anxious and yells out when trying to examine this. Intervention is needed. She will need sedation for examination. Wound nurse says it is worse today than it was just a couple days ago. The PCP (Primary Care Physician) Progress Note for R1, dated 8/23/21, documents I was asked to see the patient for a pressure wound on the left-hand thumb. My nurse practitioner sent patient to the hospital for treatment, but patent returned without any orders. Patient does not want me to look at her left thumb as patient starts hollering . Left first digit 2 cm x 2.5 cm wound present with protruding mass. Unable to tell if bone or tendon. Left thumb is contracted .: Ordered wound consult with Dr. [NAME]. Ordered left hand x-ray two-view, ESR, CRP, CMP and CBC. Start Keflex 100 mg p.o. twice daily for 7 days and Florastor 250 mg twice daily for 14 days. The PCP Progress Note for R1, dated 9/15/21, documents . I was asked to see the patient for H&P clearance for left thumb amputation. Patient had an open wound and was evaluated by hand surgeon who recommended amputation. Labs and testing and antibiotic therapy completed. Patient was seen by hand surgeon who recommended amputation. On 9/9/21 patient was seen by cardiology who performed an echocardiogram with EF (ejection fraction) . After reviewing cardiology note I do not see any clearance for surgery. Instructed nursing to call cardiology for cardiac clearance. The NP Progress Note, dated 10/14/21, documents She (R1) is scheduled for surgical intervention for her left thumb. She has a contracture that opened and her distal phalanx (finger bone) is sticking out of her skin. (Orthopedic surgeon) is going to take care of it. She is cleared for surgery for without it she will suffer. The NP Progress Note, dated 11/4/21, documents . Been trying to get her thumb fixed/amputated so she won't get osteomyelitis but can't get her cardiac clearance for surgery. She seems miserable but cannot get family to agree to comfort measures. She has no quality of life. Mainly lives with anxiety and cannot express self, dependent on all cares . All joints some degree contractures. Thumb open wound with bone exposed from contracture . (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	The facility Wound Doctor Evaluation and Management Summary, dated 8/25/21, documents Patient presents with a wound on her left, fourth finger . At the request of the referring provider (R1's PCP), a thorough wound care assessment and evaluation was performed today. She has a wound of the left, fourth finger for a least 1 days duration. There is moderate serous exudate. The patient appears to have associated pain evidenced by agitation . full thickness . Duration > 1 day . manage exudate, manage pain, palliation. Wound Size (L x W x D): 1 x 0.8 x 0.1 cm. Surface area: 0.80 cm. Exudate: Moderate Serous. Granulation tissue: 65%. Other visible tissues: 35% (Bone) . She (R1) has severe hand contractures, and the wound is on the palmar side of the proximal phalanx of thumb. Bone is visible in center of hypergranulated wound bed. She had been sent to ED (emergency department) last week, but no workup done to evaluate for osteomyelitis there. Xray was done a few days ago in (facility) and was negative. Clinically this is osteomyelitis. Medical management with at least 6 weeks of IV strength of abx (antibiotic) to try to cure. Surgical management is resection of involved bone or amputation of digit. Could refer to hand surgeon for assistance if patient is not palliative goals. Discussed with primary care NP in facility and they will arrange for referral to see hand surgeon if family agrees with that plan . Primary Dressing(s): Alginate calcium w/silver apply once daily for 30 days: tuck between thumb and first finger. The facility Wound Doctor Evaluation and Management Summary, dated 9/1/21, documents . she (R1) has a wound of the left, first finger for at least 7 days duration. There is moderate serosanguinous exudate . Wound Size (L x W x D): 1 x 1 x 0.1 cm. Surface Area: 1.00 cm. Exudate: Moderate Serosanguinous. Granulation tissue: 100%. Wound progress: No change. Additional Wound Detail: left thumb not 4th finger. EMR (electronic medical record) data entry error last visit. Very difficult to see due to contracture and she screams out when try to relax her fingers apart. Less bone visible with friable, hypergranulation over now. Has ortho consult pending . Primary Dressing(s): Alginate calcium w/silver apply once daily for 23 day: tuck between thumb and first finger. The facility Wound Doctor Progress Note, dated 9/8/21, documents Signing off on patient who remains in the facility. She has seen ortho and plans for amputation. Awaiting cardiac clearance. On 11/5/21 at 3:00 pm, V3 LPN/Wound Nurse stated the CNA's (Certified Nursing Assistants) alerted her of R1's left hand bleeding after (R1's) shower one day in August and when first assessed (V3) thought it was an abrasion but due to R1's severe contractures it is difficult to see in R1's hands. V3 stated R1's hands are completely contracted, almost in opposite direction which has caused R1's thumb bone to protrude through her skin. V3 stated when she noticed the bone, she sent R1 to the hospital for an evaluation and the hospital sent (R1) back with an Ortho (Orthopedic) consult. The Ortho doctor recommended an amputation of R1's left thumb and ordered some testing to be done. V3 stated all the labs and testing have been completed and (V3) has been going back and forth with R1's cardiologist and the Ortho to communicate. V3 stated the Cardiologist gave the ok but had questions about the anesthesia that would be used and some other questions that (V3) had the Cardiologist contact the Ortho because she didn't know the answers. V3 stated she has been going back and forth between the Ortho and Cardiologist and can't seem to get them on the same page. V3 stated R1's contractures are getting worse and it's getting more difficult to assess and treat R1's wound. V3 stated the wound clinic saw R1 a couple of times but is no longer following her because we are in process of getting R1's thumb amputated. V3 stated, I didn't think we would still be dealing with this at this point. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	On 11/8/21 at 9:25 am, V2 DON confirmed R1's therapy referrals and documentation of R1's Restorative Referral, R1's need for range of motion exercises, and was unaware that restorative was not being done for R1 or that devices were not being used for R1 to prevent contractures. V2 stated the facility has been working on getting R1's Cardiologist clearance for the amputation of her left thumb since August 2021.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 30678 Based on observation, interview, and record review the facility failed to follow a plan of care for one (R1) of three residents reviewed for falls in the sample of three. This failure resulted in R1 falling out of bed and receiving a cervical neck fracture, facial and leg bruising and experiencing increased pain. Findings include: The electronic medical record for R1 includes the following diagnoses: Cerebral Infarction, Alzheimer's disease, General Anxiety Disorder, Contractures of bilateral knee, feet, and right hand, Osteoarthritis of hip, muscle weakness, Gastrostomy feeding tube, Cardiac Pacemaker, Dementia, Weakness, Chronic Kidney Disease, and Congestive Heart Failure. The Quarterly MDS (Minimum Data Set) Assessment for R1, dated 8/9/21, documents R1 with moderately impaired cognition, requires extensive assist of two staff for bed mobility, total assist of two for transfers, does not ambulation, requires total assist of one for wheelchair locomotion, extensive assist of one for dressing and personal hygiene, and total assist of one for bathing, eating, and toileting and is always incontinent of bowel and bladder. The hospital After Visit Summary for R1, dated 10/30/21, documents Fall as the reason for visit. The Diagnoses documents, Fall from bed, initial encounter; Contusion of forehead, initial encounter; Closed nondisplaced fracture of second cervical vertebra, unspecified fracture morphology, initial encounter; Urinary tract infection without hematuria, site unspecified and Cervical collar was placed. The facility's Falls and Fall Risk, Managing policy and procedure, revised August 2008, documents Policy Statement: Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Prioritizing Approaches to Managing Falls and Fall Risk . 6. Staff will identify and implement relevant interventions (e.g., hip padding or treatment of osteoporosis, as applicable) to try to minimize serious consequences of falling. Monitoring Subsequent Falls and Falls Risk: . 1. The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling. The current Fall Care Plan for R1, created on 7/2/20 and revised on 8/10/21, documents R1 is At high risk for falls. This Care Plan lists the following interventions: Low bed at all times. Call light in reach. Follow fall protocol. Furniture in locked position, Keep needed items in reach. Maintain clear pathway in room, free of obstacles. Fall Mat to floor, rolled edged mattress to bed and cervical neck collar as ordered. The Post Fall Evaluation dated 10/30/21 at 6:00 am, documents Fall Details: R1 with unwitnessed fall in resident room at 6:00 am. R1 with bump to left side of forehead and sent to emergency room . Resident fell out of bed. Bump to left side of forehead noted. Floor mat on floor and improper bed height. Resident with socks on at time of fall. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Charge Nurse Fall Investigation: Bed boundaries is documented as the cause of the fall. Rolled out of bed. On 11/4/21 at 9:00 am, R1 was lying in a low bed with blue, black, and purple bruising to the entire left side of R1's face with a cervical collar in place around (R1's) neck and discolored bruising to R1's left lower leg and ankle. V3 LPN (Licensed Practical Nurse)/Wound Nurse was providing care to R1 with R1's bed elevated to the height of V3's waist level. R1's call light was hanging over R1's headboard. V3 exited R1's room without lowering R1's low bed to the floor position or placing R1's call light within R1's reach. On 11/5/21 at 9:20 am, V4 LPN was at R1's bedside providing care with R1's low bed positioned at the height of V4's waist. V4 exited R1's room without lower R1's low bed to floor level. On 11/8/21 at 8:18 am, R1 was lying in bed and R1's call light was hanging on the drawer handle of R1's night stand out of R1's reach. On 11/5/21 at 2:46 pm, V10 LPN stated she was working at the time R1 fell out of bed on 10/30/21 around 5:55 am and heard R1 yelling. V10 stated she entered R1's room and saw R1 laying on the floor mat face down. V10 stated she (R1) does not have a history of falls and won't try to get up from bed by herself. V10 stated R1 does have tremors in her hands and arms but can't move them around. V10 stated V11 CNA (Certified Nursing Assistant) and V12 LPN from first shift and V13 Agency CNA were present with her in R1's room. V10 stated V13 Agency CNA was scheduled to work R1's hall on third shift and had already been in R1's room to turn and reposition R1 and R1's bed should have been lower than it was. V10 stated she is unsure if V13 Agency CNA lowered R1's bed as it was positioned just above V10's knees which was about two to three feet from the floor. On 11/7/21 at 3:35 pm, V11 CNA stated she was at the desk the morning of 10/30/21 when she heard a loud noise and then heard R1 yelling out. V11 stated (V11), V12 LPN, and V13 Agency CNA ran down to R1's room, where V10 LPN was. R1 was laying on the floor, face down on the floor mat. V11 stated We didn't know what happened except that maybe she was lying too close to the edge of her air mattress. V11 stated V13 Agency CNA said she had just been in the room and had turned R1. V11 stated she noticed R1's bed was not lowered all the way down, it was up about knee height, a couple of feet or so from the floor. The Nurse assessed her, we got (R1) back into bed and sent (R1) to the hospital. V11 confirmed that R1's bed should have been lowered to the floor. On 11/7/21 at 7:46 pm, V12 LPN stated she was working first shift the morning of 10/30/21 and heard V10 LPN yelling for (V12) from R1's room. V12 stated when she got to R1's room, R1 was lying face down on the floor mat next to (R1's) bed. V12 stated V10 LPN assessed R1 while (V12) went to get papers ready to send R1 out to the hospital. V12 stated R1 did have an air mattress on her low bed at the time of the fall but didn't notice the height of R1's bed but it should have been only about ankle high from the floor. V12 also stated R1 does have slight tremors in her hands and if anxious or upset she will have increased tremors. V12 stated R1 will not try to get up by herself and is a total assist for bed mobility and transfers. On 11/5/21 at 9:25 am, 9:32 am, and 9:38 am, V4 LPN, V5 CNA, and V6 CNA respectively stated R1 is a total assist for all cares, is unable to move her arms or hands, has hand tremors but does not move around in the bed. (continued on next page)

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	11/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Washington Senior Living	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 0689 Level of Harm - Actual harm Residents Affected - Few	On 11/4/21 at 2:40 pm V2 DON (Director of Nursing) stated she completes all the facility fall investigations and then (V2) or the Care Plan Coordinator puts the new interventions on the care plan. V2 stated R1 rolled out of her bed on 10/30/21 landing face down on the fall mat. V2 stated she believes during last rounds, third shift staff turned and repositioned R1 onto R1's left side, R1 was having tremors and jerky movements of her hands which may have offset R1's air mattress causing R1 to roll out of her bed onto the floor mat. V2 DON stated R1 was sent to the local hospital and returned with a cervical fracture of her neck and bruising to her face. V2 stated R1 is unable to move on her own and won't try to get up by herself. V2 stated low beds are to be lowered as far to the floor as possible, but not to disengage the bed brake. V2 confirmed waist high was too high and that call lights should be within resident reach.