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	01/30/2023

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 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. 31682 Based on record review and interview the facility failed to notify the power of attorney and physician of resident elopements for two of three residents (R4 and R8) reviewed for elopement in the sample of nine. Findings include: The facility's Elopement and Search Policy dated 02/2014 documents, The facility will notify the physician of the resident's return and their condition when the resident is found and notify the authorized legal representative. 1. On 1-24-23 at 10:05 AM V17 (RN/Registered Nurse) stated, On 11-26-22 sometime before 5:00 AM I had left the facility to go to the gas station. When I came back, I found (R4) walking out in the North-West employee parking lot. I have no idea how long (R4) was in the parking lot. I did not document the incident, notify the physician, or notify (R4's) power of attorney. R4's Electronic Medical Record dated 11-1-22 through 1-24-23 does not include any documentation of R4's power of attorney or physician being notified of R4's elopement on 11-26-22. 2. On 1-23-23 at 4:35 PM V15 (RN) stated, I was working on 1-7-23 on the Northeast hallway. (R8) was found outside unattended in the employee parking lot by the garbage cans (approximately 50 feet from the exit door) around 5:00 in the morning. R8's Electronic Medical Record dated 1-1-23 through 1-24-23 does not include any documentation or R8's power of attorney or physician being notified of R8's elopement on 1-7-23. On 1-24-23 at 9:00 AM V20 (R8's Family Member) stated, I was not notified on (R8) getting out of the building unattended on 1-7-23. I am concerned that the facility is not watching (R8) close enough and (R8) will get lost. The facility should have notified me. On 1-25-23 at 10:00 AM V3 (Assistant Director of Nursing) stated R4's power of attorney and physician, and R8's power of attorney and physician were not notified of R4 and R8's elopements.

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
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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31682 Based on record review and interview the facility failed to prevent misappropriation of controlled medications (narcotics) for five of five residents (R2, R4, R5, R6, R7) reviewed for misappropriation of medications in the sample of nine. Findings include: The facility's Abuse Preventions Program Policy dated 11-22-2017 documents, Residents have the right to be free from abuse, neglect, exploitation, misappropriation of property, or mistreatment. Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings or money without the resident's consent. The Facility's Final Incident Report Form dated 1-11-23 and signed by V3 (Assistant Director of Nursing/ADON) documents, Upon investigation narcotic sheet reviewed showing administration at three different times from 12:40 AM to 5:40 AM (1-10-23). (R2) stated (V8) came in with (R2's) pain medication and thyroid medication at 5:30 AM and had not entered room any other time through the night. All narcotic counts and sheets have been reviewed to ensure no other residents were affected. IDT (Interdisciplinary Team) met and reviewed and updated plan of care accordingly. Video surveillance was given to local authorities, and they are conducting a formal investigation. 1. R2's MDS (Minimum Data Set) assessment dated [DATE] documents R2 is cognitively intact. R2's Electronic Physician's Order Sheets (POS's) dated 1-23-23 document, Order date: 12-29-22 Oxycodone/Acetaminophen 7.5/325 mg (milligrams) one tablet by mouth every six hours as needed for pain. R2's Controlled Drug Receipt/Record/Disposition Form dated 12-31-22 through 1-10-23 documents on 1-10-23 V8 (Agency RN/Registered Nurse) distributed one tablet of R2's Oxycodone/Acetaminophen 7.5/325 mg at 12:45 AM and another tablet at an unknown time (unreadable). R2's Medication Administration Record dated 1-1-23 through 1-31-23 does not include any documentation of V8 administering Oxycodone/Acetaminophen 7.5/325 mg to R2 on 1-10-23. On 1-23-23 at 8:40 AM R2 stated, I was asked by staff if I received my pain medication (Oxycodone/Acetaminophen 7.5/325 mg) by (V8) three times the night of 1-10-23. I most certainly did not receive my pain medicine three times. (V8) only gave me my pain medication one time in the morning. 2. R4's Electronic POSs dated 1-23-23 document, Order date: 1-2-23 Hydrocodone Acetaminophen (Norco) 10/325 mg one tablet by mouth every six hours as needed for pain. R4's Controlled Drug Receipt/Record/Disposition Form dated 1-2-23 through 1-10-23 documents on 1-10-23 V8 distributed one tablet Hydrocodone/Acetaminophen 10/325 mg at 4:00 AM on 1-10-23. R4's Medication Administration Record dated 1-1-23 through 1-31-23 does not include any documentation of V8 administering Hydrocodone/Acetaminophen 10/325 mg to R4 on 1-10-23. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. R5's MDS assessment dated [DATE] documents R5 is cognitively intact. R5's Electronic POSs dated 1-23-23 document, Order date: 12-7-22 Hydrocodone Acetaminophen 5/325 mg one tablet by mouth every six hours as needed for pain. R5's Controlled Drug Receipt/Record/Disposition Form dated 12-27-22 through 1-10-23 documents on 1-9-23 V8 distributed one tablet Hydrocodone/Acetaminophen 5/325 mg at 11:00 PM. R5's Medication Administration Record dated 1-1-23 through 1-31-23 does not include any documentation of V8 administering Hydrocodone/Acetaminophen 5/325 mg to R5 on 1-9-23. 4. R6's Electronic POSs dated 1-23-23 document, Order date: 12-21-22 Hydrocodone Acetaminophen 5/325 mg one tablet by mouth every 12 hours as needed for pain. R6's Controlled Drug Receipt/Record/Disposition Form dated 1-9-23 through 1-10-23 documents on 1-10-23 V8 distributed one tablet Hydrocodone/Acetaminophen 5/325 mg at 12:30 AM. R6's Medication Administration Record dated 1-1-23 through 1-31-23 does not include any documentation of V8 administering Hydrocodone/Acetaminophen 5/325 mg to R6 on 1-10-23. 5. R7's MDS assessment dated [DATE] documents R7 is cognitively intact. R7's Electronic POSs dated 1-23-23 document, Order date: 12-10-22 Hydrocodone Acetaminophen 5/325 mg one tablet by mouth every four hours as needed for pain. R7's Controlled Drug Receipt/Record/Disposition Form dated 1-9-23 through 1-10-23 documents on 1-10-23 V8 distributed one tablet Hydrocodone/Acetaminophen 5/325 mg at 3:00 AM. R7's Medication Administration Record dated 1-1-23 through 1-31-23 does not include any documentation of V8 administering Hydrocodone/Acetaminophen 5/325 mg to R7 on 1-10-23. On 1-23-23 at 4:00 PM V11 (CNA/Certified Nursing Assistant) stated, On 1-10-23 (V8) was falling asleep, not doing her job, and was looking like she was 'high' on drugs. I was not putting up with that. I called the police on (1-10-23) to report my suspicion. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1-23-23 at 10:00 AM V3 (ADON) stated, On 1-10-23 around 6:00 AM I got a phone call in the morning from (V17/RN/Registered Nurse) that the cops were in the building and got called because the nurse (V8/Agency RN) looked like she was 'high' on drugs. The police were talking to (V8) and made (V8) leave the premises. We (facility staff) started auditing narcotic medication sheets. (R2's) controlled substance sheet documented (V8) has given (R2) Oxycodone/Acetaminophen three times that night (1-10-23). I interviewed (R2) and she stated she did not get that medication three times. (R2) stated she had only received that medication in the morning on 1-10-23. We also noticed that (V8) had documented she had given (R4, R5, R6, and R7) a Norco that same night (1-9-23 through 1-10-23). I also asked (R5 and R7) if they had received a Norco from (V8) that night and they both said they did not. I then viewed our camera footage from 1-10-23 and the footage revealed that (V8) did not go into (R2, R4, R5, R6, or R7's) rooms to distribute their pain medications as documented on their controlled substance sheets. Based on camera footage and resident interviews it was determined that (V8) had stolen (R2, R4, R5. R6, and R7's) medications. All these medications were narcotics. I have not been able to contact (V8) since the incident. I called the agency that (V8) works for and reported the theft to them and told the agency that (V8) is no longer allowed in the facility.

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31682 Based on observation, interview and record review the facility failed to ensure exit doors were secure and the door alarm system was in working order, failed to properly assess residents at risk for elopement, failed to develop a care plan and implement interventions for residents at risk for wandering/elopement, failed to follow facility elopement policies, and failed to provide adequate supervision for three of three residents (R4, R8, R9) reviewed for elopement risk in the sample of nine. These failures resulted in cognitively impaired residents (R4, R8, and R9) who require extensive assistance with ADL's (Activities of Daily Living) exiting the facility without staff knowledge and being found on separate dates, wandering aimlessly, and confused, out in the west side of the building's parking lot approximately 50 feet from the exit doors. This parking lot is located next to a road that has high activity of traffic. R4 and R8 were found before dawn, in the dark, and the weather was chilly. R9 was found sitting on the end of a car bumper. These failures resulted in an Immediate Jeopardy. While the immediacy was removed on 1-25-23, the facility remains out of compliance at a severity Level II as the facility continues to audit all exit doors on a daily basis for six weeks and then weekly thereafter to make sure they are secure and that the alarms are present and in working order, audit all residents at risk for wandering on a weekly basis for six weeks and then quarterly thereafter, installs a new door alarm system, provides training to new staff on the elopement policy, and the quality assurance committee monitors the facility's performance to ensure that corrections are achieved. Findings include: The facility's Door Alarm Drill Policy dated 1-1-15 documents, It is the policy of this facility that the door alarm drill will function to assure exit doors are functioning properly and alert staff that a resident has left the building. It will also assure staff respond to door alarms immediately and follow the door alarm and elopement policy. The facility's Wandering Residents policy dated 08/2006 documents, Every effort will be made to prevent wandering episodes while maintaining the least restrictive environment for residents who are at risk for elopement. 1. All residents who are at risk for harm because of wandering (elopement) will be assessed. 2. The resident's care plan will be modified to indicate whether the resident is at risk for elopement episodes. Staff will be informed at shift change of the modification to the resident's care plan. 3. Interventions for elopement episodes will be entered onto the resident's care plan and medical record. 4. Should an elopement episode occur, the contributing factors, as well as the interventions tried, will be documented on the nurses' notes. 5. If a resident repeatedly wanders off the unit, a monitoring schedule will be implemented to ensure resident safety. The resident's care plan will be documented as to the implementation of the monitoring schedule. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's Elopement and Search Policy dated 02/2014 documents, Policy: To establish methods for protecting residents who are at risk for elopement and for conducting an organized search for a resident who cannot be located. 1. All nursing personnel are responsible for: a. Knowing the whereabouts of residents for which they are assigned. b. Department supervisors are responsible for conducting resident rounds. c. Staff are responsible for keeping the nurse informed of a resident's whereabouts. 3. Residents are not permitted to leave the building alone unless a physician order is present. 5. Residents who have been identified as cognitively impaired and who have been assessed as an elopement risk will be provided with an elopement prevention device or be placed in an area of the facility that has a door alarm device with audible sound, or on a secured/locked unit. 6. Facility exit door alarms are checked daily for function. All personnel are responsible for promptly reporting/replacing malfunctioning elopement prevention devices. Maintenance is responsible for fixing/replacing any exit doors that do not alarm. 8. When a resident makes repeated/continuous attempted to leave the building, the resident will be visibly observed every fifteen (minutes) until the behavior is resolved. 10. When the resident is found (after elopement) a licensed nurse will: a. Announce Code Pink All Clear over the paging system. b. Perform a clinical assessment of the resident's skin and functional status and determine if the resident requires medical interventions. g. Complete the appropriate observations/forms. h. Initiate/update the care plan to include interventions to prevent reoccurrence. 11. The Administrator/designee is responsible for notifying the State Department of Public Health and any other appropriate local authorities (Adult Protective Services, Ombudsman) of the occurrence when applicable according to state and federal requirements. 13. Appropriate security measures will be implemented to assure the resident is monitored to prevent reoccurrence. 14. All facility staff will be informed of residents at elopement risk. The facility's Doors, Locks, and Alarms Test Operation of Doors Logbook dated 11-1-22 through 1-24-23 documents the doors and alarms are only being checked once weekly instead of daily as required by the facility's Elopement and Search policy. On 1-24-23 from 8:40 AM through 9:15 AM tour was done at the facility. The North-West hallway activity exit door had a Velcro stop sign attached across and had a sign posted on the door stating, If you are caught turning off door alarms without (V1's/Administrator's) approval you will be subject to termination. Residents have been getting out of the facility because alarms have been shut off. The North Nurse's Station had a binder labeled Elopement Book. This Elopement Book contained pictures and identifying information for all residents at risk for elopement within the facility. This book did not contain pictures or identifying information of R4, R8, and R9. 1. On 1-24-23 at 10:15 AM R4 was standing up and walking around his room without assistance of staff. R4's wheelchair was located next to R4's bed. R4 was confused to person, place, and time. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 1-24-23 at 10:05 AM V17 (RN/Registered Nurse) stated, (R4) has always been disorientated and tries to open doors and leave. (R4) needs re-direction. On 11-26-22 sometime before 5:00 AM I had left the facility to go to the gas station. When I came back, I found (R4) walking out in the North-West employee parking lot. (R4) was confused. (R4) was walking without his wheelchair and had gone out of the end North-West activity door. It was chilly out and (R4) did not have a coat or shoes on. (R4) had on a t-shirt, sweatpants, and socks. (R4) was cold. I have no idea how long (R4) was in the parking lot. I brought (R4) back into the facility and notified the on-call supervisor (V19/LPN/Licensed Practical Nurse). I asked (V19) what I should do. (V19) said she would talk to (V3/Assistant Director of Nursing) and let me know. I never heard anything back from (V19) or (V3). I did not document the incident. I am not sure if any interventions were implemented to increase (R4's) supervision. I know (R4) was supervised every 15 minutes for around 24 hours, but no other interventions were implemented after that. No door alarms were alarming at the panel at the nurses' desk. The alarms did not work when (R4) went outside. I do not know how long (R4) was outside. (R4) needs staff assistance when walking. I am not aware of the facility having an elopement book with residents at risk of elopement. R4's current Electronic Diagnoses Listing documents R4 has diagnoses of Non-Traumatic Intracerebral Hemorrhage, Alcohol Abuse with Intoxication, Alcohol Dependence, Cognitive Communication Deficit, and Unsteadiness on Feet. R4's MDS (Minimum Data Set) assessment dated [DATE] and Care Plan dated 10-17-22 documents R4 is severely cognitively intact, has inattention and disorganized thinking, is totally dependent on staff for transfers, and requires extensive assistance of staff for locomotion on and off the unit. This same MDS documents R4 uses a wheelchair for locomotion. R4's Elopement Evaluation dated 1-2-23 documents, Does the resident have a history of elopement or attempted leaving the facility without informing staff? No. Does the resident wander? Yes. Is the wandering behavior a pattern, or goal-directed? No. Does the resident wander aimlessly or non-goal directed? Yes. R4's current Care Plan does not include a plan of care with interventions to address R4's wandering and elopement. R4's Electronic Medical Record dated 11-1-22 through 1-24-23 does not include any documentation, nurse assessment, or investigation regarding R4's elopement on 11-26-22. On 1-24-23 at 10:00 AM V10 (Registered Nurse/RN) stated, (R4) tries to open exit doors frequently. We (facility staff) cannot always hear the alarm going off at the nurses' station when we are at the end of the hallways. The alarms do not alarm at the doors, only at the nurses' station. On 1-24-23 at 12:35 PM V3 (Assistant Director of Nursing) stated, (R4's) record has no documentation about (R4) being found out in the parking lot unattended on (11-26-22) and (R4) has not had care plan developed or implemented regarding (R4's) elopement/wandering. There is no documentation of (R4's) family being notified of the incident. (R4's) incident has not been investigated. On 1-24-23 at 12:40 PM V22 (CNA/Certified Nursing Assistant) stated, (R4) wanders constantly and tries to get to the doors and leave. We try to re-direct him. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. On 1-23-23 at 4:35 PM V15 (RN/Registered Nurse) stated, I was working on 1-7-23 the Northeast hallway. (R8) was found outside unattended in the employee parking lot by the garbage cans (approximately 50 feet from the exit door) around 5:00 in the morning. (R8) had gone out of the activity room door to the outside. I do not know how long (R8) was outside. The door alarm did not work at the door or at the panel by the nurses' station. (R8) tries to leave the facility all of the time. (R8) goes up to the exit doors and tries to push them open. I called the on-call supervisor (V19/LPN/Licensed Practical Nurse) and informed her that (R8) was found outside, and the door alarm did not work. I was not (R8's) nurse that day. I am not sure who was the nurse. (V14/Activity Assistant) was called in to check the doors. (V14) told me that the door alarm was working. (V18/Maintenance Director) has been told numerous times that the door alarms do not work correctly and do not alarm at the panel like they should. Nothing is ever done about it. I know (R4) has gotten out of that same door unattended before and was found in the parking lot. I do not know if the facility has an elopement book. R8's current Electronic Diagnoses Listing documents R8 has diagnoses of Drug Induced Subacute Dyskinesia, Schizophrenia, Mental Disorder, Difficulty in Walking, Muscle Weakness, Cognitive Communication Deficit, Dementia, Unspecified Severity, with other behavioral disturbance, Restlessness, and Agitation. R8's MDS assessment dated [DATE] and current Care Plan documents R8 is severely cognitively impaired, has disorganized thinking, and requires extensive assistance of staff for transfers and walking, and limited assistance of staff for locomotion. R8's current Care Plan does not include a plan of care with interventions to address R8's wandering and elopement. R8's Electronic Medical Record dated 1-1-23 through 1-24-23 does not include any documentation, nurse assessment, or investigation regarding R8's elopement on 1-7-23. On 1-23-23 at 4:10 PM V13 (Activity Director) stated, (R8) comes to the activity exit door and tries to push it open. I was told that (R8) got out into the parking lot without staff knowing. I am not sure what date that was. On 1-24-23 at 9:00 AM V20 (R8's Family Member) stated, I came in the facility on 1-8-23 and was told by the staff that (R8) had gotten out of the building unattended on Saturday (1-7-23). I am concerned that they facility is not watching (R8) close enough and (R8) will get lost. (R8) is very confused and cannot be outside. I called the Administrator (V1) on Monday (1-9-23) and told him about my concerns with (R8) getting out of the building and not being watched closely. On 1-24-23 at 10:32 AM V1 (Administrator) stated, (V20/R8's Family Member) called me on Monday (1-9-23) and reported that she was upset because (R8) had been found outside unattended and nobody had notified her. I brought (R8's) incident to morning meeting the next day to be investigated by the nurse managers. I am not sure if anyone investigated the incident (R8's elopement). I know the investigation was never reported to IDPH (Illinois Department of Public Health). (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 1-24-23 at 11:25 AM V3 (Assistant Director of Nursing) stated, I was not aware that (R8) had gotten out of the facility unattended (1-7-23). No one had reported that to me. (R8's) record has no documentation about the incident and (R8) has not had an elopement risk assessment done or a care plan developed or implemented regarding (R8's) high risk of elopement/wandering. There has been no investigation completed. (R8's) family was not notified of the incident according to (R8's) medical record. The elopement book should contain all residents at risk for elopement and is located at the nurses' stations, and social service office. The elopement book has not been updated for a long time. (R4, R8, R9) information and pictures are not in the elopement book and should be. The Social Service Director (V21) is responsible to keep the elopement book updated. On 1-24-23 at 12:12 PM V19 (LPN) stated, (V15/RN) called me around 4:56 AM on 1-7-23 and reported that the staff had found (R8) outside in the employee parking lot, unattended by staff. (V15) reported to me that the door alarm did not alarm at the panel, so the staff did not know (R8) had sent outside. I told (V15) to notify (R8's) family, the physician, and (V2/Director of Nursing), and to perform an assessment of (R8). I also reported the incident in the morning meeting on Monday (1-9-23). I contacted (V18/Maintenance Director) and let him know the door alarms were not working and needed looked at. On 1-24-23 at 11:05 AM V14 (Activity Director) stated, I was called on 1-7-23 to go in and check the Northwest Activity Exit door alarm to make sure it was working because (R8) had gotten out of that door and staff found her in the parking lot. When I went in the door alarm was working. The day before I was working in activities and took Christmas supplies out to the shed. I turned the toggle on the door off so the alarm would not sound when I opened that door. I guess I am not supposed to use that door. I believe on Monday (1-9-23) V18 (Maintenance Director) zip tied the box so that the toggle switch could no longer be turned off. 3. On 1-24-23 between 9:45 AM and 10:30 AM R9 was wandering aimlessly in her wheelchair up and down the north hallways. On 1-24-23 at 1:10 PM V7 (Wound Nurse) stated, On 1-10-23 around 7:00 AM I was arriving to work and saw dietary staff talking about an old lady sitting on the end of a bumper of a blue car and was not sure who it was. I went to talk to the lady and noticed it was one of our residents (R9) sitting on a bumper of a car. (R9) stated, I am not going back. I want to go home. (R9) did not have her wheelchair with her and was cold. I then went and got a wheelchair and had the CNA's take her back to the floor. On 1-24-23 at 1:20 PM this surveyor and V7 viewed the west side parking lot that (R9) was found in on 1-10-23, (R4) was found in on 11-22-22, and (R8) was found in on 1-7-23. The parking lot exits onto Newcastle Road, [NAME] Illinois. This road has a high level of traffic with a central school and multiple businesses located on this road. V7 confirmed that R9 was found sitting on a bumper of a car approximately 50 feet from the exit doors in this parking lot. R9's Investigation Report dated 1-10-23 and unsigned documents, (R9) states that she was leaving and going home. (V17/RN) states that she took (R9) back to the Northwest desk (earlier that morning) and informed (V23/RN) that (R9) was attempting to go out the door on maintenance hall. (V23) was unaware of situation when questioned but is increasing monitoring at this time. Summary: (R9) was observed sitting on a bumper outside in the parking lot. (R9's) wheelchair was observed sitting in maintenance hallway. Maintenance cage door was unlocked which goes out into back parking lot. (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	01/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Washington Senior Living	1201 Newcastle Washington, IL 61571

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R9's current Electronic Diagnoses Listing documents R9 has diagnoses of Altered Mental Status, Chronic Respiratory Failure with Hypoxia, Cognitive Communication Deficit, and Unsteadiness on Feet. R9's MDS assessment dated [DATE] documents R9 requires extensive assistance of staff for transfers, walking, and locomotion off the unit. R9's Care Plan dated 1-20-23 documents R9 is at risk for falls due to confusion, deconditioning, gait/balance problems, incontinence, impaired mobility, and being unaware of safety needs. R9's Care Plan dated 4-14-22 through 1-9-23 did not include a plan of care to address R9's wandering behavior. R9's Elopement Evaluation dated 1-10-23 documents, Does the resident have a history of elopement or attempted leaving the facility without informing staff? No. Is the resident's wandering behavior likely to affect the safety or well-being of self/others? Yes. On 1-23-23 at 4:35 PM V15 (RN/Registered Nurse) stated, (R9) wanders in her wheelchair around all hallways. On 1-24-23 at 10:05 AM V17 (RN) stated, I know a few weeks ago (R9) was found outside in the parking lot. (R9) had went out of the door of the service hallway which is in the middle of the building between the North and South hallways. (R9) has always wandered and states she wants to go home. (R9) gets confused and would not be safe outside unattended by staff. On 1-24-23 at 1:30 PM V3 (Assistant Director of Nursing) stated, (R9) was found in the parking lot on 1-10-23. It was determined that (R9) had exited out of the middle service hallway, out of the maintenance cage (maintenance supply room) exterior door. Someone had left the cage door unlocked and (R9) was able to leave out of the exterior door. That door has no alarm on it, so staff were unaware of (R9) getting out of the facility. (R9) did not have a care plan developed for wandering or elopement risk prior to her exiting the building on 1-10-23. (R9's) Elopement Evaluation dated 1-10-23 is inaccurate and should have been coded as Yes to the question asking if (R9) has a history of elopement or attempted leaving the facility without informing staff. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 1-24-23 at 11:15 AM V18 (Maintenance Director) stated, I got a call from (V15/RN) on 1-7-23 early in the morning that (R8) was outside, and the door alarm did not work. I went in to check the alarm and (V14) said the alarm was working. The North hallway exit doors do not have alarms on the doors. When these doors are opened, they alarm at the nurses' station alarm panel (located in the center of the Northwest and Northeast hallways). There is a toggle switch on the doors that employees can use to turn off the alarms at the nurses' panel. Staff should never turn that toggle switch off. After the incident with (R8) I zip tied the toggle switch compartment shut so employees could no longer turn the alarm off. Employees are not supposed to use the end of the hallway exit doors. There are times the panel alarms for no reason. If it is really cold outside the door alarms malfunction at the panel. I have not called any alarm company in to check these door alarms for malfunctioning. I check the door alarms weekly. When (R9) got outside (1-10-23) and was found in the parking lot my cage (maintenance supply door) was unlocked. Dietary staff were trying to open the hallway door for a delivery and could not get in the hallway door, so they used a key and unlocked the maintenance room door. The dietary staff did not make sure the door was locked after they used it. When that door is left unlocked the residents can get out of the facility through the cage and out of the exterior door. The exterior door off of the maintenance room is not alarmed. On 1-24-23 at 1:38 PM V21 (Social Service Director/SSD) stated, I did not know I was in charge of updating the elopement book with information and pictures of residents at risk for elopement. I have not been updating the book. The Immediate Jeopardy started on November 26, 2022, when the facility failed to provide R4 with adequate supervision and implement elopement interventions which resulted in R4 being found outside of the facility, unattended by staff, and R4 was cold and did not have a coat or shoes on. V1 (Administrator), V3 (Assistant Director of Nursing), and V25 (Director of Operations) were notified of the Immediate Jeopardy on 1-25-23 at 12:05 PM. On 1-26-23 the surveyor confirmed through observation, interview, and record review that the facility took the following actions to remove the Immediate Jeopardy: 1. On 1-24-23 V21 (SSD) completed an updated Elopement Risk Assessment for R4, R8, and R9. 2. On 1-24-23 V28 (MDS Coordinator) developed an elopement care plan with interventions for R4, R8, and R9's. 3. On 1-24-23 (V1/Administrator) sent an initial report to IDPH (Illinois Department of Public Health) to investigate R4, R8, and R9's elopement and an investigation of these elopement was started. 4. On 1-25-23 a whole house review of elopement assessments was done and updated by V28 and V7 (Wound Nurse). 5. On 1-24-23 V18 (Maintenance Director) installed new battery-operated door alarms on the Northwest door, Northeast door, and Maintenance door to ensure staff could hear the door alarming at the location of the doors as well as at the nurses' station. 6. On 1-24-23 V1 ordered a new alarm system to put at the doors with a keypad to silence the alarms was ordered on 1.24.23 and should reach the facility by next week. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	7. On 1-24-23 and 1-25-23 V18 in-serviced all staff on the proper function of door alarms. 8. On 1-24-23 on first shift, and 1-25-23 on second and third shift V18 held elopement drills with all staff. 9. On 1-24-23 and 1-25-23 V3 (ADON) re-educated all staff on the facility's alarm policy and the elopement Policy. This education included information that residents do not have to leave the property to be considered an elopement. A second education was provided electronically on 1-24-23 and 1-25-23 via the company website for all staff to log in and complete training. 10. On 1-25-23 V2 re-educated all nurses on proper documentation when a resident gets outside the building and notifying the power of attorney, doctor, and administration when a resident gets outside of the building. 11. V18 Maintenance Director/Designee will audit all exit doors on a daily basis for 6 weeks to make sure they are secure and that the alarms are present and in working order. After 6 weeks, he will do this on a weekly basis. An audit will be turned in to Administrator at the end of each week. 12. V3 ADON/Designee will audit all residents at risk for wandering on a weekly basis for 6 weeks to be sure that their Elopement Assessment and Care Plan are up-to-date with accurate information and interventions in place. After 6 weeks, they will be audited on a quarterly basis. The Quality Assurance Committee will monitor the facility's performance to ensure that corrections are achieved. Completion Date: 1-25-23.