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	02/28/2023

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 38396 Based on observation, interview and record review, the facility failed to ensure a resident with a known diagnosis of Dementia with Behavioral disturbances and Schizophrenia was adequately supervised by staff to prevent multiple resident to resident physical and mental abuse occurrences, for three of three residents (R1, R4, R5) reviewed for abuse in a sample of six. This failure resulted in R4 experiencing pain and fear related to the abuse and R5 receiving a laceration and bruise to the forearm. Findings include: The facility's Abuse Prevention Program policy, dated 11/22/17, documents, Residents have the right to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment. This same policy also documents, Physical Abuse is the infliction of injury on a resident that occurs other than by accidental means and that requires medical attention. Physical abuse includes hitting, slapping, pinching, kicking and controlling behavior through corporal punishment. Mental Abuse is also the use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation or degradation. 1. R1's current care plan, dated 2/7/23, documents, (R1) has a diagnosis of schizophrenia and dementia with behaviors. She is alert with much confusion, poor safety awareness, and poor reasoning skills. (R1) can be paranoid and delusional at times. She is able to verbally express needs and wants. She can often become very agitated and resistive to cares and medications. She will sometimes curse at residents and others around her. She will sometimes wander toward exit doors and will sometimes attempt to leave facility through exit doors unsupervised. She is not always easily redirected. The facility's Incident Report Form, dated 2/10/23, documents that on 2/10/23, (R1) came into the dining room for lunch She went to one of the tables that she normally would not sit at. (R4) confronted (R1) verbally about being at the wrong table and that upset (R1) whom then stuck (R4) in the chest. This same report documents on 2/10/23, V11 (Certified Nursing Assistant, CNA) stated, I saw (R1) roll up to the table in the dining room where (R4) was sitting. (R1) tried to sit at the table with (R4) and (R4) told her it was not her table. (R1) usually sits at another table in the dining room. (R1) got mad and hit (R4) on the right breast. (After being separated) (R1) continued to try to claw and scream at (R4). (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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F 0600 Level of Harm - Actual harm Residents Affected - Few	The facility's Incident Report Form, dated 2/19/23, documents that on 2/19/23 at 10:00 AM, (R1) went into (R4's) room grabbing items that were not hers. When (R4) asked (R1) not to touch the items (R1) got agitated and was cursing at (R4) and struck (R4) on the left shoulder. On 2/28/23 at 11:15 AM, V9 (Certified Nursing Assistant) confirmed witnessing R1 and R4's incident on 2/19/23. V9 stated, I heard someone yell 'get out of here.' I went in the room and (R1) was holding pajamas and she gave them to me. (R1) was already yelling at (R4) saying nonsense and cuss words. I had (R4) step outside the door with her cane and as I was taking (R1) out, she (R1) hit (R4). If another resident tries to correct (R1) or tell her she's in the wrong, she wants to get aggressive with them. (R1) will hit or get them closer. When an incident happens like that it just makes (R1) very angry and she hits them and starts yelling. On 2/28/23 at 12:50 PM, R4 was lying in her bed in her room. R4 confirmed she has had incidents where she's been struck by R1. R4 stated, (R1) used to come into my room all the time. She'd take things out of here. (R1) has hit me on my right breast where I have had cancer. She also hit me on my shoulder on a different day. I was getting very leery of (R1). She made me feel afraid because she was getting scary. It hurt when she hit me. She is a strong woman. It sure did hurt. I am not sad that (R1) is gone (discharged). 2. R1's Nursing Progress notes, dated 2/17/23 at 6:49 PM, documents, (R1) was in the dining room in her wheelchair and another resident (R5) with a walker, walked by and was grabbed by the right arm. (R1) began arguing and fighting with (R5). (R1) continued to yell and try to get at the other residents. The facility's Incident Report Form, dated 2/17/23, documents, (R1) went to one of the tables that she would normally not sit at. (R5) confronted (R1) verbally about being at the wrong table and upset (R1) who then grabbed (R5's) arm. R5's Nursing Progress notes, dated 2/17/23 at 7:22 PM, documents, This nurse (V8, Registered Nurse) was made aware that there was an incident with (R5) another resident (R1) in the dining room. Went to assess (R5) and saw a discoloration/bruise to the right forearm. R5's Nursing Progress notes, dated 2/20/2023 at 12:55 PM, documents, Bruising noted to right forearm measuring 7.5 x 7.0 (centimeters), light red in color with two pin sized dark purple bruises in the center. This appears to be from an altercation that occurred on 2/17/23, monitoring orders processed. On 2/28/23 at 1:15 PM, V10 (Registered Nurse) stated, I was doing charting in the dining room to oversee things in there. I looked up and there was a confrontation. I didn't see it because I was charting but I heard aides and a resident yell. (R1) was in (R5's) spot and (R5) told her 'this is not your spot'. (R1) grabbed (R5's) arm. You couldn't understand (R1). She is very aggressive. (R1) is able to move about freely and be out fast. We try to keep track of her, but it is hard. On 2/28/23 at 1:30 PM, V8 (Registered Nurse) stated, I didn't see what happened in the dining room. The CNA's came and got me. (R1) had grabbed (R5's) arm and scratched it. (R5) had thin scratches on her arm which became larger and bruised after a day or two. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 2/28/23 at 1:50 PM, V3 (Assistant Director of Nursing) stated, (R1) has always had aggression, but it's escalated lately. We tried to keep her in closer proximity to staff. V3 confirmed there is not any documentation to show where R1 was being monitored or supervised by staff more frequently to prevent other residents from being abused.