

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 03/08/2023
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 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30312</p> <p>Based on interview and record review the facility failed to ensure documentation for resident's hospital transfer was properly completed; failed to provide documentation for needs that could not be met at the facility prior to transfer; failed to provide which services were not available at receiving facility; failed to provide a physician's order for transfer to the hospital on the date of discharge. These failures affected one of three residents (R1) reviewed for transfer/discharges in a sample of six.</p> <p>Findings include:</p> <p>An Admissions to the Facility policy dated as 2001 states, Our facility will admit only those residents who's medical and nursing care needs can be met.</p> <p>A facility Involuntary Transfer and Discharge Policy Key Elements (undated) states a requirement during an emergency resident transfer for the physical safety of resident or other residents, facility employees or visitors at the facility need physician to confirm that the transfer was necessary (Need physician's order).</p> <p>A Facility assessment dated [DATE] documents the facility can provide care for residents with psychiatric/mood disorders including residents with impaired cognition, mental disorders, Depression, Anxiety disorders, behavior that needs attention, Alzheimer's disease, and non-Alzheimer's Dementia. This Facility Assessment states it can, Manage the medical conditions and medications-related issues causing psychiatric symptoms and behavior, and can identify and implement interventions to help support individuals with issues such as dealing with Anxiety, care of someone with cognitive impairment, Depression or other psychiatric diagnoses. In addition, the Facility Assessment documents the facility will provide needed support staff to manage these patient types including Behavioral and Mental Health providers and Psychiatric Services.</p> <p>R1's list of current diagnoses includes Dementia in other diseases classified elsewhere, unspecified severity, with other behavioral disturbance, Schizophrenia, Cognitive Communication Deficit, Encephalopathy.</p> <p>A list of Discharges and transfers for 2/2023 documents that R1 was transferred to the hospital on 2/26/23.</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
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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R1's electronic progress notes dated 2/23/23 and signed by V3 (Assistant Director of Nurses/ADON) document that R1, is a safety risk to her peers AEB (as evidenced by) multiple attempts of physical aggression towards peers, wandering aimlessly into peers' rooms becoming agitated with peers when asked to exit and becoming physically aggressive with peers. (R1) is an active elopement risk putting self at potential risk of harm to self when exiting out exit doors. Action: Involuntary Discharge issued to (R1) due to facility is not the proper placement and needs a more suitable psychiatric facility. Response: MD (physician) in agreeance for safety of peers and resident - IVD (Involuntary Discharge) orders processed at this time for alternative placement of (R1).</p> <p>R1's progress notes do not indicate R1 was emergently discharged to the hospital on that date (2/23/23) nor do these progress notes document what specific needs R1 has that can be met at another facility that cannot be met at this facility.</p> <p>R1's progress notes dated 2/26/23 at 1:11a.m. document R1 was alert and oriented. Notes do not include any documentation that R1 had untoward behaviors or posed a danger to herself or others on that date. R1's nursing documentation does not show there were any other nursing or physician's progress notes entered for 2/26/23. R1's progress notes dated 2/27/23 document R1 was in the hospital.</p> <p>A Necessity of Transfer Form/Notice of Bed Hold Policy form dated 2/26/23 documents R1 was transferred/discharged to the hospital on that date (2/26/23) with verbal notice and written notice provided to V9 (R1's Power of Attorney/POA).</p> <p>R1's physician's orders (POS) do not include an order to transfer R1 to the hospital on 2/26/23.</p> <p>A Notice of Involuntary Transfer or Discharge and Opportunity for Hearing for Nursing Home Residents signed by V1 (Administrator) documents that on 2/23/23 R1/V9 were served with IVD paperwork indicating R1 would be involuntarily discharged no sooner than 30 days after receipt of this notice. This notice states the reason for the involuntary discharge is the health of individuals in the facility would otherwise be endangered, as documented by a physician in R1's clinical record.</p> <p>On 3/7/23 at 8:50 a.m. V1 stated R1 was involuntarily discharged to the hospital on 2/26/23 for aggressive behaviors towards staff and other residents. V1 stated that R1 and V9 were initially given the IVD paperwork on 2/23/23 or 2/24/23 which gave R1 30 days' notice prior to the facility discharging R1. V1 stated the facility told V9 that if R1 had to go to the hospital during those 30 days, the facility would not accept R1 back. V1 stated that when R1 had aggressive behaviors on 2/26/23, the facility sent R1 to the hospital with the intent of not allowing R1 to readmit to the facility. V1 stated R1 had a diagnosis of Dementia with Behaviors and all staff can manage residents with that diagnosis.</p> <p>On 2/7/23 at 9:20a.m and on 2/8/23 at 8:53a.m. V4 (Marketing Director) stated R1 was admitted to the facility directly from home. V4 stated he reviews residents' records who want to admit to the facility then he gives those records to the clinical team to make the final determination. V4 stated it was V3 who reviewed R1's medical records and determined R1 was appropriate for admission to the facility. V4 stated he kept in touch with the hospital after R1's admission to the hospital on 2/26/23 and he was told by the facility that they would not accept R1 back as a resident.</p> <p>(continued on next page)</p>		

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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/7/23 at 9:50 a.m., 2:50 p.m. and on 3/8/23 at 10:00a.m., 1:20p.m., and 2: 15p.m, V3 stated V3 evaluated R1 prior to admission to ensure the facility could meet R1's needs as a resident in the facility. V3 stated V3 determined that R1 was appropriate for admission. V3 stated that R1 did have the diagnoses of Dementia with behaviors and Schizophrenia at the time V3 determined the facility could meet R1's needs. V3 stated that while R1 was a resident, R1 had multiple instances of aggressive behaviors, wandering, attempts to elope, and refusing care. V3 stated that R1 was sent to the hospital several times for behavioral issues. V3 stated the facility decided it could not meet R1's needs and decided for the safety of other residents R1 needed an involuntary discharge. V3 stated the facility tried to refer R1 for admission to other long term care facilities but that R1 was not accepted. V3 stated the facility decided to issue R1/V9 an involuntary discharge order as of 2/24/23. V3 verified that V8 (R1's physician) wrote an emergency discharge order for 2/23/23 but that R1 was not actually discharged until 2/26/23 to the hospital. V3 stated that V8's order was to cover the IVD paperwork for when the facility involuntarily discharged R1. V3 stated when R1 had behaviors on 2/26/23, R1 was sent to the hospital without obtaining an additional order for discharge. During these interviews, V3 provided her printed progress note dated 2/23/23 with an undated signature from V8 written on the bottom of the page. V3 stated that the facility does not offer the mental health services that R1 needs. V3 stated that R1 needs to be transferred to a facility that can offer enough staff to monitor R1 more frequently and offer more specialized mental health care. V3 verified the facility does offer a Behavioral Health practitioner who comes to the facility on ce per month, however, R1 was never provided services from that behavioral health specialist.</p> <p>On 3/8/23 at 9:28a.m., V8 stated R1 had behavioral problems related to dementia and Schizophrenia. V8 stated the facility sought out behavioral health services by sending R1 to the emergency room to calm R1 down for one to two days. V8 stated he not did personally evaluate R1 or document any progress notes pertaining to the need for R1's involuntary discharge or the facility's inability to meet R1's needs but, instead, I rely on what the nurses tell me, and I go off what the nurses tell me. V8 verified the order V8 gave for R1's discharge was regarding R1's involuntary discharge issued a few days prior to R1's hospitalization .</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>30312</p> <p>Based on interview and record review the facility failed to provide an emergency notice of involuntary discharge or an updated, properly documented notice of involuntary discharge, and failed to have an involuntary discharge policy which reflects the requirement for 30 days' notice prior to involuntarily discharging a resident. These failures affected one of three residents (R1) reviewed for transfer and discharge in a sample of six.</p> <p>Findings include:</p> <p>A facility Involuntary Transfer and Discharge Policy Key Elements (undated) states requirements for discharges when the facility is unable to meet the resident's needs includes emergency transfers where the physical safety of resident, other residents, facility employees or visitors at the facility are at risk, Do not need a 21-day notice. State forms (Notice of IDT {involuntary discharge/transfer} and Request for Hearing) must be given to the resident at the time of transfer. Also provide a copy to the resident and responsible party. A person initiating the discharge should write 'Emergency' on the Notice of ITD form. In addition, this policy documents for Non-Emergency Transfers: Medical Reason, Requires 21-day notice (.) Need physician to confirm that the transfer was necessary (need physician's order or note) (.) Make the 'tentative transfer date' 21 days from when the notice is provided to the resident and responsible party.</p> <p>A facility admissions/transfers log dated 2/26/23 documents R1 was transferred to the hospital on that date.</p> <p>R1's electronic progress notes dated 2/23/23 and signed by V3 (Assistant Director of Nurses/ADON) documents R1, is a safety risk to her peers AEB (As evidenced by) multiple attempts of physical aggression towards peers, wandering aimlessly into peers' rooms becoming agitated with peers when asked to exit and becoming physically aggressive with peers. (R1) is an active elopement risk putting self at potential risk of harm to self when exiting out exit doors. Action: Involuntary Discharge issued to (R1) due to facility is not the proper placement and needs a more suitable psychiatric facility. Response: MD (physician) in agreeance for safety of Peers and resident IVD (Involuntary Discharge) orders processed at this time for alternative placement of (R1).</p> <p>R1's progress notes do not indicate R1 was emergently discharged to the hospital on that date (2/23/23) nor do these progress notes document what specific needs R1 has that can be met at another facility that cannot be met at this facility.</p> <p>R1's progress notes dated 2/26/23 at 1:11a.m. document R1 was alert and oriented but do not include documentation that R1 had any untoward behaviors or posed a danger to herself or others on that date. R1's nursing documentation does not show there were any other nursing or physician's progress notes entered for 2/26/23. R1's progress notes dated 2/27/23 document R1 was in the hospital as of that date.</p> <p>(continued on next page)</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A Notice of Involuntary Transfer or Discharge and Opportunity for Hearing for Nursing Home Residents signed by V1 (Administrator) documents that on 2/23/23 R1/V9 (R1's Power of Attorney/POA) were served with IVD paperwork indicating R1 would be involuntarily discharged no sooner than 30 days after receipt of this notice. This notice states its reason for the involuntary discharge as the health of individuals in the facility would otherwise be endangered, as documented by a physician in R1's clinical record. This notice has a choice of several boxes for what type of IVD R1 was receiving. The boxes included the choices of Federal Proceeding, State Proceeding, Emergency Transfer or Discharge. Only the Federal Proceeding box is marked. There is no documentation providing the contact information for the Office of the State Long Term Care Ombudsman. At the bottom of the first page of this form is an area to indicate where R1 will be transferred to on the date of transfer or discharge. This area is documented with V9's address instead of another long-term care facility or a facility able to provide the appropriate treatments and services for R1.</p> <p>On 3/8/23 at 9:38a.m. and 12:45a.m. V9 stated the facility had informed V9 several times that R1 needed to be placed in a different long-term care facility because of R1's behaviors. V9 stated that on 2/23/23 while she was at the facility, V1 (Administrator) called V9's cell phone to ask that she come to his office. V9 stated V1 and another staff member told V9 that R1 was going to be involuntarily discharged. V9 stated that she was not informed of her right to appeal this involuntary discharge, nor was she provided with the contact information for the Office of the State Ombudsman. V9 stated the facility told her R1 had 30 days before she was involuntarily discharged. V9 stated that V1 also informed her that if R1 had any further behaviors and had to be sent to the hospital, the facility would not accept R1 back. V9 stated that a few days later, on 2/26/23, V9 received a call from the facility informing her that R1 was sent to the hospital because R1 had a verbal altercation with another resident (R6). V1 stated a few days after R1's hospital admission, V9 received R1's IVD paperwork in the mail. V9 stated the IVD paperwork had not been updated and still did not have the Ombudsman contact information and it indicated R1 would be discharged to V9's home instead of another health care facility. V9 stated this form indicated R1 would be involuntarily discharged not sooner than 30 days from the date it was issued instead of indicating R1 required emergent involuntary transfer or discharge to the hospital. V9 stated she spoke with V17 (Hospital Case Manager) who informed V9 the IVD paperwork was not filled out correctly which made it invalid.</p> <p>On 3/7/23 at 8:50 a.m. V1 stated R1 was issued an IVD as of 2/23/23 or 2/24/23 because of R1's continued aggressive behaviors. V1 stated the paperwork was completed prior to R1's emergent involuntary discharge to the hospital on 2/26/23. V1 stated V1 had informed V9 that R1 was going to be involuntarily discharged in 30 days unless R1 had behaviors requiring R1 to be sent to the hospital sooner than the 30 days. V1 stated he informed V9 that if R1 required hospitalization for her behaviors during those 30 days, the facility would not accept R1 back when the hospital was ready to discharge R1. V1 stated he thought R1's IVD paperwork was completed correctly.</p> <p>On 3/8/23 at 2:15p.m. V3 stated that on 2/26/23 R1 became verbally aggressive with R6. V3 stated R1's medical record does not include documentation about this verbal altercation between R1 and R6. V3 stated, the only charting about the incident is in R6's chart. V3 stated once the facility sent a copy of R1's IVD paperwork to the States Certification and Survey Agency (SA), that Agency sent back an email informing the facility they did not use the correct IVD forms. V3 stated notice of involuntary discharge is given to residents 30 days before the planned discharge unless it is an emergency discharge.</p> <p>(continued on next page)</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/9/23 at 10:42 a.m. V13 (Ombudsman) stated although the facility sent a copy of R1's IVD paperwork to V13's office, as required, the facility did not have R1's IVD paperwork filled in correctly. V13 stated R1's IVD paperwork did not document R1 was being involuntarily transferred/discharged emergently to the hospital and the bottom section of the first page indicated R1's disposition was to V9's home address. V13 stated V13 did not know R1 had been involuntarily transferred/discharged to the hospital until V17 called her office to report that R1's emergent involuntary transfer/discharge forms were not documented appropriately, and that the facility was refusing to accept R1 back when R1 was ready for discharge from the hospital. V13 stated that the facility also failed to provide V9 with an emergency involuntary transfer/discharge form.</p>

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<p>F 0626</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy.</p> <p>30312</p> <p>Based on interview and record review the facility failed to allow a resident to return to the facility following an emergency transfer to the hospital for one of two residents (R1) reviewed for permitting residents to return after hospitalization in a sample of six.</p> <p>Findings include:</p> <p>A Necessity of Transfer Form/ Notice of Bed Hold Policy form dated 2/26/23 documents that R1 was transferred to the hospital on that date (2/26/23). This same form documents R1's Power of Attorney (V9) was notified verbally regarding R1's transfer and a written policy was mailed to V9 on 2/28/23. This policy states, A bed hold is an agreement between the community and you to keep your bed available while you are in the hospital or on therapeutic leave. If you are transferred to the hospital or take a therapeutic leave, you will receive this form and will be asked to notify us of your intent to return or be discharged from the community.</p> <p>R1's list of current diagnoses includes Dementia in other diseases classified elsewhere, unspecified severity, with other behavioral disturbance, Schizophrenia, Cognitive Communication Deficit, Encephalopathy.</p> <p>A facility discharge log documents R1 was discharged to the hospital on 2/26/23.</p> <p>R1's electronic progress notes dated 2/23/23 and signed by V3 (Assistant Director of Nurses/ADON) documents R1, is a safety risk to her peers AEB (As evidenced by) multiple attempts of physical aggression towards peers, wandering aimlessly into peers' rooms becoming agitated with peers when asked to exit and becoming physically aggressive with peers. (R1) is an active elopement risk putting self at potential risk of harm to self when exiting out exit doors. Action: Involuntary Discharge issued to (R1) due to facility is not the proper placement and R1 needs a more suitable psychiatric facility. Response: MD (physician) in agreeance for safety of peers and resident IVD (Involuntary Discharge) orders processed at this time for alternative placement of (R1).</p> <p>R1's progress notes do not indicate R1 was emergently discharged to the hospital on that date (2/23/23). R1's nursing documentation does not show there were any other nursing or physician's progress notes entered for 2/26/23. R1's progress notes dated 2/27/23 document R1 was in the hospital as of that date.</p> <p>(continued on next page)</p>		

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<p>F 0626</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A Notice of Involuntary Transfer or Discharge and Opportunity for Hearing for Nursing Home Residents signed by V1 (Administrator) documents that on 2/23/23 R1/V9 were served with IVD paperwork indicating R1 would be involuntarily discharged no sooner than 30 days after receipt of this notice. This notice gives as its reason for the involuntary discharge the health of individuals in the facility would otherwise be endangered, as documented by a physician in R1's clinical record. This notice has a choice of several boxes for what type of IVD R1 was receiving. The boxes included the choices of Federal Proceeding, State Proceeding, Emergency Transfer or Discharge. Only the Federal Proceeding box is marked. At the bottom of the first page is an area to indicate where R1 will be transferred on the date of transfer or discharge. This area is documented with V9's address instead of another long-term care facility or a facility able to provide the appropriate treatments and services for R1.</p> <p>On 3/7/23 at 7:36a.m. V17 (Hospital Case Manager) stated R1 was admitted to the emergency room as an emergency involuntary discharge on 2/26/23. V17 stated the facility told V17 right away that they would not accept R1 back as a resident. V17 stated the facility told R1 it has a Zero tolerance for residents with behaviors, and that R1 caused the facility to receive two deficient practice tags from the State Certification and Survey Agency (SA). V17 stated although R1 had some aggression while in the emergency room R1 has been an inpatient and had her medications adjusted, R1 is very calm and cooperative without aggression. V17 stated R1 is ready to be discharged back to the facility but the facility is refusing to allow R1 to return.</p> <p>On 3/8/23 at 9:38 a.m. and 12:45 p.m., V9 stated the facility had informed V9 several times that R1 needed to be placed in a different long-term care facility because of R1's behaviors. V9 stated on 2/23/23 while she was at the facility, V1 (Administrator) called V9's cell phone to ask that she come to his office. V9 stated V1 and another staff member told V9 that R1 was going to be involuntarily discharged . V9 stated the facility told her R1 had 30 days before she was involuntarily discharged . V9 stated V1 also informed V9 that if R1 had any further behaviors and had to be sent to the hospital during that 30-day period, the facility would not accept R1 back. V9 stated a few days later, on 2/26/23, V9 received a call from the facility informing her R1 was sent to the hospital because R1 had a verbal altercation with another resident (R6). V9 stated V17 told V9 the facility was refusing to allow R1 to return to the facility even though R1 was medically cleared to be discharged .</p> <p>On 3/7/23 at 8:50a.m. V1 stated R1 was issued an IVD as of 2/23/23 or 2/24/23 because of R1's continued aggressive behaviors. V1 stated the paperwork was completed prior to R1's emergency involuntary discharge to the hospital on 2/26/23. V1 stated he had informed V9 that R1 was going to be involuntarily discharged in 30 days unless she had behaviors requiring R1 to be sent to the hospital sooner than the 30 days. V1 stated he informed V9 that if R1 required hospitalization for her behaviors during those 30 days, the facility would not accept R1 back when the hospital was ready to discharge R1. V1 stated R1 needs to be transferred to different a different facility that can meet R1's needs.</p> <p>On 3/7/23 at 9:20a.m. V4 (Marketer/Liaison) stated after R1 was admitted to the hospital, he received a call from V17 (Hospital Case Manager) asking if R1 can be readmitted to the facility. V4 stated at first, he told V17 R1 could return, but then called V17 back and apologized for the confusion, but that the facility would be unable to readmit R1 to the facility because of R1's behaviors. V4 stated he was informed by facility management that the corporate office had decided R1 could not return to the facility.</p> <p>(continued on next page)</p>		

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<p>F 0626</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/8/23 at 2:15p.m. V3 stated that on 2/26/23 R1 became verbally aggressive with R6. V3 stated R1's medical record does not include documentation about this verbal altercation between R1 and R6. V3 stated the only charting about the incident is in R6's chart. V3 stated once R1 had the verbal altercation with R6, R1 was involuntarily discharged on an emergency basis to the hospital. V3 stated that R1 will not be allowed to readmit to the facility.</p> <p>On 3/9/23 at 10:42a.m. V13 (Ombudsman) stated she did not know R1 had been involuntarily transferred/discharged to the hospital until V17 called her office to report that R1's emergent involuntary transfer/discharge forms were not documented appropriately, and that the facility was refusing to accept R1 back once R1 was ready for discharge from the hospital. V13 stated even though R1 had behaviors, which the facility thought needed treated emergently in the hospital, the facility must allow R1 to return once the hospital has R1's condition stabilized and is ready to discharge R1 back to the facility. V13 stated if the facility refuses to allow R1 to return that is the same as dumping the resident at the hospital instead of providing the care they are licensed to provide such as managing the care of residents with diagnoses like R1's which includes Dementia with behaviors and Schizophrenia.</p>		

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<p>F 0740</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident must receive and the facility must provide necessary behavioral health care and services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30312</p> <p>Based on interview and record review the facility failed to provide behavioral health services as indicated in the Facility Assessment as a service offered to meet the needs of residents with mental health concerns for one of three residents (R1) reviewed for Behavioral Health Services in a sample of six. This failure resulted in R1 requiring hospitalization for behaviors and being issued an involuntary discharge order by the facility.</p> <p>Findings include:</p> <p>A Facility assessment dated [DATE] documents the facility can provide care for residents with psychiatric/ mood disorders including residents with impaired cognition, mental disorders, Depression, Anxiety disorders, behavior that needs attention, Alzheimer's disease, and non-Alzheimer's Dementia. This Facility Assessment states it can, Manage the medical conditions and medication-related issues causing psychiatric symptoms and behavior, and can identify and implement interventions to help support individuals with issues such as dealing with Anxiety, care of someone with cognitive impairment, Depression or other psychiatric diagnoses. In addition, the Facility Assessment documents the facility will provide needed support staff to manage these patient types including Behavioral and Mental Health providers and Psychiatric Services.</p> <p>R1's electronic medical record documents R1 has current diagnoses which includes Dementia in other diseases classified elsewhere, unspecified severity, with other behavioral disturbance, Schizophrenia, Cognitive Communication Deficit, Encephalopathy. R1's progress notes document R1 had progressively worsening behaviors from the time of R1's admission on 11/29/22 until R1's involuntary emergency discharge to the hospital for behavioral issues on 2/26/23. R1's progress notes document that R1's behaviors indicated R1 was actively exit seeking, physically and verbally aggressive with other residents and staff, refused cares and medications.</p> <p>R1's progress notes dated 2/23/23 and signed by V3 (Assistant Director of Nurses/ADON) document that R1, is a safety risk to her peers AEB (As evidenced by) multiple attempts of physical aggression towards peers, wandering aimlessly into peers' rooms becoming agitated with peers when asked to exit and becoming physically aggressive with peers. (R1) is an active elopement risk putting self at potential risk of harm to self when exiting out exit doors. Action: Involuntary Discharge issued to (R1) due to facility is not the proper placement and R1 needs a more suitable psychiatric facility. Response: MD (physician) in agreeance for safety of peers and resident, IVD (Involuntary Discharge) orders processed at this time for alternative placement of (R1). R1's progress notes do not indicate R1 was emergently discharged to the hospital on that date (2/23/23) nor do these progress notes document the specific needs R1 has that can be met at another facility that cannot be met at this facility.</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 03/08/2023
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 0740</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>R1's progress notes dated 2/26/23 at 1:11a.m. document R1 was alert and oriented and do not include documentation that R1 had any untoward behaviors or posed a danger to herself or others on that date (2/26/23). R1's nursing documentation does not show any other nursing or physician's progress notes entered for 2/26/23. R1's progress notes dated 2/27/23 document R1 was in the hospital. None of R1's progress notes document R1 was offered the services of behavioral health providers or Psychiatric Services as stated in the Facility Assessment.</p> <p>R1's emergency room physician's progress note dated 2/26/23 documents R1 was admitted to the hospital because of acute exacerbation of chronic Schizophrenia. R1's hospital case management records document the facility has refused to take R1 back once R1 is ready for discharge. The hospital records document as of 3/8/23, R1 was still in the hospital with no long term care placement available at that time.</p> <p>R1's behavior tracking dated 12/22, 1/23, and 2/23 documents R1 was being monitored for behaviors including refusal of medications, refusal of treatments, restlessness, and agitation.</p> <p>On 3/7/23 at 10:26 a.m., V5 (Social Services Director) stated she manages residents' behaviors in the facility. V5 stated R1 had the behaviors of exit seeking, physical and verbal aggression toward staff and other residents, refusal of cares and treatments. V5 stated she had developed and asked staff to implement many interventions to prevent or reduce R1's behavior problems. V5 stated she had several meetings with V9 (R1's Power of Attorney/POA) to try to figure out how the facility could help curb R1's behaviors. V5 stated the facility has a behavioral health nurse practitioner who was supposed to evaluate R1 for the first time on 2/2/23 and provide recommendations and treatments for R1's behaviors related to R1's dementia and Schizophrenia. V5 stated she does not know what recommendations the specialist made because she cannot find any progress notes from that evaluation. V5 stated if the behavioral health practitioner had written orders or recommendations, they would have been listed in their progress note from the visit with R1. V5 proceeded to review R1's physician's orders and a file where all the behavioral health specialist keeps their progress notes for residents they have evaluated but could not locate any such notes documenting that R1 had been seen. V5 stated she thought another long-term care facility that offers mental health services would be more appropriate for R1's mental health and behavioral needs.</p> <p>On 3/8/23 at 9:28 a.m. V8 (R1's physician) stated R1 had behavioral problems related to dementia and Schizophrenia. V8 stated the facility sought out behavioral health services by sending R1 to the emergency room to calm R1 down for one to two days. V8 stated he did not personally evaluate R1 or document any progress notes pertaining to the need for R1's involuntary discharge or the facility's inability to meet R1's behavioral needs but, instead, I rely on what the nurses tell me, and I go off what the nurses tell me.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Washington Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 Newcastle Washington, IL 61571	
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F 0740 Level of Harm - Actual harm Residents Affected - Few	On 2/7/23 at 9:50 a.m., 2:50 p.m.; and on 3/8/23 at 10:00 a.m., 1:20 p.m., and 2:15 p.m., V3 stated V3 evaluated R1 prior to admission to ensure the facility could meet R1's needs as a resident in the facility. V3 stated V3 determined R1 was appropriate for admission. V3 stated R1 did have the diagnoses of Dementia with behaviors and Schizophrenia at the time and V3 determined the facility could meet R1's needs. V3 stated that while R1 was a resident, R1 had multiple instances of aggressive behaviors, wandering, attempts to elope, and refusing care. V3 stated R1 was sent to the hospital several times for behavioral issues. V3 stated the facility decided it could not meet R1's needs and decided for the safety of other residents, R1 needed an involuntary discharge. V3 stated the facility tried to refer R1 for admission to other long term care facilities, including ones that specialize in caring for residents with behaviors, but R1 was not accepted. V3 stated the facility decided to issue R1 an involuntary discharge order as of 2/24/23. V3 stated R1 ended up being emergently transferred to the hospital for more behaviors on 2/26/23 before the 30-day involuntary discharge could take place. V3 stated the facility is not going to allow R1 to readmit once her treatment is complete at the hospital. V3 stated the facility does not offer the mental health services that R1 needs. V3 stated R1 needs to be transferred to a facility that can offer enough staff to monitor R1 more frequently and offer more specialized mental health care. V3 verified the facility does offer a Behavioral Health practitioner who comes to the facility on ce per month. However, R1 was never provided services from that behavioral health specialist. V3 stated V9 (R1's Power of Attorney) had not yet signed a consent form for R1's referral to the behavioral health specialist. V3 stated it may not have mattered that R1 was not evaluated because the behavioral health practitioner won't write phone orders or make recommendations unless she is already in the facility evaluating a resident.		