STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009740	A. BUILDING: _____ B. WING _____	C 08/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON SENIOR LIVING	1201 NEWCASTLE WASHINGTON, IL 61571

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S 000	Initial Comments Complaint Investigation: 2226863/IL150617	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b) 300.1210d)6) 300.1220b)3) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including:	S9999		

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S9999	Continued From page 2 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. These requirements were not met as evidenced by: Based on interview and record review, the facility failed to ensure fall prevention measures were in place and failed to provide sufficient supervision to prevent a fall for one of three residents (R4) reviewed for accidents in a sample of five. This failure resulted in R4, a moderately cognitively impaired resident, attempting to self-transfer from the wheelchair to the bed while wearing regular socks and no shoes, causing R4 to fall to the floor sustaining a Pelvic Fracture. Findings include: A Facility Falls Prevention-Interventions policy dated as revised 9/2004 documents fall prevention interventions related to footwear include, "Footwear properly fitted. Non-skid slippers." In addition, this policy documents fall prevention interventions regarding mobility include, "Residents placed in view of staff when out of bed."	S9999		

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S9999	Continued From page 3 R4's Hospital Physician's progress note from prior to admitting to the facility and dated 8/10/22 explains that R1's reason for hospital admission was related to, "Gradual worsening Dementia, physical deconditioning and multiple falls over last 1 year. Admission for (Long Term Care) placement." R4's Nursing progress notes dated 8/17/22 document R4 was admitted to the facility on that date (8/17/22). These same notes document that R4 had a safety concern because R4 was a fall risk. At the bottom of this same note is a place for "Clinical Suggestions," but that area was left blank. R4's Nursing progress notes dated 8/18/22 states, "Functional: Resident is able to move all extremities. Gait is unsteady. Balance is poor." At the bottom of this same note is a place for "Clinical Suggestions," but that area was left blank. R4's Nursing progress notes dated 8/19/22 at 4:32p.m. documents, "Resident is confused. Resident is disorganized in thinking. Resident is inattentive. Resident requires cues. Resident is experiencing signs of short-term memory loss. Current state of confusion is considered baseline for Resident. Level of cognitive impairment: Moderate (memory loss). Speech is coherent. Speech is clear. Resident sometimes displays the capability of understanding verbal communication. Resident is sometimes able to make self-understood," and "Safety concerns: YES. High fall risk." At the bottom of this same note is a place for "Clinical Suggestions," but that area was left blank.	S9999		

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S9999	Continued From page 4 R4's Nursing progress note dated 8/19/22 at 9:30p.m. documents, "Resident lying on Rt. (right) side in socks on floor at foot of bed. Call light is not on. Bathroom call light is not on. Resident unable to state what she was trying to do as resident is confused. Body assessment reveals Sm (small) abrasion center of forehead." R4's Post Fall Evaluation dated 8/19/22 at 9:30p.m. documents, "Fall Details: Date/Time of Fall: 8/19/22 9:30 PM. Fall was not witnessed. Fall occurred in the Resident's room. Activity at the time of fall: Transferring out of bed. The reason for the fall was not evident. Was a safety evaluation completed/documented prior to the fall: No. Safety teaching documented before the fall: No. Did an injury occur as a result of the fall: Yes. Injury details: bruise forehead. Did fall result in ER visit/hospitalization: Yes." This same evaluation lists as, "Contributing Factors" to the fall including, "Footwear at time of fall: Socks," and "Resident is confused." The conclusion documented in R4's Post Fall Evaluation includes that R4 has confusion with a history of prior falls, a history of falls at home prior to admission to the facility. R4's Serious Injury Incident Report dated 8/20/22 and signed by V3 (Assistant Director of Nurses) documents that on 8/19/22 at 9:30p.m., R4 was found lying on R4's right side on the floor at the foot of R4's bed while wearing socks on her feet. The report documents R4's Power of Attorney (POA) requested R4 be sent to the hospital for evaluation. There are no staff interviews included in this fall investigation. R4's Care Plan dated as initiated 8/18/22 but created on 8/20/22 by V3 documents, "(R4) is at risk for falls r/t (related to) Confusion,	S9999		

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S9999	Continued From page 5 Gait/balance problems." This same care plan includes an intervention added by V3, "8-19-22 non-skid socks on when shoes are not on. Date Initiated: 08/19/2022 Created on: 08/25/2022," R4's Fall Risk Evaluation completed 8/19/22 at 9:30p.m., at the time of R4's fall, documents R4 is at risk for falls. This fall evaluation lists R4's fall risks which includes intermittent confusion, a history of three or more falls in the last three months, is chairbound, has poor vision with or without glasses, has a balance problem while standing. At the bottom of this form is an area which lists check boxes with clinical suggestions based on R4's fall risks. These suggestions include rubber-soled shoes or non-skid slippers worn for ambulation, utilize a toileting program, utilize personal/pressure sensor alarms. None of the boxes next to these clinical suggestions are checked. On 8/30/22 at 10:40a.m. V3 stated she investigated R4's fall which occurred at 9:30p.m. on 8/19/22. V3 stated that R4 was admitted to the facility on 8/17/22 following hospitalization for a ground level fall while R4 was living at her home. V3 stated that R3's hospital record showed that R4 had worsening Dementia and multiple falls prior to coming to the facility. V3 stated she interviewed V7 (Certified Nurse Aide/CNA) who was R4's CNA the night R4 fell. V3 stated that V7 stated in her interview that she last toileted R4 at 8:00p.m. on 8/19/22 before R4 fell. V3 stated that V7 recounted that V7 left R4 seated in her wheelchair alone in her room while R4 was on the phone. V3 stated that V7 stated that she told R4 she would be back to assist R4 to bed after V7 took her break. V3 stated that R4 was not observed again by staff until 9:30p.m. when R4 was found on the floor. V3 stated that V2	S9999		

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S9999	Continued From page 6 (Director of Nurses) was working as R4's nurse on 8/19/22 when R4 fell. V3 stated that during V2's interview, V2 stated that when R4 fell, R4 was wearing regular socks without shoes. V3 stated that V2 verified R4 was not wearing non-skid socks at the time of her fall. V3 stated that all residents, whether they're a fall risk or not, should be provided with non-skid socks as a fall prevention measure. V3 stated that she is "trying to get staff to give all residents non-skid socks." R4's Hospital Physician's progress notes dated 8/20/22 at 1:00a.m. document that R4 presented to the emergency room following a fall to the floor during a transfer from the chair to the bed, "EMS (Emergency Medical Services) reports they were called tonight for (a) fall (as) (R4) was being transferred from a chair to bed, with head strike present. (R4) is not anticoagulated. (R4) expresses pain to the right hip but denies any other pain." This same Physician's progress note documents that a review of R4's previous hospital records from 8/10/22 shows that R4 did not have any fractures noted during that admission. R4's hospital X-ray report dated 8/20/22 at 3:59a.m. documents R4 sustained a "Right pubic rami fracture immediately adjacent to pubic symphysis," as a result of R4's fall. (A)	S9999		