STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145000	A. BUILDING _____ B. WING _____	**08/06/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to implement its policy for investigating allegations of abuse and injuries of unknown origin for one of four residents (R3) reviewed for abuse in a sample of 14. Findings include: An Abuse Prevention Program policy dated 2/2017 documents that the facility will prevent abuse by, Implementing systems to promptly and aggressively investigate all reports and allegations of abuse, neglect, exploitation, misappropriation of property and mistreatment, and making the necessary changes to prevent future occurrences. The policy further states, The nursing staff is responsible for reporting the appearance of suspicious bruises, lacerations, or other abnormalities of an unknown origin as soon as it is discovered. The report is to be documented on a facility incident report and provided to the nursing supervisor, administrator or designated individual. Following the discovery of any suspicious bruises, lacerations or other abnormalities of an unknown origin, the nurse shall complete a full assessment of the resident for other bruises, laceration, or pain. Additionally, this policy states, For resident injuries not involving an allegation of abuse or neglect, the administrator will appoint a person to gather further facts to make a determination as to whether the injury should be classified as an injury of unknown source. An Abuse Prevention Program Investigation of Skin Tear/Bruising of Unknown Source form dated 2/2017 states, Often these injuries occur with no known cause. It is the policy of this facility to investigate all skin tears and bruises in an effort to determine possible cause. R3's nurses' notes dated 5/14/20 documents that R3 had a fading bruise on his right lower back. R3's nurses' notes dated 6/26/20 document that R3 had bruising to his right lower back, right buttocks, back of right thigh, back of right knee, left lower back and buttocks. On 8/4/20 at 9:45a.m. V10 (R3's Nurse Practitioner) stated that R3 had bruises all over his back, the back of his legs and arms when she last examined him on 7/3/20. V10 stated that she did not know how R3 developed so many bruises. On 8/2/20 V4 (Licensed Practical Nurse) stated she was one of R3's nurses when he was a patient at the facility. V4 stated that R3 had a lot of bruising on his arms, legs, and back. V4 stated she never reported any of R3's bruises to the abuse coordinator because she thought they could all be attributed to R3's frequent falls. The facility's abuse investigations and incident reports do not document that R3 had bruising or that R3's bruising was investigated. On 8/2/20 at 1:30p.m. V2 (Director of Nurses) stated that nurses are supposed to report patient bruising so those bruises can be investigated. V2 stated there are no bruise investigations for R3's bruises to his arms, legs, and back to determine possible cause because R3's bruises were not reported by the nursing staff. V2 stated that after R3 went to the emergency roiagnom on [DATE], the facility looked up R3's hospital records to check on his status. V3 stated that she read in R3's hospital physician's notes that V30 (R3's family) was concerned that R3 was being abused at the facility because of R3's multiple bruises. R1's initial abuse investigation dated 7/5/20 documents that R1 fell and was sent to the emergency room for treatment where an allegation of abuse was made against the facility. This initial abuse allegation documents that an investigation was initiated and will be documented in a final report. R1's final report abuse investigation dated 7/10/20 documents that the facility read hospital documentation from R1's emergency room visit dated 7/4/20 at which time V30 accused the facility of abusing R3. The final report does not include any investigation was conducted for the allegation other than documentation in the final report that the facility attempted to contact V30. On 8/2/20 at 1:55p.m. V1 (Administrator) verified that V30's allegation of abuse related to R3's multiple bruises was not investigated.
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** Based on interview and record review the facility staff failed to report resident bruising for one of four residents (R3) reviewed for injuries of unknown source in a sample of 14. Findings include: An Abuse Prevention Program policy dated 2/2017 documents, The nursing staff is responsible for reporting the appearance of suspicious bruises, lacerations, or other abnormalities of an unknown origin as soon as it is discovered. The report is to be documented on a facility incident report and provided to the nursing supervisor, administrator or designated individual. Additionally, this policy states, For resident injuries not involving an allegation of abuse or neglect, the administrator will appoint a person to gather further facts to make a determination as to whether the injury should be classified as an injury of unknown source. An Abuse Prevention Program Investigation of Skin Tear/Bruising of Unknown Source form dated 2/2017 states, It is the policy of this facility to investigate all skin tears and bruises in an effort to determine possible cause. R3's nurses' notes dated 5/14/20 document that R3 had a fading bruise on his right lower back. R3's nurses' notes dated 6/26/20 document that R3 had bruising to his right lower back, right buttocks, back of right thigh, back of right knee, left lower back and buttocks. On 8/4/20 at 9:45a.m. V10 (R3's Nurse Practitioner) stated that R3 had bruises all over his back, the back of his legs and arms when she last examined him on 7/3/20. V10 stated that when she noted all of R3's bruises, she could not identify an immediate cause. V10 stated she did not know how or why R3 developed the bruising all over his body. On 8/2/20 at 11:00a.m. V4 (Licensed Practical Nurse) stated she was one of R3's nurses when he was a patient at the facility. V4 stated that R3 had a lot of bruising on his arms, legs, and back. V4 stated she never reported any of R3's bruises to the abuse coordinator or Director of Nurses because she thought the bruises could probably be attributed to R3's falls. The facility's abuse investigations and incident reports dated 5/1//2020 to 7/3/20 do not document that R3 had bruising or that R3 had investigations for injuries of unknown source. On 8/2/20 at 1:30p.m. V2 (Director of Nurses) stated she investigates residents' injuries of unknown source including bruises to determine their cause. V2 stated that nurses are supposed to report patient bruising so those bruises can be investigated. V2 stated there are no bruise investigations for R3's bruises to his arms, legs, and back because R3's bruises were not reported by the nursing staff.
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to thoroughly investigate an allegation of abuse for one of four residents (R3) reviewed for abuse in a sample of 14. Findings include: An Abuse Prevention Program policy dated 2/2017 documents the facility will prevent abuse by, Implementing systems to promptly and aggressively investigate all reports and allegations of abuse, neglect, exploitation, misappropriation of property and mistreatment, and making the necessary changes to prevent future occurrences. On 8/4/20 at 9:45a.m. V10 (Nurse Practitioner) stated that R3 had bruises all over his back, the back of his legs and arms when she last examined him on 7/3/20. V10 stated that she did not know how R3 developed so many bruises. V10's progress notes regarding R3 dated 7/3/20 state, Seen today for bruising on left arm. He has impressive bruising and small hematoma on posterior arm. On 8/2/20 V4 (Licensed Practical Nurse) stated she was one of R3's nurses when he was a patient at the facility. V4 stated that R3 had a lot of bruising on his arms, legs, and back which V4 thought might have been caused by R3's falls while at the facility. The facility's abuse investigations and

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

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F 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) incident reports dated 5/1//2020 to 7/3/20 do not document that R3 had bruising or that R3 had investigations for injuries of unknown source. R3's hospital physician's history and physical progress note dated 7/4/20 states, Concern for elderly abuse: (V30, R3's family) has concerns about elderly abuse, (e)specially with multiple bruising, on R3. R3's initial abuse investigation dated 7/5/20 documents that R3 fell and was sent to the emergency room for treatment where an allegation of abuse was made against the facility at that time. This initial abuse allegation report documents an investigation was initiated by the facility and the results would be documented in a final report. R3's final report abuse investigation dated 7/10/20 documents that the facility acquired R3's hospital documentation from R3's emergency room visit on 7/3/20 where V30 accused the facility of abuse. The final report does not include any investigation was conducted for the allegation other than documentation on the final report stating that the facility attempted and failed to contact V30. On 8/2/20 at 1:55p.m. V1 (Administrator) verified he knew V30 had made an allegation of abuse regarding the multiple bruises on R3's arms, legs, and back when R3 was admitted to the hospital on [DATE]. V1 stated that once he became aware of the allegation, he attempted to call V30 to discuss the abuse allegation with her. V1 stated he was unable to contact V30 and, therefore, V30's allegation of abuse related to R3's multiple bruises was not investigated.
F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to prevent the development of an unstageable pressure ulcer for one of three residents (R1) reviewed for pressure ulcers in a sample of 14. R1's pressure ulcer was identified as a stage 2 pressure ulcer on 6/20/20 but treatment orders were not obtained until 6/26/20 resulting in R1's pressure ulcer deteriorating into an unstageable pressure ulcer. Findings include: A Prevention of Pressure Wounds policy dated 1/2017 documents that, Pressure injuries are usually formed when a resident remains in the same position for an extended period of time causing increased pressure or a decrease of circulation (blood flow) to that area and subsequent destruction of tissue. The policy further states that, Pressure injuries are a serious skin condition for the resident. In addition, this policy also states, The facility should always have a system/procedure to assure assessments are timely and appropriate and changes in condition are recognized, evaluated, reported to the practitioner, physician, and family, and addressed. R1's Minimum Data Set (MDS) assessment dated [DATE] documents R1 is severely cognitively impaired and requires extensive assistance of two people for bed mobility, transfers, toilet use and hygiene. R1's MDS also documents that R1 uses a wheelchair for mobility. R1's Braden Scale for Predicting Pressure Sore Risk assessment dated [DATE] documents that R1 scored a 19 which is a low or no risk for developing pressure ulcers despite being chairfast with limited mobility. R1's admission nurse's note dated 6/19/20 does not document that a skin assessment was performed on R1 at that time. R1's nurse's note dated 6/20/20 documents a head-to-toe assessment was completed for R1 in which the assessment noted that R1's skin was within normal limits meaning no abnormalities and intact. R1's nurses' notes dated 6/21/20 document that R1 had developed a stage 2 pressure ulcer to the left buttock but no documentation that R1's physician was notified for treatment orders. There are no nurses' notes to address R1's stage 2 pressure ulcer from 6/22/20 to 6/25/20. On 6/26/20 R1's nurses' notes, entered by V27 (Wound Nurse), document that R1 had developed an open area to her left gluteal fold (buttock) and V27 had obtained a new physician's orders [REDACTED]. R1's physician's orders [REDACTED]. R1's current comprehensive care plan does not include interventions to prevent or treat actual or potential impairments to R1's skin integrity until 8/3/20. R1's wound physician's initial progress note dated 7/8/20 documents that R1 had an unstageable pressure ulcer to the left buttock, due to necrosis (dead tissue), which measured 2.7cm (centimeters) long x 2.2cm wide x 0.2cm deep. This progress note also indicated that there was scarring around R1's wound indicating she had history of a previous wound in that same area. On 8/6/20 at 8:51a.m. V27 (Wound Nurse) stated that she assessed R1's skin and noted R1's pressure ulcer on 6/26/20. V27 stated that she read through R1's transfer records from R1's previous residence and did not see any documentation that R1 had an existing wound at the time of transfer. V27 stated she also reviewed R1's physician's orders [REDACTED]. V27 verified orders to treat R1's wound were not obtained until 6/26/20. On 8/3/20 at 12:09p.m. V2 (Director of Nurses) verified that R1's transfer documentation from her previous facility does not show that R1 had a pressure ulcer at the time of discharge and prior to the transfer to this facility. V2 verified R1's pressure ulcer was not documented as discovered by the facility until 6/21/20. On 8/4/20 at 9:40a.m. V10 (R1's Nurse Practitioner) stated that V10 was R1's health care provider at R1's previous facility before she transferred to this currently facility. V10 stated that R1 did not have a pressure ulcer at the time of transfer. V10 stated that R1's stage 2 pressure ulcer which deteriorated into an unstageable pressure was an avoidable wound. V10 stated that she would have expected the facility's nursing staff to obtain a physician's treatment order as soon as R1's wound was identified.