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 03/08/2023

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 Investigations: 2321813/IL157126	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b) 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 meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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. These requirements were not met as evidenced by: 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. Findings include: A Facility Assessment dated 9/16/22 documents the facility can provide care for residents with psychiatric/ mood disorders including residents	S9999		

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S9999	Continued From page 2	S9999		

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.

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.

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

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S9999	Continued From page 3	S9999		

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.

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.

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.

R1's behavior tracking dated 12/22, 1/23, and 2/23 documents R1 was being monitored for

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S9999	Continued From page 4 behaviors including refusal of medications, refusal of treatments, restlessness, and agitation. 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. 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	S9999		

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S9999	Continued From page 5 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." 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	S9999		

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S9999	Continued From page 6 more frequently and offer more specialized mental health care. V3 verified the facility does offer a Behavioral Health practitioner who comes to the facility once 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. (A)	S9999		