STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510291	A. BUILDING: _____ B. WING _____	C 09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REFLECTIONS MEMORY CARE - WASHINGTO	1280 INDEPENDENCE COURT WASHINGTON, IL 61571

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A 000	Initial Comment Annual licensure and Complaint 2427027 / IL 177524. Violations cited for both: 295.4020 f), 295.6000 a) 13), 295.2000 c) 4), 295.4060 h) 6), and 295.4060 h) 5).	A 000		
A2000	Section 295.2000 Residency Requirements This Regulation is not met as evidenced by: Section 295.2000 Residency Requirements c) A person shall not be accepted for residency if: 4) The person requires the assistance of more than one paid caregiver at any given time with an activity of daily living; VIOLATION Based on observation, interviews, and record review, the establishment failed to discharge a resident that requires more than one paid caregiver for an activity of daily living. Findings include: On 9/11/24 at 2:20 P.M. E4 (Caregiver) and E5 (LPN) transferred R4 from her wheelchair to a chair in the TV area. R4 appeared to bear very little weight during transfer. On 9/11/24 at 2:22 P.M., E4 stated that R4 requires two assist for all transfers and has for a while.	A2000		

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A2000	Continued From page 1 R4's current records note that R4 is not on hospice. On 9/12/24 at 12:15 P.M., E2 (Regional Director of Clinical Services and Acting Wellness Director) stated that she is aware that R4 requires more care that what is allowed under the Assisted Living license and that they will be actively looking for other placement.	A2000		
A4020	Section 295.4020 Mandatory Services This Regulation is not met as evidenced by: Section 295.4020 Mandatory Services Each establishment shall provide or arrange for the following mandatory services: f) Assistance with activities of daily living as required by each resident. (Section 10 of the Act) VIOLATION Based on record review and interviews, the establishment failed to provide scheduled showers for two of five sampled residents. (R4 and R5) Findings include: On 9/11/24 at 2:22 P.M., E4 (Caregiver) stated that R4 and R5 were not given showers today even though it was there shower day. E4 stated that she is he only one working on this side and because of the short staffing, she just did not have time to give them showers. E4 stated that they have been short staffed for a while now, so	A4020		

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A4020	Continued From page 2 she has to prioritize what is most important to get done and let some things go. Facility shower sheet noted that R4 and R5 were supposed to get showers on first shift on 9/11/24. On 9/12/24 at 12:15 P.M. E2 (Regional Director of Clinical Services and Acting Director of Nursing) confirmed that the facility is short of staff and actively trying to hire caregivers.	A4020		
A4060	Seciton 295.4060 Alzheimer's and Demential Programs This Regulation is not met as evidenced by: Section 295.4060 Alzheimer's and Dementia Programs h) An establishment that offers to provide a special program for persons with Alzheimer's disease and related disorders shall: 5) Provide, in the service plan, appropriate cognitive stimulation and activities to maximize functioning, which include a structure and rhythm that are comfortable and predictable; offer an appropriate balance of rest and activity and private and social time; allow residents to express their accustomed social roles, whatever they may be; offer residents access to familiar activities that they enjoyed doing and that tap memories and retained abilities; and provide the flexibility to accommodate variations in the resident's mood, energy level, and inclination; VIOLATION	A4060		

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A4060	Continued From page 3 Based on observations and interviews, the establishment failed to provide appropriate activities. This failure has the probability to affect all 26 residents. Findings include: Observations made on 9/11/24 from 10:55 A.M. until 2:40 P.M. noted no activities provided for R1, R2, and R3, who reside on the North Unit. The North Unit has a census of 14 residents. Observations of South Unit on 9/12/24 from 8:30 A.M. until noted no activities provided. South Unit has a census of 12 residents. E8 (CNA) was the only staff observed providing cares on South Side. On 9/11/24 at 1:35 P.M., E8 stated that they have not had an Activity staff for a while now, so activities are rarely provided. On 9/11/24 at 2:22 P.M. E4 (Caregiver) stated that they do not have an Activity staff person so there is not time to provide activities. E4 stated that due to the short staffing she needs to prioritize the resident cares and Activities usually does not happen. On 9/12/24 at 12:15 P.M. E2 (Regional Clinical Director of Services and Acting Director of Nursing) stated they have not had an Activity Staff for a while and she is aware that Activities are not being provided as they should be. E2 stated that they are in the process of hiring an Activity Director had should have this issue resolved in the near future. h) An establishment that offers to provide a special program for persons with Alzheimer's disease and related disorders shall:	A4060		

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A4060	Continued From page 4 6) Provide an appropriate number of staff for its resident population. The establishment shall provide staff sufficient in number, with qualifications, adequate skills, education, and experience to meet the 24-hour scheduled and unscheduled needs of the residents and who participate in ongoing training, to serve the resident population. At a minimum, at least one staff member shall be awake and on duty at all times; VIOLATION Based on observation, record review, and interviews, the establishment failed to have an appropriate number of staff to meet the needs of the resident census. This failure has the probability to affect all 26 residents. The establishment also failed to provide the appropriate training and equipment in order to safely transfer three of five sampled residents from surface to surface. (R1, R2, and R3) Findings include: On 9/12/24 at 12:15 P.M., E1 (Executive Director) and E2 (Regional Director of Clinical Services and Acting Wellness Director) stated that they are aware that they are short staffed and that certain cares are not being provided an should be. Both stated that they should be staffing the facility with a minimum of four Caregivers and an Activity person. At the present time they are staffing the facility with two or three Caregivers and no Activity person. On 9/11/24 at 11:15 A.M. E4 (Caregiver) stated that R1, R2 and R3 all required at least two staff to transfer them from surface to surface. E4	A4060		

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A4060	Continued From page 5 stated that they need a mechanical lift for these residents but she was told they are not allowed to have mechanical lifts in the establishment. E4 stated that she feels it is unsafe to have to physically lift these residents up under there armpits when they can't bear any weight to help. On 9/11/24 between the times of 1:40 P.M. and 2:40 P.M., R1, R2, and R3 were observed being transferred from their wheelchairs to their beds. E4 and another staff member (E3 RN or E5 LPN) physically lifted each resident, by grabbing under the resident's arm pits and a gait belt. The two staff members then lifted the resident from the wheelchair to the bed, dragging each residents feet in the process. On 9/11/24 at 2:40 P.M., after E4 and E5 physically transferred R3 from her wheelchair to her bed, E5 stated that she can't believe they don't have a mechanical lift for these three residents that don't bear any weight. E5 stated that it's dangerous for the safety of the staff and the residents to physically lift them under their armpits. Staffing schedules for August 2024 and September 2024 noted that the facility is staffed with only three caregivers at most on first shift and no Activity Staff.	A4060		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: Section 295.6000 Resident Rights a) No resident shall be deprived of any rights,	A6000		

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A6000	Continued From page 6 benefits, or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of his or her status as a resident of an establishment, nor shall a resident forfeit any of the following rights: 13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor; VIOLATION Based on observation, record review, and interviews, the establishment neglected to provide incontinent care and repositioning for three of five sampled residents. (R1, R2, R3) Findings include: R1, R2, and R3's current Service Plans note that they need extensive staff assistance with incontinence care and mobility. On 9/11/24, R1 was observed sitting in the same position in a reclined wheelchair from 11:00 A.M. until 2:00 P.M.. At 2:00 P.M., E4 (Caregiver) and E3 (R.N.) transferred R1 from the wheelchair to his bed. R1 was noted to be saturated with urine and his coccyx was slightly reddened. E5 stated that R1 had not been given incontinent care or repositioning since around 9:30 A.M.. E4 stated she knows R1 should be provided repositioning and incontinent care at least every two hours but has been unable to provide that care because they are so short staffed. On 9/11/24, R2 was observed sitting in the same position in a reclined wheelchair from 11:00 A.M. until 1:20 P.M.. At 1:20 P.M., E4 and E3 transferred R2 from the wheelchair to her bed. R2	A6000		

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A6000	Continued From page 7 was noted to be saturated with urine and feces. Both R2's buttocks were reddened. E4 stated that she due to the short staffing she has not been able to provide any repositioning or incontinence care for R2 since around 9:45 A.M.. On 9/11/24, R3 was observed sitting in the same position in a relined wheelchair from 11:00 A.M. until 2:40 P.M.. At 2:40 P.M., E4 and E5 (LPN) transferred R3 from the wheelchair to her bed. R3 was noted to be saturated with urine and a large amount of feces. R3's coccyx was reddened. E4 stated that R3 had not been repositioned or provided incontinent care since around 9:45 A.M.. On 9/12/24 at 12:15 P.M., E2 (Regional Director of Clinical Services and Acting Wellness Director) stated that she has been aware of the shortage of staff and has been actively trying to get staff hired to resolve this ongoing issue.	A6000		