STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008528	A. BUILDING: _____ B. WING _____	C 08/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHAWNEE SENIOR LIVING	1901 13TH STREET HERRIN, IL 62948

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S 000	Initial Comments Complaint Investigation 2056075/IL125390	S 000		
S9999	Final Observations Statement of Licensure Violations 300.1210b) 300.1210c) 300.1210d)3) 300.1210d)6) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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: 3) Objective observations of changes in a resident's condition, including mental and	S9999	**Attachment A** **Statement of Licensure Violations**	

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emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

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 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These requirements were not met as evidenced by:

Based on interview and record review, the facility failed to assess a confused, agitated resident at high risk for falls and failed to restrict a resident's access to potentially hazardous chemicals for 1 resident of 3 residents (R5) reviewed for accidents and hazards in the sample of 10. This failure resulted in R5, while agitated and confused, falling out of bed and fracturing his pelvis.

Findings include:

R5's Face Sheet documented an admission date of 06/26/20 and a discharge date of 07/05/20. R5's Admission Diagnoses List dated 06/26/20 documented diagnoses including Sepsis, Unspecified Organism, Post Traumatic Stress Disorder, Schizoaffective Disorder, Chronic

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Obstructive Pulmonary Disease, and Cognitive Communication Deficit. R5's Fall Risk Assessment dated 06/26/20 documented a score of 13, indicating R5 was at high risk for falls. R5's Care Plan dated 06/29/20 documented a problem area of "(R5 is at) Risk for falls due to impaired mobility and having a history of falls," and "(R5) is at risk for constipation due to decreased mobility, medication side effects, and pain." A 06/30/20 Brief Interview for Mental Status documented a score of 4, indicating R5 experienced severe impairment in cognition. R5's July 2020 Medication Administration Record (MAR) documented that R5 had a bowel movement on 06/28/20 on day shift, there were no further bowel movements documented, and the documentation ends at R5's 07/04/20 transfer to the hospital.

1. A Nursing Progress Note dated 07/04/20 at 9:45pm, authored by V9 (Registered Nurse) stated "(R5) rolled out of bed this night... Transferred to hospital for further evaluation." A Fall Report dated 07/04/20 stated, "(R5) was laying on the floor, confused at intervals, unable to explain why he was getting out of bed." A 07/04/20 Emergency Department Note stated, "(R5 was) Brought to emergency room for evaluation of a fall and lethargy. Patient has been more lethargic all day today. Patient rolled out of bed and landed on the left side." A CT (Computed Tomography) (of the) Abdomen (and) Pelvis dated 07/05/20 documented, "There is a large quantity of stool within the rectum...Fecal impaction is not excluded...A jagged fracture is present at the right inferior pubic ramus which is new as compared to 10/02/19."

On 08/04/20 at 8:30am, V19 (R5's family member) stated R5 was admitted to the facility in late June 2020. V19 stated that a few days after

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R5's admission, extended family members reported to V19 that they saw R5 during a window visit (Covid-19 precautions) and R5 looked "sick" and told them "They're killing me here" without further explanation. V19 stated on 07/05/20 she was contacted by the facility that R5 fell out of bed and was sent to the emergency room, where it was discovered that R5 had fractured his pelvis in this fall.

On 08/06/20 at 2:35pm, V13 (Certified Nursing Assistant/CNA) stated she was working evening shift (2:00pm-10:00pm) with R5 on 07/04/20 at the time of the fall. V13 stated V14 (CNA) was working the hall with her. V13 stated during the evening, R5 was very confused, shaky, and agitated, and this was not his baseline behavior. V13 stated R5 historically had difficulty communicating and was not able to tell them what was going on with him. V13 stated it was the Fourth of July holiday, R5 was a veteran with a history of Post Traumatic Stress Disorder (PTSD), and V13 had wondered if hearing fireworks had anything to do with his presentation that evening. V13 stated from 6pm on, she and V14 asked V9 several times to assess R5, and V13 and V14 told V9 they thought perhaps R5 needed to go to the hospital. V13 stated V9 said she was aware R5 had PTSD and maybe the fireworks were upsetting him, and she "was not sure what reason we would have to send him out." V13 stated she believed V9 would have briefly seen R5 during medication pass that evening, but she does not know if V9 assessed R5 or called the physician about him, as V9 did not communicate that to her. V13 stated about an hour before shift change, she and V14 repositioned R5 toward the wall and tried to comfort him. V13 stated R5 was upset, agitated, and more confused. They then put the bed in the

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lowest position and left the room. V13 stated R5 did not have a fall mat listed as an intervention. About 30 minutes before shift change, V13 was doing rounds and saw R5 lying on the floor, bleeding from his left elbow. V13 stated R5 was unable to state what had happened. V13 stated she called for help, V9 responded, assessed R5 and called the ambulance, and R5 was transported to the emergency room.

On 08/07/20 at 4:00pm, V14 corroborated V13's account of the events of 07/04/20 as outlined above. V14 stated by the time she and V13 put R5 to bed, R5 was, "Shaking and incoherent."

On 08/06/20 at 1:45pm, V9 stated she was working with R5 from 6pm on 07/04/20 but does not remember any of the related details. V9 stated she cannot remember if R5 had any fall precautions in place. V9 stated she cannot remember if R5 was a high risk for falls but "Most of our residents are." V9 stated she could not remember any details about what R5's status was that evening.

On 08/07/20 at 9:50am, V17 (Medical Doctor/R5's Physician) stated R5 was a newly admitted resident and he had not yet seen him but his Nurse Practitioner, V18, had done a new patient evaluation on R5.

On 08/07/20 at 1:15pm, V18 stated she saw R5 as a new patient on 06/29/20 at the facility. V18 stated R5 had multiple serious medical problems including Chronic Obstructive Pulmonary Disease, Atrial Fibrillation, Arteriosclerotic Heart Disease, Post Traumatic Stress Disorder, Schizoaffective Disorder, and Sepsis secondary to Pneumonia.

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R5's Nursing Progress Notes for the day of 7/4/20 fail to document any of the confusion, agitation, or any other behaviors R5 was experiencing that night before he fell.

On 08/11/20 at 9:00am, V2 (Director of Nursing) acknowledged R5's confusion, PTSD, and bowel impaction could have been contributing factors in his fall. V2 stated that on 07/04/20 when V13 and V14 realized R5 needed assessment by V9, they should have completed an ALERT form on the computer system which prompts the nurse to assess the resident. V2 confirmed this had not been done and R5 was therefore not assessed. V2 verified R5 had not had a bowel movement in six days at the time of the fall. V2 stated when a resident does not have a bowel movement in three days time, the computer system flags an alert for staff to assess the resident. V2 stated this did not occur in R5's case and she is unsure why.

An undated Notification of Resident Change in Condition Policy stated, "It is the policy of this facility to promptly notify the resident, their legal representatives, and attending physicians of changes in the residents health condition.. (including)a significant change in the residents physical, mental, or psychosocial status.i.e. deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complication...Clinical change in condition is determined by resident visualization, medical record review, clinical assessment findings, and care plan review."

2. On 08/04/20 at 8:30am, V19 stated she obtained R5's medical records from the facility and in reviewing them found that on 06/29/20, R5 had accidentally ingested wound cleanser. R5

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stated the documentation stated the facility tried to contact her about this incident without success, which V19 stated was possible. V19 stated considering R5's confused mental status, V19 was surprised R5 had access to wound cleanser.

R5's Nursing Progress Note authored by V16 (Licensed Practical Nurse), dated 06/29/20 at 9:52am documented, "...(R5) was drinking (trade name) wound cleanser, notified (V18), attempted to call (V19), unable to contact, called poison control (who stated) solution is basically benign." A corresponding Incident Report stated, "Nursing Description: (R5) was drinking roommates cleaning solution. Resident Description: 'I thought it was my water'."

On 08/05/20 at 5:30pm, V16 stated R5 was a new resident and she wasn't very familiar with him when the above referenced incident occurred. V16 stated R5's roommate had activated the call light and reported R5 was drinking wound cleanser. V16 stated R5 had gotten into a supply cart on his roommates side of room which had peritoneal dialysis supplies on it including sealed bottles of solution used to cleanse the dialysis port site. V16 stated R5 told her he thought it was bottled water. V16 stated she didn't realize R5 was confused enough to do something like this. V16 stated staff then immediately removed the supplies from the room and stored them in a locked area.

On 08/07/20 at 1:15pm, V18 stated she was still at the facility on 06/29/20 when she was informed by staff that R5 had accidentally ingested wound cleanser. V18 stated poison control was called, she again evaluated R5, and there were no sequelae to this incident. V18 stated R5 drank the wound cleanser as due to his confused mental

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S9999	Continued From page 7 state he believed it to be a bottle of water. (B)	S9999		