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 _____	08/29/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Annual Licensure Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 7 300.661 Section 300.661 Health Care Worker Background Check A facility shall comply with the Health Care Worker Background Check Act and the Health Care Worker Background Check Code. These requirements are not met as evidenced by: Based on interview and record review, the facility failed to ensure the Healthcare Worker Registry and all required background check websites were checked with results implemented. This has the potential to affect all 99 residents residing at the facility. Findings Include: The untitled resident roster, dated 8/11/2024, documents 99 residents reside at the facility. 1.V19 (Housekeeping) Personnel file documents a hire date of 05/09/2024. V19's personnel file did not include documentation the Healthcare Worker Registry, Illinois Sex Offender, Department of Corrections (DOC) Sex Offender, DOC Inmate search, DOC Wanted Fugitive, or Healthcare Human Services (HHS) Office of Inspector General (OIG) Search.	S9999		

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S9999	Continued From page 1	S9999		

On 8/22/24 at 8:56 AM, V1 (Administrator) stated V19 was hired at the facility and had never worked in the healthcare system, so was not eligible to work when they checked the Healthcare Worker Registry. V1 stated they sent V19 for fingerprints, and after they got the fingerprint results, they checked the registry again. V1 stated she doesn't know why they don't have documentation of checking the registry for V19, as well as all of the other checks that are not documented in V19's personnel record.

2. V16 (Licensed Practical Nurse) personnel file did not document license look up on the Department of Professional Regulation website.

On 8/22/24 at 8:56 AM, V1 (Administrator) stated they missed looking V16 up to verify her license was in good standing. V1 stated they had a copy of V16's license, but had not checked the Department of Professional Regulation to ensure V16's license was in good standing.

The facility undated Fingerprint Background Checks Implementation Overview documents, "Facilities will implement fingerprint Background Checks, as required by the Health Care Worker Background Check Act...Employees will need to have fingerprints done within 72 hours of hire...

(C)

300.625 a)
300.625 c)1)
300.625 c)2)
300.625 d)

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S9999	Continued From page 2 300.625 e) 300.625 g) Section 300.625 Identified Offenders a) The facility shall review the results of the criminal history background checks immediately upon receipt of these checks. c) If the results of a resident's criminal history background check reveal that the resident is an identified offender as defined in Section 1-114.01 of the Act, the facility shall do the following: 1) Immediately notify the Department of State Police, in the form and manner required by the Department of State Police, that the resident is an identified offender. 2) Within 72 hours, arrange for a fingerprint-based criminal history record inquiry to be requested on the identified offender resident. The inquiry shall be based on the subject's name, sex, race, date of birth, fingerprint images, and other identifiers required by the Department of State Police. The inquiry shall be processed through the files of the Department of State Police and the Federal Bureau of Investigation to locate any criminal history record information that may exist regarding the subject. The Federal Bureau of Investigation shall furnish to the Department of State Police, pursuant to an inquiry under this subsection (c)(2), any criminal history record information contained in its files. d) The facility shall comply with all applicable provisions contained in the Uniform Conviction Information Act. e) All name-based and fingerprint-based criminal history record inquiries shall be submitted to the Department of State Police electronically in the form and manner prescribed by the Department of State Police. The Department of State Police may charge the facility a fee for processing	S9999		

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S9999	Continued From page 3	S9999		

name-based and fingerprint-based criminal history record inquiries. The fee shall be deposited into the State Police Services Fund. The fee shall not exceed the actual cost of processing the inquiry. (Section 2-201.5(c) of the Act)
g) Facilities shall maintain written documentation of compliance with Section 300.615 of this Part.

These requirements are not met as evidenced by:

Based on record review and interview, the facility failed to comply with the identified offender program guidelines. This failure as the potential to affect all 99 residents in the facility.

Findings Include:

The untitled resident roster, dated 8/11/2024, documents 99 residents reside at the facility.

1. R95's Admission Record, with a print date of 8/26/24, documents R95 was admitted to the facility on 4/16/24, with diagnoses that include atrial fibrillation, heart failure, post-traumatic stress disorder, alcohol abuse, and depression.

R95's MDS (Minimum Data Set), dated 7/22/23, documents a BIMS (Brief Interview for Mental Status) score of 04, which indicates a severe cognitive deficit.

R95's current Care Plan documents a Focus area of "(R95) has triggered as identified offender. Date initiated: 08/13/2024." The interventions for this Focus area areas date initiated 08/13/2024 of, "Fingerprint based on background check to be completed....(R95) is to have private room at this time to prevent risk to self or others...."

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S9999	Continued From page 4	S9999		

R95's UCIA results, dated 4/17/24, documents "Multiple hits-fee fingerprints requested." R95's Fingerprint Consent Form documents R95's fingerprints were obtained on 6/30/24. R95's record does not document the Identified Offender Program was notified R95 was admitted to the facility. R95's record does not document the Illinois Sex Offender website was checked.

On 8/22/24 at 8:56 AM, V1 (Administrator) stated R95's fingerprint application was not made within 72 hours of receiving the UCIA background results, the Illinois Sex Offender website was not checked, and the Identified Offender Program was not notified R95 had admitted to the facility.

2. R101's Admission Record, with a print date of 8/26/24, documents R101 was admitted to the facility on 6/20/24, with diagnoses that include myocardial infarction, cocaine abuse, asthma, altered mental status, cognitive communication deficit, and hypertension.

R101's MDS, dated 6/27/24, documents a BIMS score of 03, indicating R101 has a severe cognitive deficit.

R101's current Care Plan documents a Focus area of "(R101) has triggered as identified offender. Date Initiated: 08/13/2024." This Focus area documents interventions initiated 8/13/24 of, "(R101) is to have fingerprint based background check completed... (R101 is to have private room at this time to prevent risk of harm to self or others..."

R101's UCIA results, dated 6/17/24, documents result is in process. R101's record does not document the date a fingerprint application was

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 5	S9999		

made or that the Identified Offender Program was notified R101 resided at the facility.

On 8/22/24 at 8:56 AM, V1 (Administrator) stated R101's fingerprint application was not made within 72 hours of receiving the UCIA background check results and the Identified Offender Program was not notified R95 resided at the facility.

3. R165's Admission Record, with a print date of 8/26/24, documents R165 was admitted to the facility on 8/5/24, with diagnoses that include osteomyelitis, heart failure, hypertension, weakness, and need for assistance with personal care.

R165's MDS, dated 8/12/24, documents a BIMS score of 13, which indicates R165 is cognitively intact.

R165's current Care Plan documents a Focus area of, "(R165) has triggered as an identified offender. Date Initiated: 08/13/24." This Focus area has interventions dated 8/13/24 of, "(R165) is to have a private room at this time to prevent risk of harm to self or others...(R165) is to have fingerprint based background check completed..."

R165's record does not document the Illinois Sex Offender website was checked or the Identified Offender Program was notified R165 resided at the facility.

On 8/22/24 at 8:56 AM, V1 (Administrator) stated the Illinois Sex Offender website was not checked for R165, and the Identified Offender Program was not notified R165 resided at the facility.

(C)

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	IL6008528	A. BUILDING: _____ B. WING _____	08/29/2024

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S9999	Continued From page 6	S9999		

300.610 a)
300.1210 b)
300.1210 c)
300.3240 a)

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 and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

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.

Section 300.3240 Abuse and Neglect

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	IL6008528	A. BUILDING: _____ B. WING _____	08/29/2024

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S9999	Continued From page 7	S9999		

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 are not met as evidenced by:

Based on interview and record review, the facility failed to ensure residents were free from verbal/mental and physical abuse for 1 of 2 (R45) residents reviewed for abuse in the sample of 51. This failure would cause a reasonable person to experience feelings of fear, anxiety, and insecurity while living in their home.

Findings Include:

R45's Admission Record, with a print date of 8/20/24, documents R45 was admitted to the facility on 10/31/19, with diagnoses that include diabetes, dysphagia, osteoarthritis, brief psychotic disorder, delusional disorder, mild cognitive impairment, and depression.

R45's MDS (Minimum Data Set), dated 8/20/24, documents R45 has a BIMS (Brief Interview for Mental Status) score of 10, which indicates a moderate cognitive impairment.

R45's current Care Plan documents a Focus Area of, "Resident is considered at risk for abuse/neglect (per assessment) due to anxiety, dependent on others, pain, displays behaviors, psychiatric hx (history). Date Initiated: 09/16/2021." The interventions documented for this Focus with an initiation date of 9/16/21 are, "Address all complaints/concerns promptly with grievance policy and procedure... Advise resident of rights yearly and PRN (as needed) ... Complete risk for abuse/neglect assessment quarterly....

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	IL6008528	A. BUILDING: _____ B. WING _____	08/29/2024

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

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S9999	Continued From page 8	S9999		

Intervene if observing any resident-on-resident conflict to avoid potential abusive situation...." The interventions for this same Focus area, with an initiation date of 8/19/24 are, "8/16/2204 Daughter educated to inform administrator and/or DON (Director of Nurses) of any unusual comments made by (R45) so an investigation can be conducted to prevent any incidents of verbal or physical abuse by residents or staff...."

R45's Facility Incident Report, dated 8/12/24, documents under Final, "IDT (Interdisciplinary Team) met and reviewed incident. Staff and resident interviews conducted. Visitor reported witnessing a nurse striking (R45) in the face and or mouth area. (R45) denied any nurse or staff member striking her in the face or mouth area. (V49/RN-Registered Nurse) denied striking (R45) at any time. All staff and resident interviews also confirmed that (V49) has not been witnessed striking any resident. (Name of Local Police) was notified of incident. NP (Nurse Practitioner) and POA (Power of Attorney) updated. (R45) feels safe at the building. She has verbalized understanding of what to do if anyone makes her feel unsafe, uncomfortable or threatens her in any way. Her and her daughter will report any incident to staff, who, in turn, will notify the Abuse Prevention Coordinator for immediate investigation. There is insufficient evidence to substantiate abuse. Care Plan updated."

R45's undated Abuse Investigation Summary documents, "Resident Interviews: (R45) 8/13/2024: This writer (V1/Administrator) and (V38, MDS Coordinator) interviewed (R45) together. This writer asked (R45) if any resident or staff member hit her on the face or mouth. She stated no. This writer asked (R45) if she has been hit anywhere on her body. She stated yes

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 _____	08/29/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 9	S9999		

on my head. Asked (R45) to point where on her head. She pointed to the back of the head. Asked (R45) who hit her on the back of the head she stated I don't know her name. Asked her if she works days or nights. She stated nights. Asked her if she knows the staff name. She stated no but she is not very nice. Asked her if her head hurts. She stated no I am ready for dinner now and took to the dinning (sic) room for supper. Employee interviews: (V6/LPN) (not dated): I have never seen a staff member hit a resident on my hall or anywhere in the building. I was not present when this incident was reported. I have seen the alleged staff member be mean or verbally aggressive with (R45). I have never seen her be verbally aggressive toward another resident. (R45) was trying to take other resident belongings and I heard (V49) tell her no do not do that you know better than that get over here and sit down and made her follow her from the start of med pass. Family Interviews if Applicable: (V57/Family Member/Visitor) 8/13/2024 reported to administrator that when she was in her (family members) room (V49) came in and gave meds to her (family members) roommate. When the resident that wanders the hallways with the walker and is constantly going in other resident rooms tried to come into my (family's) room, she heard (V49) tell her to go sit her ass down. Then about 30 minutes later she witnessed (V49) throw her hands up in the air and strike the same resident in the mouth or face area out in the hallway. She said she heard the resident state ouch you hit me. She said I was so shocked by what I saw I thought I would let you know. (V56/Family Member) 8/16/2024. I have never seen anyone mistreat my mom (R45) and she loves living there. She is happy there. (R45) did tell me about a month ago that someone hit her on the back of the head so I asked the CNA

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 _____	08/29/2024

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

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S9999	Continued From page 10	S9999		

(Certified Nursing Assistant) about it, and nobody had ever seen anyone hit her so I started watching and talking to people, but I could never catch anyone, and nobody ever saw anyone hit her. I did not say anything to anyone in the front office or the DON (Director of Nurses) about it because I thought maybe (R45) was confused or telling stories but from now on if she says something strange or does not seem right, I will report it so you can investigate it."

R45's Progress Notes document on 8/13/24 at 5:01 PM, "Note Text: Visitor alleges, that RN was redirecting resident and told resident to 'sit her ass down.' Visitor also alleges that RN hit resident in the mouth. Resident then told RN 'You hit me' without crying and resident was not in pain. RN was suspended pending investigation. Investigation started."

On 08/20/24 at 4:05 PM, V2 (Assistant Director of Nurses) stated a visitor (V57), whose family member had since passed away, said she saw a nurse (V49) hit R45 and told her to 'sit her ass down'. V2 stated this was reported to V1 (Administrator) and the nurse (V49) acted surprised, and said she didn't do it. V2 stated R45 said it happened all the time and described the nurse (V49). V2 stated the nurse had been suspended since the allegation was reported.

On 8/21/24 at 9:58 AM, V57 (Visitor) stated she spent every day at the facility with her family member. V57 stated she was in her family's room one evening with the curtain partially pulled, sitting facing the window. V57 stated it was dark outside, so she could see the reflections of what was happening in the room, in the window. V57 stated a nurse (V49) was giving the roommate

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 _____	08/29/2024

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SHAWNEE SENIOR LIVING	1901 13TH STREET HERRIN, IL 62948

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S9999	Continued From page 11	S9999		

her medications, and a confused resident with dementia (R45) walked into the room. V57 stated she was talking with her son on the phone, and she wasn't really paying attention to what the nurse was saying, until the nurse said to the confused resident (R45) who had wandered into the room "get your ass out of here." V57 stated then she saw the nurse take the back of her hand and pop the resident in the face. V57 stated it was nighttime, and she told V1 (Administrator) about it the next morning. V57 stated she had never witnessed anything like that before. V57 stated when it occurred the confused resident (R45) stated, "you hit me." V57 stated R45 then just left the area.

On 08/20/24 at 4:52 PM, V49 (Registered Nurse/RN) stated she had no answers. When asked if she had ever cursed at a resident, specifically R45, V49 stated, "No ma'am. I don't curse. I have before, a time or two, but I make it a practice not to." When asked if she had ever hit a resident, V49 stated, "One hundred percent absolutely not. I don't even know where or how this could come about."

On 08/21/24 at 8:59 AM, V56 (Family Member) stated R45 was currently in the hospital with a diagnosis of a urinary tract infection. When asked if she was aware of an allegation of abuse, V56 stated, "It wasn't an allegation, it happened." V56 stated a while back (date unknown), R45 reported to her someone had been hitting her in the head. V56 stated she talked with unknown staff, and they didn't know who she was asking about, from R45's description of the person who she reported had hit her. V56 stated since she couldn't find the person R45 described, she kept watching, and V56 stated after the visitor reported R45 had been hit by V49, R45 told V1 (Administrator) it

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 _____	08/29/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 12	S9999		

was the same nurse who hit her before. V56 stated from now on, if R45 tells her someone is hitting her, she will assume that it is happening. V56 stated V1 assured her V49 wouldn't be back to work. V56 stated there was no physical injury, but R45 was distraught when she was telling her about it. V56 stated, "Who wants to get hit in the head?" V56 stated she felt bad because a part of her didn't believe R45 when she first reported it. V56 stated R45 had to go through it, and no one was doing anything about it. V56 stated it was upsetting for R45 because she was getting hit in the head. V56 stated she was not notified of the incident until the next day, and when she asked the unknown male nurse why they waited to notify her, she was told they had to do whatever they had to do before they called.

On 8/21/24 at 9:15 AM, V6 (LPN/Licensed Practical Nurse) stated she didn't work with V49, and the only thing she witnessed was one day when V49 was coming in to relieve her, R45 was walking by. V6 stated V49 raised her voice and said, "No don't walk that way." V6 stated she didn't like the way V49 talked to R45, but she didn't think it was abusive. V6 stated after the allegation was made and V49 was suspended, she found out that Certified Nursing Assistants said V49 made R45 follow her around during medication pass, and made R45 sit with her at the nurses station.

On 8/22/24 at 1:30 PM, V8 (CNA/Certified Nursing Assistant) stated V49 was rough and hateful, but she didn't think it was abuse.

On 8/24/24 at 11:25 PM, V59 (CNA) stated V49 was stern, but she was good with the residents, and she had never witnessed abuse. V59 stated if she had, she would notify V1 immediately.

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 _____	08/29/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 13	S9999		

On 8/24/24 at 11:37 PM, V60 (CNA) stated she had worked with V49, and she was a little rude or pushy when R45 was non-compliant, going in and out of other resident rooms. V60 stated V49 would reprimand R45 and was a little loud with it, but didn't yell. V60 stated R45 had never reported abuse, but awhile back V56 (Family Member) said something to her about someone being rude to R45, but they didn't think anything of it.

On 8/21/24 at 10:43 AM, when asked why the allegation wasn't substantiated, V1 (Administrator) stated she talked to multiple staff, R45, and V57 (Visitor), who told V1 she witnessed V49 smacking R45 in the face/mouth area and heard R45 say "Ow you hit me." V1 stated when she interviewed V49, other staff, and R45, they all denied it. V1 stated R45 denied being hit in the face, but did say she had been hit in the back of the head before. V1 stated V56 (Family Member) stated at some time, maybe a month ago, R45 told V56 someone hit her in the back of the head, and they suspect it was V49. V1 stated V56 couldn't substantiate it had occurred, and thought R45 was confused. When asked how she was not substantiating the allegation of abuse when there was someone who witnessed the abuse, V1 stated an employee who works here is related to V57 (Visitor), and said V57 makes false allegations. V1 stated, "So even though (V57) said she witnessed it, since (R45) stated she was hit in the back of the head instead of in the face, I can't substantiate it." V1 stated R45 did confirm being hit in the head at some point by V49, so they are still terminating the nurse and reporting it to the Department of Professional Regulation.

The facility Abuse Policy, dated 10/2022,

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 _____	08/29/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 14	S9999		

documents, "This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff and mistreatment of residents.

(B)

4 of 7

300.610 a)
300.1210 b)
300.1210 c)
300.1210 d)1)
300.1210 d)2)
300.1210 d)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.

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 _____	08/29/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 15	S9999		

The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

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:

1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.

2) All treatments and procedures shall be administered as ordered by the physician.

3) Objective observations of changes in a resident's condition, including mental and 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.

These requirements are not met as evidenced by:

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 _____	08/29/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 16	S9999		

Based on interview, observation, and record review, the facility failed to provide medications and treatments as ordered by a physician, failed to document reassessments, and evaluate residents for advanced treatment needs for 3 (R63, R68, R100) of 3 residents reviewed for quality of care in a sample of 51. This failure resulted in R63 missing medication for approximately 30 days, suffering shortness of breath, and being admitted to the hospital for three days.

Findings include:

1. R63's Face sheet documents an admission date of 03/07/24, with diagnoses including: chronic obstructive pulmonary disease (COPD), non-st elevation myocardial infarction, essential hypertension, dementia, anxiety disorder, atrial fibrillation, and type 2 diabetes mellitus.

R63's current Care plan includes a focus area of: R63 has COPD r/t (related to) smoking: with an intervention dated: 07/01/24 of: give aerosol or bronchodilators as ordered. Monitor/document any side effects and effectiveness.

R63's Order summery sheet, dated 06/06/24, documents medications were discontinued with a line drawn through them; Lasix oral tablet 40 MG (Furosemide), give 1 tablet by mouth in the morning for edema, does not have a line drawn through it. This indicates the Lasix should have been continued.

R63's Medication Administration Record (MAR), dated June 2024, documents: Lasix oral tablet 40 MG (Furosemide) give 1 tablet by mouth in the morning for edema, with a start date of 03/08/2024 at 8:00 AM, and a D/C (discontinued)

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 _____	08/29/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 17	S9999		

dated of 06/06/2024 at 3:05 PM. The MAR, dated June 2024, documents the Lasix was not administered after 06/06/24.

The facility document titled, "eINTERACT Change in Condition Evaluation", dated 06/30/24 at 2:29 PM, documents: A. Signs & Symptoms Identified ...abnormal vital signs and shortness of breath checked. 2. This started on: 06/30/24 3. What time of day did this start? with afternoon marked ... blood pressure: 122/68 ...pulse: 88 (bpm) (beats per minute) date: 06/30/2024 14:32 (2:32 PM) pulse type: irregular - chronic ... 7. Most recent O2 (oxygen) sats (saturations): 96% date: 06/30/2024 14:31 (2:31 PM) method: oxygen via nasal cannula .... List any medication changes made in the past week: d/c (discontinued) from hospice and Lasix ... 2a. describe respiratory changes; shortness of breath is marked, 2a1a. describe shortness of breath; with abrupt onset of SOB (shortness of breath) with pain, fever, or respiratory distress ...3a. describe cardiovascular changes: with edema marked ... describe cardiovascular signs/symptoms: increased swelling of bilateral lower extremities ....Since the change in condition occurred have the symptoms or signs gotten: with 'better' marked, 1b. things that make the condition or symptoms better are: with 'applied oxygen' written in, 2. This condition, symptom or sign has occurred before: with 'yes' marked, 2a. treatment for the last episode: with 'duoneb and rescue inhaler' written in, 4. Summarize your observations, evaluation and recommendations: with 'contacted on call provider and received VO (verbal order) for duoneb q (quaque (every) 6' written in ... Were the change in condition and notifications reported to primary care clinician: with 'yes' marked, 2. Date and time of clinician notification: with '06/30/2024 at 14:31 (2:31 PM) noted, 3.

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 _____	08/29/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 18	S9999		

Recommendation of primary clinician: with 'follow up with primary provider tomorrow, call if condition becomes worse or does not improve, 5. Interventions: with 'new or change in medications' and 'oxygen' marked.

R63's progress note, dated 06/30/24 at 2:31 PM, documents a pulse oximetry of 96%, method: oxygen via nasal cannula.

R63's Physician order sheet documents an ordered date of 06/30/24 for ipratropium-albuterol 0.5 - 2.5 (3) MG/3ML solution with a status of 'on hand' documented with a start date of 07/08/2024, with no documentation of any administration of this medication.

R63's order audit report documents an order for ipramtropium-albuterol 0.5 - 2.5 (3) mg/3ml, with the box next to 'confirmed' checked with a date of 06/30/24 at 2:28 PM noted.

R63's oxygen saturation (SPO2) percentages are documented from 04/01/24 - 05/09/24 to be 96% or greater on room air. On 05/10/24 the SPO2 at 8:25 AM is documented to be 94% with oxygen via nasal cannula. On 05/27/24, 06/03/24+, 06/10/24, 06/17/24, and 06/24/24 have SPO2 of 96% or greater on room air documented. On 06/30/24 at 2:31 PM a SPO2 of 96% on oxygen via nasal cannula is documented. On 07/01/2024 at 11:15 PM a SPO2 of 96% on room air was documented. On 07/08/24 at 4:41 PM a SPO2 of 96% on oxygen via nasal cannula and 07/08/2024 at 8:52 PM a SPO2 of 96% on oxygen via nasal cannula is documented On 07/15/24 at 8:11 PM a SPO2 of 96% with oxygen via nasal cannula is documented. There are no SPO2s documented for 07/02, 07/03, 07/04, or 07/05/2024.

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 _____	08/29/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 19	S9999		

A facility document for R63, dated 6/30/24, documents under "problem/request", "resident (R63) feet swollen family and resident request examination." This document is addressed to V5 (Nurse Practitioner/NP) with the response of: CBC (complete blood count), CMP (comprehensive metabolic panel), mag (magnesium), and Hgba1c (hemoglobin A 1 C) and Lasix 20 mg PO (per os (by mouth)) from V5, with the date of 07/01/24 noted.

A facility document for R63, dated 07/03/24, documents: patient: (R63) date: 07/03/24, "problem/request: SOB (short of breath) feeling bad. She (R63) was wearing 3L O2 (oxygen) & sating (saturating) @ 71%. Bumped her (R63) up to 5L but still not feeling well", with a response from V5 of chest x-ray and UA (urinary analysis) noted on the page. At the bottom of the page there is a not written in parentheses: Pt (patient) family took her to (local town) ER (emergency room) and was admitted.

R63's progress note, dated 07/03/24 at 2:04 PM, documents: (local hospital lab) called, Res (R63) CO2 (carbon dioxide) is 42. V5 notified. No new orders at this time.

R65's hospital records, dated 07/05/24 at 2:44 PM, document: "Physical exam: constitutional: general: she (R63) is not in acute distress; appearance: she is not ill-appearing; Pulmonary: breath sounds: rales present, no wheezing; Abdominal: general: there is no distension. Review of Systems: Respiratory: positive for shortness of breath, negative for cough. Cardiovascular: positive for leg swelling, negative for chest pain and palpitations. Medical Decision Making: 64 y.o. (year old) female presents to the ER as described. Admit for COPD exacerbation

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 _____	08/29/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 20	S9999		

and volume overload. Clinical Impression: as of 07/05/24 at 7:50 PM: pneumonia of lower lobe due to infectious organism, unspecified laterality, COPD exacerbation, and acute pulmonary edema. Chief complaint patient presents with: shortness of breath. R65 is a 64 year old female with pmh of COPD on 4 L O2, memory loss nursing home resident presented in ED (emergency department) for worsening sob, weight gain, leg swelling for last weeks. Recently she was admitted for cardiac arrest, was discharged to nursing home with hospice care, however patient/family declined hospice two weeks ago. Was not on Lasix for two weeks, however started on Monday. At 6:47 PM Review of Systems: No intake/output data recorded. I/O (input/output) this shift: In 300 (IV piggyback:300) out: -. Physical exam: Pulmonary: breath sounds: wheezing present. Abdominal: general: there is distension, musculoskeletal: right lower leg: edema present. Left lower leg: edema present. Laboratory results: collection time: 07/05/24 at 3:16 PM Carbon dioxide 45 (HH) reference range: 21-31 mmol/L (millimoles/liter), blood urea nitrogen 28 (H) reference range: 7 - 25 mg/dl (milligrams/deciliter), creatinine 1.50 (H) reference range 0.60 - 1.30 mg/dl, X-ray chest 1 view result date 07/05/24: impression: Bibasilar atelectasis or pneumonia. Intake/output summary (last 24 hours) at 07/06/2024 at 11:45 AM: gross per 24 hour: intake 700 ml output 600 ml net 100 ml. Physical exam: Respiratory: Lungs are diminished to auscultation bilaterally. Respiratory effort is normal. No accessory muscle use. Results from last 7 days: BNP B (B-type natriuretic peptide) 07/05/24 at 3:16 PM - 375 pg/ml (picogram/milliliters) and 07/05/24 at 10:24 PM 281 pg/ml. Current facility administered medications: arformoterol-budesonide 15mcg - 0.5 mg combo (combination) neb (nebulizer) BID

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 _____	08/29/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 21	S9999		

(bis in die (twice a day)) on 07/06/24 at 7:35 AM, carvedilol tablet 3.125mg BID 07/06/24 at 9:43 AM. Furosemide (Lasix) injection 80 mg BID 07/06/24 at 9:59 AM prednisone tablet 50mg daily on 07/06/24 at 9:43 AM, and spironolactone tablet 25 mg daily at 07/06/24 at 9:43 AM. On 07/06/24 at 6:13 PM patient presents with: shortness of breath; subjective : sob better, objective: hypervolemic. I/O this shift: in 241 out: 1200. Physical exam: Pulmonary: breath sounds: wheezing present. Abdominal: general: there is distension, musculoskeletal: right lower leg: edema present. Left lower leg: edema present. Intake/output summary (last 24 hours) at 07/07/2024 at 10:44 AM gross per 24 hour: intake 799.43 ml, output 3100ml net -2300.57 ml. Physical exam: Neck: supple, mild but improved JVD (jugular vein distention) is present, Respiratory: lungs are diminished to auscultation bilaterally, respiratory effort s normal. There is no accessory muscle use. On 07/07/24 at 9:40 PM I/O last 3 completed shifts: in: 1479.4 out 4375. Intake/output summary (last 24 hours) at 07/08/2024 at 11:32 AM, gross per 24 hour: intake 1388 ml, output 1975 ml net -587ml. On 07/08/24 at 11:31 AM progress notes document: assessment: principle problem: pneumonia of lower lobe due to infectious organism, unspecified laterality. Assessment & plan: 1. Acute on chronic heart failure with preserved ejection fraction-appears well compensated on exam. Will decrease Lasix to 20 mg daily which should be continued at discharge, continue spironolactone 25 mg daily, low sodium diet and daily weights. 2. Acute on chronic hypoxic hypoxic respiratory failure secondary to COPD. 3. AKI (acute kidney injury) is improving, creatinine is 1.6 today. R65's hospital discharge summary dated 07/08/24 at 12:09 PM documents: primary discharge diagnosis: pneumonia of lower lobe

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 _____	08/29/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 22	S9999		

due to infectious organism, unspecified laterality and heart failure exacerbation (probably right heart)."

On 08/14/24 at 2:15 PM, V6 (LPN) stated if she had a resident that had a 71% SPO2, she would get a hold of V5 (Nurse Practitioner/NP) after she bumped up the oxygen, and see if she wanted the resident sent out. When R63 had the SPO2 of 71%, she contacted V5, and she gave an order for an in house x-ray on 07/03/24. "The company that does the in-house x-ray is supposed to be same day, but now they are taking 2 to 3 days to get to the facility. (V5) is aware of the x-rays taking that long to be done. Usually, (R63's) oxygen will come back up. All the SPO2 levels are documented on the MAR."

On 08/15/24 at 10:18 AM, V24 (family) stated she took R63 out to the ER (Emergency Room) on 07/05/24. V24 stated she came to visit and R63 was struggling to breathe; she had more shortness of breath than usual, she was a grayish color, and her feet were so swollen they would not fit into her shoes, and she has loose fitting sandals. A CNA (Certified Nurse Assistant) asked if she wanted R63 to see V5 because she was in the building, but she stated, no, she thought she needed to go to the hospital. V5 had not done anything yet, and R63 was having problems. V24 stated R63 came to the facility after being in the hospital with pneumonia and edema. It was the hospital that she was in prior to this facility that identified the heart concerns and gave her Lasix. She does not understand why they discontinued her Lasix. Then when they prescribed the Lasix again around the beginning of July, it was at half the dose she was on.

On 08/15/24 at 12:58 PM, V6 (Licensed Practical

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 _____	08/29/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 23	S9999		

Nurse/LPN) stated when V5 (Nurse Practitioner) gave the new orders after R63 was discontinued from hospice, she believes that could be when the Lasix was discontinued. She would not have been given a reason why it was discontinued. She is not sure how to look for the old orders, so that would just be her guess.

On 08/19/24 at 2:12 PM, V47 (LPN) stated she can see where the order for Ipramtropium-albuterol was put in on 06/30/24, but it is not on the MAR for June, and she does not see where she received any in July, but the start date was 07/08/24.

On 08/19/24 at 2:13 PM, V6 stated she has Ipramtropium-albuterol on the cart. She does not remember ever giving R63 the medication. V6 stated she can see the order from 06/30/24, but it is not on the June MAR. She does see the order on the July MAR, and the start date is 07/08/24. She believes it has a start date that is different than expected because the order was not confirmed; the order will not show up on the MAR until the order is confirmed.

On 08/15/24 at 4:15 PM, V1 (Administrator) stated, "From looking at (R63's) order sheet from when her hospice medications were discontinued, it appears the medications that were discontinued have a line through them. The Lasix order does not have a line through it, so following the pattern I see, I do not know why the Lasix order was discontinued; it does not appear it should have been."

On 08/19/24 at 1:22 PM, V8 (CNA) stated she "kind of" remembers R63 in that timeframe before she went out to the hospital; she remembers her looking grayish.

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 _____	08/29/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 24	S9999		

On 08/19/24 at 2:16 PM, V1 (Administrator) stated, "If we had a resident that had a low oxygen saturation rate and her oxygen was increased and she was still feeling bad, especially at 71%, I would expect they would be sent out." V1 stated she would expect if an order for a chest x-ray was put in, stat, it would be done in 4 to 6 hours; a standard x-ray would be a day or two, so it would depend on the way the x-ray was ordered. V1 stated she does not know why the start date for the duoneb is not 06/30 for R63.

On 08/20/24 at 3:35 PM, V5, Nurse Practitioner, stated she does not know anything about R63's Lasix being discontinued, or why it would be. She did not discontinue R63's medications after she was discontinued from hospice care, that would be V48 (Physician). V5 stated she did not get notified of R63 having a SPO2 of 71%; they could have notified the Nurse Practitioner on call. V5 stated she did not give the order for ipratropium-albuterol; it must have been one of the Nurse Practitioners on call.

On 08/21/24 at 10:10 AM, V35 (Licensed Practical Nurse/LPN) stated she worked on 06/30/24. She stated someone came and got her from the dining room and told her, "it's an emergency". She assessed R63, who was a gray blue color. V35 stated she took her SPO2 (oxygen level) and it was 88% with no oxygen. "(R63) has COPD (Chronic Obstructive Pulmonary Disease); she has oxygen and a nebulizer in her room. V35 had an order for the duoneb (nebulizer treatment) before, so I called (V5) to get an order for the medication and gave it to her. If her SPO2 did not come up right away, I would have sent her out."

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 _____	08/29/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 25	S9999		

On 08/21/24 at 1:26 PM, V48 (Physician) stated he does not have any notes from the end of May to July. Nothing in his notes is indicating that he discontinued the Lasix after R63 came off of hospice care. V48 stated, "I am looking at her hospital notes and her creatinine was up a bit, but not bad, her CO2 runs in the high 30s typically with her history of smoking and COPD, so a CO2 of 42 would not be that alarming. (R63) does not have great kidney function, so we have to watch how much Lasix (R63) is given. I did not realize in house x-rays took that long, most of my facilities can get an x-ray on the same day, or at the latest the next morning. If I was only given the information of: a resident's oxygen saturation was 71% with 3 L of oxygen and it was raised to 5 L and the resident was still feeling bad, I would say they should have been sent out, without having any follow up oxygen saturations or information on status."

On 08/21/24 at 1:40 PM, V2 (Assistant Director of Nursing/ADON) stated he would expect if the nurses had a resident that had a low oxygen saturation to apply oxygen or increase oxygen, and contact the Nurse Practitioner. V2 stated if the condition persists, he would expect the nurse to call 911. He would expect if the Nurse Practitioner was contacted, staff would document that they were contacted and what the response was. In the situation with R63, he would expect that a Nurse Practitioner would have been contacted, but he would not know that for sure without a progress note.

On 08/21/24 at 3:25PM, V6 stated she did notify V5 via text message on 07/03/24 of R63's oxygen level. V6 stated V5 did respond back later to her, and ordered a chest x-ray. V6 stated V5 never ordered for a recheck of R63 oxygen saturation.

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 _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 26	S9999		

V6 stated she was working two halls on that day and didn't have a lot of time. V6 stated she did check on R63, but didn't chart it, because she didn't have time, was short of staff, and was working two halls. V6 stated she put a late entry in today regarding R63 on 07/03/24. V6 stated she didn't have proof on her phone of the text message. V6 stated she erases all her messages daily.

2. R68's face sheet documents R68 was admitted to the facility on 12/21/24, with diagnoses that include: unilateral primary osteoarthritis, left knee, pain in right knee, unspecified injury of right lower leg, sequela, polyneuropathy, morbid (severe) obesity due to excess calories, and unspecified abnormalities of gait and mobility.

R68's MDS (Minimum Data Set), dated 5/01/2024, documents a BIMS (Brief interview for Mental Status) score of 15, indicating R68 is cognitively intact. Section GG-Functional Abilities and Goals documents V68 is dependent on staff for toileting hygiene, showering, and bathing. V68 is listed as partial/moderate assist for personal hygiene.

R68's current Care Plan documents Care Areas of: R68 has skin impairment with risk for pressure injury development related to: Immobility. R68's interventions include: Administer treatments as ordered, monitor for effectiveness. Assess/record/monitor wound healing weekly. Measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Monitor for infection. Report improvements and declines to the MD. Needs assistance to turn/reposition approximately every 2 hours, more often as needed or requested.

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 _____	08/29/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 27	S9999		

A document in R68's medical record, dated 07/18/2024, titled "Specialty Physician Wound Evaluation & Management Summary", documents a skin tear to the right thigh and a rash to the right thigh. The wound to the right thigh was described as a skin tear, a surgical excisional debridement procedure was performed, and the following dressing treatment plan was ordered: Primary Dressing(s)-Alginate calcium apply once daily for 30 days; Collagen powder apply once daily for 30 days; Silver sulfadiazine, apply once daily for 30 days. Secondary Dressing(s)-Gauze Island with boarder apply once daily for 30 days. The rash to the right leg was diagnoses as Candidiasis rash of the right leg. The following treatment plan was ordered. Fluconazole 150mg orally. Repeat dose in 7 days, clotrimazole 1% as directed.

A document in R68's medical record, dated 07/25/2024, titled "Specialty Physician Wound Evaluation & Management Summary", documents a follow up for wound to the right thigh. It further documents the wound is resolved. There is no mention anywhere on this document about the rash to the right leg.

R68's July Medication Administration Record (MAR) and the Physician's Order Sheet reveals the order for Fluconazole 150mg orally. Repeat dose in 7 days was not started or administered to R68.

R68's July Treatment Administration Record (TAR) and Physician's Order Sheet reveals the order for the treatment to the skin tear to the right thigh and rash was not started or administered to R68.

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 _____	08/29/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 28	S9999		

R68's shower sheets document she received a shower on 07/18/24, when areas of skin alteration were noted. R68 received a shower or bed bath on 07/22, 07/25, 08/01 and 08/12, and no areas of skin alteration were noted.

On 08/13/2024 at 12:45 PM, V3 (LPN/Infection Prevention Nurse) stated V2 (Assistant Director of Nursing/ADON) takes care of wound rounds. V3 stated R68 last treatment orders that ended on 06/13/2024; her only current order was for Nystatin powder. V3 stated it would be her expectation the staff that receives these orders to put them in and start them. V3 stated she would immediately assess V68's skin today, and contact the doctor if there were any concerns.

On 08/14/24 at 12:00 PM, V37 (Certified Nurse's Assistant/CNA) was providing incontinence care for R68. An area was observed on R69's right hip that was scabbed over with brown/red eschar; no signs of infection noted on surrounding tissue. R68 stated she wasn't sure how it got there, and then said she thought she got it from her wheelchair. R68 asked V37 to please wipe the area on her leg because some people forget to clean it when they provide care, and it burns. V37 lifted R68's right leg into the air and used a wipe to wipe what appeared to be a macerated/abrased area on upper inner thigh area. R68 stated staff aren't doing any current treatments to the area on her right leg, it has been there 3-4 weeks and the nurses were putting some kind of cream and a band aid on it at one time. R68 was not sure what the actual treatment was or exact dates of the treatment.

On 08/20/2024 at 1:42 PM, V1 (Administrator) stated it is the responsibility of the DON (Director of Nursing) or ADON (Assistant Director of

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 _____	08/29/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 29	S9999		

Nursing) in the DON'S absence to follow up on wound rounds and orders. V2 stated it is also the responsibility of all the nurses; the wound doctor informs the floor nurses of what the plan of care is.

3. R100's Face Sheet documents an admission date of 06/18/24, with diagnoses of UTI (Urinary Tract infection), Enterocolitis due to clostridium difficile, type 2 diabetes mellitus, and neuromuscular dysfunction of the bladder.

R100's Minimum Data Set (MDS), dated 06/25/24, documents a BIMS (Brief Interview for Mental Status) score of 15, which indicates R100 is cognitively intact. R100's MDS also documents substantial/maximal assist with toileting, showers, and dressing.

R100's Care Plan, dated 06/19/24, documents a Focus area of a foley catheter related to: urinary retention, neurogenic bladder. Interventions include in part, monitor/record/report to MD (Medical Doctor) for s/sx (signs and symptoms): pain, burning blood tinge urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp (temperature), urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, or change in eating pattern. There is no care plan related to history or risk of Urinary Tract Infections.

R100's local hospital discharge summary documents an admission date of 08/02/24, and a discharge date of 08/07/24, which documented in part under "Active Issues requiring Follow-up" Jardiance stopped due to fungal UTI (Urinary Tract Infection)/chronic foley. Hospital course documented R100 also had leukocytosis, Candida UTI, foley catheter exchange following

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 _____	08/29/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 30	S9999		

admission. Home Jardiance discontinued. Treat with oral fluconazole. Under "Discharge Medications" the following is new medications are documented: Fluconazole 200 mg (milligrams), oral, daily, for Candida UTI: Quantity 11 tablets and Vancomycin 125 mg capsules 1 capsule two times a day orally, every 6 hours scheduled: Quantity 28 capsules. Stopped medications: Jardiance 25mg tablets.

R100's current Physician Orders documents no fluconazole order. On 08/10/24, a new order was documented for Jardiance oral tablet 25mg give 1 tablet by mouth in the morning for DM (Diabetes Mellitus).

On 08/14/24 at 12:10 PM, V4 (Licensed Practical Nurse/LPN) stated R100 was not on fluconazole and he was never started on it when he came back from the hospital on 08/07/24. V4 said the Jardiance was stopped on return from the hospital, but was restarted on 08/10/24. V4 said there was no note in the progress notes to say why the Jardiance was restarted.

On 08/14/24 at 12:43PM, V3 (Infection Preventionist) stated since she looked at the discharge summary today, she noticed R100 did have an order for fluconazole, and an order to stop the Jardiance. V3 said V4 (Licensed Practical Nurse/LPN) told her R100 had orders that didn't get transferred over when he returned on 08/07/24. V3 stated R100 should have been started on fluconazole for his UTI. V3 said it does say to stop the Jardiance related to the UTI. V3 stated it was stopped on 08/07/24, but was restarted on 08/10/24. V3 stated she does not know why the Jardiance was restarted. V3 said there is no progress notes stating why the Jardiance was restarted. V3 said she would have

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 _____	08/29/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 31	S9999		

expected a progress note stating why the Jardiance was restarted. V3 stated R100 was in the hospital for a UTI from 08/02/24, until returning on 08/07/24. V3 stated she doesn't know why they missed the other orders because they did start the vancomycin that was ordered on the discharge summary. V3 stated because they did not start the fluconazole for R100, which was ordered for his urinary tract infection, it could have caused problems or even harm to R100, because he did not get the treatment for his UTI as ordered. V3 stated she was going to call V5 (Nurse Practitioner) to see what she wanted the facility to do, since they missed the new order from the hospital for fluconazole for R100's UTI.

R100's Progress notes, dated 08/14/24 at 1:34 PM, documented, "New order per V5. UA (Urinalysis) with culture if indicated. R100 agrees with new orders.

R100's Urinalysis with Culture collected on 08/15/24. The Final Report, completed on 08/18/24, documented urine culture with Mixed Urogenital Flora. V5 (Nurse Practitioner) signed off on Urinalysis with culture on 08/19/24 with no new orders.

On 08/20/24 at 1:40 PM, V48 (Medical Doctor) said, "(R100) is in pretty bad shape. I was not aware that the facility did not follow the discharge instructions to start fluconazole for (R100's) UTI and to discontinue Jardiance. (R100) should have been started on the fluconazole when he returned from the hospital. I don't know why (R100) did not start the fluconazole. The medication would have been beneficial to treat (R100's) Urinary Tract Infection. I did see that the facility did a Urinalysis with culture for (R100) on 08/15/24. The final culture of the urinalysis and the results showed

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 _____	08/29/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 32	S9999		

Mixed urogenital flora." V48 said he does agree no treatment is needed at this time related to the current urine culture. V48 said he saw on the hospital discharge they wanted to stop the medication Jardiance. V48 said he understands why the hospital would have wanted that medication stopped, because it removes the glucose from your body in your urine. V48 said the Jardiance should have been stopped until the urinary tract infection was resolved, then re-started, because Jardiance has a lot of other benefits such as cardiac benefits. V48 said he is glad R100 was restarted back on Jardiance, but it should have been at a later time. V48 said he agrees with the Nurse Practitioner starting him back on Jardiance. V48 said the vancomycin would not have altered the culture results of the urinalysis.

On 08/20/24 at 3:52PM, V5 (Nurse Practitioner) said she was made aware of the order for fluconazole on 08/15/24, when one of the nurses told her the order got missed from the 08/07/24 discharge summary. V5 said she ordered a urinalysis to be done on 08/15/24 to see if R100 still had a UTI, and if he still needed the fluconazole or another medication. V5 stated the fluconazole should have been given as ordered from the hospital, but the nursing staff missed it. V5 said R100 needed the fluconazole for his UTI. V5 said when she found out R100 didn't get the fluconazole, they did a repeat UA with Culture, if indicated. V5 said they did get the urine back with the final culture and it showed Mixed urogenital flora. V5 said she did not order for R100 to have any new medication. V5 said the UTI did clear up. V5 said she did restart the Jardiance on 08/10/24. V5 said she wasn't made aware the reason the Jardiance was stopped, but she believes he needed the Jardiance for its other benefits. V5

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 _____	08/29/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 33	S9999		

said she wasn't given the full (hospital) discharge summary when R100 got back to the facility to know they stopped the Jardiance related to his Urinary Tract Infection. V5 said since R100's UTI is cleared, she would prefer that R100 continue the Jardiance.

The facility policy titled "Admissions to the Facility", revised 12/2006, documents the following under Physician Admission Orders: Prior to or at the time of admission, the resident's attending physician must provide the facility with information needed for the immediate care of the resident, including orders covering at least, B. Medication orders, including (as necessary) a medical condition or problem with each medication.

4. R100's Care Plan, dated 06/19/24, with a Focus area of, "(R100) has altered skin integrity and/or risk for pressure injury development related to disease process impaired mobility, weakness". Interventions for this focus area include in part: Weekly skin check. Notify nurse immediately of any new areas of skin breakdown: redness, blisters, bruises, or discoloration noted during bathing or daily care.

R100's Progress notes document on 08/05/24 at 6:38AM, R100 is currently in the hospital. Progress note, dated 08/07/24 at 7:15PM, documents R100 returned from hospital. No skin assessment was noted on readmission from the hospital in R100's progress notes.

R100's Specialty Physician Wound Evaluation and Management Summary, dated 08/08/24, documents under "History" chief complaint, "(R100) has wounds on his sacrum, right groin, left foot, right elbow, left hand, right dorsal hand,

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 _____	08/29/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 34	S9999		

right foot. At the request of the referring provider. A thorough wound care assessment and evaluation was performed today."

On 08/15/24 at 11:30 AM, V21(Licensed Practical Nurse/LPN) and V41(LPN) were performing treatments to R100, when V21 stated all treatments were completed. Three dressings were noted to R100's left upper mid back that appeared older with exudate on them. V21 stated she was not aware of any treatment to R100's left upper mid back. V21 removed all three dressings, which had exudate on the dressings. All three dressings were dated 08/06/24, with no initials. V21 said she was not aware of any open areas to left mid upper back. V21 stated R100 does not have any treatment to those areas.

R100's Physician Orders documents a order on 06/18/24 Skin checks every day shift every Mon (Monday), Thu (Thursday). An order, dated 06/18/24, skin assessment on shower days every day shift every Mon, Thu. No treatment order for upper left back was noted in Physician orders.

R100's Bath and Skin Report Sheet for August 2024 documents on 08/08/24, a bed bath was given, with no new skin areas documented. 08/15/24 Bed bath documented with no new skin areas documented.

On 08/20/24 at 1:06 PM, V21 stated after she discovered the three areas to R100's left upper mid back, she did call the wound doctor. V21 stated the wound doctor said he would come in and look at the new areas and decide what treatment is needed, if any. V21 said the wound doctor is aware R100 has a diagnosis of bullous pemphigoid. V21 said R100 gets blisters often. V21 said the wound care doctor did come in and

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 _____	08/29/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 35	S9999		

evaluate the three areas to R100's left upper mid back, and did not want treatment started at this time, because the areas were drying up.

The facility policy titled "Pressure Ulcers/Skin Breakdown", dated 8/2008, documents the nurse shall assess and document/report the following: Full assessment of skin condition including but not limited to location, stage or partial/full thickness, length, width, and depth, presence of exudates or necrotic tissue.

(A)

5 of 7

300.610 a)
300.1210 b)
300.1210 c)
300.2900 d)2)

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 and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

Section 300.1210 General Requirements for Nursing and Personal Care

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 _____	08/29/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 36	S9999		

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.

Section 300.2900 General Building Requirements
d) Doors and Windows
2) All exterior doors shall be equipped with a signal that will alert the staff if a resident leaves the building. Any exterior door that is supervised during certain periods may have a disconnect device for part-time use. If there is constant 24 hour a day supervision of the door, a signal is not required.

These requirements are not met as evidenced by:

Based on interview and record review, the facility failed to ensure residents assessed as being at risk for elopement were supervised and interventions were implemented to prevent elopement for 2 of 3 (R96 and R162) residents reviewed for accidents and supervision in the sample of 51. This failure resulted in R96, who had a history of elopement, and was assessed as being at risk of elopement, exiting the facility when a visitor entered, without staff knowledge, walking half the length of the facility and re-entering through the kitchen door that is located at the end of the facility, and R162 exiting

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 _____	08/29/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 37	S9999		

the facility through a window, crossing a busy highway, and walking approximately 1.3 miles without staff knowledge.

Findings Include:

1. R96's Admission Record, with a print date of 8/16/24, documents R96 was admitted to the facility on 6/12/24, with diagnoses that include dementia, anxiety disorder, weakness, cognitive communication deficit, conduct disorder, delirium, major depressive disorder, and insomnia.

R96's MDS (Minimum Data Set), dated 7/12/24, documents a BIMS (Brief Interview for Mental Status) score of 04, which indicates a severe cognitive deficit.

R96's current Care Plan documents a Focus area of, "Is an elopement risk/wanderer related to: Disoriented to place, History of attempts to leave facility unattended, Impaired safety awareness. Date Initiated: 07/01/2024." This Focus area documents the following interventions: "(electronic monitoring device) (wandering) management system at all times. Date Initiated: 07/01/2024 .Resident to be seen by Geri-psych (geriatric psychiatry). Date Initiated: 07/31/2024. Psych NP (Psychiatric Nurse Practitioner) to do med review (medication review) and medication adjustment one on one care till (until) able to rest and sleep. Date Initiated: 07/15/2024.Initiate monitoring of change of behaviors after family visits. Date Initiated: 07/18/2024. Implement one to one observation anytime resident begins wandering hallways, displaying anxiety after family visits and attempts exit seeking. Date Initiated 07/16/24. Front door to remain locked, and sign posted for visitors to ring doorbell and

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 _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 38	S9999		

visitors can now only enter with staff assistance. Date Initiated: 08/08/24. Sign to be posted at front and back entrance for all staff and visitors to look behind them before opening door and re-direct (R96) away from doorway before entering or exiting. Date Initiated: 08/08/2024.Check (electronic monitoring device) battery function weekly and PRN (as needed). Date Initiated: 07/01/2024.Check (electronic monitoring device) placement every shift and PRN (as needed). Date Initiated: 07/01/2024. Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Date Initiated: 07/01/2024.Monitor for fatigue and weight loss. Date Initiated: 07/01/2024.Offer a warmed blanket. Date Initiated: 07/01/2024.Offer reassurance appropriate to the concern. Dated Initiated: 07/01/2024. Offer to take to a scheduled or planned activity. Date Initiated: 07/01/2024.Offer to take to the toilet or assist with continence care. Date Initiated: 07/01/2024. Provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures, and memory boxes. Date Initiated: 07/01/2024 .Redirect resident when wandering or exit seeking. Date Initiated: 07/01/2024. Resident is to be one on one anytime the resident starts to wander, and exit seek. Resident is to remain one on one until behavior resolves. One on One is to be implemented every time this behavior occurs. Date Initiated: 8/15/2024. Return to bed for additional rest or comfort. Date Initiated: 07/01/2024. Scan (electronic monitoring device) every shift for battery percentage, ensure placement and skin integrity. Location: LLE (left lower extremity). Date Initiated 08/05/2024. Use distraction to change thought pattern. Date Initiated: 07/01/2024."

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 _____	08/29/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 39	S9999		

R96's Elopement Evaluation, dated 7/10/24, documents a score of 04, indicating R96 is at risk of elopement.

R96's Elopement Evaluation, dated 8/6/24, documents a score of 08, which indicates R96 is at risk of elopement.

R96's Elopement Evaluation, dated 8/14/24, documents a score of 09, which indicates R96 is at risk of elopement.

R96's Progress Notes, dated 8/3/24, documents, "(V21, LPN/Licensed Practical Nurse) advises resident had left the building and no alarm sounded. Found the (electronic monitoring device) was malfunctioning r/t (related to) placement and extra socks. Contacted ADON (Assistant Director of Nurses - V2 RN/Registered Nurse) and reported resident leaving the building. Awaiting further direction at this time. POA (Power of Attorney) aware. One on one direct supervision with resident directly after occurrence until confirmed wanderguard placement and activation."

A Facility Incident Report regarding R96, dated 8/3/24, documents, "IDT (Interdisciplinary Team) met and reviewed incident. Complete head count was conducted. NP (Nurse Practitioner) and POA (Power of Attorney) notified. Investigations immediately conducted. Staff, resident and visitor interviews conducted. (R96) was seen ambulating the long-term care hallways on video camera. Then (R96) was seen at (name) nursing station with (V32, CNA/Certified Nursing Assistant). At 3:15 pm a visitor was entering front entrance facility when (R96) exited the facility. Visitor told (R96) she is not supposed to be outside. (R96) told visitor 'well I am going outside'. Visitor

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 _____	08/29/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 40	S9999		

proceeded down to his father's room and did not inform the facility staff that a resident had exited the facility. (R96) walked out the front entrance and immediately re-entered the facility through the dietary door. The dietary staff took the resident to the (name) nurse station and informed the nurse that (R96) came into the dietary exit door from outside the facility. When the staff started checking (R96) (electronic monitoring device) the visitor stated I forgot to tell you that she went outside when I was coming in. (R96) (electronic monitoring device) transmitter was checked, and the red light was blinking. Blinking light indicates transmitter is active. When the transmitter was checked with the transmitter tester it indicated the transmitter was active. All resident (electronic monitoring device) transmitters were checked for the red blinking light, checked with transmitter tester and at each exit door and all alarms sounded. All staff was in-serviced with elopement policy, checking transmitters for red blinking light and checking with transmitter tester. Visitors inserviced upon entering facility not to let residents out and to immediately notify staff if it occurs. Medication review was completed, NP (Nurse Practitioner) and POA (Power of Attorney) updated, Care Plan Updated. Front door was locked, and sign posted for visitors to ring doorbell and visitors can not only enter with staff assistance. 15 minute safety checks were initiated. NP and POA updated. Care Plan updated."

On 8/14/24 at 10:01 AM, V21 (Licensed Practical Nurse/LPN) stated she didn't recall what happened on 8/3/24 when R96 left the facility without staff knowledge. R96's progress note, dated 8/3/24, was reviewed with V21 and she stated, "No.", when asked if she could recall the events.

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 _____	08/29/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 41 On 8/14/24 at 10:03 AM, V31 (CNA/Certified Nursing Assistant) stated she was in with another resident, and when she came out, a nurse (V21) was walking with R96, and stated the kitchen staff just let R96 in the back door. V31 stated she never heard the alarm sound. V31 stated they kept R96 with them after that, because they do 15-minute checks when R96 has elopement behaviors. V31 stated she was walking with a visitor to let them out the front door, when the visitor said R96 got out the door when they came in. V31 stated the visitor tried to stop R96, but she said she was going. V31 stated that is when they started locking the front door. When asked if the door alarm should sound even if it was opened by a visitor, V31 stated it should, and they had checked R96's (electronic monitoring device) and it was on, and the battery level was working. V31 stated she didn't know why the alarm didn't sound. V31 stated they have a little box they hold up to the bracelet, and it will say if it is on and check the battery level. V31 stated there is also a blinking light on the bracelet, and if it is blinking, it means the bracelet is working. When asked if there was a way to see if the alarm would sound, V31 stated they took R96 to the door to see if would sound. V31 stated she wasn't there when it was checked. V31 stated they check the bracelet daily, and have always checked placement, and if the light on the bracelet was blinking. V31 stated she had forgotten they could check the battery level with the box. V31 stated they were shown how to check it after R96 eloped on 8/3/24. V31 stated R96's wanderguard was working, and they have no idea what happened. On 08/14/24 at 12:28 PM, V33 (Dietary Aid/Cook) stated she was working on 8/3/24 between 3:00 and 3:30 PM, when R96 came into the kitchen.	S9999		

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 _____	08/29/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 42	S9999		

V33 stated they thought it was V30 (Dietary Manager) coming in the door, but when it opened it was R96. V33 stated the door she entered is down by the dumpsters, near the stop sign on the south side of the facility. V33 stated she took R96 to the unit, and she was unable to locate the nurse. V33 stated once she found V21 (LPN), she (V21) got an attitude and then came back into the kitchen and told them to mind their own business; she had gotten R96 another (electronic monitoring device). V33 stated she never heard an alarm sound.

On 8/14/24 at 10:05 PM, V35 (Anonymous) stated she was down the hall doing treatments, when V21 stated to her the kitchen staff said R96 was outside, and knocked on the Dietary door. V35 stated V21 walked R96 up to the front door to see if the door would alarm, and it didn't. V35 stated R96 was then placed on one to one, and V21 left the floor. V35 stated she thought V21 was calling to report the elopement to management, but she didn't. V35 stated she called V2 (Assistant Director of Nursing/ADON) to report it. V35 stated she later found out, R96 pushed past a visitor that was entering the facility and was let outside. V35 stated R96 was placed on one to one after the incident. V35 stated she didn't go with V21 when she walked R96 to the front door to see if the alarm would sound. When asked why it wouldn't alarm, V35 stated it may be an equipment malfunction. V35 stated they had training after the incident on how to check the battery and how to check for placement. V35 stated they placed a new (electronic monitoring device) bracelet on R96 after the incident, and they verified everyone else's (electronic monitoring device)were working. V35 stated she knows now how to check the bracelets. V35 stated they have a device that checks the battery.

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 _____	08/29/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 43	S9999		

V35 stated she didn't have any idea how to use it before the incident, but now she does. When asked if she was aware they could check the battery's prior to this incident, V35 stated, "No, not a clue." V35 stated prior to this incident where they documented the checks, it said to check placement. V35 stated so they were checking placement, not to make sure it was working properly.

On 8/14/24 at 1:56 PM, V34 (Plant Operations Manager) stated they check the (electronic monitoring device) weekly, and staff check each day. V34 stated maintenance checks all the door alarms, but doesn't check the individual bracelets. V34 stated the nurses check the individual bracelets. V34 stated the nurses have a tester on the med cart, and it reads the warranty date, serial number, and tells if the battery is good. V34 stated if the battery is not good, it says it is zero, and to replace it. V34 stated they should be tested daily. V34 stated he is sure it is a manufacturer recommendation. V34 stated they are getting ready to enhance the system they have. When asked why the alarm didn't sound, V34 stated they called him and he in-serviced everyone, but R96's alarm was functioning properly. V34 stated they figured out staff had put the code in for another resident, and there is a 30 second delay on the door alarm, and before that 30 seconds was up the visitor let R96 out.

The (electronic monitoring device) manufacturer recommendations were provided by V34, and they document the following, "Testing Tags Accutech Tags operate by internal battery. Over the course of normal operations, Tags (wanderguards) eventually lose battery power and the Tags will need to be replaced. The Tag battery is not replaceable. For maximum protection of

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 _____	08/29/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 44	S9999		

residents or assets, Accutech recommends that tags be tested on a weekly basis. There are many ways that you can test Tags: Enter a monitored zone, With an S-TAD, the Keypad's Auxiliary LED (Yellow) will light when a Tag is detected (Optional: additional wire required). Check Visual Pulse LED if present."

On 8/14/24 at 4:40 PM, V1 (Administrator) stated on 8/3/24, she got a call at home telling her R96 eloped, and they didn't know how she got out. V1 stated R96 left out the front door and came in the Dietary door. V1 stated she came to the facility and when she got there, they went through the entire building because the staff were all questioning the alarm system. V1 stated apparently a visitor came in, and R96 was trying to leave. V1 stated the visitor told R96 he didn't think she was supposed to leave, and she did anyway. V1 stated the visitor said he forgot to tell anyone she left, until he heard staff talking about it. V1 stated she checked the cameras, and R96 was seen wandering the hallway by the time clock around 3:00 PM. V1 stated R96 was with V32 (CNA) at the nurse's station and then the visitor was coming in around 3:15 PM. V1 stated based on when kitchen staff take their lunch breaks, R96 entered the kitchen right before 3:30 PM. V1 stated they took R96 to the nurse and she was assessed. V1 stated no one remembers hearing an alarm. V1 stated the facility staff checked R96's (electronic monitoring device) and told her it was working, and then took R96 to the door, and no alarm sounded. V1 stated they first checked the alarm by the blinking light that indicates it was working, then they checked it against the door once, and it didn't work and then again, and it did work. V1 stated they got a different (electronic monitoring device) bracelet for R96, and it alarmed as it should. V1 stated

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 _____	08/29/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 45	S9999		

they checked every resident's bracelet against all three doors, and they all alarmed as they should. V1 stated she decided they needed to lock the doors because they can't have visitors letting people outside and staff not know they are gone. V1 stated it may have been a delay on the alarm after the code was put in for someone else, but they can't say for sure that is what happened. V1 stated before this incident, staff were checking placement and to ensure the red light was blinking on the bracelet. V1 stated after this incident, the staff were educated to use the tester to make sure the battery was full. V1 stated they didn't use the tester on R96's bracelet until she came into the facility, and when she checked it with the tester, it was working as it should. V1 stated she had R96 assessed by the psychiatric nurse, and they did medication adjustments. V1 stated she was diagnosed with a urinary tract infection, but it wasn't a bad one. V1 stated after the elopement on 8/3/24, R96 was placed on one to one.

R96's Resident Safety Checks reviewed, and do not document safety checks were being done on 8/3/24.

2. R162's Admission Record, with a print date of 8/16/24, documents R162 was admitted to the facility on 7/31/24, with diagnoses that include unspecified dementia, altered mental status, anxiety disorder, cognitive communication deficit, weakness, insomnia, and suicidal ideations.

R162's MDS, dated 8/7/24, documents a BIMS score of 09, which indicates a moderate cognitive impairment.

R162's Elopement Evaluation, dated 7/31/24, documents a risk for wandering/elopement was

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 _____	08/29/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 46	S9999		

identified.

R162's Elopement Evaluation, dated 8/9/24, documents a score of 07, which indicates R162 is at risk for elopement.

R162's current Care Plan documents a Focus area of, "Is an elopement risk/wanderer related to: Impaired safety awareness, dementia with mood disturbance. Date Initiated: 08/01/2024." The interventions documented for this Focus area are "Check (electronic monitoring device) battery function weekly and PRN (as needed). Date Initiated: 08/01/2024. Check (electronic monitoring device) placement every shift and PRN. Date Initiated: 08/01/2024 .Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Resident prefers watching television and being able to go out to smoke every couple of hours. Date Initiated: 08/01/2024 .Identify pattern of wandering: Is wandering purposeful, aimless, or escapist? Is resident looking for something? Does it indicated the need for more exercise: Intervene as appropriate. (R162) wanders purposefully looking for her family and wandering (sic) why she is here. Date Initiated: 08/01/2024. Offer a warmed blanket. Date Initiated 08/01/2024. Offer food or snacks. Date Initiated: 08/01/2024. Offer to take to a scheduled or planned activity. Date Initiated: 08/01/2024. Redirect resident when wandering or exit seeking. Date Initiated: 08/01/2024. Resident is to be one on one due to elopement out of the window. Date Initiated: 08/16/2024. Resident to be one to one at all times due to exit seeking behaviors. Date Initiated 08/16/2024. Use distraction to change thought pattern. Date Initiated: 08/01/2024. (electronic monitoring device) to be applied at all times. Date Initiated:

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 _____	08/29/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 47 08/01/2024." R162's Facility Incident Report Form, dated 8/9/24, documents, "Investigation conducted. IDT met and reviewed incident. Resident and staff interviews conducted. A visitor came to visit (R162) when it was discovered that (R162) could not be located. A full facility head count was conducted and determined (R162) was not in the building. All other residents were accounted for. Facility and facility grounds searched with no findings of (R162). While search was in process a staff member was notified by phone from the (local) Police department that (R162) was at the (name of business) on (name of road). Staff members then got into vehicle and went to collect (R162). (R162) was found safe with no injuries or any signs of distress. MD (physician) and Family member notified of resident elopement and safe entry back into the facility. Nurse completed full body assessment and vital signs upon reentry to facility with no abnormal findings. Safety checks initiated and (R162) was placed 1:1 at this time. (R162) admitted to kicking out the window screen and jumping out the window during interview which resulted in the alarm not sounding. Staff then assisted to check windows or any other possible site of exit. It was found on a closed Memory unit that a window was open with screen bent and had been kicked out. Upon these findings immediate interventions placed with placing a sign on the closed memory unit and placing an alarm on the closed doors that will sound anytime the doors are opened. Upon further investigation and interview with (R162) it is noted that (R162) was complaining of bilateral knee pain. Call placed to NP (Nurse Practitioner) (V5) with new orders for bilateral knee X-ray and UA (urinalysis) with culture if indicated. All labs and Xray results with negative findings. Staff	S9999		

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 _____	08/29/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 48	S9999		

continues to monitor resident for any changes in mood, status, or behavior. No changes noted. MD and family member updated on findings of investigation. Care plan updated."

On 8/15/24 at 1:00 PM, V10 (Certified Nursing Assistant/CNA) stated she was working when R162 eloped. V10 stated R162 had called the police earlier that day. V10 stated she was working in the dining room, and everyone had been fed. V10 stated R162's family member came into the facility around 12:45 or 1:00 PM looking for R162 and they couldn't find her. V10 stated they searched each room and down the unit R162 lived on. V10 stated she didn't see R162 had opened a window. V10 stated V38 (MDS Coordinator) said the local police had "pinged" R162's phone and got her location. V10 stated they went to get her, and she was inside a place of business drinking water. V10 stated R162 was disoriented and confused. V10 stated she offered R162 a cigarette and told her they would call her family. V10 stated prior to his incident, R162 had never succeeded in eloping. V10 stated the window R162 went out was on the closed memory unit, and all the staff but one person was in the dining room, and that one person was passing meal trays.

On 8/15/24 at 2:32 PM, V36 (CNA) stated she noticed right after lunch R162 was gone. V36 stated they looked through the whole building and outside, and there was a window on the closed memory unit that was open, and the screen was bent. V36 stated they assumed R162 went out the window because she was wearing a (electronic monitoring device) and no alarm went off. V36 stated they looked for approximately 20 minutes and was not able to locate R162. V36 stated R162 had been calling 911 all day that day.

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 _____	08/29/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 49	S9999		

V36 stated V38 (MDS Coordinator) told her and V10 that R162 was on a nearby road. V36 stated then they got a call R162 was at a local business. V36 stated once they got to R162, she told them she went out a window. V36 stated R162 was very emotional, not angry or combative, just really sad. V36 stated they did a skin check when they got back to the facility. V36 stated she wasn't aware of R162 exiting the facility prior to this incident. V36 stated R162 had a (electronic monitoring device) on, and the light was blinking indicating that it was working.

On 8/15/24 at 2:56 PM, V21 (Licensed Practical Nurse/LPN) stated she was working on the day R162 eloped, but she had no information related to it. V21 stated she knows nothing.

On 08/15/24 at 4:05 PM, V3 (Infection Preventionist/Licensed Practical Nurse/LPN) stated she was working in the conference room, and sometime around 2:00 PM, she heard a page overhead that they needed a facility head count. V3 stated unknown staff told her R162 was missing. V3 stated they completed the head count and did not locate R162. V3 stated they had people searching outside the building and down the road. V3 stated they found an open window on the closed memory unit, with the screen bent, where it had been kicked out. V3 stated she thought V38 got a phone call stating they had R162 at a local business. V3 stated staff offered to go pick R162 up and bring her back to the facility. V3 stated R162 is a newer admission, they did an elopement risk assessment on her, and she was assessed as being at risk for elopement. V3 stated she wasn't aware of that risk prior to admission she thought she just had behavior/psychiatric issues. V3 stated when R162 got back to the facility they did an assessment,

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 _____	08/29/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 50	S9999		

checked her vital signs, and called their corporate team, who had them place her on one to one observation. V3 stated she took R162's statement, and she was confused and didn't remember leaving. V3 stated she spoke with her later on and she said her knee was hurting. V3 stated when she asked her what she did to her knee, R162 stated it was probably when she "kicked that thing out" so she could "escape". V3 stated they also placed an alarm on the closed memory units door so they would know if anyone entered the unit. When asked if she knew how long R162 had been gone, V3 stated she had been seen 30 minutes prior to them realizing she was missing.

On 08/15/24 at 4:41 PM, V37 (CNA) stated around 11:30 AM, right before lunch, R162 came out of the activity room and handed her phone to her. V37 stated it was the local police, and R162 had called them and asked for help. V37 stated she explained to the police R162 was a confused resident. V37 stated R162 was sitting in the activities room. V37 stated she left and went to the dining room. V37 stated about 20 or 30 minutes later, after lunch the announcement went out for a head count. V37 stated she went out the back door with another CNA to look for R162. V37 stated she was checking windows, but didn't think to look on the closed memory unit. V37 stated her boyfriend, who also works at the facility, came to pick her up, so it was probably closer to 2:00 PM when they were looking for R162. V37 stated then the police called and said they had located R162.

On 8/16/24 at 11:51 AM, V38 (MDS Coordinator) stated she was making rounds when V37 (CNA) came up to her and said R162 hadn't been seen for 15 minutes. V38 stated she paged for a head

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 _____	08/29/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 51	S9999		

count and directed two CNA's to go out the back door to look, and her and the Business Office Manager started out the front door. V38 stated on her way out the door, the local police called and said they had one of the residents at a local place of business. V38 stated V10 and V36 (CNA's) went to pick her up. V38 stated R162 was sitting on a couch with a few workers, was in no distress, and had no injuries. V38 stated R162 said she had "escaped" V38 stated they placed R162 on one to one when they got her back to the facility, and moved her to a different room where the window goes out to the courtyard instead of outside. V38 stated R162's (electronic monitoring device) was in place and working when they got her, but because she went out a window, it didn't alarm. V38 stated R162 was leaving in two days because family had someone in place to provide 24-hour care at home.

On 8/16/24 at 2:43 PM, V39 (LPN) stated she was working on the day R162 eloped. V39 stated R162 was agitated earlier in the day. V39 stated she was in the dining room when an unknown CNA came in and said R162 had called 911, and they heard her tell them we were holding her hostage. V39 stated about 20 minutes later, R162's family member brought her clothes, and they weren't able to find her. V39 stated she had checked R162's (electronic monitoring device) earlier in the day, and it was working and in place. V39 stated the police found her at the (place of business) a little over a mile from the facility. V39 stated R162 said she had jumped out of the window. V39 stated R162 complained of knee pain after she returned to the facility, and they x-rayed it with no findings.

On 8/19/24 at 9:29 AM, V44 (Family Member) stated R162 went on a "walkabout" and when she

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 _____	08/29/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 52	S9999		

got back to the facility, they placed her on one to one. V44 stated prior to admission to the facility, R162 had a history of wandering away. V44 stated when she left the facility, R162 made it to the gas station on the main corner in town. V44 stated someone from the nursing home called the police and they found her.

On 8/19/24 at 12:55 PM, V1 (Administrator) stated on the day R162 eloped, she was out of state, and wasn't involved in the incident. V1 stated the facility did notify her R162 had left the facility. V1 stated she was told R162 kicked out a window and was gone 10-15 minutes. V1 stated once R162 was back in the facility, she said she hurt her leg kicking out the window.

According to Google Maps, it would take the average person approximately 27 minutes to walk from the facility to the place of business she was located at.

According to the website https://www.wunderground.com/history/daily/us/il/herrin/KMWA/date/2024-8-9., the temperature between 12:45 PM and 2:45 PM was 79 degrees Fahrenheit.

The facility Elopement and Search (Code Amber) Policy, dated 1/2023, documents, " Policy: To establish methods for protecting residents who are at risk for elopement and for conducting an organized search for a resident who cannot be located. Policy Specifications: 1. All nursing personnel are responsible for: a. Knowing the whereabouts of residents for which they are assigned. b. Department Supervisors are responsible for conducting resident rounds. C. Staff are responsible for keeping the nurse informed of a resident's whereabouts ...5.

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 _____	08/29/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 53	S9999		

Residents who have been identified as cognitively impaired and who have been assessed as an elopement risk will be provided with an elopement prevention device (arm or ankle bracelet) or be placed in an area of the facility that has a door alarm device with audible sound, or on a secured/locked unit. 6. Bracelets will be observed for placement and checked for function daily. Facility exit door alarms are checked daily for function. All personnel are responsible for promptly reporting/replacing malfunctioning elopement prevention devices. Maintenance is responsible for fixing/replacing any exit doors that do not alarm. 7. All personnel are responsible for promptly going to the location and determining the cause of the activated audible door alarm. 8. When a resident makes repeated/continuous attempts to leave the building, the resident will be visibly observed every fifteen (15) until the behavior is resolved. In the event the resident continues to attempt to leave the building, a staff member will be assigned to provide one/one supervision and the physician notified. The resident will remain on one/one supervision until the behavior resolves or alternative interventions are initiated (i.e. elopement prevention device, secured/locked unit, or placed in an area of the facility that has a door alarm device). 9. In the event a resident cannot be located the following procedure is to be implemented: a. The charge nurse of the missing resident will announce "CODE AMBER (name of the floor/unit of the missing resident)" over the paging system. b. The Administrator and the Director of Nursing will immediately be notified. c. All available staff will immediately report to the nursing floor/unit of the CODE AMBER to be informed of the identity of the missing resident. The nurse should provide staff a description of what they look like, what they are wearing, etc.). d. The charge nurse will

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 _____	08/29/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 54	S9999		

assign available staff to search each of the following areas including: i. Each floor/nursing unit/hallway. The resident rooms should be searched including the bathrooms and closets. ii. Gathering areas such as lounges, dining rooms, therapy rooms, shower rooms. iii. Offices, equipment rooms, utility rooms. Even rooms that are locked should be unlocked and searched. iv. Outside building grounds including the parking lot, storage sheds, ponds, wooded areas, patio, etc. v. Some staff members should also be immediately assigned to start searching off facility premises such as streets, surrounding areas containing woods, ponds, railroad tracks within close proximity of the facility, etc. vi. Notify the police department to assist in the search if resident is not promptly found. (Authorities should be called early enough to avoid police canines loss of tracking ability, if needed). vii. Notify additional off-duty personnel for search assistance as needed. viii. Notify the attending physician and authorized legal representative. ix. Assign one individual to gather and have available for reference: information to identify the resident, such as general description, picture, clothing being worn, etc ....10. When the resident is found a licensed nurse will: a. Announce "CODE AMBER ALL CLEAR" over the paging system. b. Perform a clinical assessment of the resident's skin and functional status and determine if the resident requires medical intervention(s). c. Notify the physician of the resident's return and their condition. d. Provide emergency care as needed and implement physician order(s). e. Notify the authorized legal representative. f. Notify all persons assisting with the search if they are outside of the building. g. Complete the appropriate observations/forms. h. Initiate/update the care plan to include interventions to prevent reoccurrence."

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 _____	08/29/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 55 (A) 6 of 7 300.610 a) 300.1210 b) 300.1210 c) 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 and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. 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.	S9999		

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 _____	08/29/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 56	S9999		

These requirements are not met as evidenced by:

Based on observation, interview, and record review, the facility failed to develop/revise and implement interventions to ensure preventative measures are consistently implemented for pica (ingesting non-food items) behavior for 1 (R45) of 1 resident reviewed for accidents and supervision in the sample of 51. This failure resulted in R45 ingesting multiple non-food items, including a plastic bag and a bleach wipe.

Findings Include:

R45's Admission Record, with a print date of 8/20/24, documents R45 was admitted to the facility on 10/31/19, with diagnoses that include diabetes, dysphagia, osteoarthritis, brief psychotic disorder, delusional disorder, mild cognitive impairment, and depression.

R45's MDS (Minimum Data Set), dated 8/20/24, documents R45 has a BIMS (Brief Interview for Mental Status) score of 10, which indicates a moderate cognitive impairment.

R45's current Care plan documents a Focus area of, "Resident has been caught eating cigarette butts, eating pages out of her bible, & and eating dirt. Resident may display episodes of eating other non-food items." The Focus area documents, "10/19/2020 Pica DX (diagnosis). 10/2/2023 tears pages from books in library in order to chew on them. Resident has a behavior of going into people's rooms and taking their snacks or other items. When asked she has the behavior of denying and hiding what she has

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 _____	08/29/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 57	S9999		

taken, Date Initiated: 10/16/2020." This Focus area documents the following interventions, "Allow her to keep a few snacks in her room. Date Initiated: 10/20/2023.Allow resident to sit at nurse's station for monitoring (ensure resident is wearing mask) Date Initiated: 02/18/2021.Anticipate and meet needs. Date Initiated: 10/16/2020. Encourage participation in activities of interest Date Initiated: 02/18/2021 .... If reasonable, discuss behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable. Date Initiated: 10/16/2020.Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes. Date Initiated: 10/16/2020. Offer a piece of candy, Date Initiated: 02/18/2021.Offer a piece of gum Date Initiated: 02/18/2021.Offer a snack Date Initiated: 02/18/2021.Praise any indication of progress/improvement in behavior. Date Initiated: 10/16/2020 ...Snack box to be at nurses station to include various snacks that resident can choose from between smoke breaks and meals, Date Initiated: 02/18/2021."

R45's Documentation Survey Report dated July-24 under Intervention/Task- "putting non-food items in mouth" documents R45 attempted to ingest non-food items on 7/3-7/7, 7/9, 7/10, 7/17-7/21, 7/25, and 7/31/24 (6 AM to 2 PM); 7/1, 7/3, 7/5, 7/7-7/9, 7/14, 7/17-7/21, 7/26, and 7/27/24 (2 PM to 10 PM); 7/2 and 7/18/24 (10 PM to 6 AM). R45 did not attempt to ingest non-food items on 7/1, 7/2, 7/8, 7/13, 7/15, 7/16, 7/22, and 7/26-7/29/24 (6 AM to 2 PM); 7/4, 7/6, 7/12, 7/16, 7/23, and 7/30/24 (2 PM to 10 PM); 7/1, 7/3, 7/4, 7/6- 7/9, 7/13-7/15, 7/17, 7/20, 7/22, 7/24-7/27, and 7/29-7/31/24 (10 PM to 6 AM). R45 was unavailable 7/10/24- 2 PM to 10 PM, 7/11/24- all

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 _____	08/29/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 58	S9999		

three shifts, 7/12/24- 6 AM to 2 PM and 10 PM to 6 AM. There is no documentation for the other days and shifts.

R45's Documentation Survey Report, dated Aug-24, under Intervention/Task- "putting non-food items in mouth" documents R45 attempted to ingest non-food items on 8/1-8/7, 8/9- 8/14-8/16, and 8/22 (6 AM to 2 PM), 8/1, 8/4, 8/5, 8/7-8/12, 8/14-8/16, 8/21-8/23 (2 PM to 10 PM), and 8/1, 8/4, 8/8, and 8/10/24 (10 PM to 6 AM). R45 did not attempt to ingest non-food items on 8/3 24 (2 PM to 10 PM), and 8/3, 8/5, 8/6, 8/11-8/14, 8/16, 8/17, 8/21-8/23, and 8/25/24 (10 PM to 6 AM). R45 was unavailable 8/17/24- 2 PM to 10 PM and 10 PM to 6 AM, 8/18/24 - 6 AM to 2 PM and 2 PM to 10 AM, 8/19/24- all three shifts, 8/20/24- 6 AM to 2 PM, 8/21/24- 6 AM to 2 PM and 10 PM to 6 AM, and 8/25/24- 6 AM to 2 PM. There is no documentation for the other days and shifts.

R45's POC (point of care) Response History, with a print date of 8/26/24, documents the following narratives related to R45's behavior tracking; 8/1/24 11:47 PM, "resident is constantly taking things off carts to eat, also taking cups to eat. 8/4/24 8:26 PM, "plastic paper" 8/4/24 11:22 PM, "paper and plastic" and 8/5/24 8:51 PM, "chewing on paper and gloves- redirected but unable to stop behavior."

R45's Progress Note, dated 7/25/24 at 9:08 AM, documents, "Note Text: Res (resident) was observed by (V8), CNA (Certified Nursing Assistant) chewing on mircro (sic) kill bleach wipes. (V8) took the wipes away from res (resident) and instantly reported the incident to this nurse (V6/Licensed Practical Nurse-LPN) and (V1), Administrator. This nurse called poison

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 _____	08/29/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 59	S9999		

control to inform them of the incident and to see what further action should be taken. Per poison control: make sure the res drinks some fluids and eats a snack. Monitor res for dermological (sic) s/s (signs/symptoms) to her hands and face such as a small rash, burning, itching, irritation. Keep res at your facility at this time. No need to send her to the hospital. Call us back in 1 hour to give us an update on how res is doing. (V8), CNA washed res hands and face. Res is currently drinking a soda and eating a snack. No s/s of skin irritation, upset stomach, or nausea. (V5), NP (Nurse Practitioner) notified. Res daughter notified. Will continue to monitor res."

R45's Progress Note, dated 7/25/24 at 10:30 AM, documents, "Note Text: This nurse spoke c (with) poison control again to update them on res status. Res is showing no s/s of upset stomach, skin irritation, or feeling sick in any way. Res is at her normal baseline. Poison control said thank you for the update and that res should be completely fine then."

R45's Progress Notes, dated 8/17/24 at 12:52 PM, documents R45 was transferred to the local hospital for evaluation after a syncopal episode and with abnormal vital signs. R45 was admitted to the hospital for evaluation.

R45's Progress Notes document on 8/21/24 at 1:24 PM, "RN (Registered Nurse) at (name of local hospital) called to give report. Report as follows: Pt (patient) was admitted to us c (with) syncope. Head CT (computerized tomography) negative. She has had a few hypoglycemic episodes since being here, so we changed her insulin orders. She had a mild UTI (urinary tract infection) that we treated c (with) Rocephin. She will not be coming back on an ATB (antibiotic).

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 _____	08/29/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 60	S9999		

Her B/P (blood pressure) has slightly been elevated. Her last BM (bowel movement) was today. Staff observed what looked to be a plastic bag slightly protruding out of her anus. General surgery was consulted but pt was able to pass it c (with) the help of laxative. It ended up being a (name brand) bag. No new med orders except to stop Glipizide."

R45's local hospital records, dated 8/17/24, documents R45 was evaluated at the local emergency room after a syncopal episode at the facility. The hospital records document R45 was admitted for evaluation and treatment for diagnosis of urinary tract infection. R45's hospital records documents on 8/18/24 under Hospitalist Cross Cover Note, "Alerted by RN (Registered Nurse) to patient voicing need for bowel movement with PCT (patient care technician) observed suspected rectal FB (foreign body) that "looks like a plastic bag" Pt (patient) seen and assessed ...remains confused. Unreliable historian. On external exam, stool noted however no visible FB. No abdominal tenderness. No bleeding. Response: KUB (kidney, ureter, bladder x-ray), trial lactulose, RN to monitor for bowel movement, Will consult surgery in AM, if FB observed by nursing staff does not pass with BM (bowel movement) may need surgical evaluation." R45's hospital records document under Acute Care Surgery Progress Note, dated 8/20/24, "(R45) .. admitted after a syncopal episode. General surgery was consulted due to concern for rectal foreign body. Overnight RN reported patient voiced need to have a BM and observed what appeared to look like a plastic bag protruding from her rectum at times. Patient is a poor historian due to underlying dementia. RN at bedside reports patient has attempted to eat telemetry leads and IV (intravenous) tubing during

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 _____	08/29/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 61	S9999		

admission ...Interval HPI (history of present illness) Pt (patient) up in chair. Had bowel movement overnight which resulted in passing plastic foreign body, appeared similar to a (name brand) sandwich bag. Per PCT, pt seems hungry, asking about meals. VSS (vital signs stable) no acute events reported overnight .... Assessment/Plan Surgery service consulted for rectal FB. Pt passed foreign with stool overnight ...Will obtain repeat imaging as pt ahs (sic) hx (history) of PICA, unable to give history .... No acute surgical intervention .... Rectal FB- passed plastic "(name brand plastic) baggie. No FB palpable on rectal exam .... Bowel regimen, Resume regular diet, Con't (continue) sitter and environment modifications to reduce ingestion of FB ..."

R45's Progress Notes, dated 8/21/24 at 2:22 PM, documents R45 arrived back to the facility on 8/21/24 via ambulance.

On 8/22/24 at 8:39 AM, V36 (CNA/Certified Nursing Assistant) stated R45 has Pica and eats books and tried to eat the bandage off her roommate's wounds. V36 stated R45 has tried to eat the stuffing out of her adult brief, and they have to take it from her. V36 stated they try to keep an eye on R45. V36 stated R45 has started eating (white foam) cup with straw, and gloves on top of the cart. Next to the open cart was a three-drawer stand. V62 (Activities Director) opened the drawers and noted activities of daily living supplies including toilet paper, rubber bands, razors, denture cleaner, room deodorizer, depends, and other care supplies. The nurses station desk located on R45's hall had several boxes of gloves on the counter.

On 8/22/24 at 1:24 PM, V61 (CNA) stated R45

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 _____	08/29/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 62	S9999		

eats all types of paper, toilet paper, paper towels, and plastic. V61 stated R45's daughter brings in snacks in (plastic) bags, and she has attempted to eat the bag, gloves, and adult diapers. When asked what they do to prevent R45 eating non-food items, V61 stated they take everything from her pockets and ask her to remove items from her mouth. V61 stated she wasn't sure when R45's daughter had last visited, since she had recently had surgery and wasn't able to come to the facility. V61 stated every time R45 goes back to her room they have to empty her pockets. V61 stated R45 is constantly chewing on stuff. On 8/22/24 at 1:24 PM, this surveyor walked with V61 to R45's rooms and looked through the drawers on her bedside table and they were empty. V61 stated she heard R45 had a bleach wipe, but she wasn't working, and wasn't sure how R45 got it.

On 8/22/24 at 1:30 PM, V8 (CNA) stated anytime she sees R45 with a non-food item she takes it away. V8 stated she was supervising R45 while smoking today (8/22/24), and she attempted to eat a cigarette, but she was able to stop her. V8 stated R45 puts the cigarette out, breaks it apart, and eats the tobacco and paper that is on the outside of the tobacco. V8 stated they had to call poison control a while back (date unknown) for her eating a bleach wipe someone had left on the handrail near her room. V8 stated she hadn't seen R45 eat plastic, but she had heard about the hospital report and when they give R45 snacks at night they are in a bag, and she would almost guarantee that is where R45 got it.

On 8/22/24 at 2:45 PM, V56 (Family Member) stated the hospital called (8/21/24) and told her R45 was returning to the facility. V56 stated R45 has been eating non-food items for a while now.

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 _____	08/29/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 63	S9999		

V56 stated R45 moved to the facility over two years ago, and it started after she was admitted. When asked if she knew what the facility did to prevent R45 from ingesting non-food items, V56 stated they watch her. V56 stated they don't let her have paper, but she will sneak and get stuff. V56 stated she had to stop bringing her cookies in a bag. V56 stated she thought the last time she brought something to her, something happened because they called her and asked her not to bring things in bags. V56 was not able to remember the exact date, but stated it had been a while. V56 stated R45 had never gotten choked, but the hospital told her she had eaten plastic when they called her (8/21/24).

On 8/22/24 at 4:16 PM, V1 (Administrator) stated she had heard about R45 ingesting a plastic bag. V1 stated they catch R45 eating paper multiple times a day and when they do, they offer R45 a snack or a piece of gum. V1 stated R45 is care planned for eating non-food items. V1 stated she caught her today (8/22/24) trying to rip papers out of the books in the library, and asked her if she was hungry and offered her a snack. V1 stated she wasn't aware of R1 eating plastic bags before, but was aware of her having bleach wipes in her mouth. V1 stated they called poison control when they found she had them in her mouth. V1 stated bleach wipes are not supposed to be accessible to the residents. V1 stated she went around and asked everyone how they were left out and no one could tell her. V1 stated they also checked all the medication carts, which is where they keep them. V1 stated she wasn't sure if she documented what she did. When asked if they did anything else, V1 stated they checked the halls to make sure there weren't any more out. V1 stated V6 (LPN) was working at the time and stated R45 hadn't ingested the bleach wipes. V1

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 _____	08/29/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 64	S9999		

stated she asked V6 where R45 got them, and V6 didn't know.

The Summary provided to this surveyor on 8/26/24 documents on 7/25/24, R45 was chewing on micro kill bleach wipes. Under Resident Interviews the Summary documents, "(R45) 7/25/24 Asked (R45) where she got the wipes from, and she stated Over (sic) there and pointed down the hall toward the nurse's station. Asked (R45) why she was chewing on the wipe. She stated I don't know. Asked (R45) if she swallowed what she was chewing on and she stated no. Asked (R45) if she was hungry or wanted a snack. She stated no. Asked (R45) if she wanted anything to chew on, she stated no." Under Final Summary/conclusion the Summary documents, "Called Poison control and NP (Nurse Practitioner). No new orders from NP. Followed Poison control directions. (V38, MDS Coordinator) and this writer (V1) also went down al (sic) hallways and nursing station and looked for any chemicals or bleach wipes accessible to residents. All medication carts where bleach wipes are located were locked. Clean supply room was also locked. Checked (R45) room for any bleach wipes or chemical in room. None Found."

On 8/24/24 at 11:25 PM, V59 (CNA) stated she provided care to R45 at times. V59 stated she had caught R45 chewing on paper towels, tissue, gloves, and would ask her to spit them out. V59 stated she never saw R45 eating anything else. V59 stated she would attempt to redirect R45 if she found anything in R45's possession. V59 stated they take any excess paper towels and toilet paper out of the adjoining bathrooms.

On 8/24/24 at 11:30 PM, when asked if she had

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 _____	08/29/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 65	S9999		

ever witnessed R45 eating non-food items, V58 (LPN) stated, "All the time." V58 stated they stop R45 and take things away from her. V58 stated they are vigilant about taking things away and making sure R45 doesn't ingest unsafe things. When asked what they do to prevent R45 from ingesting non-food items, V58 stated, "It is less of prevent and more try to stop before it makes it to her mouth." V58 stated she wasn't aware of R45 ingesting plastic. V58 stated it is mostly paper, paper towels, and cardboard from the boxes of gloves. V58 stated snacks are served in bags, and R45 prefers sandwiches and graham crackers. V58 stated a couple of times, R45's family has brought in something in cardboard containers, but she had never seen R45 with a (brand name) bag. V58 stated the bags the facility snacks are served in are the kind that fold over, not zip. V58 stated when she gives R45 snacks, she makes sure she takes them out of the wrapping first.

On 8/24/24 at 11:37 PM, V60 (CNA) stated she had witnessed R45 eat non-food items. V60 stated it was usually paper towels, stuff off their carts, boxes of gloves, (white foam) cups, trash bags, and trash. When asked what they did to prevent R45 from ingesting non-food items, V60 stated they try to keep paper towels and the trash can out of the bathroom. V60 stated it is a constant battle with R45. V60 stated R45 tries to ingest items off their carts, and they try to get to her as quickly as possible. V60 stated R45 is quick, and she does it all night. V60 stated they have to keep the snacks in the med room because R45 will grab them. V60 stated they have sandwiches, vanilla wafers, and graham crackers. V60 stated it is all prepackaged other than the sandwiches and vanilla wafers. V60 stated she hadn't seen R45 attempt to ingest

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 _____	08/29/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 66	S9999		

plastic but said, "I wouldn't put it past her." V60 stated she had never seen R45 eat plastic bags, but she had seen her eat gloves.

On 8/26/24 at 9:33 AM, V6 (LPN) stated she didn't think R45 ingesting non-food items was being behavior tracked. V6 stated they have on the medication administration to offer her snacks at certain times. V6 stated they offer R45 food, drinks, and activities if they see her attempting to ingest non-food items. When asked what they do to prevent R45 from ingesting non-food items, V6 stated they have taken the trash can out of her bathroom and there are no paper towels in her bathroom. V6 stated there really is no preventing it. V6 stated R45 will go to the library and rip pages out of books. V6 stated they also follow her down the hall when they see her walking, which is another prevention they implement. V6 stated she was working when R45 got the bleach wipe. V6 stated (V8/CNA) reported R45 was chewing on it. V6 stated she called poison control and then talked with them again about an hour later. V6 stated she didn't know where R45 got the wipe. V6 stated R45 had no negative outcomes. V6 stated the snacks are served from the kitchen and depending on what the snack is, it may be served on a plate or in a bag. V6 stated she takes R45's snacks out of the baggies if it is served in one.

On 8/26/24 at 4:18 PM, when asked what the facility does to prevent R45 from ingesting non-food items, V2 (Assistant Director of Nursing/ADON) stated he knows they watch her when she goes to the library because she rips the papers out of the books and puts them in her pockets. V2 stated he watched R45 on Friday (8/23/24) put the napkin off her silverware in her pocket. V2 stated R45 will eat the paper off the

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 _____	08/29/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 67	S9999		

nurse's station desk. V2 stated before R45 "pilfers" something off the linen cart, she will look around to see if anyone is watching. V2 stated R45 will eat wipes and tell the staff she doesn't have anything in her mouth when they can clearly see it. When asked what they do to prevent her from ingesting non-food items, V2 stated he would check her medical record. V2 stated he would check her chart because he didn't know what they had in place at the moment. V2 stated, "I honestly think she needs 1:1 care because she is going to end up eating something and hurting herself. I feel like it is only a matter of time." V2 stated R45 always wants to be in her room or out smoking. V2 stated if R45 isn't being monitored in her room, she would eat the wrapper if they gave her a snack to eat in her room. This surveyor reviewed R45's hospital notes with V2 related to R45 passing a (name brand) bag in her stool. V2 stated they leave snacks out at night, and it is possible R45 grabbed a snack and went to her room, and she could have eaten the bag the snack was wrapped in. V2 stated he didn't know how long it would take a bag to pass through the gastrointestinal system. This surveyor reviewed with V2 the items observed on R45's hall, and asked if there was any intervention related to ensuring items R45 had attempted to ingest were not readily available to her, and V2 stated he didn't know. V2 stated when staff are complaining about R45, he tells them to bring the linen cart to the other hall. V2 did not know where R45 got the bleach wipes she attempted to ingest. V2 stated maybe behind the nurse's station, because he knows she goes back there looking for items. When asked what his expectation would be for R45's care, V2 stated, "I have asked to have a 1:1 for her. It was my concern on Friday or the day she got back. Because I literally watched her like five times having stuff in her pockets and

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 _____	08/29/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 68	S9999		

trying to eat stuff in her room."

On 8/26/24 at 4:33 PM, V1 (Administrator) stated R45 was diagnosed with Pica (ingesting non-food items) a few years ago. V1 stated she didn't remember if they did any labs when she was first diagnosed. V1 stated she recently asked for lab work, and she knows R45 had a full iron work up when she was in the hospital (8/17/24-8/21/24) and it was normal. V1 stated she reviewed the care plan with the Psychiatric Nurse Practitioner (V68), and the only thing she could think of was to do a pica basket, and use it as a praise system. V1 stated they had tried the nicotine patch in the past, but then R45 started eating those. V1 stated nurses will take R45 with them when they do medication pass because if they don't, R45 will be going into other resident rooms and going through their belongings and their garbage. V1 stated no one admitted to leaving the bleach wipes out. When asked if she had ever considered not having items R45 had ingested readily available on her hall, V1 stated she wasn't aware R45 was attempting to eat other items until recently. V1 stated she didn't know R45 was eating gloves, cups, and "all that" until she pulled the behavior tracking narratives today, 8/26/24. V1 stated they are going to do something different now. V1 stated the only thing facility staff reported R45 was attempting to ingest to her was the paper, cigarettes, and bags her daughter brought snacks in. When asked about the snacks the facility provides, V1 stated they are delivered to the nurses station. V1 stated staff told her they gave her the snacks to eat at the nurse's station. V1 stated if that is going to be an issue, then they will have to go back to locking the snacks up in the employee break room. When asked if she knew where R45 got the (name brand) bag she passed while at the hospital, V1 stated she would

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 _____	08/29/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 69	S9999		

have to call V56 (Family Member) and see when she brought R45 something in a (name brand) bag. When asked when V56 last visited R45, V1 stated the last time she spoke with V56 was on 8/16/24, when V56 told her she had surgery and wouldn't be in for a while. V1 stated she believes it is a true Pica behavior, and as far as she knows, R45 has never choked on anything. V1 stated R45 used to smoke three packs of cigarettes a day, and the family asked them to reduce the amount she smoked due to the cost, and that is when R45 began eating cigarettes and paper.

On 8/26/24 at 4:06 PM, V5 (Nurse Practitioner) stated she didn't know how long it would take a (name brand) baggie to pass through the gastrointestinal system. V5 stated she didn't know what the cause of R45's Pica was, but she thought it was probably behavioral. V5 stated R45 always gets all kinds of lab work done at the facility and there is no specific lab to do for Pica. When asked if there was any possible negative impact from attempting to ingest a bleach wipe, V5 stated she wasn't aware R45 was chewing on a bleach wipe. V5 stated unless R45 was vomiting or something, then there really isn't anything to do other than monitor her. When asked what her expectations would be to prevent R45 from ingesting non-food items, V5 stated the only thing they can do is offer R45 other things such as frequent snacks or suckers. V5 stated R45 is ambulatory, so they can't really chase her around the building. V5 stated she knew they did an iron work up at her last admission to the hospital (8/17-8/21/24), and it was normal.

R45's Smoking Assessment, dated 7/11/23, documents R45 is a supervised smoker due to being unsafe and unable to follow smoking rules

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 _____	08/29/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 70	S9999		

on her own. This is the most recent smoking assessment, and it doesn't address R45 attempting to ingest cigarettes.

On 8/27/24 at 6:01 PM, V1 (Administrator) stated the facility did not have a pica policy.

(A)

7 of 7

300.610 a)
300.1210 b)
300.1210 c)
300.1210 d)2)

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 and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

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

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 _____	08/29/2024

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

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S9999	Continued From page 71	S9999		

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:
2) All treatments and procedures shall be administered as ordered by the physician.

These requirements are not met as evidenced by:

Based on observation, interview, and record review, the facility failed to provide nutritional supplements, monitor weights, and implement interventions for 2 (R53 and R100) of 8 residents reviewed for nutrition in a sample of 51. This failure resulted in R53, who only weighed 76 pounds and had a recent 23% weight loss in 6 months, not receiving the ordered nutritional supplements to be able to maintain a healthy weight.

Findings include:

1. R53's Face Sheet documents R53 is a female resident with diagnoses including: unspecified dementia unspecified severity with mood disturbance, anemia, chronic embolism and thrombosis of unspecified axillary vein, essential hypertension, underweight, tremor, cognitive communication deficit, acute embolism and thrombosis of unspecified deep veins of left lower extremity, acute embolism and thrombosis of right subclavian vein, and portal vein thrombosis.

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 _____	08/29/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 72	S9999		

R53's Minimum Data Sheet (MDS), dated 05/2024, documents no BIMS (Brief Interview for Mental Status) was conducted due to resident is rarely/never understood. R53's MDS documents R53 is dependent for eating.

R53's Order summary report documents a dietary order of regular diet with pureed texture, nectary consistency, offer fortified foods at all meals. Super cereal at breakfast, double eggs at breakfast, and offer thickened nutritional shakes TID (three times a day) use a straw with all drinks for nutrition, with an order date of 03/19/2024, and a start date of 03/19/2024, with no end date documented.

R53's care plan documents a focus area, dated 09/06/24, of: R53 has potential nutritional problem (weight loss) related to: poor intake, underweight, dementia and interventions listed as: monitor wts (weights) as ordered dated 06/30/23, monitor/document/report to MD (Medical Doctor) PRN (as needed) for s/sx (signs/symptoms) of dysphagia: pocketing, chocking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat, or appears concerned during meals dated 05/31/23, monitor/record/report to MD PRN s/sx of malnutrition: emaciation (cachexia), muscle wasting, significant weigh loss: >5% in 1 month, >7.5% in 3 months, > 10% in 6 months with a date initiated of 05/31/23, provide and serve diet as ordered. Monitor intake and record q (every) meal (03/19/24) pureed, nectar consistent fluids, fortified foods all meals, super cereal with breakfast double eggs at breakfast, ice cream @ (at) supper, use straws with all drinks dated 03/20/2024, provide and serve supplements as ordered with an initiated date of 06/05/23, and RD

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S9999	Continued From page 73	S9999		

to evaluate and make diet change recommendations PRN, with a date initiated of 05/31/23.

R53's progress note: dietary note, dated 07/16/24 at 10:40 AM, documents: "RD (Registered Dietician) WT (weight)/wound note. (R53) has 23% weight loss for 6 months. (R53's) ht (height) is 67 inches and has a wt (weight) of 76 # (pounds) on July 2nd with a BMI (body mass index): of 12%. On June 11 (R53's) wt was 79 #, in April 82 pounds, and in January 99 #. (R53) has variable meal intakes as reported. (R53) is fed/assisted at meals. (R53) has severe dementia. She has treatments to wound on lt (left) buttock and skin tear lt sacrum. She is receiving MVI (multivitamin), Vit (vitamin) C, Zinc, (liquid protein medical food) and (arginine supplement drink) BID (twice a day) to help with healing. Continue pureed-NTL (nectar thick liquids) diet, fortified foods, SC (super cereal) at B (breakfast), double eggs at B (breakfast), thickened health shakes TID/(with) meals. Noted Res (resident) has been medically declining. Offering additional cals (calories)/pro (protein). Encourage intakes. Include extra marg (margarine)/butter all meals. Monitor skin, WTs (weights) and further needs."

R53's progress note: dietary note, dated 06/16/24 at 9:47 PM, documents: note text: "RD WT/wound note. Res (R53) with 25% wt loss/6 months. Ht: 67 inches, June 11 wt:79# BMI: 12, March wt: 83#, Dec (December) wt: 106#. Variable meal intakes as reported. Res (R53) fed/assisted at meals. Has severe dementia. Tx: wound (lt) lat buttock/chronic ulcer and ABTX - cellulitis (Rt) elbow. receiving MVI, Vit C, Zn, (liquid protein medical food) and (arginine supplement drink) BID to help with healing.

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S9999	Continued From page 74	S9999		

Continue pureed-NTL diet, fortified foods, SC at B, double eggs at B, thickened health shakes TID/meals. Noted Res (R53) has been medically declining. Offering additional cals/pro. Encourage intakes. Offer snacks between meals. Monitor skin, Wts, further needs."

R53's progress note by V5 (Nurse Practitioner), dated 07/22/24, documents a visit date of 07/11/24, and a diagnosis of failure to thrive in adult, dated 07/22/24.

On 08/12/24 at 12:16 PM, R53 did not receive a health shake with her lunch; she only had a glass with thickened water. R53 was being assisted by a staff member.

On 08/13/24 at 12:14 PM, R53 did not receive a health shake with her lunch; she had one glass of an opaque thickened liquid in front of her.

On 08/13/24 at 12:42 PM, V11 (Certified Nurse Aide/CNA) who was assisting R53 stated R53's drink was thickened water.

On 08/14/24 at 8:04 AM, R53 did not receive a health shake with her breakfast; she had a thickened cranberry juice. She did not receive a double portion of eggs. There were no eggs observed on R53's meal tray.

On 08/14/24 at 12:18 PM, R53 did not receive a health shake with her lunch.

On 08/14/24 at 12:18 PM, V11, who was assisting R53, stated R53's only drink was thickened water. V11 stated, "(R53) can eat good some days, and sometimes she will turn her head."

On 08/15/24 at 8:01 AM, R53 did not receive a

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	IL6008528	A. BUILDING: _____ B. WING _____	08/29/2024

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S9999	Continued From page 75	S9999		

health shake with her breakfast or a double portion of eggs; she had one glass of thickened cranberry juice.

On 08/15/24 at 8:07 AM, V9 (CNA) who was assisting R53, stated, "(R53) had the hot cereal with the extra butter and sugar and stuff put in it, pureed sausage, and pureed pancakes, with thickened cranberry juice."

On 08/15/24 at 12:11 PM, R53 did not receive a health shake with her lunch; she had one glass of thickened cranberry juice with lunch.

On 08/15/24 at 1:16 PM, V9 (CNA) who was assisting R53 stated she has not seen R53 with a health shake, that "would probably be a good thing for her because she drinks better than she eats."

On 08/15/24 at 4:17 PM, V12 (Dietary manager) stated, "If (R53) is ordered to have a health shake, she should have received a health shake, and she should have received it three times a day if that is what is ordered for her. The kitchen puts them in a pan to give out to the residents that are supposed to receive them. (R53) should have received the double eggs with every breakfast. They put thickener on the carts for every dining room, so the CNA's can thicken the drinks that need to be thickened. The fortified foods are made with powered milk, brown sugar, white sugar, or butter."

On 08/19/24 at 2:44 PM, V30 (Registered Dietitian) stated R53 is about 77 pounds; she does not know if she has been over a 100 pounds; she would have to be able to see her chart. V30 stated she has ordered the health shakes three times a day for her to hope to

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 _____	08/29/2024

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SHAWNEE SENIOR LIVING	1901 13TH STREET HERRIN, IL 62948

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S9999	Continued From page 76	S9999		

maintain her weight; she does not know if she would gain weight. V30 stated she would expect her to be receiving all three health shakes a day and the double eggs for protein. She would expect all residents that she recommends health shakes or other supplements for to receive them. At this facility, the fortified foods are considered whole milk.

On 08/20/24 at 3:35 PM, V5 (Nurse Practitioner) stated, "(R53) should receive the supplements and diet as recommended by (V30)."

2. R100's Face Sheet, dated 08/15/24, documents an admission date of 06/18/24, with diagnoses of acquired absence of other toes, Enterocolitis due to clostridium difficile, type 2 diabetes mellitus, urinary tract infection, heart failure, iron deficiency anemia, gastrointestinal hemorrhage, and dysphagia.

R100's Minimum Data Set (MDS), dated 06/25/24, documents in Section C a BIMS (Brief Interview for Mental Status) score of 15, which indicates R100 is cognitively intact. Section GG documents independent with eating and substantial/maximal assist with toileting, showers,

R100's Progress note, dated 08/13/24 at 1:48PM from V30 (Registered Dietitian), documents, "(R100) reported 20% WT (Weight loss)/1 mo. (Month). July 5 WT (Weight): 176# (Pounds) June WT: 221#. (R100)re-admitted to facility with DX (Diagnosis) C-diff (clostridium difficile), UTI (Urinary Tract Infection), continue with previous recommendations. Monitor WT's closely. Refer prn (as needed)".

On 08/14/24 at 12:45 PM, R100's tray was sitting on his bedside table covered with aluminum foil

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 _____	08/29/2024

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S9999	Continued From page 77	S9999		

along with thickened cranberry juice and thickened water; both were also covered with saran wrap. R100 was sitting in bed. R100 stated he wasn't hungry and didn't want to eat.

On 08/15/24 at 10:40 AM, R100 stated he has had a significant weight loss. R100 said he doesn't like the food at the facility. R100 said they don't ever offer him an alternative, but he doesn't ask for one either. R100 said he does like the oatmeal at breakfast, but that usually is one of the main meals he eats. R100 said the food they usually serve him he doesn't eat. R100 said he believes this is why he has lost so much weight because he doesn't like a lot of the food they serve him.

On 08/19/24 at 8:40 AM, R100 had his plate in front of him with oatmeal and toast. R100 said he feels like he ate better this weekend then he usually does. R100 said the food was a little better this weekend, and he did not ask for an alternative.

On 08/18/24 at 8:50 AM, V40 (Speech Language Pathologist) stated she feels like R100 does good with his thickened liquids and mechanical soft diet. V40 stated R100 is not coming out of his room into the dining room to be monitored right now because he is on contact isolation related to c-diff. V40 said R100 really didn't come out much when he wasn't on contact isolation, but he did come out on occasion. V40 said R100 said he doesn't like a lot of the things they serve at the facility.

On 08/18/24 at 1:00 PM, R100's room tray had sauerkraut with polish sausage and vegetables, and one glass of cranberry juice thickened to honey constituency. R100 consumed his glass of

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SHAWNEE SENIOR LIVING	1901 13TH STREET HERRIN, IL 62948

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S9999	Continued From page 78	S9999		

cranberry juice and maybe 25% of his meal. R100 stated he fed himself a little bit, but didn't eat much.

On 08/18/24 at 3:00 PM, V30 (Registered Dietitian) stated R100 could not have super cereal related to him being a diabetic. V30 said she knows R100 is on a supplement for wound healing. V30 stated she is not done reviewing charts for weight changes yet this month. V30 said next week she will look at R100's weight changes. V30 said she does remember charting on R100 on 08/13/24, and she said she knows R100 did have c-diff from his recent hospital stay. V30 said she didn't realize R100's weight loss was the month prior to him having c-diff. V30 said next week, she will look at adding double eggs and whole milk to R100's diet. V30 was not aware R100 had the 20% weight loss from June to July until R100 notified her of the weight loss. V30 said nobody notified her of significant weight changes all the time. V30 said its "hit and miss"; usually when they do notify her, it's about a resident on a tube feeding or resident on dialysis. V30 said no one notified her of R100 having any weight loss. V30 said if they would have notified her sooner, it would of had an impact on the weight loss. V30 would have been able to start interventions earlier. V30 said with that much of a weight loss, he should have been added to daily weights, not monthly. V30 said she does have focus groups she works on; she runs a report when she comes in to see what all residents have had weight losses. V30 said when she notices a significant weight change, she sends a note to the Director of Nursing with recommendations she would recommend to help with the weight loss. V30 said the 20% weight loss on R100 should have been sent to her immediately. V30 said she does know]R100 is on a supplement for

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S9999	Continued From page 79 his pressure ulcers. V30 said]they did add a nutritional supplement with a vitamin supplement for his wounds. V30 said]if they would have notified her sooner, she could have done more to help prevent further decline in weight and would have created a fax of recommendations to send to the medical director and director of nursing. On 08/21/24 at 12:03 PM, V12 (Dietary Manager) stated she was not aware of R100 having over a 20% weight loss in one month. V12 said she used to get a weight log monthly, or every other week, about who lost or gained weight. V12 said she hasn't got a weight log for resident who lost or gain in a "long time". V12 doesn't even know who gained or	S9999		