

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146036	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/04/2024
NAME OF PROVIDER OR SUPPLIER Shawnee Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE 1901 13th Street Herrin, IL 62948	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43088</p> <p>Based on interview and record review, the facility failed to ensure residents were free from misappropriation of medications for 3 of 3 residents (R1, R2, and R3) reviewed for misappropriation of property in the sample of 7.</p> <p>Findings Include:</p> <p>1. R1's face sheet documented an admitted to the facility on [DATE], with diagnoses including: Type 2 Diabetes Mellitus with Diabetic Nephropathy, Osteoarthritis, Morbid Obesity, Chronic Gout, and Low Back Pain.</p> <p>R1's cumulative Physician Order Summary documents a 9/13/20 order for oxycodone-Acetaminophen 10-325 milligrams, take 1 tablet by mouth 4 times a day for pain.</p> <p>R1's Minimum Data Set (MDS), dated [DATE] Section C0500, documents a Brief Interview for Mental Status (BIMS) score of 15, indicating R1 is cognitively intact.</p> <p>2. R2's face sheet documented an admitted [DATE], with diagnoses including: Chronic Pain and Wedge Compression Fracture of Third Lumbar Vertebra.</p> <p>R2's cumulative Physician Order Summary documents a 3/13/23 order for Hydrocodone-Acetaminophen 7.5-325 milligrams, take 1 tablet every 8 hours as needed for moderate pain.</p> <p>R2's MDS, dated [DATE], Section C0500, documents R2 has a BIMS score of 15, indicating R2 is cognitively intact.</p> <p>3. R3's face sheet documented an admitted [DATE], with diagnoses including: Primary Osteoarthritis, Unspecified Dementia, Pain in Right Hip, and Weakness.</p> <p>R3's cumulative Physician Order Summary documents an 11/7/20 order for Tramadol 50 milligram tablet, give 100 milligrams by mouth three times a day for pain.</p> <p>R3's MDS, dated [DATE], section C0500, documents a BIMS score of 10, indicating R3 has moderate cognitive impairment.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146036	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/04/2024
NAME OF PROVIDER OR SUPPLIER Shawnee Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE 1901 13th Street Herrin, IL 62948	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility document labeled Abuse Investigation Summary, with an incident date of 1/31/24, documents the following:</p> <p>.Initial Allegation: It was brought to the ADON (V6 Former Assistant Director of Nursing/ ADON) attention that there was a possible drug diversion from (V3 Licensed practical Nurse/ LPN) .</p> <p>.Resident Interviews: (R1) BIMS of 15 cognitively intact. Alert to person, place and time. Resident stated she has received her pain medication 4 times a day and she does not recall missing any of her medications. She states she would know if she did not get her medication, she would know it because she would not be able to go without it. (R2) BIMS of 15 cognitively intact. Alert to person, place and time. Resident states the nurses bring me my pain meds twice a day. I (R2) am supposed to ask for them, but they bring them to me when I do. They have never missed giving me the medicine. It might take them a little bit sometimes, but I always get it. (R3) BIMS score of 11 moderate impairments. (R3) is very hard of hearing and when asked if she gets her pain medication every day, she smiles at you and states well yes, I think so. I don't hurt. It is difficult to determine if she understands the questions because of her difficulty in hearing .</p> <p>.Employee Interviews: (V3, LPN) 1/31/2024 pulled into HR (Human Resources). Interviewed by (V2- Director of Nursing) and (V15, HR Director). (V3) immediately stated I am being set up before the (V2) DON and (V15) HR director could even explain to nurse why she was being interviewed. When (V3) was asked to report to work care for mandatory drug testing, she stated I will not take a drug test because I will pop positive for Tramadol, Norco, and Percocet. She stated she had old prescriptions for the Tramadol and Norco, but her mother gives her the Percocet. She also stated that what she does on her own time is her business .</p> <p>.1. (R1) resident</p> <p>A. On January8, 2024: 2 cards of 30 pills of oxycodone was delivered to the facility and signed into the narcotic binder and locked box.</p> <p>B. Medication administration times are 0800, 1300, 1700 and 2100.</p> <p>C. Oxycodone was given 4 times a day from 01/08 starting at 1700 through 01/15 at 2100 on eMar (electronic Medication Administration Record) which accounts for 1 card of 30 pills of oxycodone.</p> <p>D. On 01/15: 1 card of oxycodone was subtracted from the card count on narcotic record.</p> <p>E. Oxycodone was given on e[DATE] times a day from 01/16 starting at 0800 through 01/23 at 1300 which accounts for 1 card of 30 pills of oxycodone.</p> <p>F. On 01/23: 1 card oxycodone was subtracted from the card count on narcotic record which would account for the 2 cards that was delivered on January 8th.</p> <p>G. On 1/23 2 cards of 30 pills of oxycodone was delivered to the facility and signed into the narcotic binder and locked narc box.</p> <p>H. On 1/29/24 (V3) subtracted 1 card of oxycodone from the narcotic log.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146036	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/04/2024
NAME OF PROVIDER OR SUPPLIER Shawnee Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE 1901 13th Street Herrin, IL 62948	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>I. On eMar from 1/23 at 1700 through 1/28 at 2100- 22 doses of oxycodone was administered to (R1).</p> <p>J. On 1/29 (V3) started a new count sheet and administering oxycodone from a new card of 30.</p> <p>J. (sic) On 1/31 (V3) was questioned why she subtracted 1 card of oxycodone from the narcotic box and binder when there was supposed to be 8 pills left on the card according to the eMar. When (V6) went to the narcotic book and was not at medical records and or scanned into chart.</p> <p>2. (R2) resident</p> <p>A. On 01/15 a card of hydrocodone was removed from count and a new card of 30 was started.</p> <p>B. 1/16 through 1/29 (R2) was administered 16 doses of Hydrocodone on eMar.</p> <p>B. (sic) On 1/29 (V3) removed the hydrocodone card from count. Which would have left 14 pills on card.</p> <p>C. On 1/31 (V3) was questioned why she subtracted 1 card of oxycodone from the narcotic box and binder. When (V6) went to narcotic book to pull the oxycodone pill count log it was missing from the narcotic book, and it was not in medical records or scanned into chart.</p> <p>3. (R3) resident</p> <p>A. On 01/14 two cards of tramadol (30 pills per card) were delivered and signed into the narcotic binder and locked box.</p> <p>B. From 01/14 through 01/19 30 doses of tramadol are accounted for on the eMar and narcotic pill count sheet.</p> <p>C. From 01/19 through 01/25 30 doses of Tramadol are accounted for on eMar and narcotic count sheet.</p> <p>D. On 01/24 two cards of tramadol (30 pills per card) were delivered and signed into narcotic binder and narcotic locked box.</p> <p>E. On 1/26 through 1/29 11 doses of tramadol were given leaving 19 pills left on the card.</p> <p>F. On 1/29 (V3) removed 1 card of tramadol from the binder and narcotic locked box count.</p> <p>G. On 01/31 (V3) was questioned why she subtracted 1 card of Tramadol from the narcotic box and binder. When (V6) went to the narcotic book to pull the oxycodone pill count log, it was missing from the narcotic book, and it was also not in medical records or scanned into chart .</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146036	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/04/2024
NAME OF PROVIDER OR SUPPLIER Shawnee Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE 1901 13th Street Herrin, IL 62948	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>.(V6, Former ADON) notified Administrator of potential drug diversion. Investigation conducted. Resident and staff interviews conducted. Investigation concluded that all residents received their pain medications as directed. Facility assumed the cost and replaced the medication from pharmacy. Investigation also concluded that nurse in question (V3) could not provide evidence that medications were destroyed after removing them from locked narcotic box and that the forms were removed from secure location by the nurse in question (V3). (V3) denied incident and stated she was being framed by coworkers. Nurse in question also refused to go for drug testing and admitted she would test positive for 3 drugs, naming the three drugs in question for possible diversion. Nurse in question stated that she did not have a script for the three drugs she would test positive for because she gets them from her mother. She also could not remember what she did with the missing narcotic count sheets. She denied taking the medications. (V3) stated the cards were empty when she removed them from the narcotic sheet and lock box. Nurse resigned effective immediately. Incident reported to IDPH (Illinois Department of Public Health). Interviewed residents and staff. Incident reported to the Illinois State Police Medicaid Fraud Control Unit Abuse/ Neglect Hotline .Incident reported to IDFPR (Illinois Department of Financial Professional Regulation) . Also submitted online complaint form through IDFPR .</p> <p>The Abuse Investigation Summary documents the name of the investigator as V1 (Administrator) and documents a date of 2/7/24.</p> <p>The facility's January 2024 Controlled Substance Package Inventory Log documented the addition and subtraction of cards of medications to the running count in the locked narcotic box in the medication cart as follows:</p> <p>1/8/24 2 cards of Percocet (oxycodone) added for R1.</p> <p>1/15/24 1 card of Percocet removed for R1.</p> <p>1/22/24 1 card of Percocet removed for R1.</p> <p>1/23/24 2 cards of Percocet added for R1.</p> <p>1/29/24 1 card of Percocet removed for R1.</p> <p>1/11/24 1 card of Norco (hydrocodone) added for R2.</p> <p>1/15/24 1 card of Norco removed for R2.</p> <p>1/29/24 1 card of Norco removed for R2.</p> <p>1/3/24 1 card of tramadol removed for R3.</p> <p>1/3/24 1 card of tramadol added for R3.</p> <p>1/9/24 1 card of tramadol removed for R3.</p> <p>1/13/24 1 card of tramadol removed for R3.</p> <p>1/14/24 2 cards of tramadol added for R3.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146036	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/04/2024
NAME OF PROVIDER OR SUPPLIER Shawnee Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE 1901 13th Street Herrin, IL 62948	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1/19/24 1 card of tramadol removed for R3.</p> <p>1/24/24 2 cards of tramadol added for R3.</p> <p>1/25/24 1 card of tramadol removed for R3</p> <p>1/29/24 1 card of tramadol removed for R3.</p> <p>The January 2024 Controlled Substance Package Inventory Log documented on 1/29/24, V3 (LPN) signed out R1's card of Percocet, R2's card of Norco (hydrocodone), and R3's card of Tramadol.</p> <p>Packing Slips from (Facility's Pharmacy) documented the facility received 2 cards of 30 oxycodone on 1/8/24 and 01/23/2024 for R1, 1 card of 30 hydrocodone on 1/11/24 for R2, and 1 card of 30 tramadol on 1/3/24 for R3 and 2 cards of 30 tramadol on 1/14/24 and 1/24/24 for R3.</p> <p>R1's January 2024 eMAR documented R1 received oxycodone 4 times a day from 01/23/2024 through 01/29/2024 (with a total of 22 doses administered). R2's January 2024 eMAR documented R2 received hydrocodone as needed from 01/22/2024 through 01/29/2024 (with a total of 9 doses given). R3's January 2024 eMAR was reviewed and documented R3 received tramadol 3 times a day from 01/24/2024 through 01/29/2024 (with a total of 17 doses given).</p> <p>On 03/22/2024 at 10:43 A.M., V1 (Administrator) stated V6 (Former ADON), who reported the narcotic incident, was no longer employed at the facility. V1 stated she thought one of the nurses following V3 thought the count was off and couldn't find the cards and the sign out sheets. V6 was the Assistant Director of Nursing (ADON) at that time and started the investigation.</p> <p>On 03/22/2024 at 1:30 P.M., V1 stated the facility hasn't really implemented any new processes since the drug diversion incident. V1 said she called the pharmacy to inquire about an automated medication dispensing cabinet. V1 said the pharmacy representative explained the facility cannot lock up over 10 narcotic medications in an automated medication dispensing cabinet. V1 stated all nursing staff will be educated on Monday 03/25/2024 for completing in-house random drug tests. V1 stated she did not report the allegation of the drug diversion incident to local law enforcement. V1 said she was not aware she had to.</p> <p>On 03/22/2024 at 1:41 P.M., V2 (Director of Nursing/DON) stated the diversion was reported to V6 (Former ADON). V2 stated she was not at work on the day it was reported. V2 said V1(Administrator) and V6 had completed the investigation. V2 said V3 (LPN) refused a drug screen, and she was the only employee the investigation was focused on. V2 stated the facility has strong nurses now who pay close attention to the narcotic logs, and all staff know the proper way to report anything that looks abnormal to herself or V1. V2 said the facility requires two employees to sign when narcotics are destroyed.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146036	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/04/2024
NAME OF PROVIDER OR SUPPLIER Shawnee Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE 1901 13th Street Herrin, IL 62948	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 03/28/2024 at 10:49 A.M., V4 (Licensed Practical Nurse/ LPN) stated on 01/29/2024, she came in at 2:00 P.M. V4 said she completed the narcotic count with V3 (LPN). V4 stated the count at that time was correct. V4 said later in the shift, she realized the count was wrong but couldn't figure out how. V4 thought the narcotic count sheets were missing for R1, R2, and R3. V4 said no cards with medications were left in the drawer for R2. V4 stated R2 did not have his narcotic pain medication in the medication cart, but was ok with taking Tylenol. V4 stated the facility has an emergency box of medications if the resident needed the PRN (as needed) narcotic medication, and it could have been obtained. V4 said she then reported the possible issue with R1, R2, and R3's pain medication missing to V5 (Infection Control Nurse/ LPN) later in the shift when she realized it.</p> <p>On 03/28/2024 at 11:45 A.M., V5 (Infection Control Nurse/ LPN) stated V4 reported that there were some narcotic sheets missing and it seemed odd. V5 said V4 reported it later in the day on 1/29/24. V5 stated when V5 and V6 (Former ADON) came in the next morning on 1/30/24, they started investigating the issue. V5 stated V3 (LPN) said the cards were empty and the sheets were placed in medical records. V5 stated they looked for missing narcotic sheet papers and could not find them. V5 stated she then reported it to V6.</p> <p>On 03/28/2024 at 11:57 A.M., V6 (Former ADON) said she was the Assistant Director of Nursing (ADON) at the time this incident occurred. V6 stated a nurse brought it to her attention that there were three narcotic signs out sheets missing. V6 said she could not recall who the nurse was that brought this to her attention. V6 said she then started talking to staff to determine when the sheets and potential medications went missing. V6 said she and V15 (Human Resources Director) spoke with V3 (LPN). V6 said V3 reported that V3 was scatter brained and was not sure where she placed the sheets when they were completed. V6 stated they should have been immediately placed in medical records, as it is near the nurse's station. V6 said at some point in the conversation with V3, she asked V3 to produce the sheets or take a drug test. V6 said V3 then became very defensive, and stated if she would take a drug test it would be positive for the medications that were in question. V6 said V3 stated her mother gave her the same medications that were in question. V6 said V3 did not have a prescription for those medications, and V3 refused drug test again because V3 would be positive, and the facility would fire her. V6 said V3 was offered by V6 to resign or take a drug test. V6 said V3 went back to the medication cart and came back to conference room a little bit later with a piece of paper. V6 said the paper stated V3 was being set up by other staff who work for the facility, and V3 had worked with those staff at other places and there were problems. V6 said V3 resigned effective immediately. V6 said R1, R2, and R3's narcotic sign out sheets were never found. V6 said she did not notify the police. V6 said she was not aware that the police had to be notified.</p> <p>On 03/28/2024 at 1:00 P.M., R1 stated she does not have any concerns getting pain medications. R1 stated she knows she must ask for the pain medications and the nurses bring them to her. R1 said she could not recall a time she couldn't get her pain medications as ordered. R1 stated she is unaware of any issues with the pharmacy delivering her medications.</p> <p>On 03/28/24 at 11:11 A.M., R2 stated he has no issues getting meds, and doesn't remember not getting or not having pain meds when he needs them. R2 stated when he receives his pain medications, it helps with the pain. R2 could not recall a time where there have been any issues getting medication when asked.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146036	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/04/2024
NAME OF PROVIDER OR SUPPLIER Shawnee Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE 1901 13th Street Herrin, IL 62948	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 03/28/2024 at 11:20 A.M, R3 was interviewed, and used a white board to communicate due to being hard of hearing. R3 was asked via white board if she has problems getting her pain medications. R3 replied - sometimes I do. R3 was then asked to explain and said she sometimes she has problems swallowing the medications. R3 was asked if the facility has medications when R3 needs them and R3 responded yes, they always have the medications that I need. R3 said she has no issues with her medications.</p> <p>The facility's 10/27/14 Controlled Substance Storage policy documented, . Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal and record keeping in the facility in accordance with federal, state and other applicable laws and regulations . D. A controlled substance accountability record is prepared by the pharmacy/ facility for all Schedule II, III, IV, and V medications (See Forms: Controlled Substance Count Record .) Including those in the emergency kit, unless accountability is captured electronically. The following information is completed on the accountability form upon dispensing or receipt of a controlled substance .: 1) Name of resident, if applicable. 2) Prescription number, if applicable. 3) Name, strength, and dosage form of medication. 4) Date received. 5) Quantity received. 6) Name of nurse accessing the medication supply E. At each shift change, or when keys are transferred, a physical inventory of all controlled substances, including refrigerated items is conducted by two licensed nurses and is documented . F. Any discrepancy in controlled substance counts is reported to the director of nursing and pharmacy PIC (Pharmacist in Charge) immediately. The director of designee investigates and makes every reasonable effort to reconcile all reported discrepancies. The director of nursing documents irreconcilable discrepancies in a report to the administrator. 1) If a major discrepancy or a pattern of discrepancies occurs, or if there is apparent criminal activity, the director of nursing notifies the administrator and consultant pharmacist/ (Pharmacy Name) PIC immediately. 2) The administrator, consultant pharmacist . and/ or the director of nursing determine whether other action(s) are needed, e.g., notification of police or other enforcement personnel. 3) The medication regimen of residents using medications that have such discrepancies are review to assure the resident has received all medications ordered and the goal of therapy is met . 4) Controlled substance inventory is regularly reconciled to the Medication Administration Record (MAR) and Forms: Controlled Substance Count Record . G. Current controlled substance accountability records are kept in the MAR, or designated book. Completed accountability records are submitted to the director of nursing and kept on file for [5] years at the facility .</p> <p>A facility policy titled, Abuse Prevention Program, dated 10/2022, documents the following: .Policy: This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property . 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 . Misappropriation of Resident Property means the deliberate misplacement, exploitation, or wrongful temporary, or permanent use of a resident's belongings or money without the resident's consent . Informing local law enforcement. The facility shall also contact local law enforcement authorities . in the following situations: . When there is a reasonable suspicion that a crime has been committed in the facility by a person other than a resident .</p> <p>49714</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146036	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/04/2024
NAME OF PROVIDER OR SUPPLIER Shawnee Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE 1901 13th Street Herrin, IL 62948	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43088</p> <p>Based on interview and record review, the facility failed to implement the facility's abuse policy for 3 of 3 residents (R1, R2, and R3) reviewed for misappropriation of property in a sample of 7.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. R1's face sheet documented an admitted to this facility on 08/21/2018, with diagnoses including: Osteoarthritis, Morbid Obesity, Chronic Gout, and Low Back Pain. R1's cumulative Physician Order Summary documents a 9/13/20 order for oxycodone-Acetaminophen 10-325 milligram, take 1 tablet by mouth 4 times a day for pain. 2. R2's face sheet documented an admitted [DATE], with diagnoses including: Chronic Pain and Wedge Compression Fracture of Third Lumbar Vertebra. R2's cumulative Physician Order Summary documents a 3/13/23 order for Hydrocodone-Acetaminophen 7.5-325 milligram, take 1 tablet every 8 hours as needed for moderate pain. 3. R3's face sheet documented an admitted [DATE], with diagnoses including: Primary Osteoarthritis, Unspecified Dementia, Pain in Right Hip, and Weakness. R3's cumulative Physician Order Summary documents an 11/7/20 order for Tramadol 50 milligram tablet, give 100 milligrams by mouth three times a day for pain. <p>The facility document labeled Abuse Investigation Summary with an incident date of 1/31/24 documents the following:</p> <p>.Employee Interviews: (V3 Licensed Practical Nurse/LPN) 1/31/2024 pulled into HR (Human Resources). Interviewed by (V2-Director of Nursing) and (V15 Human Resources Director). (V3) immediately stated I am being set up before the (V2) DON and (V15) HR director could even explain to nurse why she was being interviewed. When (V3) was asked to report to work care for mandatory drug testing, she stated I will not take a drug test because I will pop positive for Tramadol, Norco, and Percocet. She stated she had old prescriptions for the Tramadol and Norco, but her mother gives her the Percocet. She also stated that what she does on her own time is her business .</p> <p>.(V6 Former ADON) notified Administrator of potential drug diversion. Investigation conducted. Resident and staff interviews conducted . Investigation also concluded that nurse in question (V3) could not provide evidence that medications were destroyed after removing them from locked narcotic box and that the forms were removed from secure location by the nurse in question (V3). (V3) denied incident and stated she was being framed by coworkers. Nurse in question also refused to go for drug testing and admitted she would test positive for 3 drugs, naming the three drugs in question for possible diversion. Nurse in question stated that she did not have a script for the three drugs she would test positive for because she gets them from her mother. She also could not remember what she did with the missing narcotic count sheets. She denied taking the medications. (V3) stated the cards were empty when she removed them from the narcotic sheet and lock box . Incident reported to the Illinois State Police Medicaid Fraud Control Unit Abuse/ Neglect Hotline .</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146036	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/04/2024
NAME OF PROVIDER OR SUPPLIER Shawnee Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE 1901 13th Street Herrin, IL 62948	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 03/22/2024 at 1:30 P.M., V1 stated she did not report the allegation of the drug diversion incident to local law enforcement. V1 said she was not aware she had to. V1 stated the facility hasn't really implemented any new processes since the drug diversion incident. V1 said she called the pharmacy to inquire about an automated medication dispensing cabinet.</p> <p>On 03/28/2024 at 11:57 A.M., V6 (Former ADON) said she was the Assistant Director of Nursing (ADON) at the time this incident occurred. V6 stated a nurse brought it to her attention that there were three narcotic signs out sheets missing. V6 said she could not recall who the nurse was that brought this to her attention. V6 said she then started talking to staff to determine when the sheets and potential medications went missing. V6 said she and V15 (Human Resources Director) spoke with V3 (LPN). V6 said V3 reported V3 was scatter brained and was not sure where she placed the sheets when they were completed. V6 stated they should have been immediately placed in medical records, as it is near the nurse's station. V6 said at some point in the conversation with V3, she asked V3 to produce the sheets or take a drug test. V6 said V3 then became very defensive, and stated if she would take a drug test it would be positive for the medications that were in question. V6 said V3 stated her mother gave her the same medications that were in question. V6 said V3 did not have a prescription for those medications, and V3 refused drug test again because V3 would be positive, and the facility would fire her. V6 said V3 was offered by V6 to resign or take a drug test. V6 said V3 went back to the medication cart and came back to conference room a little bit later with a piece of paper. V6 said the paper stated V3 was being set up by other staff who work for the facility, and V3 had worked with those staff at other places and there were problems. V6 said V3 resigned effective immediately. V6 said R1, R2, and R3's narcotic sign out sheets were never found. V6 said she did not notify the local police. V6 said she was not aware that the police had to be notified.</p> <p>A facility policy titled, Abuse Prevention Program, dated 10/2022 documents the following: .Policy: This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property . 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 . Misappropriation of Resident Property means the deliberate misplacement, exploitation, or wrongful temporary, or permanent use of a resident's belongings or money without the resident's consent . Informing local law enforcement. The facility shall also contact local law enforcement authorities . in the following situations: . When there is a reasonable suspicion that a crime has been committed in the facility by a person other than a resident .</p> <p>49714</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146036	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/04/2024
NAME OF PROVIDER OR SUPPLIER Shawnee Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE 1901 13th Street Herrin, IL 62948	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43088</p> <p>Based on interview and record review, the facility failed to operationalize its Abuse Policy by notifying local law enforcement when a reasonable suspicion of a crime has been committed in the facility for 3 of 3 residents (R1, R2, and R3) reviewed for abuse in the sample of 7.</p> <p>Findings include:</p> <ol style="list-style-type: none"> R1's face sheet documented an admitted to this facility on 08/21/2018 ,with diagnoses including: Type 2 Diabetes Mellitus with Diabetic Nephropathy, Osteoarthritis, Morbid Obesity, Chronic Gout, and Low Back Pain. R1's cumulative Physician Order Summary documents a 9/13/20 order for oxycodone-Acetaminophen 10-325 milligram, take 1 tablet by mouth 4 times a day for pain. R2's face sheet documented an admitted [DATE], with diagnoses including: Chronic Pain and Wedge Compression Fracture of Third Lumbar Vertebra. R2's cumulative Physician Order Summary documents a 3/13/23 order for Hydrocodone-Acetaminophen 7.5-325 milligram, take 1 tablet every 8 hours as needed for moderate pain. R3's face sheet documented an admitted [DATE], with diagnoses including: Primary Osteoarthritis, Unspecified Dementia, Pain in Right Hip, and Weakness. R3's cumulative Physician Order Summary documents an 11/7/20 order for Tramadol 50 milligram tablet, give 100 milligrams by mouth three times a day for pain. <p>The facility document labeled Abuse Investigation Summary, with an incident date of 1/31/24, documents the following:</p> <p>.Employee Interviews: (V3 LPN) 1/31/2024 pulled into HR (Human Resources). Interviewed by (V2-Director of Nursing) and (V15 HR Director). (V3) immediately stated I am being set up before the (V2) DON and (V15) HR director could even explain to nurse why she was being interviewed. When (V3) was asked to report to work care for mandatory drug testing, she stated I will not take a drug test because I will pop positive for Tramadol, Norco, and Percocet. She stated she had old prescriptions for the Tramadol and Norco, but her mother gives her the Percocet. She also stated that what she does on her own time is her business .</p> <p>.(V6 Former ADON) notified administrator of potential drug diversion. Investigation conducted. Resident and staff interviews conducted . Investigation also concluded that nurse in question (V3) could not provide evidence that medications were destroyed after removing them from locked narcotic box and that the forms were removed from secure location by the nurse in question (V3). (V3) denied incident and stated she was being framed by coworkers. Nurse in question also refused to go for drug testing and admitted she would test positive for 3 drugs, naming the three drugs in question for possible diversion. Nurse in question stated that she did not have a script for the three drugs she would test positive for because she gets them from her mother. She also could not remember what she did with the missing narcotic count sheets. She denied taking the medications. (V3) stated the cards were empty when she removed them from the narcotic sheet and lock box . Incident reported to the Illinois State Police Medicaid Fraud Control Unit Abuse/ Neglect Hotline .</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146036	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/04/2024
NAME OF PROVIDER OR SUPPLIER Shawnee Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE 1901 13th Street Herrin, IL 62948	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 03/22/2024 at 1:30 P.M., V1 stated she did not report the allegation of the drug diversion incident to local law enforcement. V1 said she was not aware she had to.</p> <p>On 03/22/2024 at 1:41 P.M., V2 (Director of Nursing/DON) stated the diversion was reported to V6 (Former ADON). V2 stated she was not at work on the day it was reported. V1(Administrator) and V6 had completed the investigation.</p> <p>On 03/28/2024 at 11:57 A.M., V6 (Former ADON) said she was the Assistant Director of Nursing (ADON) at the time this incident occurred. V6 stated a nurse brought it to her attention that there were three narcotic signs out sheets missing. V6 said she could not recall who the nurse was that brought this to her attention. V6 said she then started talking to staff to determine when the sheets and potential medications went missing. V6 said she and V15 (Human Resources Director) spoke with V3 (LPN). V6 said V3 reported V3 was scatter brained and was not sure where she placed the sheets when they were completed. V6 stated they should have been immediately placed in medical records, as it is near the nurse's station. V6 said at some point in the conversation with V3, she asked V3 to produce the sheets or take a drug test. V6 said V3 then became very defensive, and stated if she would take a drug test it would be positive for the medications that were in question. V6 said V3 stated her mother gave her the same medications that were in question. V6 said V3 did not have a prescription for those medications and V3 refused drug test again because V3 would be positive, and the facility would fire her. V6 said V3 was offered by V6 to resign or take a drug test. V6 said V3 went back to the medication cart and came back to conference room a little bit later with a piece of paper. V6 said the paper stated V3 was being set up by other staff who work for the facility, and V3 had worked with those staff at other places and there were problems. V6 said V3 resigned effective immediately. V6 said R1, R2, and R3's narcotic sign out sheets were never found. V6 said she did not notify the police. V6 said she was not aware that the police had to be notified.</p> <p>The facility's 10/27/14 Controlled Substance Storage policy documented, .Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal and record keeping in the facility in accordance with federal, state and other applicable laws and regulations . F. Any discrepancy in controlled substance counts is reported to the director of nursing and pharmacy PIC (Pharmacist in Charge) immediately. The director of designee investigates and makes every reasonable effort to reconcile all reported discrepancies. The director of nursing documents irreconcilable discrepancies in a report to the administrator. 1) If a major discrepancy or a pattern of discrepancies occurs, or if there is apparent criminal activity, the director of nursing notifies the administrator and consultant pharmacist/ (Pharmacy Name) PIC immediately. 2) The administrator, consultant pharmacist . and/ or the director of nursing determine whether other action(s) are needed, e.g., notification of police or other enforcement personnel .</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146036	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/04/2024
NAME OF PROVIDER OR SUPPLIER Shawnee Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE 1901 13th Street Herrin, IL 62948	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A facility policy titled, Abuse Prevention Program, dated 10/2022, documents the following: .Policy: This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property . 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 . Misappropriation of Resident Property means the deliberate misplacement, exploitation, or wrongful temporary, or permanent use of a resident's belongings or money without the resident's consent . Informing local law enforcement. The facility shall also contact local law enforcement authorities . in the following situations: . When there is a reasonable suspicion that a crime has been committed in the facility by a person other than a resident .</p> <p>49714</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146036	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/04/2024
NAME OF PROVIDER OR SUPPLIER Shawnee Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE 1901 13th Street Herrin, IL 62948	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43088</p> <p>Based on interview and record review, the facility failed to maintain accurate records of narcotics and administer medications to meet the needs of the residents for 3 of 3 residents (R1, R2, and R3) reviewed for pharmacy services in a sample of 7.</p> <p>Findings include:</p> <p>1. R1's face sheet documented an admitted to this facility on 08/21/2018, with diagnoses including: Type 2 Diabetes Mellitus with Diabetic Nephropathy, Osteoarthritis, Morbid Obesity, Chronic Gout, and Low Back Pain. R1's cumulative Physician Order Summary documents a 9/13/20 order for oxycodone-Acetaminophen 10-325 milligram, take 1 tablet by mouth 4 times a day for pain.</p> <p>R1's Minimum Data Set (MDS), dated [DATE] Section C0500, documents a Brief Interview for Mental Status (BIMS) score of 15, indicating R1 is cognitively intact.</p> <p>2. R2's face sheet documented an admitted [DATE], with diagnoses including: Chronic Pain and Wedge Compression Fracture of Third Lumbar Vertebra. R2's cumulative Physician Order Summary documents a 3/13/23 order for Hydrocodone-Acetaminophen 7.5-325 milligram, take 1 tablet every 8 hours as needed for moderate pain.</p> <p>R2's MDS dated [DATE], Section C0500, documents R2 has a BIMS score of 15, indicating R2 is cognitively intact.</p> <p>3. R3's face sheet documented an admitted [DATE], with diagnoses including: Primary Osteoarthritis, Unspecified Dementia, Pain in Right Hip, and Weakness. R3's cumulative Physician Order Summary documents an 11/7/20 order for Tramadol 50 milligram tablet, give 100 milligrams by mouth three times a day for pain.</p> <p>R3's MDS dated [DATE], section C0500, documents a BIMS score of 10, indicating R3 has moderate cognitive impairment.</p> <p>On 03/22/2024 at 10:43, V1 (Administrator) stated V6 (Former Assistant Director of Nursing/ADON) who reported the narcotic issue is no longer here. V1 stated she thought one of the nurses following V3 (Licensed Practical Nurse/LPN) thought the count was off, and couldn't find the cards and the sign out sheets. V6 was the ADON at that time, and started the investigation.</p> <p>On 03/22/2024 at 1:41 P.M., V2 (Director of Nursing/DON) stated the diversion was reported to V6 (Former ADON). V2 stated she was not at work on the day it was reported. V1 and V6 had completed the investigation. V2 said V3 (LPN) refused a drug screen, and she was the only employee that the investigation was focused on. V2 stated the facility has strong nurses now who pay close attention to the narcotic logs, and all staff know the proper way to report anything that looks abnormal to herself or V1.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146036	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/04/2024
NAME OF PROVIDER OR SUPPLIER Shawnee Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE 1901 13th Street Herrin, IL 62948	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 03/28/2024 at 10:49 A.M., V4 (Licensed Practical Nurse/ LPN) stated on 01/29/2024, she came in at 2:00 P.M. V4 said she completed the narcotic count with V3 (LPN). V4 stated the count at that time was correct. V4 said later in the shift, she realized the count was wrong, but couldn't figure out how. V4 thought the narcotic count sheets were missing for R1, R2, and R3. V4 said no cards with medications were in the narcotic drawer in the medication cart for R2. V4 said R2 did not have his narcotic pain medication in the medication cart, but was ok with taking Tylenol. V4 stated the facility has an emergency box of medications; if the resident needed the PRN (as needed) narcotic medication it could have been obtained. V4 said she then reported the possible issue with R1, R2, and R3's pain medication missing to V5 (Infection Control Nurse/ LPN) later in the shift when she realized it.</p> <p>On 03/28/2024 at 11:45 A.M., V5 (Infection Control Nurse/ LPN) stated V4 reported there were some narcotic sheets missing and it seemed odd. V5 said V4 reported it later in the day on 1/29/24. V5 stated when V5 and V6 (Former ADON) came in the next morning on 1/30/24, they started investigating the issue. V5 stated V3 (LPN) said the cards were empty and the sheets were placed in medical records. V5 stated they looked for missing narcotic sheet papers and could not find them. V5 stated she then reported it to the V6.</p> <p>On 03/28/2024 at 11:57 A.M., V6 (Former ADON) said she was the Assistant Director of Nursing (ADON) at the time this incident occurred. V6 stated a nurse brought it to her attention there were three narcotic signs out sheets missing. V6 said she could not recall who the nurse was that brought this to her attention. V6 said she then started talking to staff to determine when the sheets and potential medications went missing. V6 said she and V15 (Human Resources Director) spoke with V3 (LPN). V6 said V3 reported V3 was scatter brained and was not sure where she placed the sheets when they were completed. V6 stated they should have been immediately placed in medical records, as it is near the nurse's station. V6 said R1, R2, and R3's narcotic sign out sheets were never found.</p> <p>The facility document labeled Abuse Investigation Summary, with an incident date of 1/31/24, documents the following:</p> <p>.Initial Allegation: It was brought to the ADON (V6 Former Assistant Director of Nursing/ ADON) attention that there was a possible drug diversion from (V3 Licensed practical Nurse/ LPN) .</p> <p>.1. (R1) resident</p> <p>A. On January8, 2024: 2 cards of 30 pills of oxycodone was delivered to the facility and signed into the narcotic binder and locked box.</p> <p>B. Medication administration times are 0800, 1300, 1700 and 2100.</p> <p>C. Oxycodone was given 4 times a day from 01/08 starting at 1700 through 01/15 at 2100 on eMar (electronic Medication Administration Record) which accounts for 1 card of 30 pills of oxycodone.</p> <p>D. On 01/15: 1 card of oxycodone was subtracted from the card count on narcotic record.</p> <p>E. Oxycodone was given on e[DATE] times a day from 01/16 starting at 0800 through 01/23 at 1300 which accounts for 1 card of 30 pills of oxycodone.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146036	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/04/2024
NAME OF PROVIDER OR SUPPLIER Shawnee Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE 1901 13th Street Herrin, IL 62948	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>F. On 01/23: 1 card oxycodone was subtracted from the card count on narcotic record which would account for the 2 cards that was delivered on January 8th.</p> <p>G. On 1/23 2 cards of 30 pills of oxycodone was delivered to the facility and signed into the narcotic binder and locked narc box.</p> <p>H. On 1/29/24 (V3) subtracted 1 card of oxycodone from the narcotic log.</p> <p>I. On eMar from 1/23 at 1700 through 1/28 at 2100- 22 doses of oxycodone was administered to (R1).</p> <p>J. On 1/29 (V3) started a new count sheet and administering oxycodone from a new card of 30.</p> <p>J. (sic) On 1/31 (V3) was questioned why she subtracted 1 card of oxycodone from the narcotic box and binder when there was supposed to be 8 pills left on the card according to the eMar. When (V6) went to the narcotic book and was not at medical records and or scanned into chart.</p> <p>2. (R2) resident</p> <p>A. On 01/15 a card of hydrocodone was removed from count and a new card of 30 was started.</p> <p>B. 1/16 through 1/29 (R2) was administered 16 doses of Hydrocodone on eMar.</p> <p>B. (sic) On 1/29 (V3) removed the hydrocodone card from count. Which would have left 14 pills on card.</p> <p>C. On 1/31 (V3) was questioned why she subtracted 1 card of oxycodone from the narcotic box and binder. When (V6) went to narcotic book to pull the oxycodone pill count log it was missing from the narcotic book, and it was not in medical records or scanned into chart.</p> <p>3. (R3) resident</p> <p>A. On 01/14 two cards of tramadol (30 pills per card) were delivered and signed into the narcotic binder and locked box.</p> <p>B. From 01/14 through 01/19 30 doses of tramadol are accounted for on the eMar and narcotic pill count sheet.</p> <p>C. From 01/19 through 01/25 30 doses of Tramadol are accounted for on eMar and narcotic count sheet.</p> <p>D. On 01/24 two cards of tramadol (30 pills per card) were delivered and signed into narcotic binder and narcotic locked box.</p> <p>E. On 1/26 through 1/29 11 doses of tramadol were given leaving 19 pills left on the card.</p> <p>F. On 1/29 (V3) removed 1 card of tramadol from the binder and narcotic locked box count.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146036	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/04/2024
NAME OF PROVIDER OR SUPPLIER Shawnee Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE 1901 13th Street Herrin, IL 62948	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>G. On 01/31 (V3) was questioned why she subtracted 1 card of Tramadol from the narcotic box and binder. When (V6) went to the narcotic book to pull the oxycodone pill count log, it was missing from the narcotic book, and it was also not in medical records or scanned into chart .</p> <p>.(V6, Former ADON) notified administrator of potential drug diversion. Investigation conducted. Resident and staff interviews conducted. Investigation concluded that all residents received their pain medications as directed. Facility assumed the cost and replaced the medication from pharmacy. Investigation also concluded that nurse in question (V3) could not provide evidence that medications were destroyed after removing them from locked narcotic box and that the forms were removed from secure location by the nurse in question (V3). (V3) denied incident and stated she was being framed by coworkers. Nurse in question also refused to go for drug testing and admitted she would test positive for 3 drugs, naming the three drugs in question for possible diversion. Nurse in question stated that she did not have a script for the three drugs she would test positive for because she gets them from her mother. She also could not remember what she did with the missing narcotic count sheets. She denied taking the medications. (V3) stated the cards were empty when she removed them from the narcotic sheet and lock box. Nurse resigned effective immediately. Incident reported to IDPH (Illinois Department of Public Health). Interviewed residents and staff. Incident reported to the Illinois State Police Medicaid Fraud Control Unit Abuse/ Neglect Hotline . Incident reported to IDFPR (Illinois Department of Financial Professional Regulation) . Also submitted online complaint form through IDFPR .</p> <p>The Abuse Investigation Summary documents the name of the investigator as V1 (Administrator) and documents a date of 2/7/24.</p> <p>The facility's January 2024 Controlled Substance Package Inventory Log documented the addition and subtraction of cards of medications to the running count in the locked narcotic box in the medication cart as follows:</p> <p>1/8/24 2 cards of Percocet (oxycodone) added for R1.</p> <p>1/15/24 1 card of Percocet removed for R1.</p> <p>1/22/24 1 card of Percocet removed for R1.</p> <p>1/23/24 2 cards of Percocet added for R1.</p> <p>1/29/24 1 card of Percocet removed for R1.</p> <p>1/11/24 1 card of Norco (hydrocodone) added for R2.</p> <p>1/15/24 1 card of Norco removed for R2.</p> <p>1/29/24 1 card of Norco was removed for R2.</p> <p>1/3/24 1 card of tramadol removed for R3.</p> <p>1/3/24 1 card of tramadol added for R3.</p> <p>1/9/24 1 card of tramadol removed for R3.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146036	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/04/2024
NAME OF PROVIDER OR SUPPLIER Shawnee Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE 1901 13th Street Herrin, IL 62948	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1/13/24 1 card of tramadol removed for R3.</p> <p>1/14/24 2 cards of tramadol added for R3.</p> <p>1/19/24 1 card of tramadol removed for R3.</p> <p>1/24/24 2 cards of tramadol added for R3.</p> <p>1/25/24 1 card of tramadol removed for R3</p> <p>1/29/24 1 card of tramadol removed for R3.</p> <p>The January 2024 Controlled Substance Package Inventory Log documented on 1/29/24 V3 (LPN) singed out R1's card of Percocet, R2's card of Norco (hydrocodone), and R3's card of Tramadol.</p> <p>Packing Slips from (Facility's Pharmacy) documented the facility received 2 cards of 30 oxycodone on 1/8/24 and 01/23/2024 for R1, 1 card of 30 hydrocodone on 1/11/24 for R2, and 1 card of 30 tramadol on 1/3/24 for R3 and 2 cards of 30 tramadol on 1/14/24 and 1/24/24 for R3.</p> <p>R1's January 2024 eMAR documented R1 received oxycodone 4 times a day from 01/23/2024 through 01/29/2024 (with a total of 22 doses administered). R2's January 2024 eMAR documented R2 received hydrocodone as needed from 01/22/2024 through 01/29/2024 (with a total of 9 doses given). R3's January 2024 eMAR was reviewed and documented R3 received tramadol 3 times a day from 01/24/2024 through 01/29/2024 (with a total of 17 doses given).</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146036	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/04/2024
NAME OF PROVIDER OR SUPPLIER Shawnee Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE 1901 13th Street Herrin, IL 62948	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's 10/27/14 Controlled Substance Storage policy documented, . Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal and record keeping in the facility in accordance with federal, state and other applicable laws and regulations . D. A controlled substance accountability record is prepared by the pharmacy/ facility for all Schedule II, III, IV, and V medications (See Forms: Controlled Substance Count Record .) . The following information is completed on the accountability form upon dispensing or receipt of a controlled substance .: 1) Name of resident, if applicable. 2) Prescription number, if applicable. 3) Name, strength, and dosage form of medication. 4) Date received. 5) Quantity received. 6) Name of nurse accessing the medication supply E. At each shift change, or when keys are transferred, a physical inventory of all controlled substances, including refrigerated items is conducted by two licensed nurses and is documented . F. Any discrepancy in controlled substance counts is reported to the director of nursing and pharmacy PIC (Pharmacist in Charge) immediately. The director of designee investigates and makes every reasonable effort to reconcile all reported discrepancies. The director of nursing documents irreconcilable discrepancies in a report to the administrator. 1) If a major discrepancy or a pattern of discrepancies occurs, or if there is apparent criminal activity, the director of nursing notifies the administrator and consultant pharmacist/ (Pharmacy Name) PIC immediately. 2) The administrator, consultant pharmacist . and/ or the director of nursing determine whether other action(s) are needed, e.g., notification of police or other enforcement personnel. 3) The medication regimen of residents using medications that have such discrepancies are review to assure the resident has received all medications ordered and the goal of therapy is met . 4) Controlled substance inventory is regularly reconciled to the Medication Administration Record (MAR) and Forms: Controlled Substance Count Record . G. Current controlled substance accountability records are kept in the MAR, or designated book. Completed accountability records are submitted to the director of nursing and kept on file for [5] years at the facility .</p> <p>49714</p>		