STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146036	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shawnee Senior Living	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)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40666 Based on observation and interview, the facility failed to provide mouthcare for 1 (R9) of 3 residents reviewed for ADL's (Activities of Daily Living) in the sample of 9. The findings include: R9's Admission Record documents R9 was readmitted to the facility on [DATE], and includes diagnoses of unspecified intracranial injury with loss of consciousness of unspecified duration, sequela, gastrostomy status, non-pressure chronic ulcer of buttock with fat layer exposed, pressure ulcer of left hip, stage 3, and pressure ulcer of other site, stage 3. R9's Minimum Data Set (MDS), with Assessment Refernce date of 4/25/24 ,documents a Brief Interview for Mental Status (BIMS) score of 03, which indicates R9 has severe cognitive impairment. R9's MDS documented R9's Swallowing/Nutritional Status as receiving a feeding tube. The MDS section for Functional Abilities and Goals documents R9 has impairment of both upper and lower extremities, is dependent for personal hygiene, oral hygiene, shower/bath, and requires a mechanical lift. (Dependent is defined as the helper does all of the effort .resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity). R9's Care Plan documents a Focus Area stating R9 has an ADL self-care deficiency related to: Res (resident) has long history of TBI (Traumatic Brain Injury). Family states he has had a gradual decline over past [AGE] years. Has contractures of BLE (bilateral lower extremities) with a date initiated of 07/02/2018. R9 has interventions listed of Dependent for Grooming/Hygiene initiated on 11/19/23 and revised on 5/1/24, Dependent on staff for tube feeding initiated on 5/1/24, and Provide oral hygiene every AM, PM and PRN (as needed) initiated on 11/19/23. On 6/26/24 at 10:00 AM, R9 was observed to have a gastrosomy tube. R9's hands were contracted, and R9's mouth was observed to have grayish colored patches on his front teeth and around the sides of his gums. R9's bottom lip had 3 areas of dry skin that were yellowish in color. This surveyor asked V19 (Certified Nurse Aide/CNA) about the state of R9's mouth, and V19 stated, Yes, (R9) needs some mouth care. V19 said it looked like it hadn't been done in a while. There were no mouth swabs/foam applicators, mouthwash solution or lubricant in R9's room or bathroom. V19 left the room to retrieve mouth care items. V19 returned and used 2-3 foam applicators dipped in water to swab R9's mouth. V9 then used a wet washcloth to moisten the dry skin on R9's lips and the dry skin patches came off leaving skin intact. (continued on next page)

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/26/24 at 11:10 AM, V15 (CNA) said she provides mouth care a couple times a day to her residents. V15 said R9 keeps phlegm in his mouth and his lips are usually dry. V15 said she has reported it to the nurse. On 6/27/24 at 3:00 PM, V2 (Director of Nurses/DON) said it is her expectation residents receive mouth care every shift. There was no documentation found or presented by the facility to show evidence of daily mouth care being provided to R9. The facility's Mouth Care policy (revised April 2007) documents, Purpose: the purposes of this procedure are to keep the resident's lips and oral tissues moist, to cleanse and freshen the resident's mouth and to prevent infections of the mouth. Under Steps in the Procedure: .7. Position the emesis basin on the towel under the resident's chin. 8. Gently open the resident's mouth. (Place one hand on the chin and gently press downward.) 9 .Inspect mouth for sores and other abnormal findings and report any findings to the nurse.10. With your free hand, moisten the applicators with the mouthwash solution. 11. Insert the applicator into the resident's mouth. 12. Thoroughly wipe the roof of the resident's mouth, inside the cheeks, the tongue, and the teeth with the applicator. (Note: Change the applicator frequently.) 13.Place all used applicators into the emesis basin. 14. Rinse the resident's mouth by using clear (fresh) water on the applicators. 15. Dry the resident's face and chin area. Remove the towel. 16. Moisten the inside of the resident's mouth, tongue and lips. Use a prepared swab or a water soluble lubricant . The policy further states under Documentation: The following information should be recorded in the resident's medical record, if applicable: 1. The date and time the mouth care was provided. The name and title of the individual(s) who provided the mouth care. All assessment data obtained concerning the resident's mouth. The certified nursing assistant should report to the licensed nurse to record in the medical record. 2. Complaints of pain or discomfort of mouth. The certified nursing assistant should report to the licensed nurse to record in the medical record. 3. If the resident refused the treatment, the reason(s) why and the intervention taken. 4. The signature and title of the person recording the data. Under Reporting: 1. Notify the supervisor if the resident refuses the mouth care. Notify the nurse of any moth (sic) sores or other abnormal findings. 2. Report other infonnation in accordance with facility policy and professional standards of practice.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40666 Based on interview and record review, the facility failed to prevent an accident for 1 (R2) of 3 residents reviewed for accidents in the sample of 9. This failure resulted in R2 receiving a 2 cm (centieter) laceration to the right side of the forehead and being sent to the emergency room requiring 2 sutures. Findings Include: R2's Admission Record documents R2 was admitted to the facility on [DATE], and is [AGE] years old. R2's Admission Record documents diagnoses including but not limited to Diagnoses: Transient cerebral ischemic attack, unspecified, vascular dementia, unspecified severity, with other behavioral disturbance, other idiopathic peripheral autonomic neuropathy, chronic pain syndrome, unspecified glaucoma, unspecified macular degeneration, legal blindness, fibromyalgia, chronic pulmonary embolism, long term (current) use of anticoagulants, abnormal posture, weakness, and history of falling. R2's Minimum Data Set (MDS), with Assessment Reference date of 3/25/24, documents a Brief Interview for Mental Status (BIMS) score of 09, which indicates R2 has moderate cognitive impairment. R2's MDS for Functional Abilities and Goals documents R2 uses a manual wheelchair and was coded as dependent for the ability to wheel 50 feet with 2 turns or to wheel 150 feet in a small corridor or similar space. (Dependent is defined as the helper does all of the effort .resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity). R2's Care Plan includes a focus area documenting R2 is at risk for falls related to: Weakness/Recent Infections, Dementia, Hx (history) of falls at home, self transfers initiated on 11/15/19 and revised on 7/23/23. Interventions include 4/12/14 High Back w/c (wheelchair) initiated on 4/25/24 and 6/15/24 bilateral foot pedals to w/c initiated on 6/21/24. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The State of Illinois - Illinois Department of Public Health Long Term Care Facility Serious Injury Incident Report submitted by the facility documented R2 sustained a fall with physical harm or injury on June 15, 2024 at 11:30 AM. The incident report documented the following under Detailed Incident Summary: Resident (R2) is alert with intermittent confusion. BIMS: 10 severe cognitive impact. Diagnosis: TIA (transient ischemic attack) vascular dementia, blindness, neuropathy. Resident transfers with assist x (times) 2, may use hoyer lift when weak. Requires assistance with long distance ambulation using high back wheelchair. On 6-15-2024 at approximately 11:30, CNA (Certified Nursing Assistant) was assisting resident with ambulation in w/c (wheelchair) when she unexpectedly put her feet down, causing her to become entangled and fall forward out of chair. Resident does not remember the incident so is unable to say why she put her feet down while being assisted in the wheelchair. Resident propels self short distances and has not required foot pedals until this incident. Previously, she was able to hold legs up without difficulty. A laceration was noted to right side of forehead. First aid applied. Resident neuro checks WNL (within normal limits), vital signs stable, resident unable to provide statement as to what happened. Neurochecks initiated, NP (Nurse Practitioner) and resident's daughter notified. Resident sent to ER (emergency room) for evaluation via EMS (Emergency Medical Service). 6-15-2024 at 15:55 (3:55 PM) resident returned from ER to facility via EMS. All CT's (computed tomography) are negative, two stitches to right forehead. Bruising to right side of head. Resident can have extra strength Tylenol for pain and was put on Macrobid 100mg BID (twice daily) x 5 days for UTI (urinary tract infection). Interventions include Med (medication) review, ABX (antibiotic) therapy for UTI and bilateral foot pedals. IDT (interdisciplinary team) met, Physician, POA (Power of Attorney), and care plan updated. R2's local hospital records include an ED (Emergency Department) Provider Note, dated 6/15/24, and documented Pt (patient) brought by EMS from (name of nursing facility). EMS states the staff was pushing her in the wheel chair and she fell forward and hit her head. She has this circular puncture wound noted to the right side of his forehead. They said there was nothing there that could have caused it. The ED Provider Note further documents a Clinical Impression of: Fall, initial encounter, Laceration of forehead, initial encounter, and Acute cystitis without hematuria. An ED Procedure Note documents a Laceration Repair to R2's forehead, laceration lengh of 2 cm (centimeters), repair type was sutures and number of sutures was documented as 2. New Prescriptions given were Acetaminophen 500 mg (milligram) 1 tablet as needed every 6 hours for pain and Nitrofurantoin Macrocrystalmonohydrate (Macrobid) 100 mg by mouth two times a day for 5 days. On 6/25/24 at 2:00 PM, V7 (Certified Nurse Aide/CNA) stated he was pushing R2 to the dining room for lunch and she put her feet down and fell forward. V7 said he tried to grab her to keep her from falling, but that didn't work. V7 said he did not have any foot rests on the wheelchair when he was pushing R2. V7 said it happened so fast. V7 said R2 had been able to hold her feet up prior to the incident, but after the incident, a couple of other CNA's told him that she would put her feet down at times. V7 stated he felt really bad. On 6/27/24 at 3:00 PM, V2 (Director of Nurses/DON) stated she did the reportable incident on R2. V2 said R2 did self propel short distances and was good about keeping her feet up on longer distances, but that day she just put her feet down and fell forward. The facility's Fall Policy titled Falls - Clinical Protocol documents a section of Assessment and Recognition which includes the following: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	4. The staff will document risk factors for falling in the resident's record and discuss the resident's fall risk. a. Risk factors for subsequent falling include lightheadedness or dizziness, multiple medications, musculoskeletal abnormalities, peripheral neuropathy, gait and balance disorders, cognitive impainnent, weakness, environmental hazards, confusion, visual impainnent, and illnesses affecting the central nervous system and blood pressure. 5. The physician will identify medical conditions affecting fall risk (for example, a recent stroke or medications associated with increased falling risk) and the risk for significant complications of falls (for example, increased fracture risk in someone with osteoporosis or increased risk of bleeding in someone taking an anticoagulant).