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 07/24/2024
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)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49664 Failures at this level require more than one Deficient Practice Statement. A. Based on observation, interview, and record review, the facility failed to ensure a resident was free from neglect when they failed to accurately assess, treat, and prevent a significant decline in condition for 1 (R1) of 3 residents reviewed for neglect in the sample of 24. This failure resulted in R1, who has a history of confusion with infections, experiencing altered mental status and refusing overall care after being diagnosed with a urinary tract infection. R1's refusals of care additionally led to R1 developing a Stage 3 pressure ulcer, an unstageable pressure ulcer with sepsis secondary to skin and soft tissue infection, subsequently requiring an 11-day hospitalization for IV antibiotic therapy. This failure resulted in an Immediate Jeopardy, which was identified to have begun on 6/19/2024 when R1 was readmitted to the facility from a hospitalization . R1 was on a physician ordered treatment for urinary tract infection, yet the facility failed to implement interventions to prevent worsening of infection. R1 endured confusion with delusions related to infection, which led to refusal of medications and refusal of care with activities of daily living. R1's refusal of care included care with incontinence and repositioning, which led to development of pressure ulcers. R1's facility acquired pressure ulcers were not treated, and led to hospitalization on [DATE] for sepsis related to infection of skin and soft tissue in relation to the stage 3 pressure ulcer and unstageable pressure ulcer. V1 (Administrator) was notified of the Immediate Jeopardy on 7/11/2024 at 2:12 PM. The surveyors confirmed by observations, interview, and record review the Immediate Jeopardy was removed on 7/17/2024, but the noncompliance remains at a Level Two due to additional time needed to evaluate the implementation and effectiveness of in-service training. Findings Include: R1's Admission Record documents R1 was admitted to the facility on [DATE]. R1's POS (Physician order sheet), dated 7/2024, list diagnoses that include angina pectoris, heart failure, GERD (Gastroesophageal Reflux Disease), unspecified dementia, unspecified severity with other behavioral disturbances, atrial fibrillation, type 2 diabetes mellitus, paranoid schizophrenia, chronic kidney disease stage 4, hypothyroidism, chronic peripheral disease, gout, and COPD (Chronic Obstructive Pulmonary Disease). (continued on next page)

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 07/24/2024
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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's MDS (Minimum Data Set), dated 4/10/2024, documents a BIMS (Brief Interview for Mental Status) score of 15, which indicates R1 is cognitively intact. The same MDS section GG documents R1 requires substantial/maximal assistance with toileting/hygiene and with shower/bathing, and R1 requires assistance for sit to lying, sit to stand, chair/bed to chair transfer, toilet transfer, and tub/shower transfers. R1's care plan, dated 4/12/2024, documents R1 has risk for skin impairment and risk for pressure injury related to impaired mobility/use of assistive device, chronic kidney disease, and cardiac issues. Documented interventions include: minimize exposure to moistures and keep skin clean and dry especially fecal contaminant, assist with turning and positioning approximately every 2 hours and more often if needed or requested, and notify nurse immediately of any new areas of skin breakdown. R1's care plan also dated 4/12/2024 documents R1 is considered at risk for abuse/neglect (per assessment) due to depression, being dependent on others, Schizophrenia. Documented goals include R1 will be free from harm secondary to abuse/neglect through the review period with interventions including Report any suspected of abuse/neglect to Administrator immediately. R1's Progress Note, dated 6/19/2024 at 7:45 PM, documents, (R1) was returned to the facility via ambulance from local hospital with orders for Augmentin 875-125 mg (milligrams) twice daily for 10 days to treat urinary tract infection with ESBL (extended spectrum be-lactamase) in the urine. The same note documents R1 was alert and oriented to person, place, and time, refused a skin evaluation and was refusing to take medications as ordered. R1's Nursing Notes documents on 6/21/2024 at 5:11 PM, referral information faxed to a behavioral hospital for possible placement related to (R1's) delusions, refusal of care, and verbal behaviors. R1's Progress Note dated 6/21/2024 at 3:08 PM, documents, Resident refused to get up out of bed. He is mumbling to himself unable to understand what he is saying. He refused to take all meds. He would not allow writer to take his vitals. He did allow (blood glucose monitoring) to be done in thumb only but refused sliding scale coverage. He did eat about half of his breakfast and lunch. R1's Progress Note, dated 6/23/2024 at 5:27, PM documents, Resident has been in room talking to people that are not there all day he was heard telling people to get out of his room and mumbling under his breath. He refused to get up this shift has refused all meds. He did allow (blood glucose monitoring) but not insulin. R1's Progress Note, dated 6/24/2024 at 2:28 PM, documents, Res (resident) refusing to take meds and insulins. Refusing to get out of the bed as well as get dressed. Res educated on the importance of taking meds. Res became verbally aggressive and argumentative. Res non-compliant. (V26, Physician) notified. R1's Progress Note, dated 6/27/2024 at 4:13 AM, documents, refused meds and meals for past 1-2 weeks. R1's Progress Note, dated 6/28/2024 at 3:26 PM, documents, CNA (Certified Nursing Assistant) states that resident has been incontinent of stool and is lying in his bed with genitals exposed and refusing to be changed. V23 (Nurse Practitioner/NP) present for conversation and aware of continued behaviors. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's Progress Notes, dated 6/28/2024 at 3:44 PM by V2, documents, this writer spoke with (V23), NP (Nurse Practitioner) regarding (R1's) continued behaviors, (V23) reports that she spoke with (V26, Physician) about (R1) and stated they both feel that IM (Intramuscular) medication is needed but they are fearful for the safety of staff if they were to attempt to administer an IM medication to resident and therefore feel that a placement in a behavioral health facility is the best option at this time. On 7/1/2024 an order was given by (V18, Psychiatric Nurse Practitioner) gave an order for Haldol solution three times a day with meals. R1's Progress Notes, dated 7/1/2024 at 2:55 AM, documents, All shift resident has refused to let staff change him. Resident's bed is saturated in urine and dripping into the floor. Resident has a puddle of urine under his bed and was trailing to the door. Resident let staff clean the urine from his bed to the door but refused to let staff change him or clean under the bed. When cleaning under the bed was mentioned, the resident started yelling 'no' at the staff. Resident has been pleasant since that interaction and calling for needs. R1's Progress Note, dated 7/2/2024, signed by V2 (DON/Director of Nursing) documents, spoke with (V23) about resident's altercation with (R9) and CNA. (V23) immediately called (V26) and reported to (V26) (R1's) aggressive behavior. (V26) and (V23) agree that (R1) must be sent to ER for evaluation. (V26) advises to send resident to ER and to call local police if needed to assist EMS (Emergency Medical Services) with the transfer. (V26) states At this point you have to get (R1) out of there. What he has done tonight is assault and it is not safe for (R1) or other residents for him to remain in the building. Floor nurse (V7 Licensed Practical Nurse) notified of order to send to ER and transfer process begun at this time. R1's Progress Notes, dated 7/2/2024 at 6:45 PM, documents, (R1) was transported out by way of local ambulance service to local hospital after an altercation with (R9). Noted local police contacted and sent an officer in case assistance was needed due to acts of violence. R1's Shower Sheets, dated June 2024, documents R1 refused showers on 6/24/24 and 6/25/2024. The last documented shower R1 received was on 6/11/2024. There were no other showers documented indicating R1 did not receive a shower for 22 days. R1's Medication Administration Record (MAR), dated June 2024, documents Augmentin 875-125 mg one tab every 12 hours for bacterial infection for 10 days, start date of 6/19/2024. This same MAR documents from the dates of 6/19/2024 through 6/29/2024, R1 refused Augmentin 875-125 mg, 16 out of 20 offered dosages. The same document contains a physician order for another antibiotic of Levaquin 500mg, give one tablet by mouth one time a day for urinary tract infection for 7 days with start date of 6/20/2024, the same MAR documents R1 refused Levaquin 500mg 5 out of 7 offered doses. R1's Treatment Administration Record (TAR), dated 6/1/2024-6/30/2024, documents a physician's order for skin checks scheduled every Monday and Thursday with a start date of 9/17/2020. The TAR documents R1 refused the skin checks on 6/20/2024, 6/24/2024, and 6/27/2024. The same TAR documents a physician order for antifungal powder under bilateral breast folds, bilateral abdominal folds and groin every bedtime, start date of 11/22/2023. The TAR documents R1 refused treatment from 6/19/2024 to 6/30/2024. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's local hospital ER (emergency room) record, dated 7/2/2024, documents R1 reports he is here to have his wounds on his bottom addressed. This is the only area of pain that he has. No other complaints. Calm and cooperative at this time in ER. The ER's Impression and Disposition notes under clinical impression documents the following: 1. Sepsis due to unspecified organism, unspecified whether acute organ dysfunction present. 2. Altered mental status, unspecified altered mental status type. 3. Cystitis. Differential Diagnosis includes but not limited to, UTI (urinary tract infection), Electrolyte abnormality, medication induced psychiatric illness. Hospital Progress Notes on 7/3/2024 at 1:36 AM documents Sepsis secondary to skin and soft tissue infection. Hospital Wound Care Notes on 7/3/2024 at 10:00 AM documents, wound care consult completed at this time. Patient noted to have ITD (Intertriginous Dermatitis) to bilateral axilla's, bilateral chest folds, bilateral abdominal flanks, bilateral groin, and inner thighs and to scrotum and coccyx. Patient noted to have evolving DTPI (Deep Tissue Pressure Injury) to right buttocks and Stage 3 pressure injury to left buttocks. Left buttocks, stage 3 wound measuring 4 cm (centimeters) length, 2.5 cm width, 0.3 cm depth and wound surface area 10 cm. Right buttocks DTPI measuring 3 cm length, 2cm width, 0.3cm depth and 6 cm wound surface area. The hospital records from theER on [DATE] at 1:36 AM, indicates R1 was given IV (Intravenous) antibiotics of Vancomycin 2 gm (grams) and Levofloxin 750 mg (milligrams) after blood cultures were obtained. On 7/10/2024 at 11:17 AM, V9 (Certified Nurse Assistant/CNA) stated she sometimes takes care of R1. V9 stated, I had noticed for the last 2 weeks or more (R1) had not been acting himself. He has been refusing care and having bad behaviors. (R1) did get sent to the hospital and he is still there. On 7/10/2024 at 11:25 AM, V6 (Licensed Practical Nurse/LPN) stated she had taken care of R1, as he is on her hall. V6 stated, I noticed a change with (R1) the last 2 weeks. (R1) had been more violent and was refusing care. (R1) was supposed to be taking antibiotics for a urinary tract infection, but he was refusing his medications. V6 stated the floor nurses do treatments on the residents except for Thursdays because that is the day that the wound doctor comes to the facility. V6 stated she was not aware of any wounds on R1, and he was not getting any treatments. V6 stated she heard of his behaviors when he tried to pull another resident out of the bed. On 7/10/2024 at 11:20 AM, V5 (CNA) stated she always works 6am to 2pm shift. V5 states she normally takes care of R1. V5 stated, (R1) was always fine until the last few weeks, and he started refusing care. V5 stated, I did not know of any wounds on (R1). We tried to provide care to him, but he would get upset. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 7/10/2024 at 12:00PM, V7 (Licensed Practical Nurse/LPN) stated she works all halls here, and she is familiar with R1, as she takes care of him when she works his hall. V7 stated the floor nurses do the treatments on the residents. V7 stated, I was here when (R1) tried to pull (R9) out of bed. (R1) had tried to go into (R9's) room several times on that day and we had to keep redirecting him. I moved my medication cart down the hall closer to (R9's) room so that I could keep an eye on the situation. (R1) went into (R9 's) room and started yelling that (R9) was causing electrical shock to his beard and something about black stuff, then (R1) grabbed (R9's) foot and tried to drag him out of bed. When the CNA tried to separate them, (R1) hit (V14, Certified Nurse Assistant) in the abdomen, and (R1) had earlier grabbed (R9's) over bed table and threw it. I witnessed (R1) trying to grab (R9) out of bed. V7 was asked if she felt this was considered abuse to R9, she replied, No because (R1) did not do that intentionally because he did not know what he was doing. V7 stated, Prior to 2 weeks or so ago, (R1) was so sweet and real easy going. I was unaware of any wounds on (R1) until right before I sent him out to the hospital the last time on 7/2/2024. (V12, CNA) was helping try to get (R1) ready to be transported to the hospital and she noted a large wound to (R1's) buttocks, (V12) reported it to me immediately, but when I went into the room to assess the wound (R1) refused, so I did not get to even look at it. V7 was asked how often they did skin checks on R1, and V7 stated weekly. V7 stated they document those on the (MAR) Medication Administration Record. On 7/10/2024 at 3:55 PM, V12, CNA, stated she works the hall where R1 resides. V12 stated, I had taken care of (R1) for a long while. (R1) was always nice up until the last month to month and a half. V12 stated, (R1) was refusing all care as of lately. One day we went in his room, and (R1) was drenched in urine, the floor had urine everywhere, and the mattress was leaking urine on the floor and under the bed. It was bad. (R1) allowed us to clean the urine off the floor, but would not let them clean under the bed, clean him up or change the mattress out. V12 stated, We offered care for days before (R1) went to the hospital, but he just refused. When V12 was asked about any skin issues with R1 she stated, I would apply powder to his groin area prior to his refusal of care because it was gaulded, but on the day we were getting ready to send him out to the hospital, I noticed a big circular area on (R1's) bottom and it was bleeding pretty good. I then went to (V7, LPN) and told her, but (R1) refused to let (V7) look at it and then the ambulance came. I was not aware the big area on (R1's) bottom was there until that day. V12 stated R1 is wheelchair bound, but R1 can walk a few steps. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 7/11/2024 at 2:59 PM, V18 (Psychiatric Nurse Practitioner) stated she started seeing R1 about 2 years ago. V18 stated R1 told her he first started having issues like delusions/hallucination when he got a UTI. V18 stated, I was asked to stop the Zyprexa a couple of years ago because he didn't have the proper diagnosis to support giving it. (R1) was a very pleasant and very knowledgeable man that was always alert and oriented x 4. V18 stated she was not aware of any psychiatric problems over the past 2 years until recently. V18 stated she had gotten a couple of calls from the facility about R1's behaviors lately and R1 refusing care. V18 stated she had talked with V23 (Nurse Practitioner/NP) and the staff about giving some medication IM (intramuscular) so they could get him better, and hopefully R1 would start taking his regular medications, antibiotics, and especially his insulin. V18 stated, The nurses would not give the medications IM due to it being unsafe for the nurses and I was told they could not hold him down to administer it. V18 stated she expressed concerns with him not getting his insulin, and she even offered to come to the facility and give the IM injections herself. V18 stated, The facility declined my offer because they stated he would refuse. V18 stated at this point, he was harmful to himself and others. V18 was asked if she felt the UTI could have caused the hallucinations/delusions, she replied, Due to the infection effects, it possibly started when (R1) refusing medications then refusing care and has had a definite effect on his well-being. V18 stated she feels R1 is misdiagnosed , and she feels he does not have Schizophrenia. V18 stated, First, Schizophrenia is a mental illness that is continuous, and he has been off medications for 2 years with no issues. V18 then stated she feels like he has bipolar, and that is why he can go for a while without medications before any issues come up. V18 stated, Sometimes any type of infection can cause confusion and that leads to other issues in people that are normally not confused. On 7/12/2024 at 8:01 AM, V27 (Healthcare Power of Attorney for R1) stated, I was not sure where (R1) was at this time. Before coming to the nursing home, (R1) was at another hospital because he wasn't taking his medications and got violent. This all started with a urinary tract infection. Once he got over the infection, he went back to his normal self and did good. (R1) has been a preacher for several years. (R1) never had his own church, but helped churches and filled in when a pastor was not available. I didn't know he was back in the hospital. V27 was asked if she was aware an Involuntary Discharge had been issued to the resident from the nursing home, and she stated, No, I didn't know. V28 (family member) was present on the phone call and stated, His behaviors are always triggered by infections. V27 was asked if she was aware of any skin issues like wounds and she stated, No, I didn't know anything about this either. On 7/12/2024 at 8:40 AM, R1 was visited at the local hospital. R1 was sitting up in bed watching television. R1 was alert and oriented x 4. R1 stated he is feeling much better. R1 stated his bottom is not hurting like it was so he thought his wounds were healing. R1 stated he got the wounds while at the facility. R1 stated, When I get any kind of infection it goes to my brain for some reason, and I am not right when I do get an infection. R1 stated he wants to go back to the facility. R1 was asked if he was aware of possibly not being able to return to the facility and he said, No, I don't know anything about that. R1 stated he is taking his medication and he is taking his insulin when he needs it. R1 stated he must take medications for his Neuropathy; he stated it is Gabapentin and it does help me. R1 also stated he has hypothyroidism, and he takes Levothyroxine for that as well. R1 stated he was tired and was going to take a nap at this time. R1 then stated, I miss my friends at the facility, and I teach Bible study classes there as well. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 7/12/2024 at 8:25AM, V29 (Case Manager at local hospital) stated (R1) is doing much better now that the infection is better. V29 stated, Facility said if he was seen by Psych (inpatient) that he could come back, but the behavioral hospital denied him after review of his hospital course, and said it was a medical issue. V29 stated R1 is taking his medications and his wounds are healing. V29 stated he is showing signs of sundown syndrome, as he tries to refuse medications at night, but is fine throughout the day. On 7/12/2024 at 11:07 AM, V3 (LPN/Licensed Practical Nurse/Infection Preventionist) was asked to describe R1 prior to 6/19/2024. V3 stated R1 was alert and oriented x4, he led Bible Study at the facility. V3 stated she noticed his behaviors when they moved a roommate in with R1. V3 stated, The resident we moved in was on Enhanced Barrier Precautions, and this set (R1) off. (R1) became withdrawn and was going to the dining room, but was observed talking back to himself, but it escalated. He was saying things about his family coming through the backdoor and threw stuff on him causing skin issues. This was definitely a change in condition. We know when (R1) starts acting off, he is afraid of an infection. I believe he was freaked out about the roommate that we had moved in, but we didn't leave that roommate in there very long at all. (R1) will come and ask us to do a urinalysis when he thinks he is getting a UTI because he is scared to get any kind of infection. We had received orders for urinalysis, but (R1) was refusing to give us a urinalysis for several days. He finally went to the ER because of his groin pain and cellulitis. V3 explained what happened once he returned from that hospitalization . V3 stated, Well, the hospital stated he was taking his medications, but we found out later that he did not take medications there either, and he had ripped out his IV's. V3 stated R1 returned 6/19/2024, with antibiotic orders for UTI. He was still having delusions and was refusing medications, and he was refusing care. When V3 was asked if the Healthcare Power of Attorney was called, she stated, I believe she was, but every time we talk to her, she is always saying (R1) wants attention, and he knows I am busy with my son who has cancer. V3 stated The hospital can do more than we can, he is a bigger guy. V3 was asked, since she was the Infection Control Preventionist Nurse, was she looking at R1 from an infection standpoint, V3 replied, I was focused on the behaviors more, but he wouldn't let me screen him about infections, and I believe half of his problems were stemming from infections. V3 was asked if she was aware of his wounds and she stated, No, I do not do skin checks or deal with wounds. V3 stated she was with V2 when they went to the hospital to give IVD (Involuntary Discharge) papers. V3 stated, (R1) was alert, but I questioned if he understood what all we were reading and telling him, about the appeal process. V3 was asked about the lack of care, especially from 6/19/2024 through 7/2/2024. She stated, We tried to do more for (R1), and we felt if we sent him to the hospital that they would just send him right back. When (R1) tried to pull another resident out of bed, this was an isolated incident besides hitting the CNA in the stomach. Again, we looked more at the psych and behaviors even though we knew he did this with infections. V3 stated, I am going to review the updates, but I did see the pictures of his wounds that were taken at the hospital, and they didn't look good, but I did not know he had those. (continued on next page)

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 7/12/2024 at 9:40 AM, V2 (Director of Nursing/DON) was asked to explain issues with R1, from the time of readmission from the hospital on 6/19/2024. V2 stated, (R1) had been having unusual behaviors like, refusing medications, he would say that he didn't need his medications, and he was refusing care up until he went back to the hospital on 7/2/2024. (R1) was sent out to the ER at his request on 6/16/2024 because he was having pain in his groin area. He was admitted for cellulitis of the groin area then noted to have a urinary tract infection (UTI). (R1) was being seen by the wound doctor for the yeast on his groin area, but had refused to allow the wound doctor to see him the last couple of times. (R1) came back on 6/19/2024, was refusing medications including antibiotics for UTI. We were trying to get him into a behavioral facility because of his Psych (psychiatric) issues. I was aware (R1) was refusing all care most of the time. V2 stated she received a call one night from the facility that (R1) had so much urine everywhere in his room, his mattress was saturated and leaking on the floor, the urine was even running out into the hallway. (R1) would only let the staff mop the hallway and barely in his room. V2 was asked if care was provided at that time to clean up R1 and change out the mattress, V2 stated, (R1) would not let the staff clean anything else. I was looking more at the Psych issues than I was the medical issues. During interview, V2 reviewed the shower sheet documentation for R1 from the time of readmission 6/19/2024 until R1 went back out to the hospital on 7/2/2024, and there were no showers given due to refusals. V2 stated, I was not aware of any wounds on (R1), and nobody reported wounds to me, and I do all the wounds in the facility and round with the wound doctor on Thursdays. V2 stated, We did call the EMS (Emergency Medical Services) on 6/10/2024 and for (R1) to go out to the ER, but EMS would not take him because he refused, and he was able to answer all their questions appropriately. V2 was asked how they got him to go to the hospital on 7/2/2024, she stated, He didn't have a choice; he tried to harm another resident. V2 was asked if she was aware there was documentation of talk between V23 (NP) and V26 (physician) about giving medications IM to help get R1 care, but there was concern with the safety for the staff. V2 replied, Yes, I made that entry, and I was worried that staff would get hurt because (R1) is a big strong guy, and I didn't want any staff to get harmed. When V2 was asked if R1 received care from 6/19/2024 through 7/2/2024, she stated, No, not really, he was refusing all care. We were documenting to try to get enough documentation to get him out to a behavioral facility to help with his Psych issues. On 7/12/2024 at 9:10 AM, V1 (Administrator) stated she was out of town the week of 7/2/2024, when she got the call from V2 (DON/Director of Nursing). V1 stated V2 had a report of abuse with R1 and another male resident. V1 stated V2 reported R1 was sent out to the hospital. V1 stated she received another call a little later from V2, who stated Corporate contacted her and said they had to give an Involuntary Discharge (IVD) to R1. V1 stated she told V2 that many others had to be contacted before an IVD could be given, including the Ombudsman, and it was too late in the night for all those calls. V1 stated someone called V2 and said R1 qualified for IVD because he was harmful to himself and others. V1 said on 7/3/2024, V2 and V3 (LPN/Licensed Practical Nurse/Infection Control Nurse) took IVD papers to R1 at the local hospital. V1 stated she was pretty sure V27 (Healthcare Power of Attorney for R1) was called about the IVD. V1 stated, I think it was an emergency discharge. We want (R1) back if he gets his infections taken care of because he goes over the deep end when he gets an infection. It's a cycle he has done before. (R1) is normally our best resident, he is [NAME] President of Resident Council, he teaches Bible Study classes, and he is our facility Santa Claus every year, and he does so well with the kids that the employees bring in to see him as Santa. When V1 was asked if she knew R1 had pressure ulcers that he acquired at the facility she stated, No, I did not know that. I get updates from the hospital, but I only look at Case Manager notes. V1 stated she hates that, but he was refusing all care for a while. V1 stated she was going to go see R1 at the hospital as she really wants to get him back to the facility. V1 stated, We all love (R1), and we want him here. (continued on next page)

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 07/24/2024
NAME OF PROVIDER OR SUPPLIER Shawnee Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE 1901 13th Street Herrin, IL 62948	

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 7/12/2024 at 1:57 PM, V23 (Nurse Practitioner) stated, I have known and cared for (R1) for a long time. V23 stated normally R1 is a pleasant guy that is alert and oriented x4. V23 stated, I feel (R1) needs inpatient psych to get his meds regulated. V23 stated she had worked closely with V18 (Psych NP) regarding R1. V23 stated V18 ordered Haldol liquid and they tried giving it to R1 in a drink, and R1 wouldn't drink it. V23 stated, I was afraid someone would get hurt if they tried to give him an IM injection. V23 stated, That would only help for a little bit though. V23 stated, (R1) was urinating everywhere and was pouring urine all over himself, was laying in urine and feces, and refused care for long periods of time. V23 was asked if she was aware of the wounds on R1's buttocks and she stated, I didn't know anything about wounds, but have seen the pictures taken at the hospital. V23 stated, (R1) was always cautious about getting a UTI and (R1) would come and tell me that he needs a UA (urinalysis) because he may be getting a UTI. V23 stated, I ordered a UA when the staff told her that he was talking to himself, but (R1) refused it. V23 stated she would stop by and check on him and he would say, I am doing ok, then I would walk past the doorway and he would be talking to the television. V23 stated, I was there the night (R1) went out the last time and I had them to call the police to come because I was afraid R1 would hurt someone because he is a big strong guy. V23 was asked if she felt the infection caused the confusion and delusions and she stated, It is hard to say which came first the psych issues or the infection. V23 stated, I was aware (R1) was refusing care including personal care and refusing medications with most concerning medications of antibiotics. On 7/12/2024 at 12:50 PM, V26 (Physician/Medical Director) stated he was aware of R1's behaviors. V26 stated he was aware R1 tried to harm another resident and R1 went out to the hospital. V26 was asked if he was aware R1 was refusing all care from the staff, he stated, I was aware he was refusing medications, but was not aware of how long he was refusing. V26 was asked if he was aware R1 refused all care from 6/19/2024 through 7/2/2024 and he stated, (V18 Psych NP) has been dealing with him mostly, but I wasn't aware that he refused care for that many days. V26 was asked if he talked with V18 at one point about possibly giving medications IM so R1 would allow care or be sent to the ER, V26 stated, Yes, but I was told they were afraid someone would get hurt as he is a big guy, but I have been hit myself and I am sure you have too. V26 stated, My biggest concern was that (R1) was going to hurt himself or other residents. V26 stated, I am sure they tried to care for him, and I know (V18) was trying, sometimes it is just difficult. The tipping point is why they sent him out, when he tried to pull the other guy out of the bed. V26 was asked if he felt like R1 was harming himself by refusing care and medications, V26 replied, Of course he was. V26 stated, I know (V23) had gone to see him including the day they sent him out. V26 was asked if he knew about the wounds R1 had once he got to the ER, and he stated, No, nobody has told me about that. V26 was asked if he felt the infection could have caused the behaviors which led to the lack of care, which in turn caused the wounds and he stated, Well lack of care can cause wounds and infection of any kind can cause worsening of confusion. Infections are rough on some folks. V26 was asked if he felt R1 was causing harm to himself by refusing his medications including Insulin and antibiotics and refusal of care and he replied, Yes, he was not helping his situation. V26 stated R1 has been at the facility a long time and is usually very pleasant and active in different activities there. R1's Progress Note, dated 7/13/24 at 3:40 PM, documents R1 returned to the facility and is alert and oriented x 3, has no complaints, and is cooperative. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility policy titled Pressure Ulcers/Skin Breakdown - Clinical Protocol (revision date August 2008) documents under section Assessment and Recognition: 1. Document an individual's significant risk factors for developing pressure sores, for example immobility, recent weight loss, and a history of pressure ulcers. In addition, the nurse shall assess and document/report the following: a. Full assessment of skin condition including but not limited to location, stage or partial/full thickness, length, width, depth, presence of exudates or necrotic tissue. B. Pain assessment, c. Resident's mobility status, d. current treatments, including support surfaces, e. all active diagnosis. Under the section titled Cause Identification it documents 1. Identify factors contributing or predisposing residents to skin break [TRUNCATED]

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32765 Based on interview and record review, the facility failed to thoroughly investigate allegations of witnessed peer to peer abuse when they failed to substantiate that abuse occurred, and failed to investigate one allegation of abuse for 4 of 7 (R6, R7, R8, R9) residents reviewed for abuse in the sample of 24. Findings Include: The facility policy Abuse Prevention Program (dated 10/2022) documents, 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. This will be done by: .establishing an environment that promotes resident sensitivity, resident security and prevention of mistreatment; identifying occurrences and patterns of potential mistreatment . implementing systems to promptly and aggressively investigate all reports and allegations of abuse, neglect, exploitation, misappropriation of property and mistreatment, and making the necessary changes to prevent future occurrences .Definitions .Abuse: Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means .Abuse is willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting physical harm, pain, or mental anguish to a resident Residents who allegedly abused another resident shall be immediately evaluated to determine the most suitable therapy, care approaches, and placement, considering his or her safety, as well as the safety of the other residents and employees of the facility. In addition, the facility shall take all steps necessary to ensure the safety of residents including, but not limited to, the separation of the residents Internal Investigation: 1. All incidents will be documented, whether or not abuse, neglect, exploitation, mistreatment or misappropriation of resident property occurred, was alleged or suspected. 2. Any incident or allegation involving abuse, neglect, exploitation, mistreatment or misappropriation of resident property will result in an investigation. 1. R8's Admission Record, with a print date of 7/18/24, documents R8 was admitted to the facility on [DATE], with diagnoses that include Alzheimer's disease, dementia, diabetes, anxiety disorder, and obesity. R8's MDS, dated [DATE], documents R8 has a BIMS score of 07, which indicates R8 has a moderate cognitive deficit. R8's current Care Plan documents a Focus area of, (R8) is an Abuse risk of 2 due to being dependent on others as well as anxiety. Date Initiated: 08/17/2023. The intervention for the Focus area, dated 8/17/23, documents, We will monitor for any signs of abuse as well as keep an open line of communication open between staff and resident. R8's facility Progress Notes provided to this surveyor do not document any notes related to the allegations of peer-to-peer abuse. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shawnee Senior Living	1901 13th Street Herrin, IL 62948

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F 0610

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

R4's Admission Record, with a print date of 7/15/24, documents R4 was admitted to the facility on [DATE], with diagnoses that include dementia, diabetes, polyneuropathy, hypertension, cognitive communication deficit, and anxiety disorder.

R4's Minimum Data Set (MDS), dated [DATE], documents a BIMS (Brief Interview for Mental Status) score of 01, which indicates R4 has a severe cognitive deficit. This same MDS documents under Behavior R4 does not have hallucinations but does have other behavioral symptoms not directed toward others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily waste, or verbal/vocal symptoms like screaming, disruptive sounds).

R4's current Care Plan documents a Focus area of, (R4) a behavior problem related to urinating in trash cans and hallways he does have episodes of grabbing, hitting at, and wandering. Date Initiated: 10/16/2024. This Focus area documents the following interventions, Administer medications as ordered. Monitor/document for side effects and effectiveness. Date Initiated 05/22/2024.Anticipate and meet needs for toileting. Date Initiated 10/16/2023. Praise any indication of progress/improvement in behavior. Date Initiated 10/16/2023. This care plan does not document specific person-centered interventions to prevent physical aggression against peers.

The Facility Incident Report, dated 4/28/24, documents under Final: (R8) reported to nurse that while she was self-propelling from front lobby to (name of) unit, she was struck in head by open hand of (R4). In interview (R8) at first denied pain, but then later stated that she had a headache and requested Tylenol. Upon inspection of resident head, no marks or swelling noted. There is insufficient evidence to substantiate abuse.

The facility Abuse Investigation Summary documents under Employee Interviews related to the 4/28/24 incident between R4 and R8, (V13/CNA-Certified Nursing Assistant)-4/29/24 1400 (2:00 PM) I was the CNA on (name of unit) today. My resident (R8) came to me and told me (R4) had hit her in the head with his hand when she was by the porch. I did not notice any marks on (R8), but she was upset and complained of her head hurting. I took (R8) to the nurse (V21/RN-Registered Nurse).

The Facility Incident Report, dated 5/6/24, documents under Final: (V13/CNA) reported to DON (Director of Nurses/V2) that she had witnessed (R4) make contact with (R8)'s forehead with an open hand while both residents were in the dining room. There was no harm intended and no injury resulted. In interview (R8) initially reported that she had been hit in the head by a man but unable to recall when it had happened. Resident denied being in any pain. Upon inspection no marks or swelling noted. There is insufficient evidence to substantiate abuse.

The facility Abuse Investigation Summary, dated 5/6/24, documents under Employee Interviews, (V13, CNA) 5/6/24 1500 (3:00 PM) reports that she witnessed (R4) smack (R8) in the forehead while both residents were in the dining room. (V13) reports that (R8) was trying to talk to (R4) and that (R4) told (R8), No! and tried to move away from her but (R8) continued to try to talk to (R4) and then (R4) lightly smacked (R8)'s forehead. (V13) then reported incident to DON (V2) and reports no other residents or staff were around for incident.

On 7/11/24 at 9:21 AM, R8 stated she didn't have any serious issues with peers. R8 stated R4 was doing something, and she told him to be careful. R8 stated R4 hit her in the forehead twice. R8 stated she wasn't afraid of him or anyone else at the facility, but she does avoid him now.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/11/24 at 11:10 AM, V13 (CNA) stated she had witnessed R4 hit R8 in the dining room. V13 stated R8 was just talking to R4, and he got agitated and hit her in the forehead. V13 stated it was an open hand smack, R8 backed away, and she reported it. V13 stated that wasn't the first time he hit R8, and R4 also hit R7. V13 stated she wasn't sure why he hit them in the forehead. V13 stated it typically happens in the dining room or in the lobby. V13 stated there were no injuries and R4 doesn't usually hit them very hard. V13 stated R8 just tries to steer clear of (R4). On 7/18/24 at 9:28 AM, V25 (RN/Registered Nurse) stated they redirect R4, but they have to watch how they approach him, or he will get aggressive. V25 stated she had never witnessed R4 be aggressive with peers. V25 stated it seemed like R4 was targeting R8. V25 stated R4 had hit R8 on the head a couple of times in the dining room so she was steering clear of him. V25 stated R8 ate in a different dining room for a while but it seems to have gotten better. R7's Admission Record, with a print date of 7/18/24, documents R7 was admitted to the facility on [DATE] with diagnoses that include unspecified dementia, hypertension, anxiety disorder, and cognitive communication deficit. R7's MDS, dated [DATE], documents a BIMS score of 03, which indicates a severe cognitive deficit. R7's current Care Plan documents a Focus area of (R7) is at risk for abuse related to depression, anxiety, dependent on others and behaviors. Date Initiated: 05/26/2024. The interventions for this Focus area, dated 5/26/2024, are documented as, Address all complaints/concerns promptly with grievances policy and procedure .Advise resident of rights yearly and PRN (as needed).Complete risk for abuse/neglect assessment quarterly. Ensure staff is educated on Abuse/Neglect. Intervene if observing any resident-on-resident conflict to avoid potential abusive situation.Observe for any s/s (signs/symptoms) of Abuse. Report any signs of abuse to Administrator) (abuse coordinator), DON, or Supervisor All Staff (sic) and follow all (name of survey agency) and facility protocols related to reporting suspected abuse . The facility Abuse Investigation Summary, dated 5/10/24, documents, Final: Receptionist (V34) witnessed (R4) strike (R7) on top of the head. No other staff or residents nearby to witness incident. Both residents with severe cognitive impact and alert only to self per baseline. (R7) was standing at the front door looking out the window which is where (R4) also likes to stand to look outside. There was no harm intended and no injury resulted. In interview (R7) denied being in any pain. Upon inspection no marks or swelling noted There is insufficient evidence to substantiate abuse. On 7/11/24 at 9:28 AM, R7 denied being afraid of anyone and denied abuse. R7 appeared confused and was not able to answer detailed questions appropriately. R7 did not have any signs of obvious distress. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/15/24 at 12:14 PM, V34 (Medical Records/Receptionist) stated she witnessed R4 hit R7 both times. V34 stated R4 didn't like R7 being there. V34 stated R4 said something to R7, and then started hitting her on top of the head with his fist. V34 stated R7 told R4 it hurt and to stop hitting her. V34 stated there weren't any apparent injuries. When asked how R4 appeared when he was hitting R7, V34 stated, He was angry. V34 stated she would consider it abuse. V34 stated she separated them and let the nurse know R4 had hit R7. V34 stated there was another time R4 hit R7. V34 stated it was at the front door and he was trying to get R7 to move. V34 stated R4 slapped R7 on top of the head. V34 stated R7 was upset and told R4 she wished he would quit hitting her. V34 stated R7 was angry and R4 appeared mad. V34 stated she wasn't sure what interventions were implemented to prevent the abuse. V34 stated anytime she sees R7 coming to the front door she redirects her away because she knows it would probably happen again. V34 stated R7 hardly ever comes to the front door now. On 7/15/24 at 11:00 AM, when asked if she was involved in the abuse investigations, V3 (LPN/Infection Preventionist) stated she helps at times. When asked why the peer-to-peer abuse that is witnessed is not substantiated, V3 stated that is something corporate told them to add on. On 7/15/24 at 3:37 PM, V2 (Director of Nurses) stated R7 is the resident R4 gets agitated with at the front door. V2 stated she it was like R4 got mad that R7 was able to stand there but he wasn't. When asked how that was a behavior and not abuse, V2 stated, That is a good question. On 7/16/24 at 8:54 AM, V1 (Administrator) stated R4 can't talk, so he tends to tap people to get their attention. V1 stated she didn't consider that a willful acts of abuse, but they have to type it up. V1 stated if the resident is confused, it is usually not substantiated. When asked where the second investigation on R7 was, V1 stated she wasn't aware of any other incident. Then V1 stated she spoke with V34, and they didn't do a report on the second incident because V1 and V2 were walking up to the front office and witnessed the event. V1 stated R7 was hanging on to the front door handle trying to stand up from her wheelchair when R4 walked up to her and tapped her on the shoulder. V1 stated R7 said 'stop hitting me' and they told R7 he wasn't hitting her that he was just trying to get her attention. V1 stated R4 knows the alarm goes off if they get too close to the door. V1 stated that is the second incident V34 was talking about, but they didn't write it up as an abuse investigation. V1 stated they didn't consider it abuse. On 7/22/24 at 10:28 AM, this surveyor reviewed with V34 her previous interview where she stated R4 had hit R7 on the head while at the front door on two separate occasions. When asked if that interview was still accurate, V34 stated, From where I was standing, he could have. V34 stated she knows V1 (Administrator) was there and said to whoever else was up there (unknown staff) that it wasn't a reportable because R4 was just trying to get R7 away from the door. Reviewed the interview again with V34, and asked if she saw R4 hit R7 in the head on both occasions. V34 stated, It might have been on the shoulder. V34 stated, I know (R7) said 'quit hitting me' or something like that. When asked if she was now saying R4 didn't hit R7 on the head, V34 stated he may have come down on her shoulders; he was just trying to get her away from the doors. 2. R9's Admission Record, with a print date of 7/22/24, documents R9 was admitted to the facility on [DATE] with diagnoses that include anxiety disorder, chronic obstructive pulmonary disease, and weakness. R9's MDS, dated [DATE], documents a BIMS score of 15, which indicates R9 is cognitively intact. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R9's current Care Plan documents a Focus area of ,(R9) is a 3 for risk of abuse due to being dependent on others as well as suffering from anxiety and behaviors. Date Initiated 02/10/2023. The intervention documented for this Focus area is, By monitoring for all signs of abuse and keeping an open communication between patient and staff, as well as keeping him involved in activities he enjoys. Date Initiated: 02/10/2023. R1's Admission Record, with a print date of 7/15/24, documents R1 was admitted to the facility on [DATE] with diagnoses that include heart failure, diabetes, paranoid schizophrenia, conversion disorder with seizures, and unspecified dementia. R1's MDS, dated [DATE], documents a BIMS score of 15, indicating R1 is cognitively intact. R1's current Care Plan documents a Focus area of, Resident is considered at risk for abuse/neglect (per assessment) due to depression, being dependent on others, Schizophrenia. Date Initiated 09/23/2021. This Focus area includes the following interventions, dated 09/23/2021, Address all complaints/concerns promptly with grievance policy and procedure. Advise resident of rights yearly and PRN. Complete risk for abuse/neglect assessment quarterly.Intervene if observing any resident-on-resident conflict to avoid potential abusive situation Report any suspected of abuse/neglect to administrator immediately. R1's care plan does not document a focus area for physical aggression. The Facility Incident Report, dated 7/2/24, documents under Final Report, (R1) went into (R9's) room and grabbed (R9's) feet attempting to pull him out of bed claiming (R9) was shooting him with black stuff. (R1) punched CNA in stomach as she was attempting to separate residents. Residents immediately separated by staff. Head to toe assessments completed with no areas observed. Local police were notified. (R1) was transferred to ER via EMS (Emergency Medical Services) for psych evaluation. (R9) reports in his interview that (R1) entered his room and grabbed his left leg and was yelling at him. (R9) unable to recall exactly what (R1) was yelling. When (R9) was asked if he feels safe continuing to live here, he states, 'Yes, I feel safe here.' Staff continues to observe resident for changes in mood, status, or behavior. (R1) and his POA served with involuntary discharge notice and notified of his right to appeal and provided with a postage paid, pre-addressed envelope if he wishes to do so. Ombudsman and (name of survey agency) notified of involuntary discharge notice being served. Investigation determined there is insufficient evidence to substantiate abuse due to lack of physical or mental harm. R1's Progress Notes, dated 7/2/24 5:22 PM, documents, This writer spoke with (V23, Nurse Practitioner) about resident's altercation with other resident and CNA. (V23/Nurse Practitioner) immediately called medical director (V26) and reported to (V26) resident's aggressive behavior. (V26) and (V23) agree that resident must be sent to ER for evaluation. (V26) advises to send resident to ER and to call local police if needed to assist EMS with the transfer. (V26) stated, 'At this point you have to get him out of there. What he has done tonight is assault and it is not safe for (R1) or other residents for him to remain in the building.' On 7/10/24 at 11:00 AM, R9 stated, The man next door came in the other day and grabbed my feet, he was trying to drag me off the bed. The staff came right in and stopped him and he hit one of them. (R1) has gone to the hospital now and I don't think he is coming back. He didn't hurt me. He had come in here a few other times that day saying stuff I didn't understand. I do feel safe here now, but it was scary for a minute. (continued on next page)

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 07/24/2024
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)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/10/24 at 12:00 PM, V7 (LPN/Licensed Practical Nurse) stated she works all halls here and she is familiar with R1 as she takes care of him when she works his hall. V7 stated she was working when R1 tried to pull another resident (R9) out of bed. V7 stated R1 had tried to go into R9's room several times on that day and they had to keep redirecting him. V7 stated she moved her medication cart down the hall closer to R9's room so that she could keep an eye on the situation. V7 stated R1 went into R9's room and started yelling that R9 was causing electrical shock to his beard and something about black stuff. V7 stated R1 grabbed R9's foot and tried to drag him out of bed. V7 stated when the V14 (CNA) tried to separate them, R1 hit the V14 in the abdomen. V7 was asked if she felt this was considered abuse to R9, she replied, No, because (R1) did not do that intentionally because he did not know what he was doing. On 7/17/24 at 1:42 PM, V14 (CNA) stated she was working when R1 attempted to pull R9 out of the bed by his feet. V14 stated they heard R9 screaming, when they got to his room, R9's feet were hanging out of the bed and R1 was saying R9 was going to hurt him. V14 stated the nurse was helping R9 and she attempted to push R1's wheelchair out of R9's room. V14 stated R1 was fighting her and saying he was going to get him. V14 stated R1 then hit her in the stomach. V14 stated she would consider it abuse. On 7/15/24 at 3:37 PM, V2 (DON/Director of Nurses) stated R1 was given an involuntary discharge after the incident occurred between R1 and R9. When this surveyor asked if she could explain how the incident was serious enough to issue an involuntary discharge, but they didn't substantiate abuse, V2 stated she couldn't explain it. On 7/16/24 at 8:54 AM, V1 (Administrator) stated she was out of town when the incident occurred, so she didn't have firsthand knowledge of what occurred. 3. R6's Admission Record, with a print date of 7/18/24, documents R6 was admitted to the facility on [DATE], with diagnoses that include unspecified dementia, weakness, anxiety disorder, and atrial fibrillation. R6's MDS, dated [DATE], documents a BIMS score of 09, indicating R6 has a moderate cognitive deficit. R6's current Care Plan documents a Focus area of, (R6) is at low risk for abuse related to: dependent on others and anxiety. Date Initiated: 03/13/2024. This Focus area includes interventions, dated 3/13/24, of, 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. Ensure staff is educated on Abuse/Neglect. Intervene if observing any resident on resident conflict to avoid potential abusive situation. Observe for any s/s (signs/symptoms) of Abuse. Report any signs of abuse to Administrator (abuse coordinator), DON, or Supervisor All Staff and follow all (name of survey agency) and facility protocols related to reporting suspected abuse. R3's Admission Record ,with a print date of 7/15/24, documents R3 was admitted to the facility on [DATE] with diagnoses that include Alzheimer's Disease, dementia, adult failure to thrive, heart disease, major depressive disorder, anxiety disorder, brief psychotic disorder, and convulsions. R3's MDS, dated [DATE], documents a BIMS score of 00, which indicates a severe cognitive deficit. This same MDS documents R3 has physical behavioral symptoms directed towards others. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Shawnee Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE: 1901 13th Street Herrin, IL 62948	

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R3's current Care Plan documents a Focus area of, (R3) has the potential to demonstrate physical behaviors hitting grabbing, related to Dementia, anxiety, brief psychotic disorder, h/o (history of) behavior. Date Initiated: 01/06/2023. Interventions for this Focus area include the following: 1/1/23- monitor for changes in mood or behaviors.Send to ER (emergency room) for eval (evaluation) and treatment upon return, psych (psychiatric) med (medication) review. 1/5/24- med review, obtain labs and UA (urinalysis). 2/6/24- adm (administer) medications as ordered. 1/6/23- Administer medications as ordered. Monitor/document for side effects and effectiveness. Assess and anticipate residents needs: food, thirst, toileting needs, comfort level, body positioning, pain, etc. Assist (R3) to develop more appropriate methods of coping and interacting (R3) to express feelings appropriately. Communication: provide physical and verbal cues to alleviate anxiety, give positive feedback, assist verbalization of source of agitation, assist to set goals for more pleasant behavior, or encourage seeking out of staff member when agitated .Evaluate for side effects of medication. SS (social services) to assist with finding placement closer to family per family request .Use distraction to redirect train of thought.When agitated: intervene before agitation escalates, guide away from source of distress, and engage calmy in conversation. If response is aggressive, staff should remain calm and consider approaching at a later time . The Facility Incident Report, dated 7/3/24, documents under Final . Incident was witnessed by staff. Activity director witnessed (R3) wheel up to (R6) in the activity room and grab (R6's) right arm. (R3) then proceeded to hit (R6) on her right arm. No other staff report witnessing the incident. Residents were separated. (R6's) arm was assessed. There were no signs of injury noted. Medication review completed. Care plan updated. MD and POA updated. Investigation determined there is insufficient evidence to substantiate abuse due to lack of physical or mental harm. On 7/11/24 at 9:15 AM, when asked if any other resident had ever hurt or slapped her, R6 stated, Nothing major. R6 stated she was never hurt and was not afraid of anyone. On 7/11/24 at 9:11 AM, R3 was sitting in a chair in the hallway, near the nurses station. R3 appeared clean and well-groomed. This surveyor was talking with R3 when a nurse walked by and touched R3's blanket. R3 smacked her in the chest. R3 was not interviewable. On 7/15/24 at 8:25 AM, V16 (Activities Director) stated she witnessed R3 wheel up next to R6 and hit her multiple times in the arm. V16 stated she wasn't sure if something happened to provoke R3. V16 stated R3 had those behaviors, and she asks R3 to sit in the hallway during activities since there are more people in the room and R3 doesn't do well in crowded areas. When asked if R3 was able to do any activities, V16 stated she watches tv and comes to the music activities. V16 stated R6 was not hurt when R3 hit her. On 7/15/24 at 3:37 PM, when asked why all of the witnessed peer to peer abuse was not substantiated, V2 (Director of Nursing) stated when they do an investigation, they send it to corporate for approval before submitting their report. V2 stated corporate always has them add in Investigation determined there is insufficient evidence to substantiate abuse due to lack of physical or mental harm. V2 stated they say they can't substantiate abuse, and that it was more of a behavior related to dementia. (continued on next page)

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 07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shawnee Senior Living	1901 13th Street Herrin, IL 62948

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/16/24 at 8:54 AM, V1 (Administrator) stated abuse is willful and intentional, and with most resident-to-resident altercations the resident has dementia or is trying to get someone's attention. V1 stated if the resident is confused, abuse is not usually substantiated. V1 stated they can't say they are willfully and intentionally trying to harm someone if they have dementia.

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NAME OF PROVIDER OR SUPPLIER: Shawnee Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE: 1901 13th Street Herrin, IL 62948	

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49664 Based on observation, interview, and record review the facility failed to identify, treat, and prevent the development of pressure ulcers for 1 of 3 residents (R1) reviewed for pressure ulcers in the sample of 24. This failure resulted in R1 developing a Stage 3 wound and an Unstageable wound to bilateral buttocks. Findings include: R1's Admission Record documents R1 was admitted to the facility on [DATE]. R1's Physician's Order Sheet (POS), dated 7/2024, documents diagnoses including angina pectoris, heart failure, GERD (Gastroesophageal Reflux Disease), unspecified dementia, unspecified severity with other behavioral disturbances, atrial fibrillation, type 2 diabetes mellitus, paranoid schizophrenia, chronic kidney disease stage 4, hypothyroidism, chronic peripheral disease, gout, and COPD (Chronic Obstructive Pulmonary Disease). R1's MDS (Minimum Data Set), dated 4/10/2024, documents a BIMS (Brief Interview for Mental Status) score of 15, which indicates R1 is cognitively intact. The same MDS section GG documents R1 requires substantial/maximal assistance with toileting/hygiene and with shower/bathing, and R1 requires assistance for sit to lying, sit to stand, chair/bed to chair transfer, toilet transfer, and tub/shower transfers. Section M, Skin Conditions, of the same MDS does not document any unhealed pressure ulcers/ injuries, venous or arterial ulcers, or any other ulcers, wounds, or skin problems for R1. R1's Progress Note, dated 6/28/2024 at 3:26 PM, documents, CNA (Certified Nursing Assistant) states that resident has been incontinent of stool and is lying in his bed with genitals exposed and refusing to be changed. (V23, Nurse Practitioner) present for conversation and aware of continued behaviors. R1's Progress Note, dated 6/28/2024 at 3:44 PM, by V2 (Director of Nursing) documents, This writer spoke with (V23, Nurse Practitioner) regarding (R1's) continued behaviors. (V23) reports that she spoke with (V26, Physician) about (R1) and stated they both feel that IM (Intramuscular) medication is needed, but they are fearful for the safety of staff if they were to attempt to administer an IM medication to resident, and therefore feel that a placement in a behavioral health facility is the best option at this time. R1's Progress Note, dated 7/1/2024 at 2:55 AM, documents, All shift resident has refused to let staff change him. Resident's bed is saturated in urine and dripping into the floor. Resident has a puddle of urine under his bed and was trailing to the door. Resident let staff clean the urine from his bed to the door but refused to let staff change him or clean under the bed. When cleaning under the bed was mentioned, the resident started yelling 'no' at the staff. Resident has been pleasant since that interaction and calling for needs. R1's progress notes, dated 7/2/2024 at 6:45 PM, documents R1 was transported out by way of local ambulance service to local hospital after an altercation with R9. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Shawnee Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE 1901 13th Street Herrin, IL 62948	

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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 0686 Level of Harm - Actual harm Residents Affected - Few	R1's local hospital ER (emergency room) record, dated 7/2/2024, documents R1 reports, he is here to have his wounds on his bottom addressed. This is the only area of pain that he has. No other complaints. Calm and cooperative at this time in ER. The ER's Impression and Disposition notes under clinical impression documents the following: 1. Sepsis due to unspecified organism, unspecified whether acute organ dysfunction present. 2. Altered mental status, unspecified altered mental status type. 3. Cystitis. Differential Diagnosis includes but not limited to, UTI (Urinary Tract Infection), Electrolyte abnormality, medication induced psychiatric illness. Hospital Progress Notes on 7/3/2024 at 1:36 AM documents Sepsis secondary to skin and soft tissue infection. Hospital Wound Care Notes on 7/3/2024 at 10:00 AM documents, wound care consult completed at this time. Patient noted to have ITD (Intertriginous Dermatitis) to bilateral axilla's, bilateral chest folds, bilateral abdominal flanks, bilateral groin, and inner thighs and to scrotum and coccyx. Patient noted to have evolving DTPI (Deep Tissue Pressure Injury) to right buttocks and Stage 3 pressure injury to left buttocks. Left buttocks, stage 3 wound measuring 4 cm (centimeters) length, 2.5 cm width, 0.3 cm depth and wound surface area 10 cm. Right buttocks DTPI measuring 3 cm length, 2cm width, 0.3cm depth and 6 cm wound surface area. The hospital records from theER on [DATE] at 1:36 AM, indicates R1 was given IV (Intravenous) antibiotics of Vancomycin 2 gm (grams) and Levofloxin 750 mg (milligrams) after blood cultures were obtained. On 7/12/2024 at 8:40 AM, R1 was visited at the local hospital. R1 was sitting up in bed watching television. R1 was alert and oriented x 4. R1 stated he is feeling much better. R1 stated his bottom is not hurting like it was so he thought his wounds were healing. R1 stated he got the wounds while at the facility. R1 stated, When I get any kind of infection it goes to my brain for some reason, and I am not right when I do get an infection. On 7/10/2024 at 11:25 AM, V6 (Licensed Practical Nurse/LPN) stated she had taken care of R1, as he is on her hall. V6 stated, I noticed a change with (R1) the last 2 weeks. (R1) had been more violent and was refusing care. (R1) was supposed to be taking antibiotics for a urinary tract infection, but he was refusing his medications. V6 stated the floor nurses do treatments on the residents except for Thursdays, because that is the day that the wound doctor comes to the facility. V6 stated she was not aware of any wounds on R1, and he was not getting any treatments. V6 stated she heard of his behaviors when he tried to pull another resident out of the bed. On 7/10/2024 at 12:00PM, V7 (LPN) stated she works all halls here, and she is familiar with R1 as she takes care of him when she works his hall. V7 stated, Prior to 2 weeks or so ago, (R1) was so sweet and real easy going. I was unaware of any wounds on (R1) until right before I sent him out to the hospital the last time on 7/2/2024. V7 stated, (V12 Certified Nursing Assistant/CNA) was helping try to get (R1) ready to be transported to the hospital and she noted a large wound to (R1's) buttocks. (V12) reported it to me immediately, but when I went into the room to assess the wound, (R1) refused, so I did not get to even look at it. V7 was asked how often they did skin checks on R1, and V7 stated weekly. V7 stated they document those on the Medication Administration Record (MAR). On 7/10/2024 at 11:17 AM, V9 (CNA) stated she sometimes takes care of R1. V9 stated, I had noticed for the last 2 weeks or more (R1) had not been acting himself. He has been refusing care and having bad behaviors. (R1) did get sent to the hospital and he is still there. On 7/10/2024 at 11:20 AM, V5 (CNA) stated she always works 6am to 2pm shift. V5 states she normally takes care of R1. V5 stated, (R1) was always fine until the last few weeks, and he started refusing care. I did not know of any wounds on (R1). We tried to provide care to him, but he would get upset. (continued on next page)

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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 0686 Level of Harm - Actual harm Residents Affected - Few	On 7/10/2024 at 3:55 AM, V12 (CNA) stated she works the hall where R1 resides. V12 stated, I had taken care of (R1) for a long while. (R1) was always nice up until the last month to month and a half. When V12 was asked about any skin issues with R1 she stated, I would apply powder to his groin area prior to his refusal of care because it was gaulded, but on the day we were getting ready to send him out to the hospital, I noticed a big circular area on (R1's) bottom and it was bleeding pretty good. I then went to (V7, LPN) and told her, but (R1) refused to let (V7) look at it and then the ambulance came. I was not aware the big area on (R1's) bottom was there until that day. V12 stated R1 is wheelchair bound but R1 can walk a few steps. V12 stated R1's showers are scheduled for Tuesday and Saturdays on day shift. V12 stated she didn't ever give showers to him because she works evenings. On 7/12/2024 at 8:01 AM, V27 (Healthcare Power of Attorney for R1) was asked if she was aware of any skin issues like wounds and she stated, No, I didn't know anything about this either. On 7/12/2024 at 8:25AM, V29 (Case Manager at local hospital) stated, (R1) is doing much better now that the infection is better. V29 stated R1 is taking his medications and his wounds are healing. On 7/12/2024 at 9:10 AM, V1 (Administrator) was asked if she knew R1 had some wounds that he acquired at the facility, and V1 stated, No, I did not know that. I get updates from the hospital, but I only look at Case Manager's notes. On 7/12/2024 at 9:40 AM, V2 (Director of Nursing) was asked to explain issues with R1 from the time of readmission from the hospital on 6/19/2024. V2 stated R1 would say he didn't need his medications, and he was refusing care up until he went back to the hospital on 7/2/2024. V2 stated, (R1) was being seen by wound doctor for the yeast on his groin area, but had refused to allow the wound doctor to see him the last couple of times. I was not aware of any wounds on (R1), and nobody reported wounds to me, and I do all the wounds in the facility and rounds with the wound doctor on Thursdays. V2 stated she was aware R1 was refusing all care most of the time. V2 stated she received a call one night that R1 had so much urine everywhere in his room, his mattress was saturated and leaking on the floor, the urine was even running out into the hallway. V2 stated he would only let the staff mop the hallway and barely in his room. V2 stated he would not let the staff clean anything else. V2 stated, I was looking more at the Psych issues than I was the medical issues. On 7/12/2024 at 12:50 PM, V26 (Physician) was asked if he knew about the wounds R1 had when he got to the ER, and he stated No, nobody has told me about that. V26 was asked if he felt the infection could have caused the behaviors which led to the lack of care, which in turn caused these wounds, and he stated, Well lack of care can cause wounds and infection of any kind can cause worsening of confusion. Infections are rough on some folks. On 7/12/2024 at 1:57 PM, V23 (Nurse Practitioner) stated, I have known and cared for (R1) for a long time. Normally, (R1) is a pleasant guy that is alert and oriented x4. V23 was asked if she was aware of the wounds on R1's buttocks and she stated, I didn't know anything about wounds but have seen the pictures taken at the hospital. I was aware (R1) was refusing care including personal care and refusing medications with most concerning medications of antibiotics. V23 stated R1 was urinating everywhere and was pouring urine all over himself and was laying in urine and feces and refused care. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R1's (TAR) Treatment Administration Record, dated 6/1/2024-6/30/2024, documents a physician order for skin checks scheduled every Monday and Thursda,y with a start date of 9/17/2020.The R1's TAR documents R1 refused the skin checks on 6/20/2024, 6/24/2024, and 6/27/2024. The same TAR document a physician order for antifungal powder under bilateral breast folds, bilateral abdominal folds and groin every bedtime, start date of 11/22/2023. The TAR documents R1 refused treatment from 6/19/2024 to 6/30/2024. R1's Medication Administration Record (MAR), dated June 2024, documents Augmentin 875-125 mg one tab every 12 hours for bacterial infection for 10 days, start date of 6/19/2024. This same MAR documents from the dates of 6/19/2024 through 6/29/2024, R1 refused Augmentin 875-125 mg, 16 out of 20 offered dosages. The same document contains a physician order for another antibiotic of Levaquin 500 mg, give one tablet by mouth one time a day for urinary tract infection for 7 days with start date of 6/20/2024, the same MAR documents R1 refused Levaquin 500mg 5 out of 7 offered doses. R1's Shower Sheets, dated June 2024, documents R1 refused showers on 6/24/24 and 6/25/2024. The last documented shower R1 received was on 6/11/2024. There were no other showers documented indicating R1 did not receive a shower for 22 days. The facility policy titled Pressure Ulcers/Skin Breakdown - Clinical Protocol (revision date August 2008) documents under section Assessment and Recognition 1. Document an individual's significant risk factors for developing pressure sores, for example immobility, recent weight loss, and a history of pressure ulcers. In addition, the nurse shall assess and document/report the following: A. Full assessment of skin condition including but not limited to location, stage or partial/full thickness, length, width, depth, presence of exudates or necrotic tissue. B. Pain assessment, C. Resident's mobility status, D. current treatments, including support surfaces, E. all active diagnosis. Under section titled Cause Identification documents, 1. Identify factors contributing or predisposing residents to skin breakdown; for example, medical comorbidities such as diabetes, congestive heart failure, overall medical instability, cancer, or sepsis, causing catabolic state, and macerated or friable skin. 2. Document any signs/symptoms of infection, skin condition assessment, the impact of comorbid conditions on wound healing, etc.

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	07/24/2024

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)

F 0689

Level of Harm - Immediate jeopardy to resident health or safety

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 32765

Based on observation, interview, and record review, the facility failed to ensure residents assessed as being at risk for elopement were supervised, interventions to prevent elopement were implemented, and incidents of elopement were thoroughly investigated for 1 of 3 (R16) residents reviewed for accidents and supervision in the sample of 24. This failure resulted in R16, who had a history of elopement and was assessed as being at risk of elopement, exiting the facility and walking approximately two tenths of a mile down a busy road without staff supervision.

This failure resulted in an Immediate Jeopardy, which was identified to have begun on 6/13/24 when R16 was identified to be at risk for elopement and the facility did not implement interventions to prevent elopements. On 6/16/24, R16 attempted to exit the facility and while facility staff were looking for an elopement bracelet to put on R16, R16 left the facility and was located approximately 25 yards from the facility. R16 again exited the facility on 7/10/24. R16 walked approximately two tenths of a mile down the busy street before being joined by staff and approximately eight tenths of a mile down the same street before staff were able to convince R16 to return to the facility.

V1 (Administrator) was notified of the Immediate Jeopardy on 7/11/24 at 2:12 PM. The surveyors confirmed by observations, interview, and record review the Immediate Jeopardy was removed on 07/17/24, but the noncompliance remains at a Level Two due to additional time needed to evaluate the implementation and effectiveness of in-service training.

Findings Include:

R16's Admission Record, with a print date of 7/15/24, documents R16 was admitted to the facility on [DATE], with diagnoses that include unspecified dementia, cognitive communication deficit, altered mental status, and delirium.

R16's Minimum Data Set, dated dated [DATE], documents a Brief Interview for Mental Status score of 03, which indicates a severe cognitive deficit.

R16's Elopement Evaluation, dated 6/13/24, documents a score of 01, which indicates R16 is at risk of elopement. This same assessment documents R16 has a history of attempted elopement and wandering aimlessly. They were no interventions addressed as part of this evaluation.

R16's Progress Notes document the following:

6/13/24 Elopement Score 1.0, History of elopement while at home. Yes .

(continued on next page)

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 07/24/2024

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	6/16/24 6:29 PM, Resident noted attempted exit through back staff entrance at 1720 (5:20 PM), also witnessed by (V13/CNA-Certified Nursing Assistant). Upon entry resident resistant to moving away from door and had to be corralled back towards unit. Once she was back on the unit this nurse (V21/RN-Registered Nurse) and (V30, CNA) went looking for a wanderguard transponder. We looked on (unit name) with no success. Then went down to (unit name). While in the med (medication) room looking, I texted (V2/Director of Nurses/DON) to ask if there was an extra in her office or another location and then heard the front door alarm go off. I immediately headed in that direction walking very briskly. As I came through the main dining room, CNA (V31) said that it was (R16). I ran towards the front door. At the door, (name of family member) was frantically trying to get into the door to alert us that she (R16) was out of the building. Once getting out of the door the resident was noted down the road about 25 yards north of the building. Upon reaching her she was verbally combative and physically evasive. CNA (V31 and V32) were able to calm resident and get her to agree to come back into the building. DON (Director of Nursing) immediately notified. DON in at 1740 (5:40 PM) to address .NP (Nurse Practitioner) notified at 1814 (6:14 PM). Attempt made to contact resident's husband .No answer. Message left for call back. The facility Abuse Investigation Summary, dated 6/16/24, documents under Initial Allegation, A visitor was entering the building when (R16) attempted to go out the open front door. As the visitor was telling (R16) that she needed to stay inside, (R16) became verbally aggressive and went out the door. Visitor immediately ran to get staff for help. Abuse coordinator notified. Wanderguard placed on resident. Facility head count conducted, and all residents accounted for. NP (Nurse Practitioner) and spouse notified. All exit doors wander guard alarms checked. Investigation begun Final Summary/conclusion: Investigation conducted. IDT (Interdisciplinary) met and reviewed incident. Resident and staff interviews conducted. A visitor was entering the building when (R16) attempted to go out the open front door. As the visitor was telling (R16) that she needed to say inside, (R16) became verbally aggressive and went out the door. Visitor immediately ran to get staff for help. Another resident with a wanderguard alarm in place was near the front door at time of elopement which set off the wanderguard alarm causing more staff to come to the front door to assist. Resident was assisted back inside the building by nurse and CNA's (certified nursing assistants). Resident continued to be physically evasive and stated, I've got to go get my husband. Please my house is just right down the road here and I have to go get my husband! Abuse coordinator and DON notified. Wanderguard placed on resident. Facility head count conducted, and all residents accounted for. NP and spouse notified. All exit doors wander guard alarms checked. Staff continues to monitor resident for changes in mood, status, or behavior. No changes noted. MD (physician) and POA (power of attorney) updated on findings of investigation. Care plan updated. R16's Elopement Evaluation, dated 6/21/24, documents a score of 03, which indicates R16 is at risk of elopement. This assessment documents R16 has a history of or attempted leaving the facility without informing staff, verbally expressed desire to go home, packed belongings, and/or stayed near an exit door, wanders, wandering behavior likely to affect the safety or well-being of self/others, and is a recent admission. (continued on next page)

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 07/24/2024
NAME OF PROVIDER OR SUPPLIER Shawnee Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE 1901 13th Street Herrin, IL 62948	

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	R16's Progress Notes, dated 6/26/24 at 11:00 PM, document, Employee entrance door alarming at 1940 (7:40 PM), (V22, Licensed Practical Nurse/LPN), went to check door and check outside for residents. Resident was urinating behind employee entrance. Resident was redirected and assisted back inside. Resident reports she was looking for husband and trying to go home. Resident was brought back inside, toileted and pajamas placed on. Resident then was assisted to bed. Said nurse (V22) administered HS (hour of sleep) medications, medications taken whole without difficulty. (V2/DON) notified .husband notified, and on-call MD (physician) notified. Resident diagnosed with unspecified dementia with agitation, altered mental status, cognitive communication deficit. (R16) is ambulatory and wanders throughout facility, staff redirects resident and brings her back to assigned hall. Resident agitated with staff at present time redirection attempt. The facility Abuse Investigation Summary, dated 6/26/24, documents under Initial allegation: Wander-guard alarm system alerted staff to the back door. Staff immediately responded and discovered (R16) right outside the doorway and escorted her back inside . Final summary/conclusion: Wander guard alarm system alerted staff to the back door. Staff immediately responded and discovered (R16) right outside the employee entrance door at the back of the building. When found resident was directly behind the employee door urinating. Staff escorted her back inside and to her unit. Head to toe assessment preformed with no abnormalities noted. IDT met and reviewed incident. Resident and staff interviews conducted. Abuse coordinator and DON notified. Wander guard in place and functioning properly. Facility head count conducted, and all residents accounted for. NP and spouse notified. All exit doors wander guard alarms checked. (V18/Psychiatric NP) contacted to complete a med (medication) review. Staff continues to monitor resident for changes in mood, status, or behavior. No changes noted. MD and POA updated on findings of investigation. Care plan updated. R16's Order Summary Report active orders as of 7/15/24 includes the following physician orders; Monitor Wander Guard each shift for placement, start date 6/28/24. R16's current Care Plan documents the Focus area dated 7/1/24 of Is an elopement risk/wanderer related to: Disoriented to place, History of attempts to leave facility unattended, Impaired safety . This same Focus area documents the following interventions all initiated on 7/1/24, Check wanderguard battery function weekly and PRN (as needed) .Check wanderguard placement every shift and PRN Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book Monitor for fatigue and weight loss .Offer a warmed blanket Offer food or snacks .Offer reassurance appropriate to the concern . Offer to take to a scheduled or planned activity . Offer to take Thereto the toilet or assist with incontinence care .Provide structured activities: toileting, walking inside and outside, reorientation strategies including sings, pictures, and memory boxes .Redirect resident when wandering or exit seeking .Return to bed for additional rest or comfort .Use distraction to change thought pattern .Wanderguard applied at all times On 7/10/24 at 2:55 PM, R16 was sitting in the common area just outside the dining room. R16 appeared clean and well-groomed. R16 was alert, confused, but pleasant. R16 was saying she wanted to go home. R16 stated it is like being in jail because they won't let her leave. (continued on next page)

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	R16's Progress Note, dated 7/10/24 at 1650 (4:50 PM), documents, .This writer (V1/Adminstrator) heard wander guard alarm sound around 4:50 PM at front door. This writer watched (V17/RN) respond to alarm. At 1452 (V19/Corporate Chef) came into office and stated 'I think one of your residents went out the front door.' This writer out (sic) front door and witnessed (R16) walking across front parking lot and (V17) and the IDPH (Illinois Department of Public Health) surveyor (name of surveyor) walking behind her attempting to re-direct her. She became agitated with their attempts to re-direct and started running. She ran out into the road and started running north down the roadway. The IDPH surveyor (name of surveyor) and (V17) could not catch up to (R16) and she kept telling them to get away from them that she was going home. This writer ran past (V17) and (name of surveyor) and was able to catch up to (R16) and began walking side by side with (R16). This writer attempted to re-direct her back to facility and she said no I am going home. I just live down the road here. I have to get back to my kids. (R16) continued to walk with this writer approximately 5 blocks down the road. This writer told (V17/RN) to call 911 and family during the unsuccessful attempts to re-direct (R16) back to facility. (V17) did go back to facility to get vehicle in the event (R16) would be able to be re-directed back to facility. This writer and V17 stayed with (R16) until (name of local police) and family responded. The (name of local police) were unsuccessful in their attempts to re-direct (R16) back to facility also. The son (V20) was able to get (R16) into his vehicle and bring her back to facility. (R16) was taken back to room to have assessment and vital taken. This writer also notified (V18/Psychiatric Nurse Practitioner) for a medication review. (V18) reviewed medication list. New orders were reported to nurse and orders processed. The IDPH surveyor (as described above) reported to this surveyor on 7/10/2024 at 4:52PM the following occurred: The IDPH surveyor walked out the front door of the facility. When the IDPH surveyor approached the front door there was an elderly couple coming through the second set of double doors. The lady was in front and using a walker, the IDPH surveyor approached to help her with the door. As the lady was coming through the door, suddenly another female resident (R16) went through the lady in front of the gentleman that was coming in the door. The other female resident (R16) exited the facility and went through the second set of doors. The door alarm sounded. The IDPH surveyor went out the doors to the front parking lot of the facility and approached R16 and attempted to get her to go back into the facility. The IDPH surveyor was aware R16 was not supposed to be out of the facility since she had observed R16 being redirected earlier in the day. R16 stated, No I am going home. V19 (Regional Chef) pulled up close to the facility and stated he had come back to the facility to return a charger he took. The IDPH surveyor explained to V19 she had tried to get R16 back into the facility and she wouldn't go back in with her. V19 asked the resident to go in with him and she wouldn't go. When asked if he had her V19 replied, I will go in and get the administrator. R16 then started walking to the north end of the parking lot. The IDPH surveyor stayed with R16 attempting to redirect her back to the facility. R16 told the IDPH surveyor she was pregnant and needed to go home then went onto the main road heading north. The IDPH surveyor stayed with the resident, and she began running down the side of the road. V17 (RN) came and then stated she couldn't run. Then V1 came running up the road yelling at R16 to stop running but R16 kept running. Once V1 caught up to the resident the IDPH surveyor returned to the facility. The IDPH surveyor (as described above) reported to this surveyor on 7/10/24 at 5:27 PM R16, V20 (Family Member), and V1 (Administrator) came back into the facility. At that time, V1 stated they had to call the local police and V20 to get R16 to come back to the facility. V1 stated R16 got all the way to the end of the road. R16's hair was wet with sweat and V20 stated, I have to take her to the nurse and get her vital signs, she is hot. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 7/11/24 at 11:10 AM, V13 (CNA) stated R16 tried to get out of the facility a lot, about ten times a day. V13 stated R16 is always going to the back door and knows to hold the door for 15 seconds to get it to stop alarming because she used to work at the facility. V13 stated R16 left not more than a week ago but stopped herself. V13 stated there was four staff with her and they followed R16. When asked what interventions were in place to prevent R16 from eloping, V13 stated R16 didn't reside on the hall she typically worked on, but when R16 was with her, she would have her help fold laundry. V13 stated R16 will sit and talk to residents and likes to read magazines to them. V13 stated they just keep R16 busy. On 7/11/24 at 11:31 AM, V11 (CNA) stated R16 was fairly new to the facility. V11 stated she had met her and R16 was a busy body. V11 stated R16 didn't reside on the hall she typically worked on. V11 stated she wasn't familiar with R16's interventions, but today she combed R16's hair, took her out on the enclosed patio, and sometimes R16 goes into laundry and folds towels. V11 stated it is hard to keep R16 busy. When asked if she had any concerns with residents who wander, V11 stated she didn't think there was enough entertainment for them. V11 stated there is not enough staff to keep the residents who wander busy. On 7/12/2024 at 12:33 PM, V17 (RN) stated she responded to the door alarm on 7/10/24 and saw a female resident and her husband standing at the front window. V17 stated there was a male resident (R4) standing close to the doors, and he wears an elopement alert bracelet. V17 stated she thought R4's elopement alert bracelet set off the alarm due to him standing close to the doors. V17 stated R4 tends to go out the door, so she was trying to get him away from the door and she turned the alarm off. V17 stated, I suspected he (R4) was the one that set off the alarm. V17 stated she didn't go outside to see if another resident had exited. V17 stated, (V19/Corporate Chef) came in and told us that (R16) was outside, so I responded by going outside to get her. V17 stated when she looked out the window, she saw the state surveyor and R16 at the end of the parking lot and by the time she got there R16 was down the road. V17 stated she caught up with them and told the state surveyor she couldn't run, then V1 caught up with them. V17 stated, I was concerned because people fly down that road, I know because I live down that road and there are no sidewalks on either side of that road. V17 stated that once the Administrator was with the resident, she went back to get her car so she could turn on the flashers to slow down the cars so they wouldn't hit R16. V17 stated she also called the police and V20 (Family Member) to help get R16 safe and back to the facility. On 7/15/24 at 12:14 PM, V34 (Receptionist/Medical Records) stated R16 had been attempting to elope all day on 7/10/24. V34 stated when R16 would see someone come up to the door she would run up to it. V34 stated she was watching R16 and would keep her from going out. V34 stated she wasn't aware of R16 getting out of the facility prior to 7/10/24. V34 stated she didn't know what interventions were in place to keep R16 from eloping. On 7/15/24 at 3:37 PM, V2 (DON) stated she wasn't at the facility on 7/10/24 when R16 eloped. This surveyor reviewed with V2 the incident and V17's interview that she didn't go outside when she heard the alarm. V2 stated she believed it was the policy of the facility to look outside and call a full facility head count. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 7/16/24 at 8:28 AM, V21 (RN/Registered Nurse) stated R16 was not his resident, but he was called to her unit because she was attempting to exit the facility through the activity room door on 6/16/24. V21 stated her attempt to leave prompted him to look for an elopement alert bracelet. V21 stated while he was looking for the bracelet, he heard the alarm going off and went to the front door. V21 stated a family member was between the two sets of doors and said she had tried to stop her. V21 stated R16 was approximately 25 yards down the street when he got outside. V21 stated R16 was very resistant to coming back to the facility and became verbally combative. V21 stated they did eventually get R16 back to the building. V21 stated as far as he knew, it was the first time R16 had attempted to and/or eloped. V21 stated when he left R16 to look for the elopement alert bracelet, there were several staff members with R16, and he wasn't sure where R16 was while he was looking and/or how she got out of the facility without staff being aware. When asked if he could remember interventions that were in place to prevent elopement prior to 6/16/24, V21 stated there was no elopement alert bracelet in place, and he couldn't remember any specific interventions. When asked what current interventions were in place to prevent elopement, V21 stated he wasn't sure if they were care planned, but R16 liked to fold clothes and clean up after meals. V21 stated the facility setting makes R16 feel like she is working. V21 stated evening is worse, but R16 always wanders and is exit seeking. V21 stated they are short staffed, and he didn't feel like they had enough staff to meet the needs of the residents. V21 stated he felt like R16 needed to be 1:1. V21 stated 2 nurses and 2-3 CNA's are not enough eyes to keep an eye on her. V21 stated they don't have enough staff to implement person centered interventions to prevent behaviors. On 7/17/24 at 8:37 AM, V1 (Administrator) stated they did not have an elopement alert bracelet on R16 after she was assessed on 6/13/24 as being an elopement risk. V1 stated she talked with staff to determine who monitored R16 on 6/16/24 after she was exit seeking and before she eloped, and she was not able to find anyone who was responsible for ensuring R16 didn't elope while they were looking for the bracelet. V1 stated R1's Care Plan for elopement was not implemented until 7/1/24. According to this interview, there were no specific person-centered interventions implemented to prevent R16 from eloping from 6/13/24 when she was assessed as being at risk for elopement until 7/1/24 and there are no person-centered interventions currently in place. On 7/17/24 at 11:25 AM, V33 (LPN/Licensed Practical Nurse) stated she was working on 6/16/24. V33 stated R16 was attempting to leave, and she and V21 went to look for an elopement alert bracelet. V33 stated a staff member (unknown) stated R16 was on the parking lot by the front door. When asked if anything was put in place to keep R16 from eloping while they looked for the elopement alert bracelet, V33 stated, Not that I am aware of. On 7/17/24 at 2:35 PM, V30 (CNA) stated R16 does exit seek and she has exited the facility. V30 stated it gets worse in the evening, and she has learned that if she keeps R16 busy it is better. V30 stated she will find things for her to do such as talk to other residents, or help her with a task by walking with her when she is getting something. V30 stated she also calls R16's son to talk with her and that helps as well. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 7/18/24 at 12:54 PM, V32 (CNA) stated R16 has gotten out of the facility a couple of times. V32 stated there was one incident (6/16/24) when R16 got out and was walking down the road. V32 stated she, V31, and V21 were chasing R16, and they were able to redirect her back into the facility. R32 stated R16 didn't have an elopement alert bracelet on, and she believed the facility staff were looking for one to place when R16 exited the facility. When asked what happened between R16's attempt on 6/16/24 and R16 exiting the facility, V32 stated it was dinner time, they have family members come in through that time frame, and they told them R16 was outside. V32 stated she was not aware R16 was exit seeking before 6/16/24. V32 stated on some days they have enough staff and other days they don't. When asked if they had enough staff to monitor and implement interventions for residents who have exit seeking behaviors, V32 stated, No, I wouldn't say that. On 7/20/24 at 10:52 PM, V31 (CNA) stated she was working when R16 exited the facility on 6/16/24. V31 stated she is usually the one who responds to the door alarms when they go off. V31 stated R16 likes to slip through the doors when visitors come in. V31 stated R16 knows how to work the system and is very charming. V31 stated on 6/16/24 she responded to the front door alarm and V21 was right behind her. V31 stated the intervention in place on 6/16/24 was to respond to the door alarm and try to get her back in as quickly as possible. V31 stated they did not have interventions in place then like they do now. V31 stated she was not aware R16 was an elopement risk prior to her elopement on 6/16/24. On 7/22/24 at 1:18 PM, V22 (LPN) stated she was working on 6/26/24 when R16 exited the facility. V22 stated she heard the alarm and immediately went to check on it and she thought she saw R16 dart out the employee entrance door. V22 stated she followed her out and R16 was just outside the door, but not outside the building. V22 stated R16 had her pants down and was urinating. V22 stated she redirected R16 back into the facility. The facility Missing Resident and Elopement Policy and Procedure, dated 8/10/23, documents, It is the policy of this facility to provide a safe environment for all residents. We will properly assess residents and plan the care to prevent accidents related to wandering behavior or elopement. Procedure Assessment and Identification of Wandering Residents 1. History of behaviors, including wandering, will be obtained prior to admission. 2. A resident with Alzheimer's/Dementia that is ambulatory will be considered at risk for elopement and an appropriate care plan will be put in place Residents identified at risk of elopement: Residents whose assessment identified wandering behavior shall also be considered at risk for elopement. If a resident is identified at risk for elopement, the following steps will be taken.: 1. If clinically indicated, an alarm bracelet will be placed on the resident to audibly alert staff of attempts by the resident to exit, in facilities with this capability. 2. The residents care plan shall address behavior using resident specific goals and/or approaches as assessed by the interdisciplinary team .4. Facility staff will ensure that all exit alarms will be responded to immediately When a door alarm sounds: When any door alarm sounds, staff shall: 1. Check the alarm panel to determine which door has been opened. Do Not Assume someone else has already done this. 2. Check the exit door for any exiting resident by means of a visual check. Also perform search of building parameter (sic) for exited resident. 3. If a resident is discovered outside the facility inappropriately, staff will assist him/her back into the facility. Follow the confirmed elopement procedure. 4. Reset the door alarm after it is determined by visual check that no resident has exited the facility inappropriately or is returned to the facility. The Immediate Jeopardy that began on 6/13/24 was removed on 07/17/24 when the facility took the following actions to remove the immediacy: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	*R16 was safely brought back into building on 7/10/24, elopement evaluation completed on 7/10/24, medication review completed on 7/10/24, medications adjusted on 7/10/24. Initiated monitoring of change of behaviors after family visits on 7/11/24, on 7/15/24 monitored behavior after family visits and identified increased exit seeking behavior, care planned for increased safety checks during the evening hours after family visits until behavior resolves on 7/16/24. Also discussed with family potential activities for re-direction during increased anxiety periods on 7/17/24. *Residents who are wander risks are at potential risk to be affected by the same alleged deficit. An audit was completed by the administrator (V1) and (V36) MDS coordinator on 7/17/24 of all wandering residents and no issues were identified *The Administrator (V1) and Maintenance Director (V35) in-serviced staff on 7/16/24 and 7/17/24 on the facility Elopement and Search (Code Amber) policy. Inservice included the topics elopement assessment, placing wander guard alarm band immediately when identified at risk, physician orders and where to locate the wander guard bands. Inservice included location of wander guard exit doors, wander guard alarm panels. Inservice included topics who responds to alarms, search indoors and outdoor perimeter, announcing alarm and calling all clear when resident is returned safely to building. Inservice includes remaining with resident and completing safety checks until exit seeking behavior resolves. *All staff have been in serviced on the Elopement and search code amber policy and will be in serviced prior to their next scheduled shift. *In-services were initiated on 7/16/24 and 7/17/24 and will continue to be given by Administrator designee prior to the staff next scheduled shift until completed. *The administrator has ensured all residents who are at risk for elopement have been assessed and appropriate interventions have been implemented. *The Administrator (V1) has reviewed the policy and procedure Elopement and Search Code [NAME] Policy and no updates at this time. *Administrator (V1) and/or designee will complete one Elopement drill rotating shifts daily for 2 weeks. Any areas for improvement will be immediately addressed. *Director of Nursing/DON (V2) and or designee will audit all new admissions/re-admission 5 days a week for 4 weeks for Elopement evaluation, wander guard placement if applicable and interventions initiated, interventions on care plan. Any issues will be addressed immediately. *Administrator (V1) or designee will audit incidents of elopement 5 days a week for 4 weeks to ensure they were thoroughly investigated. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	*Results of all audits will be discussed at QAPI in meetings and any further recommendations of interdisciplinary team will be immediately implemented and audit until 100 percent compliance.