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	07/16/2025

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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

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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 0600 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free from physical abuse for 2 of 4 residents (R1, R2) reviewed for abuse in the sample of 4. This failure resulted in R1 stabbing R2 in the back multiple times with an ink pen and both R1 and R2 being sent to the emergency room for evaluations. This past noncompliance occurred between 7/11/25 and 7/12/25.The findings include:R1's admission Record documented an admission Date of 5/30/24 and listed diagnoses including Unspecified Dementia, Major Depressive Disorder, and Anxiety Disorder. R1's Minimum Data Set (MDS) dated [DATE] documented a Brief Inventory for Mental Status (BIMS) Score of 8, indicating R1 has moderate deficits in cognition. R1's Care Plan dated 6/9/25 documented a problem area, (R1) has been the recipient and aggressor of verbal and physical aggression related to dementia, and continual reorganization of personal belongings and environment.R2's admission Record documented an admission Date of 6/26/24 and documented diagnoses including Epilepsy and Cerebral Palsy. R1's MDS dated [DATE] documented a BIMS score of 13, indicating R2 has minimal deficits in cognition. R2's Care Plan dated 5/21/25 documented a problem area, (R2) has been the recipient and aggressor of verbal and physical aggression related to poor coping skills.A Facility Incident Report Form dated 7/6/25 at 9:20 AM, authored by V1, Administrator, documented, Altercation reported to Abuse Coordinator by nursing staff. (R1) and (R2) were arguing in the hall over a jacket. (R2) called (R1) a curse word and attempted to take the jacket away from (R1) resulting in (R1)'s arm being scratched. Both residents were immediately separated and the jacket was taken to determine who the jacket belonged to. Residents were assessed. (R1)'s scratch was cleansed and treatment [sic] as ordered. No other signs of injury or pain were noted. Notified Power of Attorney and Nurse Practitioner of incident for both residents. Investigation begun.A Facility Incident Report Form dated 7/11/25 at 8:30am, authored by V1 documented, (R2) reported that (R1) stabbed her in the back with a pen. (R1) was assessed and multiple puncture marks were visualized on (R1)'s back. (R1) and (R2) both were sent to the hospital for evaluation. (Local Police Department) (was) notified. Geriatric Psychiatry and Family Practice Nurse Practitioners notified. Power of Attorney/Family notified for both residents. Investigation begun.A Facility Incident Report Form dated 7/11/25 at 10:30am, authored by V1 documented, During investigation of previous incident (7/11/25 at 8:30am), (R1) informed (V1) that (R1) had a bruise on her forehead. (R1) stated she did not report the bruise or incident to anyone. Both residents are separated. Both residents sent to ER (Emergency Room) for evaluation. (Local Law enforcement), Geriatric Psychiatry and Family Practice Nurse Practitioners notified. Power of Attorney/Family notified for both residents. Investigation begun.R1's History of Present Illness from the local ER dated 7/11/25 documented, (R1) is a [AGE] year old female brought to ER for a mental health exam following stabbing another patient at a local nursing home. She reports an incident at her nursing home where she used a ballpoint pen to defend herself against another resident who she describes as, 'feisty,' and, 'argumentative.' This documentation goes on to state, She mentions a bruise on her forehead, which she attributes to being hit by the same resident two days ago. Review of Systems: Psychiatric: She exhibits impaired recent memory. Patient does seem to have appropriate judgement, but lost control after repeated offenses from the fellow resident she stabbed. Medical decision making: Urinalysis is slightly positive for infection. Patient was started on Ceftin. Patient will be returned to the nursing home. Nursing home staff will need to take appropriate measures to keep the two residents apart. I do not have concern patient will attack anyone else outside of being attacked herself.R2's History of Present Illness from the local ER dated 7/11/25 documented, The patient was stabbed at her facility with a pen by another patient, in her right upper back. 10 total superficial wounds noted to right shoulder and back. Patient states, I was visiting my friend and another person who wasn't supposed to be in the room stabbed me with a pen in the back. Resident is alert and oriented to person, place, time, and purpose. There were no signs of infection, but I will put her on Bactrim for infection prevention. There was no documentation in the ER records as to R2 causing a bruise on R1's forehead, or any evidence of a psychiatric evaluation being done on R2. On 7/15/25 at 8:55am, R1 was alert only to herself. R1 was observed to be on one to one observation with CNA (Certified Nursing Assistant) staff. R1 was noted to have a large healing bruise to the left forehead. When asked about the bruise, R1 stated, She did that to me. It was another resident. R1 stated she could not remember the other residents name, but referred to her with feminine pronouns. R1 stated this resident, date unknown, saw R1 in the hall and accused R1 of stealing her jacket, which R1 denied. R1 stated that

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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 - Few	Respond appropriately to all alleged violations. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to investigate a bruise of unknown origin as potential physical abuse for 1 of 4 residents (R1) reviewed for abuse in the sample of 4.R1's Face Sheet documented an admission Date of 5/30/24 and listed diagnoses including Unspecified Dementia, Major Depressive Disorder, and Anxiety Disorder. R1's Minimum Data Set (MDS) dated [DATE] documented a Brief Inventory for Mental Status (BIMS) Score of 8, indicating R1 has moderate deficits in cognition. R1's Care Plan dated 6/9/25 documented a problem area, (R1) has been the recipient and aggressor of verbal and physical aggression related to dementia, and continual reorganization of personal belongings and environment.R2's Face Sheet documented an admission Date of 6/26/24 and documented diagnoses including Epilepsy and Cerebral Palsy. R1's MDS dated [DATE] documented a BIMS score of 13, indicating R2 has minimal deficits in cognition. R2's Care Plan dated 5/21/25 documented a problem area, (R2) has been the recipient and aggressor of verbal and physical aggression related to poor coping skills.A Facility Incident Report Form dated 7/11/25 at 8:30am, authored by V1 documented, (R2) reported that (R1) stabbed her in the back with a pen. (R1) was assessed and multiple puncture marks were visualized on (R1)'s back. (R1) and (R2) both were sent to the hospital for evaluation. (Local Police Department) (was) notified. Geriatric Psychiatry and Family Practice Nurse Practitioners notified. Power of Attorney/Family notified for both residents. Investigation begun.A Facility Incident Report Form dated 7/11/25 at 10:30am, authored by V1 documented, During investigation of previous incident (7/11/25 at 8:30am), (R1) informed (V1) that (R1) had a bruise on her forehead. (R1) stated she did not report the bruise or incident to anyone. Both residents are separated. Both residents sent to ER (Emergency Room) for evaluation. (Local Law enforcement), Geriatric Psychiatry and Family Practice Nurse Practitioners notified. Power of Attorney/Family notified for both residents. Investigation begun.A Nursing Progress Note in R1's medical record dated 7/9/25, authored by V7, Assistant Director of Nurses, documented, Resident seen walking in the hallway and noted to have a bruise to forehead above left eye/eyebrow. Appears to be in different stages of healing indicating this may be an old bruise. This nurse asked resident if she had fallen and she was unsure but thought she may have. She was unable to recall when, where, how, or any details pertaining to a possible fall. Bruise to face approximately 4 centimeters measured by this nurse. Resident denies any adverse effects such as pain or headache at this time. (Residents current) Nurse notified of events who stated he will continue to monitor.On 7/15/25 at 8:55am, R1 was alert only to herself. R1 was observed to be on one to one observation with CNA (Certified Nursing Assistant) staff. R1 was noted to have s a large healing bruise to the left forehead. When asked about the bruise, R1 stated, She did that to me. It was another resident. R1 stated she could not remember the other residents name, but referred to her with feminine pronouns. R1 stated this resident, date unknown, saw R1 in the hall and accused R1 of stealing her jacket, which R1 denied. R1 stated that was all she remembered about that incident, but stated the other resident must have stayed mad about the jacket, because at some point after, she came into R1's room and punched R1 on the forehead. R1 stated R1 then stabbed the other resident in the back with an ink pen, In self- defense. I was trying to get her off meOn 7/15/25 at 9:05am, R2 was alert and oriented to person, place, and time. R2 was observed to be under one to one observation from CNA staff. R2 was observed to have at least ten pinprick sized scabs over her upper back. R2 denied ever hitting R1 on the forehead or scratching R1's arm.On 7/15/25 at 9:38am, V1 stated on 7/11/25, V2, Director of Nurses, brought R2 to her to report what happened with R1. V1 stated she interviewed R2 who said R2 asked R1 to leave the other residents room, and R1 started poking R2 in the back with a pen. V2 stated she then interviewed R1, who showed V1 a bruise on R1's forehead and R1 indicated it was caused by R2 punching R1 in the head. V1 stated she was unaware of the bruise to R1's forehead or of R1's report that it was caused by R2. On 7/15/25 at 10:05am, V7, Assistant Director of Nurses, stated she was walking past R1 in the hallway on 7/9/25, when she saw R1 and noticed R1 had a bruise over the left eye. V7 asked R1 what happened, and initially R1 said she couldn't remember but then said she didn't want to talk about it, which is often her response to questions. V7 stated during the conversation, R1 stated she thought maybe she fell but wasn't sure. V7 stated she consulted with V2, Director of Nurses, who told V7 to measure the bruise, which measured 4 centimeters. V7 stated V2 advised V7 that since the bruise was under 7 centimeters in diameter, the bruise did not have to be reported to V1 as the Abuse Coordinator as possible abuse. On 7/15/25 at 10:15am, V2 stated on 7/9/25, V7 approached V2