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	10/22/2025

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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F 0689 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 safely transfer a resident with a mechanical lifting device for 1 of 3 (R1) residents reviewed for accidents in a sample of 3. This failure resulted in R1 sustaining an impacted fracture of the right humeral neck.This past noncompliance occurred from 10/10/25 to 10/16/25.Findings include:R1's admission Record documents an admission date of 1/29/21, with diagnoses including unspecified sequelae of cerebral infarction, hemiplegia and hemiparesis following other nontraumatic intracranial hemorrhage affecting right dominant side, unspecified fracture of upper end of right humerus, initial encounter for closed fracture, muscle wasting and atrophy, not elsewhere classified, other lack of coordination.R1's Minimum Data Set (MDS) dated [DATE], documents a Brief Interview for Mental Status (BIMS) of 9, indicating R1 is moderately cognitively impaired. Section GG-Functional Abilities documents that R1 is Dependent - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity for transfers.R1's current Care Plan documents that R1 is at risk for falls related to impaired mobility, with a history of falls, suprapubic catheter, and a history of cerebral vascular accident with hemiplegia. The focus area documents R1 is dependent on staff with lower body dressing, putting on/taking off footwear, transfers and toilet hygiene, with interventions including, transfers require a sling lift, with an initiation date of 6/17/2024. The same Care Plan also documents that R1 requires assist with all ADL's (Activities of Daily Living) related to impaired mobility and right sided weakness with interventions including Bed mobility requires ext (extensive) assist of 2 with an initiation date of 10/21/19.R1's Physician's Order Sheet with a print date of 10/21/25 documents an order for R1 to be transferred via sling lift, with an initiation date of 6/17/24.R1's Injury Investigation Summary with an incident date of 10/10/25, that was completed by V2 (Director of Nursing/DON) states in the final summary/conclusion On 10/10/25 R1 was being transferred with a sit to stand by R5 (CNA) when she experienced a syncopal episode and was then lowered back to wheelchair.the employee who performed the transfer was given 3-day suspension, coaching on Kardex and provided further transfer training.R1's final Serious Injury Incident and Communicable Disease Report documents an incident date and time of 10/10/25 at 8:07pm. Under detailed incident summary documents (R1) is. dependent upon staff for transfers and ambulation and requires max assist for most ADL's. On 10/10/25, (R1) was being transferred with the sit to stand when she experienced a syncopal episode then lowered back to wheelchair. Resident was assessed by nurse and no obvious injuries were noted. Resident complained of right shoulder pain and heat pack applied. (V8 Nurse Practitioner) notified and ordered stat imaging. In house imaging showed impacted fracture of the humeral neck with no significant displacement.Resident was sent to (local hospital) ER (Emergency Room) for further evaluation.R1's Progress Notes document on 10/10/25 at 9:19pm, X-ray performed and results of x-ray faxed to facility. Res. (resident) has possible Fx (fracture) to Right humeral head. X-ray results show impacted transverse Fx of the humeral neck with no significant displacement. Per results, clinical correlation is requested to determine the age of the fracture. POA (Power of Attorney) notified of x-ray results and POA stated he was made aware of incident that possibly caused fracture earlier on this date. POA requesting res. be sent to hospital for further evaluation/tx (treatment.) Resident made aware of x-ray results and POA request and thanked this nurse for update. Res. stating she is in constant pain and hopes the hospital will help with the pain.R1's Progress Notes document on 10/10/25 at 11:13pm, Late entry: (local) EMS (Emergency Medical Services) arrive at approx. (approximately) 2130 (9:30PM) for transport resident to hospital.R1's ED (Emergency Department) Provider Notes from the local hospital with a date of service of 10/10/25 at 10:12pm documents that R1 presented to the Emergency department for a right humerus fracture. This document states that R1 fell at the facility out of a sit to stand lift.On 10/20/25 at 10:34am, R1 stated she could not remember how she was injured.On 10/21/25 at 11:16am, V1 (Administrator) stated on 10/11/25 they identified a failure with the incident that occurred the evening of 10/10/25 involving R1. V1 stated they immediately started an investigation as soon as they were notified of the incident and the Quality Assurance Committee immediately started to develop a plan of correction.On 10/22/25 at 12:37pm, V5 (Certified Nursing Assistant/CNA) states that R1 needed to go to the bathroom. V5 stated he was unsure how R1 transferred, so he asked her, and she told him the sit to stand. V5 stated that she transferred to the toilet with the sit to stand without incident. V5 stated when he lowered her back into her chair, it appeared she passed out. V5 stated he immediately alerted the nurse. V5 stated