| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 146036 | A. Building<br>B. Wing | 01/08/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Shawnee Senior Living | 1901 13th Street<br>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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide the identified level of supervision and assistance required to prevent PICA behaviors for one of three residents (R4) reviewed for supervision in the sample of 11. Findings include:R4's admission record documents an admission date of 10/31/19 with the following diagnoses in part; Brief psychotic disorder, other specified eating disorder, delusional disorders and depression.R4's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status (BIMS) of 3, indicating R4 is severely cognitively impaired. In section E-Behavior, R4 is coded to have other behavioral symptoms not directed towards others occurring 1 to 3 days. In section I-Active Diagnoses, R4 is coded to have malnutrition and a psychotic disorder (other than Schizophrenia).R4's current care plan documents a focus area of (R4) is at risk for psychosocial issues related to communication issues, impaired cognitive functioning due to dementia, behaviors such as physical and verbal aggression towards staff and wandering, (resident requires a 1:1 sitter), resident has a PICA behavior often eating cigarette butts, plastic, Styrofoam, and pages from books, chronic pain from osteopenia, chronic back pain, and left hip pain, use of psychotropic medications to help manage anxiety, depression, and for behavioral management. Resident is a current smoker but needs supervision due to PICA behavior and unsafe smoking habits. Date initiated 8/11/25. With interventions including, 1:1 R/T (related to) Dx: PICA requiring close observation. (no initiation date listed).R4's Documentation Survey Report dated September 2025 under Intervention/Task- putting non-food items in mouth documents R4 attempted to ingest non-food items on 9/3, 9/4, 9/5, 9/10, 9/11, 9/12, 9/15, 9/16, 9/17, 9/18, 9/22, 9/23, 9/24, and 9/28. There were no notes documented for any of these dates with specifics on the behavior. R4's Documentation Survey Report dated October 2025 under Intervention/Task- putting non-food items in mouth documents R4 attempted to ingest non-food items on 10/1, 10/2, 10/4, 10/8, 10/11, 10/12, 10/14, 10/20, 10/28, 10/29, and 10/31. There were no notes documented for any of these dates with specifics on the behavior. R4's Documentation Survey Report dated November 2025 under Intervention/Task- putting non-food items in mouth documents R4 attempted to ingest non-food items on 11/1, 11/4, 11/5, 11/6, 11/9, 11/12, 11/19, 11/22, 11/25, 11/26 and 11/30. There were no notes documented for any of these dates with specifics on the behavior. R4's Documentation Survey Report dated December 2025 under Intervention/Task- putting non-food items in mouth documents R4 attempted to ingest non-food items on 12/2, 12/3, 12/4, 12/6, 12/7, 12/8, 12/9 12/12 12/15, 12/25, and 12/26. There were no notes documented for any of these dates with specifics on the behavior. R4's progress notes dated 10/4/25 at 4:07pm, Resident has had 3 loose stools and has been putting the stool in her mouth each time CNA (Certified Nursing Assistant) reported.R4's progress note dated 10/4/25 at 11:59am, Was Resident Safety Check sheet completed? every shift for resident safety. Was a behavior observed? YES. Resident was found rummaging through a desk drawer behind the nurse's station where she had found a package of cigarettes. She took a bite out of one of them<br><br>(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: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 146036 | A. Building<br>B. Wing | 01/08/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Shawnee Senior Living | 1901 13th Street<br>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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | before staff intervention occurred.R4's progress note dated 12/9/25 at 8:39am, Reported to this nurse by night shift nurse that res. was inappropriately handling own BM (bowel movement) when the night shift CNA was doing bed check. (V2) RN DON notified. (V14) NP (Nurse Practitioner) . notified. Verbal orders received from NP to d/c (discontinue) seroquel 25mg and start abilify 5mg. Called .POA (Power of Attorney)/daughter to update on orders. (Name of daughter) gave verbal consent to start abilify and stated she would like her mom to be fed at all meals. (Name of daughter) thanked this nurse for update and stated she will be here at noon to feed her. On 12/31/25 at 10:34am, V8 (Licensed Practical Nurse) stated he was R4's dayshift nurse on 12/9/25. V8 stated R4 had been found ingesting her own feces on night shift, he spoke with R14 (Nurse Practitioner) and her medications were changed around and she was immediately placed back on 1:1 supervision. V8 stated if a behavior is observed, it is documented in a resident's chart so that management can review it and address it accordingly. V8 stated Certified Nursing Assistants complete behavior tracking, but anyone aware of a behavior should be charting on it and CNA's should be reporting behaviors to the nurse.On 12/31/26 at 11:35am, V1 (Administrator) stated R4 was not on 1:1 from 9/19-12/9 because she was not exhibiting PICA behaviors, which is putting nonfood items in her mouth. V1 stated R4 was on safety checks which meant that staff rounded on her once every 15 minutes.On 1/5/25 at 9:47am, V14 (NP) stated she had not received report of R4 having PICA behaviors or ingesting her own feces until 12/9. V14 stated if it would have been reported to her, 1:1 would have been the first intervention initiated.On 1/7/26 at 10:21am, V11 (Certified Nursing Assistant/CNA) stated if she marked yes under the behavior tracking for Putting nonfood items in her mouth, the behavior was occurring. V11 stated sometimes it might just be her hair, but she will put anything in her mouth she can get her hands on, hair ties, cigarettes, paper towels, toilet paper. V8 stated management took R4 off 1:1 for a while because they believed that if they kept her room really clean and a close eye on her she would not have the behaviors as much. V8 stated in the behavior tracking if you check yes on putting nonfood items in her mouth, a box will pop up where you can type in what behavior she is having, like a little note. V8 stated she tries to put in a note. V8 stated no one asks any follow-up questions to behavior tracking.On 1/7/26 at 10:48am, V2 (Director of Nursing/DON) stated she reviews behavior tracking/progress notes once every 72 hours and results are discussed in IDT (Interdisciplinary Team). V2 stated the reason that R4 was not on 1:1 from 9/19-12/9 was because she was not having PICA behaviors. V2 stated when staff trigger a behavior it should give CNA's the option to write a note that shows up in the progress note and they should be putting what the behavior is.On 1/7/26 at 1:38pm, V1 stated she was not aware of R4 having any behaviors between 9/19 and 12/9. V1 stated V2 (DON) reviews behavior tracking and progress notes and will report findings at morning meetings. V1 stated when they were notified of R4's behavior on 12/9, they immediately placed her back on 1:1.Undated facility policy titled, Behavior Management Policy states in the section titled Standards . 6. Staff will increase observation of the resident as per plan of care and behavior management plan . 10. Behavior tracking forms are used to document the frequency of occurrence of target problem behaviors. Staff on all shifts will document observations so that occurrences may be periodically tabulated and analyzed. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 146036 | A. Building<br>B. Wing | 01/08/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Shawnee Senior Living | 1901 13th Street<br>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 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident must receive and the facility must provide necessary behavioral health care and services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide person-centered interdisciplinary behavioral health services and appropriate supervision to 1 of 3 residents (R4) reviewed for behavioral health services in the sample of 11. Findings include:R4's admission record documents an admission date of 10/31/19 with the following diagnoses in part; Brief psychotic disorder, other specified eating disorder, delusional disorders and depression.R4's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status (BIMS) of 3, indicating R4 is severely cognitively impaired. In section E-Behavior, R4 is coded to have other behavioral symptoms not directed towards others occurring 1 to 3 days. In section I-Active Diagnoses, R4 is coded to have malnutrition and a psychotic disorder (other than Schizophrenia.R4's current care plan documents a focus area of (R4) is at risk for psychosocial issues related to communication issues, impaired cognitive functioning due to dementia, behaviors such as physical and verbal aggression towards staff and wandering, (resident requires a 1:1 sitter), resident has a PICA behavior often eating cigarette butts, plastic, Styrofoam, and pages from books, chronic pain from osteopenia, chronic back pain, and left hip pain, use of psychotropic medications to help manage anxiety, depression, and for behavioral management. Resident is a current smoker but needs supervision due to PICA behavior and unsafe smoking habits. Date initiated 8/11/25. With interventions including: 1:1 R/T (related to) Dx: PICA requiring close observation. (no initiation date listed). Monitor behavior episodes and attempt underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes. (no initiation date listed).R4's Documentation Survey Report dated September 2025 under Intervention/Task- putting non-food items in mouth documents R4 attempted to ingest non-food items on 9/3, 9/4, 9/5, 9/10, 9/11, 9/12, 9/15, 9/16, 9/17, 9/18, 9/22, 9/23, 9/24, and 9/28. There were no notes documented for any of these dates with specifics on the behavior.R4's Documentation Survey Report dated October 2025 under Intervention/Task- putting non-food items in mouth documents R4 attempted to ingest non-food items on 10/1, 10/2, 10/4, 10/8, 10/11, 10/12, 10/14, 10/20, 10/28, 10/29, and 10/31. There were no notes documented for any of these dates with specifics on the behavior.R4's Documentation Survey Report dated November 2025 under Intervention/Task- putting non-food items in mouth documents R4 attempted to ingest non-food items on 11/1, 11/4, 11/5, 11/6, 11/9, 11/12, 11/19, 11/22, 11/25, 11/26 and 11/30. There were no notes documented for any of these dates with specifics on the behavior.R4's Documentation Survey Report dated December 2025 under Intervention/Task- putting non-food items in mouth documents R4 attempted to ingest non-food items on 12/2, 12/3, 12/4, 12/6, 12/7, 12/8, 12/9 12/12 12/15, 12/25, and 12/26. There were no notes documented for any of these dates with specifics on the behavior.R4's progress notes dated 10/4/25 at 4:07pm, Resident has had 3 loose stools and has been putting the stool in her mouth each time CNA (Certified Nursing Assistant) reported.R4's progress note dated 10/4/25 at 11:59am, Was Resident Safety Check sheet completed? every shift for resident safety. Was a behavior observed? YES. Resident was found rummaging through a desk drawer behind the nurse's station where she had found a package of cigarettes. She took a bite out of one of them before staff intervention occurred.R4's progress note dated 12/9/25 at 8:39am, Reported to this nurse by night shift nurse that res. was inappropriately handling own BM (bowel movement) when the night shift CNA was doing bed check. (V2) RN DON notified. (V14) NP (Nurse Practitioner) . notified. Verbal orders received from NP to d/c (discontinue) seroquel 25mg and start abilify 5mg. Called .POA (Power of Attorney)/daughter to update on orders. (Name of daughter) gave verbal consent to start abilify and stated she would like her mom to be fed at all meals. (Name of daughter) thanked this nurse for update and<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 146036 | A. Building<br>B. Wing | 01/08/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Shawnee Senior Living | 1901 13th Street<br>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 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | stated she will be here at noon to feed her. On 12/31/25 at 10:34am, V8 (Licensed Practical Nurse) stated he was R4's dayshift nurse on 12/9/25. V8 stated R4 had been found ingesting her own feces on night shift, he spoke with R14 (Nurse Practitioner) and her medications were changed around and she was immediately placed back on 1:1 supervision. V8 stated if a behavior is observed, it is documented in a resident's chart so that management can review it and address it accordingly. V8 stated Certified Nursing Assistants complete behavior tracking, but anyone aware of a behavior should be charting on it and CNA's should be reporting behaviors to the nurse.On 12/31/26 at 11:35am, V1 (Administrator) stated R4 was not on 1:1 from 9/19-12/9 because she was not exhibiting PICA behaviors, which is putting nonfood items in her mouth. V1 stated R4 was on safety checks which meant that staff rounded on her once every 15 minutes.On 1/5/25 at 9:47am, V14 (NP) stated she had not received report of R4 having PICA behaviors or ingesting her own feces until 12/9. V14 stated if it would have been reported to her, 1:1 would have been the first intervention initiated.On 1/7/26 at 10:21am, V11 (Certified Nursing Assistant/CNA) stated if she marked yes under the behavior tracking for Putting nonfood items in her mouth, the behavior was occurring. V11 stated sometimes it might just be her hair, but she will put anything in her mouth she can get her hands on, hair ties, cigarettes, paper towels, toilet paper. V8 stated management took R4 off 1:1 for a while because they believed that if they kept her room really clean and a close eye on her she would not have the behaviors as much. V8 stated in the behavior tracking if you check yes on putting nonfood items in her mouth, a box will pop up where you can type in what behavior she is having, like a little note. V8 stated she tries to put in a note. V8 stated no one asks any follow-up questions to behavior tracking.On 1/7/26 at 10:48am, V2 (Director of Nursing/DON) stated she reviews behavior tracking/progress notes once every 72 hours and results are discussed in IDT (Interdisciplinary Team). V2 stated the reason that R4 was not on 1:1 from 9/19-12/9 was because she was not having PICA behaviors. V2 stated when staff trigger a behavior it should give CNA's the option to write a note that shows up in the progress note and they should be putting what the behavior is.On 1/7/26 at 1:38pm, V1 stated she was not aware of R4 having any behaviors between 9/19 and 12/9. V1 stated V2 (DON) reviews behavior tracking and progress notes and will report findings at morning meetings. V1 stated when they were notified of R4's behavior on 12/9, they immediately placed her back on 1:1.Undated facility policy titled, Behavior Management Policy states in the section titled Policy It is the policy of this facility that all residents shall be assisted and monitored for mental, emotional, and behavioral changes as well as physical condition and appropriate interventions initiated. Staff actions will be directed toward symptom awareness, symptom description and monitoring in order to identify goals interventions and approaches.Undated facility policy titled, Behavior Management Policy states in the section titled Policy Specifications: To designate responsibilities of the interdisciplinary team when residents exhibit inappropriate, problematic or disruptive behavior symptoms which are potentially harmful to the health or welfare of the resident or other residents or staff, and address guidelines for facility staff interventions. To assure appropriate assessments are conducted to rule out environmental or medical causes of behavior. |