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	01/20/2026

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 0692 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to identify severe weight loss of three residents and failed to provide needed interventions to prevent further weight loss for 3 of 3 residents (R1, R3 and R7) reviewed for weight loss in a sample of 7. This failure resulted in R1, R3 and R7 experiencing severe weight loss.Findings include:1.R1's admission record documents an admission date of 6/27/2024 and includes diagnoses of Chronic Systolic Heart Failure, Dysphagia, Emphysema, Chronic Respiratory Failure, Type 2 Diabetes Mellitus, Essential Hypertension, Anxiety, Dementia, Depression and Atrial Fibrillation. R1's Minimum Data Set (MDS) dated [DATE] includes a Brief Interview for Mental Status (BIMS) score of 5 suggesting severe cognition impairment. R1's section GG documents R1 requires supervision or touching assistance with eating. R1's Care Plan documents R1 is at risk for nutrition/hydration issues related to Insulin Dependent Diabetes Mellitus, Chronic Obstructive Pulmonary Disease Congestive Heart Failure (CHF), Dysphagia, Anxiety, Depression, Chronic Respiratory Failure. Interventions include to monitor/record/report to MD (Medical Doctor) as needed of malnutrition, Emaciation, muscle wasting, significant weight loss: >5% 1 month, >7.5% in 3 months, >10% in 6 months, date initiated 6/28/24. Provide regular pureed texture diet with regular consistency liquids as ordered and monitor intake and record every meal, with a revision date of 7/22/25. RD (Registered Dietitian) to evaluate and make diet change recommendations as needed; On date initiated 6/28/2024. R1's Physician's Order Summary Report documents R1 in on a regular diet, pureed texture, regular consistency, super cereal at breakfast, whole milk at breakfast for diet. Order start date is 10/16/2024. R1's Weights and Vitals Summary printed 1/15/26 documents R1's weights were taken daily some of these weights include:12/2/25= 135.4 pounds, 12/10/25= 121.4 pounds, 12/14/25= 113.8 pounds, 12/17/25= 116 pounds, 12/24/25= 115.9 pounds, 12/30/25= 120.2 pounds. 1/3/26= 119.5 pounds, 1/7/26= 116.5 pounds, 1/13/26= 106.6 pounds.R1's 1/13/26 weight triggered a warning on the summary that documented: Comparison weight 12/14/25, 113.8 pounds, indicating a 6.3 % weight loss over 30 days with weight loss of 7.2 pounds. Comparison weight for 10/15/25, 135.2 pounds, indicating a 21.2% weight loss of 28.6 pounds in 3 months. Comparison weight 7/18/25, 134 pounds, indicating a 20.1% weight loss of 27 pounds in 6 months. Weight calculations for 30 days, 3 months, and 6 months signify a severe weight loss for all three intervals calculated. R1's Electronic Health Record documents the last visit R1 had with V10 (Previous Registered Dietitian/RD) was on 6/9/25. This note documents R1's weight was 134 pounds and that R1 had a weight gain of 11.7% in 6 months. This note documented R1's meal intakes were 51-100% that R1 was on daily weights due to CHF and was on comfort measures. R1's pureed diet was to be continued. R1's Nutritional intakes sheet for the month of January 1st through 13th document as follows: Breakfast meal intakes documents 4 days of 0 - 25% eaten, 3 days of 26-50% eaten, 2 days of 51-75% eaten, and 3 days of 76-100% eaten. Lunch intake documents, 6 days of 0-25% eaten, 1 day of 51-75% eaten, 3 days of 76-100% eaten and 1 day without documentation. Dinner meal documents, 2 days of 0-25% eaten, 3 days of 26%-50% eaten, (continued on next page)

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 B. Wing	01/20/2026

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 0692 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	2 days of 51%-75% eaten, 1 day of 75-100% eaten and 3 days of no documentation. On 1/15/2026 at 12:07PM, V2 stated when R1 admitted on [DATE] she was admitted on hospice and discharged from hospice on 10/4/2025. V2 stated the last time the RD saw R1 was on 6/9/2025 but she (V2) had sent information to the RD about R1 but never got a response. V2 stated the RD would review the weights and would see who she felt needed seen. On 1/15/2026 at 2:30PM, V2 (Director of Nursing) reviewed R1's weights with this surveyor and confirmed that R1 had a significant weight loss for the last 1 month, 3 months and 6 months. V2 was asked if any new interventions were put into place for R1 regarding R1's weight loss and V2 stated, No, I already looked but I did reach out to the previous RD but she didn't respond. V2 presented weight notifications (Progress notes) and emails with the following dates 6/2/2025, 8/6/2025, and 9/23/2025 that were sent to the previous RD but they all contained notifications of weight gains. No documentation was provided of notifications of weight losses. V2 then stated they didn't put in any interventions in place for R1's weight loss and verified that R1 had not been seen by the RD since 6/9/2024. V2 stated she reviews the monthly weights herself. V2 was asked if they had IDT (Interdisciplinary Team Meetings) that involve the Dietary Manager, herself, Administrator, Care Plan Coordinator, and assistant Director of Nursing, V2 stated they do not have IDT meetings. V2 stated they look at weights in morning meeting everyday if there are weights done. V2 was asked if she sends a list of new residents, residents with weight losses, and residents with wounds to the RD so they can be seen on next visit and V2 stated, No the RD comes in and gets the monthly weights and she sees whoever she feels needs to be seen. V2 stated that the previous RD has been fired because they were not satisfied with her services, and she has been replaced by a new RD that started this month (January) but the new RD has not been in the facility yet and she is doing telehealth visits at this time. V2 stated she is the only one that reviews the monthly weights. On 1/16/2025 at 11:45AM, V2 (Director of Nursing/DON) provided a list made by the new RD of visits that occurred on 1/8/2026 and R1 was not seen. V2 stated this list was from the new RD who has not yet been in the facility, so visits have been through telehealth. On 1/15/2026 at 11:59AM, V5 (Certified Nursing Assistant/ CNA) stated she took care of R1 most days and she had noticed the last week before R1 was sent to the hospital that R1 was not hardly eating anything and that was even with assistance. V5 stated R1 required total care except she could fed herself most of the meals when she would eat. V5 stated she does- not remember if she notified of R1's decreased appetite. On 1/15/2026 at 12:05PM, V6 (CNA) stated he also helps care for R1 and stated R1 usually fed herself. On 1/15/2026 at 2:45PM, V8 (Nurse Practitioner/NP) stated she is familiar with R1, and she sent her out to the hospital on 1/13/2026. V8 stated she saw her on 1/13/2026 nd R1 did look bad, so she sent her out. V8 stated she was notified on December 8th that R1 wasn't eating very good, so she did labs and KUB (images of Kidneys, Ureters, and Bladder) resulted with a Urinary Tract Infection and was treated for that infection. V8 checked R1's chart and stated she did not receive anything recently about R1's weights. V8 stated she was notified in August 2025 of a weight gain but that was the last notification for R1 in regard to R1's weights. V8 looked through R1's electronic chart for notifications from the RD or nursing in regard to R1's weight loss but could not find any notifications. V8 also looked through a stack of RD recommendations in a folder for notifications from the previous and new RD for recommendations on R1's weight loss and did not have any for R1. V8 stated if there are concerns presented to her from the RD and discussion would have been had and she would normally agree to whatever recommendation the RD would have. R8 said she would then sign the recommendation and turn them in to the DON. On 1/15/2026 at 12:17PM, V7 (Physician/Medical Director) stated he had never seen R1 at the facility. V7 was asked about weight losses and V7 stated the weights and things of that sort are handled by V8 NP. V7 (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 B. Wing	01/20/2026

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 0692 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	stated V8 gets the recommendation and address those while in the facility on her rounds.During this investigation no observations were made of R1 due to R1 being hospitalized at the time of this survey.2. R3's admission Record documents admission date of 10/25/2025 and includes diagnoses of Type 2 Diabetes Mellitus, Fracture of Left Pubis, Candidal 26, Epilepsy, Anxiety, Muscle wasting and Atrophy and Dysphagia. R3's Minimum Data Set (MDS) dated [DATE] includes a Brief Interview for Mental Status (BIMS) score of 13 suggesting cognition is intact. Section GG-Functional Abilities documents R3 requires supervision or touching assistance for eating and oral hygiene. R3 requires partial/moderate assist with personal care. Section K- Swallowing/ Nutrition documents that R3 has no swallowing issues.R3's diet orders dated 5/25/2025 show upon admission R3 had orders for a pureed diet, high protein, 75 GM (gram)Carbs, 2 GM Sodium, no sweetened beverages. On 10/31/2025 diet was changed to regular diet, regular texture, regular consistency for liquids. On 11/18/2025 diet was changed to regular, mechanical soft, with regular liquids. On 11/26/2026 diet was changed to a regular diet, regular texture, regular fluid consistency, bite size-staff may need to assist if patient is unable to cut with fork/knife, offer diet drinks/condiments. R3's current Care Plan documents a focus area of: Usual ADL (Activities of Daily Living) Performance, R3 is able to eat with supervision, created on 10/28/25. Interventions include: R3 is able to eat with supervision from staff. R3's Care Plan does not address any focus areas related to nutrition or weight loss.R3's Weights and Vitals Summary printed 1/15/26 documents R3's weights as follows: Height is 71 inches. admission weight on 10/26/2025 = 129 pounds, 11/21/2025 = 123 pounds, 11/25/2025 = 121.6 pounds, 12/9/2025 = 124.4 pounds, 1/7/2026 = 115.8 pounds. R3 's weight record had 2 inaccurate weights entered on 12/2/2025 of 155.2 pounds and on 12/16/2025 weight of 167.8 pounds. On 1/15/2025 at 2:30PM, V2 verified that these weights were inaccurate and should have prompted reweighs. These weights document that R3 had a 6.9% weight loss from 12/9/25 to 1/7/26 with a loss of 8.6 pounds and a 13.2 pound weight loss or 10.2% since admission (3 months). R3's weight calculations show severe weight loss for 30 days and 3 months. According to the Adult BMI (Body Mass Index) Calculator located at https://www.cdc.gov/bmi/adult-calculator/index.html. R3 has a BMI of 17.1 indicating R3 is considered underweight.On 1/16/2025 at 1:00PM requests were made for R3's intake sheets to both V1 and V2. During this investigation none were provided via email or paper copy. R3's Nutrition/Dietary Note authored by V10 dated 12/8/25 documents R3 consumes 51-100% of meal intakes, has a weight of 155 pounds, a weight range of 121-129 pounds and needs assistance at times to cut up meats. Continue regular diet, include diet drinks/condiments to help control glucose levels. On 1/15/2025 at 2:30PM, V2 was asked about R3's weight loss and V2 stated when R3 admitted she had several diet changes but mainly the consistency of her food is what was altered. V2 stated R3 was a very picky eater and will ask for substitutes at times especially grilled cheese. V2 stated she knew R3 was not eating good. V2 acknowledged that R3 had a weight loss. V2 verified that the weight given to V10 for R3 on 12/8/25 was an inaccurate weight and V10 based her assessment off of the inaccurate weight on 155 pounds. R3's Nutritional Care Report made by V11 (new RD) dated 1/8/2025, documents R3, under Summary reads: Recommend continuing current diet and encourage intake. On this same document under action reads: weight needed (reweight. Weekly weight, etc.) On 1/16/2026 at 9:42AM, R3 was observed sitting in the dining room visiting with other residents while they colored. R3 was asked if she was aware of having a weight loss, R3 stated, yes I know I have lost some weight. R3 was asked if she knew why she was losing weight, R3 stated, Yes I hate the food here and they serve our food cold, and I just can't stand to eat it. R3 was asked if she ever ask for alternates and R3 stated, I have at times, and they usually will give me a grilled cheese, but I can't live on grilled cheese alone. R3 was asked if she is offered snacks in between meals or at bedtime and (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 B. Wing	01/20/2026

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 0692 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	R3 stated, They will not give us snacks in between meals and they tell us we will have to wait for our next meal. R3 stated we sometimes get offered snacks at bedtime but sometimes we don't. R3 was asked if a dietitian has visited her at the facility to talk about her diet and/weights, R3 stated, no I have not seen a dietitian and no there has not been anyone talk to me about my weight loss. R3 stated she gets weighed but it is different ones that weighs her. R3 stated, they do help me when I need help, but I just don't like the food here. R3 was well groomed and stated her only complaint is the cooks and the food. On 1/16/2026 at 9:15AM, V9 (CNA) stated she works mostly on Reclaim 1 hall and takes care of R3. V9 stated the weights are done by whoever is working on the assigned days to obtain weights. V9 was asked if they ever must do reweighs and V9 stated occasionally we are asked to reweigh. V9 stated we the CNAs do the weights and then give them to the nurse and the nurse puts them in the computer. V9 stated the CNA's record the intakes of meals as well. V9 was asked if snacks are offered in between meals and at bedtime, V9 stated we don't offer snacks throughout the day but try to offer snacks at bedtime. V9 stated if a resident asks for a snack throughout the day we try to get snacks for them. V9 stated sometimes we run out of specific snacks and sometimes the kitchen does not put out the bedtime snacks because sometimes they run out of snacks. V9 stated R3 does not like a lot of the foods we offer, and she does not eat that good and will sometimes want a substitute. V9 stated there have been times that R3's son will bring her in food, and she will eat that good. V9 was asked if everyone knew about the weight losses with R3 and V9 stated we do the weights and turn those in to the nurses. V9 also stated we keep a weight book at the nurse's station as well and it keeps a record of the weights and who is to be weighed daily, weekly, and monthly. V9 stated the nurses review the weights and puts them in the computer and the DON reviews the weights as well. 3. R7's admission Record documents an admission date of 12/16/2024 and includes diagnoses of Alzheimer's Disease, Unspecified Dementia, Essential Hypertension, Hypothyroidism, Insomnia, Anxiety, Muscle Wasting and Atrophy. R7's Minimum Data Set (MDS) dated [DATE] includes a Brief Interview for Mental Status (BIMS) score of 6 suggesting severe cognition impairment. Section GG Functional Abilities documents R7 receives set up/or clean up assistance for eating. oral hygiene, toileting, upper body dressing and personal hygiene. Section K-Swallowing/Nutritional Status documents R7 has no swallowing issues. Under weight loss section it is documented that R7 had loss of 5% more in the last month or loss of 10% or more in last 6 months and R7 is not on physician-prescribed weight-loss regimen. R7's document titled Order Summary Report documents R7's has an order dated 12/17/2024, Regular Diet, regular texture and consistency, offer super cereal at breakfast, whole milk at breakfast, health shakes three times a day and offer ice cream at lunch. On 4/15/2025 and order was started for a dietary supplement of a health shake three times a day by dietary. May supplement with med pass if health shakes are not available.R7's Care plan documents R7 is at risk for nutrition/hydration issues related to Alzheimer's, Dementia, Cognition Communication deficit, Hypertension, and Hypothyroidism with revision date of 7/28/2025. Goal: R7 will be able to maintain weight without experiences any significant gains or losses with revision on 7/28/2025 and target date of 10/22/2025. Interventions include, R7 needs a calm, quiet settings at mealtimes with adequate eating times. R7 prefers to sit with current roommate. Encourage R7 socialization and interaction with table mates during meals, dated 7/28/2025. Monitor/document/report to physician for signs and symptoms of dysphagia and refusing to eat dated 7/28/2025. Monitor/record/report to physician signs and symptoms of malnutrition: Emaciation (Cachexia), muscle wasting, significant weight loss:>5% in 1 month, >7.5% in 3 months, and >10% in 6 months, dated 7/28/2025. R7's Weights and Vitals Summary printed 1/16/26 documents R7's weights to include:1/9/26= 106.2 pounds, 12/2/25= 118.6 pounds, 11/11/25= 116.8 pounds, 10/2/25= 123.4 pounds, (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 B. Wing	01/20/2026

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 0692 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	9/2/25= 132.6 pounds, 8/4/25= 135.6 pounds, 7/15/25= 131.6 pounds. R7's 1/6/26 weight triggered a warning on the summary that documented: Comparison weight 12/2/25, 118.6 pounds, indicating a 10.3 % weight loss over 30 days with weight loss of 12.4 pounds. Comparison weight for 7/5/25, 132 pounds, indicating a 19.7% weight loss of 26 pounds in 6 months. Weight calculations for 30 days and 6 months signify a severe weight loss. R7's Nutritional Intake sheets reviewed for month of January 2026, Breakfast resulted with 3 days of 0= 0-25% intake for breakfast, 6 days of 1=26%-50%, 4 days of 3= 76%-100%. Lunch resulted with 5 days of 0-25%, 5 days of 26-50%, 2 days of 51-75%, and 3 days of 76-100%. Dinner resulted with 6 days of 0-25%, 3 days of 26-50%, 1 day of 51-75%, 1 day of 76-100% and noted 5 days with no documentation.R7's Nutrition/Dietary Note by V10 dated 12/8/25 documents R7 has a 10.5% weight loss within the last three months with a weight of 119 pounds. R7 feeds self after set up with 50-100% meal intakes. Advanced age with increasing dementia. Continue reg diet with house supplement three times a day. Super Cereal at breakfast whole milk as B milk, Ice Cream at lunch. Resident being offered additional calories/protein. Encourage intakes, monitor intakes and weights, refer as needed. R7's Nutrition/Dietary Note by V10 dated10/20/25 documents RD Annual Assessment completed, refer as needed. Reviewed the Annual Assessment via electronic record with no significant changes. Assessment entailed risk for nutritional issues, labs, and current weights. R7's Nutrition/Dietary Note by V10 dated 10/14/25 documents R7 with a 7.5% weight loss within 1 month, weight fluctuating. Weight 123 pounds. R7 feeds self after set up with 50-100% meal intakes. Advanced age with increasing dementia. Continue reg diet with house supplement three times a day. Super Cereal at breakfast whole milk as B milk, include Ice Cream at lunch or additional calories. Encourage intakes, monitor intakes and weights, refer as needed. R7's Progress Notes documents with dates as follows: R7 was seen by Registered Dietitian (RD) on 12/8/2025, 10/20/2025, 10/14/2025, 7/14/2025, with new intervention on 10/14/2025 of Ice Cream at lunch. On 6/9/2025 RD notes documents to discontinue fortified foods, offer Super cereal at Breakfast, whole milk as B milk. The last intervention implemented for R7 was on 10/14/2025.On 1/16/2026 at 12:10PM, R7 was observed sitting in the dining room, slowly eating her lunch. R7 did not consume her whole meal, she mainly picked at her food. Staff was queuing R7 a few times but R7 was not eating much. R7 had a health shake and R7 was sipping on the health shake. R7 ate less than 50% of meal. R7 was not interview able during observation. When R7 was assisted by staff by staff reminding her to eat, R7 would start back to be picking at the food but not really eating much. On 1/19/2026 at 4:29PM, V2 stated R7 continues to feed herself but does require verbal ques and encouragement. V2 stated R7 does continue to eat in the dining room and enjoys visiting with the other residents. V2 stated they had the V11 (new RD) look at her again via telehealth today and will put in a new intervention for the significant weight loss. V2 stated the V11 reviewed R7's weights and has put in a new intervention today for Remeron for appetite stimulant to start tomorrow 1/20/2026. V2 stated hopefully this will help her to eat better and gain back some of her weight. On 1/16/2025 at 2:00PM, V1 (Administrator) stated the team discuss weights every morning in their meeting and V1 stated that monthly weights are reviewed by V2 as well. V1 stated they do not meet weekly to review weights because they do the review daily. On 1/16/2026 at 2:15PM, V2 was about R7's weight loss. V2 stated, well we have a lot of interventions in place for R7. When V2 was asked about the most recent weight loss not being addressed with new interventions V2 stated we will have her looked at by V11(new RD) and see what she wants us to do about the weight losses. On 1/15/2026 at 2:00PM an attempt was made to call V10 (previous RD) with no answer but message was left on voice mail. An attempt was then made again at 2:30 with no success.On 1/16/2026 at 10:00AM, V2 stated V11 (New RD) was not present in the facility. At that time an attempt was made to reach V11 by phone and was (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 B. Wing	01/20/2026

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 0692 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	unsuccessful. On 1/15/2026 at 2:56PM this surveyor went to the dietary department to speak with Dietary Manager but told dietary manager was not there.On 1/16/2026 at 9:50AM this surveyor went to the dietary department and was told the Dietary manager was not available at this time. No interview was able to be conducted with the Dietary manager during this survey. Policy titled Weight Assessment and Intervention dated with revision date of August 2008, documents the nursing staff and the Dietitian will cooperate to prevent, monitor, and intervene for undesirable weight loss or gain for our residents. Policy #6 defines Significant Weight Changes are defined as: more or less than 5% within 30 days, 7.5% or less within 90 days, and more or less than 10% within 6 months. Under #8 document shows, if a weight loss or gain meets the definition of Significant, the Dietitian should discuss with the Interdisciplinary Team if a Significant Change MDS is necessary. Under #10 the document shows, Interventions for undesirable weight loss or gain should focus first on food (e.g extra food, snacks, calorie-dense foods, etc.) Interdisciplinary Team members should consider possible interventions relevant to their discipline. The physician may order test, appetite stimulants, or medications as appropriate.