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	08/29/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49907 Based on interview and record review, the facility failed to promote dignity for while eating, recieving care, and waiting for care for 4 of 6 residents (R30, R53, R68, R259) reviewed for dignity in a sample of 51. Findings include: 1. R53's face sheet documents an admitted [DATE], which includes the following diagnoses of unspecified dementia, tremor, contracture of left hand, and weakness. R53's MDS (Minimum Data Set), dated 07/25/2024, documents a BIMS (Brief Interview for Mental Status) was not completed because R53 is rarely/never understood. Section GG-Functional Abilities and Goals documents R53 is dependent on staff for eating. R53's care plan documents she requires assist with all Activities of daily Living (ADL's) related to: Dementia, tremors and impaired mobility. She is dependent for eating. On 08/12/2024 at 12:43 PM, V23 (Certified Nurse's Assistant\CNA) and V27 (CNA) were observed to be standing while feeding R53 and other residents during lunch. On 08/13/2024 at 12:32 PM, V23 (CNA) and V15 (CNA) were observed to be standing while feeding R53 and other residents during lunch. On 08/13/2024 at 12:40 PM, V23 (CNA) stated she sometimes has too many people at once to feed and can't sit down next to everyone requiring assistance. V23 stated she knows she should sit to feed, but that sometimes staffing just does not allow for it. 2. R68's face sheet documents an admitted [DATE], which includes the following diagnoses: unilateral primary osteoarthritis, left knee, pain in right knee, unspecified injury of right lower leg, sequela, polyneuropathy, morbid (severe) obesity due to excess calories, unspecified abnormalities of gait and mobility. R68's MDS (Minimum Data Set), dated 05/01/2024, documents a BIMS (Brief interview for Mental Status) score of 15, indicating R68 is cognitively intact. (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 08/29/2024

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/14/24 at 12:00 PM, V37 (CNA) providing incontinence care on R68. V37 was observed to have not closed the blinds. R68 stated she would have preferred the blinds to be closed, but there is a fence between them and the neighbors. It was observed R68's window looks out into courtyard where residents go to smoke. 3. R259's face sheet documents an admitted [DATE], which includes the following diagnoses: severe dementia and altered mental status. R259's MDS (Minimum Data Set) documents a BIMS (Brief Interview for Mental Status) of 00, indicating R259 is severally cognitively impaired. On 08/13/2024 at 3:30 PM, R259 was observed from the hallway, lying on the side of the bed naked from the waist down, with his buttocks in the air covered in feces. R259 was yelling out. Staff were walking past R259's room. V37 (CNA) was alerted and went to provide care to the resident. On 08/13/2024 at 3:35 PM, V37 (CNA) stated, There is just not enough of us to go around to meet everyone's needs or to take the time we should, to do the little things these residents need and deserve. 41610 4. R30's face sheet documents an admitted [DATE], with a date of birth of 10/31/1928, with diagnoses including: Alzheimer's disease, age related osteoporosis without current pathological fracture, presence of cardiac pacemaker, cerebral infarction, dysphagia oropharyngeal phase, dementia, anxiety, and weakness. R30's Minimum data set (MDS), dated [DATE], documents a Brief Interview of Mental Status of 09, indicating R30's cognition is moderately impaired; section GG documents R30's eating status as needing: supervision or touching assistance - helper provides verbal cues or touching/steadying assistance as resident completes activity. R30's physician order sheet documents a dietary order for a regular diet with mechanical soft texture, fortified foods with all meals, with a start date of 01/16/23 and an end date listed of 'indefinite'. On 08/20/24 at 12:45 PM, R30 was attempting to eat her cake with her fork, and the cake kept falling off the fork onto her. She then dropped the fork onto her lap. R30 then started eating her cake with her fingers. She had cake covering her face and hands. R30 had eaten very little of her beef roast, mashed potatoes, or carrots. On 08/20/24 at 12:49 PM, When R30 was asked how she was. R30 stated, she is not ok, This is hard. I have cake all over me. iit's all over my face and my hands, they are all laughing at me, can't you help me? On 08/15/24 at 8:30 AM, V10 (CNA) stated R30 might do better if someone could help steady her hand.

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32765 Based on interview and record review, the facility failed to ensure resident rights were protected when they failed to ensure Advanced Directives were obtained and/or documented for 2 of 2 (R157 and R161) residents reviewed for advance directives in the sample of 51. Findings Include: 1. R157's Admission Record, with a print date of [DATE], documents R157 was admitted to the facility on [DATE] with diagnoses that include gangrene, cellulitis, diabetes, peripheral vascular disease, atrial fibrillation, and edema. R157's undated current Care Plan does not document a Focus Area related to Advanced Directives or R157's end of life wishes. R157's medical record did not document a POLST (Physician's Orders for Life-Sustaining Treatment) form. R157's Order Summary Report Active Orders as of [DATE] documents a physician order with a start date of [DATE] of, Comfort Measures (Allow Natural Death): Treatment goal: Maximize comfort through symptom management. Relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measure. Use oxygen, suction, and manual treatment of airway obstruction as needed for comfort. Patient prefers no transfer to hospital for life-sustaining treatments. Transfer to hospital only if comfort needs cannot be met in current location. On [DATE] at 2:53 PM, V3 (Infection Preventionist/LPN) provided this surveyor with the POLST form, dated [DATE], for R157 and stated, It is in the system now, but it wasn't done prior to today. R157's POLST form, dated [DATE], documents comfort focused treatment with R157's and V5 (Nurse Practitioner's) signature. 2. R161's Admission Record, with a print date of [DATE], documents R161 was admitted to the facility on [DATE], with diagnoses that include osteomyelitis, diabetes, peripheral vascular disease, and hypertension. R161's current Care Plan does not document a Focus area for end of life wishes/code status. R161's medical record did not document a POLST form or documentation related to R161's end of life wishes. On [DATE] at 2:53 PM, V3 (Infection Preventionist/LPN) provided this surveyor with a POLST form, dated [DATE] for R161, and stated R161 did not have a POLST prior to today. V3 stated it had been corrected in R161's medical record. R161's POLST form, dated [DATE], documents R161 is a full code. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R161's Order Summary Report with active orders as of [DATE] documents a physician order of, Full Code/Perform CPR (Cardiopulmonary Resuscitation) dated [DATE]. The facility Advance Directives policy, dated ,d+[DATE], documents, Advanced Directives will be respected in accordance with state law and facility policy Prior to or upon admission of a resident to our facility, the Social Services Director or designee will provide information to the resident concerning his/her right to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment, and the right to formulate advance directives 3. Prior to or upon admission of a resident, the Nursing and/or Social Services Director or designee will inquire of the resident, and/or his/her family members, about the existence of any written advance directives. 4. Should the resident indicates that he or she has issued advance directives about his or her care and treatment, documentation must be recorded in the medical record of such directive and a copy of such directive must be included in the resident's medical record .

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 41610 Based on interview and record review, the facility failed to provide notification of a room change for one (R63) of one resident reviewed for notification of room change in a sample of 51. Findings include: R63's census documents a room change on 08/12/24. On 08/12/24 at 2:12 PM, R63 who was alert to person, place, and time, stated she wanted to know why her room was changed. On 08/14/24 at 3:12 PM, V1 (Administrator) stated she did not know why R63's room was changed; she will have to try to find out. On 08/15/24 at 9:03 AM, V1 stated she does not have any documentation on why R63 had a room change on 08/12/24. On 08/20/24 at 8:06 AM, V1 stated they do not have a policy for notification of room changes.

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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	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** 32765 Based on interview and record review, the facility failed to ensure residents were free from verbal/mental and physical abuse for 1 of 2 (R45) residents reviewed for abuse in the sample of 51. This failure would cause a reasonable person to experience feelings of fear, anxiety, and insecurity while living in their home. Findings Include: R45's Admission Record, with a print date of 8/20/24, documents R45 was admitted to the facility on [DATE], with diagnoses that include diabetes, dysphagia, osteoarthritis, brief psychotic disorder, delusional disorder, mild cognitive impairment, and depression. R45's MDS (Minimum Data Set), dated 8/20/24, documents R45 has a BIMS (Brief Interview for Mental Status) score of 10, which indicates a moderate cognitive impairment. R45's current Care Plan documents a Focus Area of, Resident is considered at risk for abuse/neglect (per assessment) due to anxiety, dependent on others, pain, displays behaviors, psychiatric hx (history). Date Initiated: 09/16/2021. The interventions documented for this Focus with an initiation date of 9/16/21 are, 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 Intervene if observing any resident-on-resident conflict to avoid potential abusive situation The interventions for this same Focus area, with an initiation date of 8/19/24 are, 8/16/2204 Daughter educated to inform administrator and/or DON (Director of Nurses) of any unusual comments made by (R45) so an investigation can be conducted to prevent any incidents of verbal or physical abuse by residents or staff R45's Facility Incident Report, dated 8/12/24, documents under Final, IDT (Interdisciplinary Team) met and reviewed incident. Staff and resident interviews conducted. Visitor reported witnessing a nurse striking (R45) in the face and or mouth area. (R45) denied any nurse or staff member striking her in the face or mouth area. (V49/RN-Registered Nurse) denied striking (R45) at any time. All staff and resident interviews also confirmed that (V49) has not been witnessed striking any resident. (Name of Local Police) was notified of incident. NP (Nurse Practitioner) and POA (Power of Attorney) updated. (R45) feels safe at the building. She has verbalized understanding of what to do if anyone makes her feel unsafe, uncomfortable or threatens her in any way. Her and her daughter will report any incident to staff, who, in turn, will notify the Abuse Prevention Coordinator for immediate investigation. There is insufficient evidence to substantiate abuse. Care Plan updated. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	R45's undated Abuse Investigation Summary documents, Resident Interviews: (R45) 8/13/2024: This writer (V1/Administrator) and (V38, MDS Coordinator) interviewed (R45) together. This writer asked (R45) if any resident or staff member hit her on the face or mouth. She stated no. This writer asked (R45) if she has been hit anywhere on her body. She stated yes on my head. Asked (R45) to point where on her head. She pointed to the back of the head. Asked (R45) who hit her on the back of the head she stated I don't know her name. Asked her if she works days or nights. She stated nights. Asked her if she knows the staff name. She stated no but she is not very nice. Asked her if her head hurts. She stated no I am ready for dinner now and took to the dinning (sic) room for supper. Employee interviews: (V6/LPN) (not dated): I have never seen a staff member hit a resident on my hall or anywhere in the building. I was not present when this incident was reported. I have seen the alleged staff member be mean or verbally aggressive with (R45). I have never seen her be verbally aggressive toward another resident. (R45) was trying to take other resident belongings and I heard (V49) tell her no do not do that you know better than that get over here and sit down and made her follow her from the start of med pass. Family Interviews if Applicable: (V57/Family Member/Visitor) 8/13/2024 reported to administrator that when she was in her (family members) room (V49) came in and gave meds to her (family members) roommate. When the resident that wanders the hallways with the walker and is constantly going in other resident rooms tried to come into my (family's) room, she heard (V49) tell her to go sit her ass down. Then about 30 minutes later she witnessed (V49) throw her hands up in the air and strike the same resident in the mouth or face area out in the hallway. She said she heard the resident state ouch you hit me. She said I was so shocked by what I saw I thought I would let you know. (V56/Family Member) 8/16/2024. I have never seen anyone mistreat my mom (R45) and she loves living there. She is happy there. (R45) did tell me about a month ago that someone hit her on the back of the head so I asked the CNA (Certified Nursing Assistant) about it, and nobody had ever seen anyone hit her so I started watching and talking to people, but I could never catch anyone, and nobody ever saw anyone hit her. I did not say anything to anyone in the front office or the DON (Director of Nurses) about it because I thought maybe (R45) was confused or telling stories but from now on if she says something strange or does not seem right, I will report it so you can investigate it. R45's Progress Notes document on 8/13/24 at 5:01 PM, Note Text: Visitor alleges, that RN was redirecting resident and told resident to 'sit her ass down.' Visitor also alleges that RN hit resident in the mouth. Resident then told RN 'You hit me' without crying and resident was not in pain. RN was suspended pending investigation. Investigation started. On 08/20/24 at 4:05 PM, V2 (Assistant Director of Nurses) stated a visitor (V57), whose family member had since passed away, said she saw a nurse (V49) hit R45 and told her to 'sit her ass down'. V2 stated this was reported to V1 (Administrator) and the nurse (V49) acted surprised, and said she didn't do it. V2 stated R45 said it happened all the time and described the nurse (V49). V2 stated the nurse had been suspended since the allegation was reported. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 8/21/24 at 9:58 AM, V57 (Visitor) stated she spent every day at the facility with her family member. V57 stated she was in her family's room one evening with the curtain partially pulled, sitting facing the window. V57 stated it was dark outside, so she could see the reflections of what was happening in the room, in the window. V57 stated a nurse (V49) was giving the roommate her medications, and a confused resident with dementia (R45) walked into the room. V57 stated she was talking with her son on the phone, and she wasn't really paying attention to what the nurse was saying, until the nurse said to the confused resident (R45) who had wandered into the room get your ass out of here. V57 stated then she saw the nurse take the back of her hand and pop the resident in the face. V57 stated it was nighttime, and she told V1 (Administrator) about it the next morning. V57 stated she had never witnessed anything like that before. V57 stated when it occurred the confused resident (R45) stated, you hit me. V57 stated R45 then just left the area. On 08/20/24 at 4:52 PM, V49 (Registered Nurse/RN) stated she had no answers. When asked if she had ever cursed at a resident, specifically R45, V49 stated, No ma'am. I don't curse. I have before, a time or two, but I make it a practice not to. When asked if she had ever hit a resident, V49 stated, One hundred percent absolutely not. I don't even know where or how this could come about. On 08/21/24 at 8:59 AM, V56 (Family Member) stated R45 was currently in the hospital with a diagnosis of a urinary tract infection. When asked if she was aware of an allegation of abuse, V56 stated, It wasn't an allegation, it happened. V56 stated a while back (date unknown), R45 reported to her someone had been hitting her in the head. V56 stated she talked with unknown staff, and they didn't know who she was asking about, from R45's description of the person who she reported had hit her. V56 stated since she couldn't find the person R45 described, she kept watching, and V56 stated after the visitor reported R45 had been hit by V49, R45 told V1 (Administrator) it was the same nurse who hit her before. V56 stated from now on, if R45 tells her someone is hitting her, she will assume that it is happening. V56 stated V1 assured her V49 wouldn't be back to work. V56 stated there was no physical injury, but R45 was distraught when she was telling her about it. V56 stated, Who wants to get hit in the head? V56 stated she felt bad because a part of her didn't believe R45 when she first reported it. V56 stated R45 had to go through it, and no one was doing anything about it. V56 stated it was upsetting for R45 because she was getting hit in the head. V56 stated she was not notified of the incident until the next day, and when she asked the unknown male nurse why they waited to notify her, she was told they had to do whatever they had to do before they called. On 8/21/24 at 9:15 AM, V6 (LPN/Licensed Practical Nurse) stated she didn't work with V49, and the only thing she witnessed was one day when V49 was coming in to relieve her, R45 was walking by. V6 stated V49 raised her voice and said, No don't walk that way. V6 stated she didn't like the way V49 talked to R45, but she didn't think it was abusive. V6 stated after the allegation was made and V49 was suspended, she found out that Certified Nursing Assistants said V49 made R45 follow her around during medication pass, and made R45 sit with her at the nurses station. On 8/22/24 at 1:30 PM, V8 (CNA/Certified Nursing Assistant) stated V49 was rough and hateful, but she didn't think it was abuse. On 8/24/24 at 11:25 PM, V59 (CNA) stated V49 was stern, but she was good with the residents, and she had never witnessed abuse. V59 stated if she had, she would notify V1 immediately. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 8/24/24 at 11:37 PM, V60 (CNA) stated she had worked with V49, and she was a little rude or pushy when R45 was non-compliant, going in and out of other resident rooms. V60 stated V49 would reprimand R45 and was a little loud with it, but didn't yell. V60 stated R45 had never reported abuse, but awhile back V56 (Family Member) said something to her about someone being rude to R45, but they didn't think anything of it. On 8/21/24 at 10:43 AM, when asked why the allegation wasn't substantiated, V1 (Administrator) stated she talked to multiple staff, R45, and V57 (Visitor), who told V1 she witnessed V49 smacking R45 in the face/mouth area and heard R45 say Ow you hit me. V1 stated when she interviewed V49, other staff, and R45, they all denied it. V1 stated R45 denied being hit in the face, but did say she had been hit in the back of the head before. V1 stated V56 (Family Member) stated at some time, maybe a month ago, R45 told V56 someone hit her in the back of the head, and they suspect it was V49. V1 stated V56 couldn't substantiate it had occurred, and thought R45 was confused. When asked how she was not substantiating the allegation of abuse when there was someone who witnessed the abuse, V1 stated an employee who works here is related to V57 (Visitor), and said V57 makes false allegations. V1 stated, So even though (V57) said she witnessed it, since (R45) stated she was hit in the back of the head instead of in the face, I can't substantiate it. V1 stated R45 did confirm being hit in the head at some point by V49, so they are still terminating the nurse and reporting it to the Department of Professional Regulation. The facility Abuse Policy, dated 10/2022, documents, This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. 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.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41610 Based on interview and record review, the facility failed report a bruise of unknown origin to the Administrator for one (R49) of two residents reviewed for abuse in a sample of 51. Findings include: R49's face sheet documents an admitted [DATE], with diagnoses including: hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, severe protein calorie malnutrition, anxiety disorder due to known physiological condition, heart failure, dysarthria following cerebral infarction, essential hypertension, major depressive disorder, bipolar disorder, dysphagia, dementia, and duodenal ulcer. R49's Minimum Data Sheet (MDS), dated [DATE], documents a BIMS (Brief interview of mental status) of 00, indicating R49 is severely cognitively impaired. R49's Nursing note by V49 (Registered Nurse), dated 7/26/2024 at 5:55 AM, documents: Note Text: pt (patient) (R49) has what looks like a bruised eye from a couple of days ago from unknown reason given why or how?? On 08/14/24 at 4:14 PM, V1 (Administrator) stated no one had reported to her R49 had a bruised eye on 7/26/24, even though there was a note charted in R49's record. She confirmed she did not report this incident to anyone or conduct any investigation on it. The facility policy titled, Abuse Prevention Program, dated 10/2022, documents: Policy: The section titled, V. Internal Reporting Requirements and Identification of Allegations documents: The nursing staff is responsible for reporting the appearance of suspicious bruises, lacerations, or other abnormalities of an unknown origin as soon as it is discovered. The report is to be documented on a facility incident report and provided to the nursing supervisor, administrator or designated individual. Following the discovery of any suspicious bruises, lacerations or other abnormalities of an unknown origin, the nurse shall complete a full assessment of the resident for other bruises, laceration, or pain. The resident's physician and representative, if necessary, shall be notified of any incident or allegation of abuse, neglect, exploitation, mistreatment or misappropriation of resident property.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41610 Based on interview and record review, the facility failed to investigate a bruise of unknown origin and failed to provide assessments on this resident for 1 of 2 residents (R49) reviewed for abuse in the sample of 51. Findings include: R49's face sheet documents an admitted [DATE], with diagnoses including: hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, severe protein calorie malnutrition, anxiety disorder due to known physiological condition, heart failure, dysarthria following cerebral infarction, essential hypertension, major depressive disorder, bipolar disorder, dysphagia, dementia, and duodenal ulcer. R49's Minimum Data Sheet (MDS), dated [DATE], documents a BIMS (Brief interview of mental status) of 00, indicating severely cognitively impaired. R49's Nursing note by V49 (Registered Nurse), dated 7/26/2024 at 5:55 AM, documents: Note Text: pt (patient) (R49) has what looks like a bruised eye from a couple of days ago from unknown reason given why or how?? On 08/14/24 at 4:14 PM, V1 (Administrator) stated none of the nurses reported to her that R49 had a bruised eye on 7/26/24. She asked V3 (Infection Preventionist) also, but she was not told about it either. They do not have any documentation on it or an investigation, and do not know how it happened. There were no assessments found in R49's Electronic Health Record regarding the bruised eye found on 7/26/24. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled, Abuse Prevention Program, dated 10/2022, documents: V. Internal Reporting Requirements and Identification of Allegations documents: The nursing staff is responsible for reporting the appearance of suspicious bruises, lacerations, or other abnormalities of an unknown origin as soon as it is discovered. The report is to be documented on a facility incident report and provided to the nursing supervisor, administrator or designated individual. Following the discovery of any suspicious bruises, lacerations or other abnormalities of an unknown origin, the nurse shall complete a full assessment of the resident for other bruises, laceration, or pain. The resident's physician and representative, if necessary, shall be notified of any incident or allegation of abuse, neglect, exploitation, mistreatment or misappropriation of resident property. The section titled, VII. Internal Investigation documents: 3. For resident injuries not involving an allegation of abuse or neglect, the administrator will appoint a person to gather further facts to make a determination as to whether the injury should be classified as an injury of unknown source. An injury should be classified as an injury of unknown source when both of the following conditions are met: The source of the injury was not observed by any person of the source of the injury could not be explained by the resident, and the injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time. If classified as an injury of unknown source, the person gathering facts will document the injury, the location and time it was observed, any treatment given and notification of the resident's physician, responsible party. 4. Investigation Procedures: The appointed investigator will, at a minimum, attempt to interview the person who reported the incident, anyone likely to have direct knowledge of the incident and the resident, if interviewable. Any written statements that have been submitted will be reviewed, along with any pertinent medical records or other documents. Residents to whom the accused has regularly provided care, and employees with whom the accused has regularly worked, will be interviewed. 8. Final Investigation Report: The investigator will report the conclusions of the investigation in writing to the administrator or designee within five working of the reported incident.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41610 Based on interview and record review, the facility failed to complete and provide bed hold documentation for one (R63) of one resident reviewed for bed hold documentation in a sample of 51. Findings include: R63's Face sheet documents an admitted [DATE], with diagnoses including: chronic obstructive pulmonary disease, non-stemi elevation myocardial infarction, essential hypertension, dementia, anxiety disorder, atrial fibrillation, and type 2 diabetes mellitus. On 08/15/24 at 10:18 AM, V24 (Family) stated she did take R63 out to the ER (emergency room) on 07/05/24. R63's progress notes, dated 07/05/24 at 2:28 PM, documents, (V24) here to visit and she felt she needed to take (R63) to ER. (V39, Registered Nurse) attempted to stop her and told her she could be seen in house by (V5, Nurse Practitioner). (V24) felt she would be better off if she was seen in the ER (emergency room). (V39) called the daughter and let her know that (V24) had taken (R63) to the hospital. (V39) phoned (V24) and was told they were in the (local) ER. R63's progress note, dated 07/05/24 at 5:49 PM, documents: R63 was admitted to (local hospital). On 08/15/24 at 9:40 AM, V1 (Administrator) stated she will have to look for the bed hold documentation for R63. On 08/19/24 at 10:00 AM, V38 (Minimum Date Set Coordinator) stated, she could not find any bed hold information for R63's hospital visit on 07/05 - 07/08/24; they do not have it. The undated facility document titled, necessity of transfer form/notice of bed hold policy documents: Bed hold: a bed hold is an agreement between the community and you to keep your bed available while you are in the hospital or on therapeutic leave. If you are transferred to the hospital or take a therapeutic leave, you will receive this form and will be asked to notify us of your intent to return or be discharge from the community.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41610 Based on interview and record review, the facility failed to do a PASARR II (Preadmission Screening and Resident Review) for 2 of 4 residents (R15 and R49) reviewed for screenings in a sample of 51. Findings include: 1. R15's face sheet documents an admitted [DATE], with diagnoses including: dementia, type 2 diabetes mellitus, essential tremor, anxiety disorder, peripheral vascular disease, and bipolar disorder. R15's electronic medical record documents a diagnosis of bipolar disorder, dated 04/25/24. R15's electronic medical record does not contain a PASARR II for R15 after R15's diagnosis of bipolar disorder. On 08/14/24 at 3:40 PM, V1 (Administrator) stated they do not have anything that she can find for R15 for a PASARR II after she received the new diagnoses of bipolar disorder. 2. R49's face sheet documents an admitted [DATE], with diagnoses including: sequelae of cerebral infarction, vascular dementia, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, unspecified severe protein calorie malnutrition, anxiety disorder due to known physiological condition, aphasia following cerebral infarction, heart failure, dysarthria following cerebral infarction, major depressive disorder recurrent, pseudobulbar affect, dysphagia following cerebral infarction, bipolar disorder, weakness, duodenal ulcer, and thyrotoxicosis. R49's electronic medical record documents diagnoses, dated 05/05/22, of bipolar disorder and major depressive disorder. R49's electronic medical record does not contain a PASSAR II for R49 after R49's diagnosis of bipolar disorder and major depressive disorder. On 08/14/24 at 3:40 PM, V1 stated they do not have anything that she can find for R49 for a PASARR II after she received the new diagnoses of bipolar disorder or major depressive disorder. On 08/14/24 at 3:45 PM, V1 stated the facility does not have a policy for PASSAR screenings.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49907 Based on observation, interview, and record review, the facility failed to provide support for residents who require assistance completing Activities of Daily Living, including personal hygiene and eating assistance for 7 out of 11 residents (R2, R16, R30, R49, R63, R68, R74) reviewed for Activities of Daily Living assistance in the sample of 51. Findings include: 1. R2's Face sheet documents an admitted [DATE], which includes the following diagnoses: sepsis, unspecified intracranial injury with loss of consciousness, unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, muscle weakness, and abnormal posture. R2's MDS (Minimum Data Set), dated 07/25/2024, documents a BIMS (Brief Interview for Mental Status) was not completed. Section GG-Functional Abilities and Goals documents R2 is dependent for oral hygiene, toileting hygiene, showering, bathing, dressing, and personal hygiene. R2's current Care plan documents the following focus area: R2 has an Activities of Daily Living (ADL) self-care deficiency related to: R2 has a long history of traumatic brain injury (TBI). R2 has contractures of bilateral lower extremities. Dependent for Bathing requires assist of (2), Dressing, for Grooming and hygiene, and Toileting . Provide oral hygiene every AM, PM and PRN (as needed). Provide oral hygiene every shift. On 08/14/2024 at 8:48 AM, R2 appeared to have not received oral care recently. His teeth were covered in debris, and there was a thick yellow film on his tongue; his lips were flaky. On 08/15/2024 at 9:51 AM, R2 was observed to have still not received oral care. His teeth were covered in debris and there was a thick yellow film on his tongue; his lips were flaky. On 08/15/2024 at 11:12 AM, it appeared oral care had been performed on R2. On 08/15/2024 at 11:15 AM, V26 (Certified Nurse Aide/CNA) stated she performed oral care on R2 after breakfast; she stated she always tries to ensure those things get done. V26 stated she knows sometimes they are short staffed, and it may not get done timely by other staff. V26 stated she had not provided care for R2 the day before. On 08/20/2024 at 1:42 PM, V2 (Assistant Director of Nursing) stated the expectation was that oral care be given at least daily, but for some people it is specifically expected more frequently. 2. R49's Face sheet documents an admitted [DATE], which includes the following diagnoses: unspecified sequelae of cerebral infarction, vascular dementia, hemiplegia, hemiparesis following cerebral infarction affecting right dominant side, and weakness. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R49's MDS (Minimum Data Set), dated 05/13/2024, documents a BIMS (Brief Interview for Mental Status) of 00, indicating R49 is severely cognitively impaired. Section GG-Functional Abilities and Goals documents R49 requires substantial/maximal assistance for shower and bathing, toileting hygiene and dressing. R49's current Care plan documents the following focus area: R49 requires assist with ADL's related to stroke. R49 has interventions including bathing, dressing grooming and hygiene requiring an assist of one. Facility documents titled bath and skin report sheet document R49 is to receive a shower or bath on Tuesdays and Fridays on the 2-10pm shift. According to these documents for R49, she received a shower or bed bath on 07/05, 07/12, and 08/06. There are documented refusals on 07/16 and 08/16. There is no record for any showers given or refused for R49's scheduled shower dates of 07/02, 07/09, 07/19, 07/23, 07/26, 07/30, 08/02, 08/09 or 08/13. All 2024. 3. R63's face sheet documents an admitted [DATE], which includes the following diagnoses: unspecified dementia, weakness, and anxiety. R63's MDS (Minimum Data Set), dated 06/11/2024, documents a BIMS (Brief Interview for Mental Status) 09, which indicates R63 is moderately cognitively impaired. Section GG-Functional Abilities and Goals documents R63 requires setup or clean-up assistance for oral hygiene, toileting hygiene, shower and bathing and dressing. R63's current Care plan documents the following focus area: R63 has an ADL self-care deficiency related to: Dementia, Fatigue, Musculoskeletal Impairment, Pain, SOB and terminal prognosis. R63 requires one assist with bathing, dressing, grooming, and hygiene. Facility documents titled bath and skin report sheet document R63 is to receive a shower or bath on Mondays and Thursdays. According to these documents for R63, she received a shower or bed bath on 06/06, 06/10, 06/13, 06/24, 06/27, 07/01, 07/18, 08/01, 08/05. There is no record for any showers given or refused on R63's scheduled shower dates of 06/16, 06/20, 07/08, 07/11, 07/15, 07/21, 07/25, 07/28, 08/08 or 08/11. All 2024. 4. R68's face sheet documents an admitted [DATE], which includes the following diagnoses: unilateral primary osteoarthritis, left knee, pain in right knee, unspecified injury of right lower leg, sequela, polyneuropathy, morbid (severe) obesity due to excess calories, and unspecified abnormalities of gait and mobility. R68's MDS (Minimum Data Set), dated 05/01/2024, documents a BIMS (Brief interview for Mental Status) score of 15, indicating R68 is cognitively intact. Section GG-Functional Abilities and Goals documents V68 is dependent on staff for toileting hygiene, showering and bathing. V68 is listed as partial/moderate assist for personal hygiene. R68 current Care plan documents the following focus, Requires assist with Activities of Daily Living related to: Activity Intolerance and Pain impaired. With interventions including; Bathing requires max assist. Prefers day shift showers. Bed mobility require max assist. Grooming and hygiene requires assist of one. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/12/2024 at 10:07 AM, R68 stated she has a few concerns. R68 stated there should be a CNA (Certified Nursing Assistant) on each hall on her wing, and one in between both halls. R68 stated at times there is one person covering both halls; with the halls combined it is approximately 45 residents to one CNA. R68 stated there are times she will wait one to two hours after hitting her call light to get changed. R68 stated sometimes they tell her there are this many people in front of her or offer some kind of explanation, and sometimes they do not even acknowledge her. R68 stated not long ago, she did not shower for two weeks because they tell her they do not have the staff to help them get her up, because she uses a mechanical lift that requires two people to transfer her. R68 stated they will give her a bed bath but that's just not the same as getting a shower and felt very unclean. R68 stated she has had sores on her bottom before from not being changed and it took her over a year to be seen by the wound doctor, and she stated she felt like it took forever for them to heal. R68 stated she understands that second shift staffing is terrible and sometimes things happen, and she stated she knows she isn't the only person here, but she feels like she is always waiting for hours. Facility documents titled bath and skin report sheet document R68 is to receive a shower or bath on Mondays and Thursdays. According to these documents for R68, she received a shower or bed bath on 07/04, 07/08 (bed bath), 07/11, 07/15, 07/18, 07/22 (bed bath), 07/25, 08/01 (bed bath), 08/12. There were no showers, bed baths, or refusals documented for her scheduled shower dates of 07/01, 07/29, 08/05, 08/08. 5. R74's Face sheet document's an admitted 07\17\2023, which includes the following diagnoses: unspecified dementia and Parkinson's disease. R74's MDS (Minimum Data Set), dated 05/01/2024, documents a BIMS (Brief interview for Mental Status) score of 02, indicating R74 is severely cognitively impaired. Section GG-Functional Abilities and Goals documents V74 is dependent on staff for toileting hygiene, and Substantial/Maximal assistance for showering and bathing, oral hygiene, lower body dressing, and personal hygiene. R74's current Care plan documents he requires assist with ADL's related to Dementia and Impaired Balance, with interventions including, bathing requires max assist of 1. Facility documents titled bath and skin report sheet document R74 is to receive a shower or bath on Tuesdays and Fridays. According to these documents for R74, he received a shower on 07/02, 07/04, 07/07, 07/12, 07/16, 07/23, 08/06 and 08/13. There were no showers, bed baths, or refusals documented for R74's scheduled shower dates of 07/20, 07/ 27, 07/30, 08/02 or 08/09. On 08/13/2024 at 3:35 PM, V37 (CNA) stated, There is just not enough of us to go around to meet everyone's needs or to take the time we should to do the little things these residents need and deserve. On 08/15/24 at 2:32 PM, V36 (CNA) stated they don't have enough staff to meet the needs of the residents. V36 stated two aides to take care of 30 residents with behaviors isn't enough. V36 stated they can't give oral care, weights, vitals, showers aren't done timely, turning and positioning, and incontinence care can't be provided timely with the staffing they have. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/19/2024 at 1:45 PM, V38 (Registered Nurse/ RN) stated she was working as Social Services, Activities, and Business Office Manager from 11/2023 until 05/08/2024, and in May of 2024, Corporate added Marketing and Admissions to her duties due to layoffs. V38 Stated from May to the end of July 2024, she was Social Services, Activities, Business Office Manager, Marketing, and Admissions. V38 she was not trained in any of the positions. V38 stated Corporate started cutting hours; it started with floor staff, then Dietary, Housekeeping, and then management. V38 stated they had two CNA's working on their two hallways requiring the most assistance, and that isn't enough to meet the needs of the residents. On 08/20/2024 at 1:42 PM, V1 (Administrator) stated there is not a specific policy outlining how often showers should be given, however, residents are scheduled for showers two days a week, and her expectation is a shower or refusal be documented on those days. 41610 6. R30's Face sheet documents an admitted [DATE] with a date of birth of 10/31/1928 with diagnoses including: Alzheimer's disease, age related osteoporosis without current pathological fracture, presence of cardiac pacemaker, cerebral infarction, dysphagia oropharyngeal phase, dementia, anxiety, and weakness. R30's Minimum data set (MDS) dated [DATE] documents a brief interview of mental status of 09 indicating R30's cognition is moderately impaired, section GG documents R30's eating status as needing: supervision or touching assistance - helper provides verbal cues or touching/steadying assistance as resident completes activity. R30's Physician order sheet documents a dietary order for a regular diet with mechanical soft texture, fortified foods with all meals with a start date of 01/16/23 and an end date listed of 'indefinite'. On 08/12/24 at 12:14 PM, R30 struggled to eat with her spoon, dropping her food and her spoon onto her clothing protector and her lap. After dropping her spoon, she started eating with her fingers. R30 had a large amount of her food over the front of her and down her shirt and all over her hands. There was no assistance observed by staff. On 08/13/24 at 8:02 AM, R30 struggled with her utensils and ate some of her breakfast with her fingers, ground ham and chopped up scrambled eggs, R30 had a large amount of food on her blanket and clothing protector for breakfast. During lunch at 12:10 PM, R30 was struggling with her silverware, her spoon, and stated she was hungry, but she was having troubles. R30 ate some of her food with her fingers. R30 had approximately 80% of her food left on her plate, there was no assistance observed by any staff. On 08/15/24 at 8:01 AM, R30's food was dropping food from her fork onto her lap and her arm that was held up against her. She then gave up and picked up the pieces of the pancakes and ate them with her fingers along with some of her ground sausage. On 08/15/24 at 8:02 AM R30 stated, it's hard to eat. On 08/15/24 at 8:05 AM, V10 (CNA) told R30 she needs to eat more. She assisted her with a bite of her food and then walked away to assist another resident with her meal. V10 was observed assisting several residents with a bite of their food, assisting with their drink or cueing them to eat. On 08/15/24 at 8:14 AM, R30 started eating pancakes pieces off of her clothing protector that she had dropped off of her fork. She had a large portion of her food on her clothing protector. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/15/24 at 8:30 AM, R30 was leaving the dining room with the assistance of V10, she had a large amount of food on her which V10 brushed off of her. V10 stated that was normal for her (R30). She stated she was trying to assist several residents with their meals. V10 stated, R30 might do better if someone could help steady her hand. On 08/20/24 at 12:45 PM, R30 was attempting to eat her cake with her fork and the cake kept falling off the fork onto her. She then dropped the fork onto her lap. R30 then started eating her cake with her fingers. She had cake covering her face and hands. R30 had eaten very little of her beef roast, mashed potatoes or carrots. On 08/20/24 at 12:49 PM R30 stated (when asked how she was by the surveyor), she is not ok, this is hard, I have cake all over me, it's all over my face and my hands, they are all laughing at me, can't you help me. V8 (certified nurse aide (CNA)) was asked if she could assist R30 when she finished assisting another resident to her room by the surveyor. R30 stated she liked beef and carrots, but not mashed potatoes. On 08/20/24 at 12:57 PM, V8 (CNA) came and assisted R30 with her lunch. 7. R16's Face sheet documents an admitted [DATE] and a date of birth of 10/29/1930 with diagnoses including: chronic obstructive pulmonary disease, chronic diastolic heart failure, Alzheimer's disease, anemia, Parkinson's disease without dyskinesia, without mention of fluctuations, dementia, major depressive disorder, anxiety disorder, dysphagia oropharyngeal phase, chronic kidney disease, arthropathy, gastro-esophageal reflux disease without esophagitis, other idiopathic peripheral autonomic neuropathy, osteoarthritis, and type 2 diabetes mellitus. R16's MDS dated [DATE] documents a BIMS score of 03 indicating cognitively severely impaired with section GG documenting R16's eating abilities as helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently. R16's Physician order sheet documents a dietary order of a regular diet, pureed texture, nectar consistency with a start date of 04/04/2024 with no end date listed. Dietary supplements of health shakes three times a day for wt (weight) loss with a start date of 09/22/2023 and no end date listed. R16's care plan documents a focus area of: (R16) requires assist with ADLs (activity of daily living) due to weakness, impaired balance, Parkinson's, and dementia dated 08/05/2019 with interventions/tasks documenting: eating requires one assist dated 01/22/2021. On 08/13/24 at 12:28 PM, R16 had several spots of food on her clothing protector. R16's hand shook while attempting to bring the food to her mouth causing portions to all of the food to fall off of her spoon. No help was observed by staff. On 08/14/24 at 12:20 PM, R16 had her food and was attempting to eat. At 12:38 PM, R16 was attempting to drink her chocolate milk, her hand was shaking and approximately 50% of her chocolate milk spilled onto her clothing protector on her chest. R16 did not have a health shake. R16 was attempting to eat her food with her spoon, her hand shook causing the food to drop off of her spoon before she got it to her mouth. R16 hit the edge of her clothing protector up by her neck several times with her spoon causing the food to drop off of her spoon. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/14/24 at 12:57 PM, V11 (CNA) came over to assist R16 with the rest of her food. R16 ate the rest of her food when she was assisted. On 08/15/24 at 8:07 AM, R16 was struggling to reach her drinks and could only reach approximately one third of her plate. R16 would get a small portion of her food onto her spoon, she was very slow to get her hand up to where the spoon would reach her mouth. R16's hand shook during this time causing a large portion of the food she was attempting to eat to fall off of the spoon onto her. On 08/15/24 at 8:15 AM, R16 had a large portion of her food on her clothing protector. On 08/15/24 at 8:33 AM, V8 (CNA) finished assisting residents to their rooms from the dining room and started assisting R16 to finish her breakfast. On 08/26/24 at 9:33 AM, V38 (Minimum Data Set Coordinator) stated, with a MDS assessed as supervision/touching assistance the resident should be at the table with a CNA there to provide touching or guiding assistance when needed. The facility policy dated 12/2008 titled, Assistance with meals documents: residents shall receive assistance with meals in a manner that meets the individual needs of each resident.

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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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41610 Based on interview, observation, and record review, the facility failed to provide medications and treatments as ordered by a physician, failed to document reassessments, and evaluate residents for advanced treatment needs for 3 (R63, R68, R100) of 3 residents reviewed for quality of care in a sample of 51. This failure resulted in R63 missing medication for approximately 30 days, suffering shortness of breath, and being admitted to the hospital for three days. Findings include: 1. R63's Face sheet documents an admitted [DATE], with diagnoses including: chronic obstructive pulmonary disease (COPD), non-st elevation myocardial infarction, essential hypertension, dementia, anxiety disorder, atrial fibrillation, and type 2 diabetes mellitus. R63's current Care plan includes a focus area of: R63 has COPD r/t (related to) smoking: with an intervention dated: 07/01/24 of: give aerosol or bronchodilators as ordered. Monitor/document any side effects and effectiveness. R63's Order summery sheet, dated 06/06/24, documents medications were discontinued with a line drawn through them; Lasix oral tablet 40 MG (Furosemide), give 1 tablet by mouth in the morning for edema, does not have a line drawn through it. This indicates the Lasix should have been continued. R63's Medication Administration Record (MAR), dated June 2024, documents: Lasix oral tablet 40 MG (Furosemide) give 1 tablet by mouth in the morning for edema, with a start date of 03/08/2024 at 8:00 AM, and a D/C (discontinued) dated of 06/06/2024 at 3:05 PM. The MAR, dated June 2024, documents the Lasix was not administered after 06/06/24. The facility document titled, eINTERACT Change in Condition Evaluation, dated 06/30/24 at 2:29 PM, documents: A. Signs & Symptoms Identified .abnormal vital signs and shortness of breath checked. 2. This started on: 06/30/24 3. What time of day did this start? with afternoon marked . blood pressure: 122/68 . pulse: 88 (bpm) (beats per minute) date: 06/30/2024 14:32 (2:32 PM) pulse type: irregular - chronic . 7. Most recent O2 (oxygen) sats (saturations): 96% date: 06/30/2024 14:31 (2:31 PM) method: oxygen via nasal cannula List any medication changes made in the past week: d/c (discontinued) from hospice and Lasix . 2a. describe respiratory changes; shortness of breath is marked, 2a1a. describe shortness of breath; with abrupt onset of SOB (shortness of breath) with pain, fever, or respiratory distress .3a. describe cardiovascular changes: with edema marked . describe cardiovascular signs/symptoms: increased swelling of bilateral lower extremities Since the change in condition occurred have the symptoms or signs gotten: with 'better' marked, 1b. things that make the condition or symptoms better are: with 'applied oxygen' written in, 2. This condition, symptom or sign has occurred before: with 'yes' marked, 2a. treatment for the last episode: with 'duoneb and rescue inhaler' written in, 4. Summarize your observations, evaluation and recommendations: with 'contacted on call provider and received VO (verbal order) for duoneb q (quaque (every) 6' written in . Were the change in condition and notifications reported to primary care clinician: with 'yes' marked, 2. Date and time of clinician notification: with '06/30/2024 at 14:31 (2:31 PM) noted, 3. Recommendation of primary clinician: with 'follow up with primary provider tomorrow, call if condition becomes worse or does not improve, 5. Interventions: with 'new or change in medications' and 'oxygen' marked. (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 08/29/2024
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 0684 Level of Harm - Actual harm Residents Affected - Few	R63's progress note, dated 06/30/24 at 2:31 PM, documents a pulse oximetry of 96%, method: oxygen via nasal cannula. R63's Physician order sheet documents an ordered date of 06/30/24 for ipratropium-albuterol 0.5 - 2.5 (3) MG/3ML solution with a status of 'on hand' documented with a start date of 07/08/2024, with no documentation of any administration of this medication. R63's order audit report documents an order for ipramtropium-albuterol 0.5 - 2.5 (3) mg/3ml, with the box next to 'confirmed' checked with a date of 06/30/24 at 2:28 PM noted. R63's oxygen saturation (SPO2) percentages are documented from 04/01/24 - 05/09/24 to be 96% or greater on room air. On 05/10/24 the SPO2 at 8:25 AM is documented to be 94% with oxygen via nasal cannula. On 05/27/24, 06/03/24+, 06/10/24, 06/17/24, and 06/24/24 have SPO2 of 96% or greater on room air documented. On 06/30/24 at 2:31 PM a SPO2 of 96% on oxygen via nasal cannula is documented. On 07/01/2024 at 11:15 PM a SPO2 of 96% on room air was documented. On 07/08/24 at 4:41 PM a SPO2 of 96% on oxygen via nasal cannula and 07/08/2024 at 8:52 PM a SPO2 of 96% on oxygen via nasal cannula is documented On 07/15/24 at 8:11 PM a SPO2 of 96% with oxygen via nasal cannula is documented. There are no SPO2s documented for 07/02, 07/03, 07/04, or 07/05/2024. A facility document for R63, dated 6/30/24, documents under problem/request, resident (R63) feet swollen family and resident request examination. This document is addressed to V5 (Nurse Practitioner/NP) with the response of: CBC (complete blood count), CMP (comprehensive metabolic panel), mag (magnesium), and Hgba1c (hemoglobin A 1 C) and Lasix 20 mg PO (per os (by mouth)) from V5, with the date of 07/01/24 noted. A facility document for R63, dated 07/03/24, documents: patient: (R63) date: 07/03/24, problem/request: SOB (short of breath) feeling bad. She (R63) was wearing 3L O2 (oxygen) & sating (saturating) @ 71%. Bumped her (R63) up to 5L but still not feeling well, with a response from V5 of chest x-ray and UA (urinary analysis) noted on the page. At the bottom of the page there is a not written in parentheses: Pt (patient) family took her to (local town) ER (emergency room) and was admitted . R63's progress note, dated 07/03/24 at 2:04 PM, documents: (local hospital lab) called, Res (R63) CO2 (carbon dioxide) is 42. V5 notified. No new orders at this time. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	R65's hospital records, dated 07/05/24 at 2:44 PM, document: Physical exam: constitutional: general: she (R63) is not in acute distress; appearance: she is not ill-appearing; Pulmonary: breath sounds: rales present, no wheezing; Abdominal: general: there is no distension. Review of Systems: Respiratory: positive for shortness of breath, negative for cough. Cardiovascular: positive for leg swelling, negative for chest pain and palpitations. Medical Decision Making: 64 y.o. (year old) female presents to the ER as described. Admit for COPD exacerbation and volume overload. Clinical Impression: as of 07/05/24 at 7:50 PM: pneumonia of lower lobe due to infectious organism, unspecified laterality, COPD exacerbation, and acute pulmonary edema. Chief complaint patient presents with: shortness of breath. R65 is a [AGE] year old female with pmh of COPD on 4 L O2, memory loss nursing home resident presented in ED (emergency department) for worsening sob, weight gain, leg swelling for last weeks. Recently she was admitted for cardiac arrest, was discharged to nursing home with hospice care, however patient/family declined hospice two weeks ago. Was not on Lasix for two weeks, however started on Monday. At 6:47 PM Review of Systems: No intake/output data recorded. I/O (input/output) this shift: In 300 (IV piggyback:300) out: -. Physical exam: Pulmonary: breath sounds: wheezing present. Abdominal: general: there is distension, musculoskeletal: right lower leg: edema present. Left lower leg: edema present. Laboratory results: collection time: 07/05/24 at 3:16 PM Carbon dioxide 45 (HH) reference range: 21-31 mmol/L (millimoles/liter), blood urea nitrogen 28 (H) reference range: 7 - 25 mg/dl (milligrams/deciliter), creatinine 1.50 (H) reference range 0.60 - 1.30 mg/dl, X-ray chest 1 view result date 07/05/24: impression: Bibasilar atelectasis or pneumonia. Intake/output summary (last 24 hours) at 07/06/2024 at 11:45 AM: gross per 24 hour: intake 700 ml output 600 ml net 100 ml. Physical exam: Respiratory: Lungs are diminished to auscultation bilaterally. Respiratory effort is normal. No accessory muscle use. Results from last 7 days: BNP B (B-type natriuretic peptide) 07/05/24 at 3:16 PM - 375 pg/ml (picogram/milliliters) and 07/05/24 at 10:24 PM 281 pg/ml. Current facility administered medications: arformoterol-budesonide 15mcg - 0.5 mg combo (combination) neb (nebulizer) BID (bis in die (twice a day)) on 07/06/24 at 7:35 AM, carvedilol tablet 3.125mg BID 07/06/24 at 9:43 AM. Furosemide (Lasix) injection 80 mg BID 07/06/24 at 9:59 AM prednisone tablet 50mg daily on 07/06/24 at 9:43 AM, and spironolactone tablet 25 mg daily at 07/06/24 at 9:43 AM. On 07/06/24 at 6:13 PM patient presents with: shortness of breath; subjective : sob better, objective: hypervolemic. I/O this shift: in 241 out: 1200. Physical exam: Pulmonary: breath sounds: wheezing present. Abdominal: general: there is distension, musculoskeletal: right lower leg: edema present. Left lower leg: edema present. Intake/output summary (last 24 hours) at 07/07/2024 at 10:44 AM gross per 24 hour: intake 799.43 ml, output 3100ml net -2300.57 ml. Physical exam: Neck: supple, mild but improved JVD (jugular vein distention) is present, Respiratory: lungs are diminished to auscultation bilaterally, respiratory effort s normal. There is no accessory muscle use. On 07/07/24 at 9:40 PM I/O last 3 completed shifts: in: 1479.4 out 4375. Intake/output summary (last 24 hours) at 07/08/2024 at 11:32 AM, gross per 24 hour: intake 1388 ml, output 1975 ml net -587ml. On 07/08/24 at 11:31 AM progress notes document: assessment: principle problem: pneumonia of lower lobe due to infectious organism, unspecified laterality. Assessment & plan: 1. Acute on chronic heart failure with preserved ejection fraction-appears well compensated on exam. Will decrease Lasix to 20 mg daily which should be continued at discharge, continue spironolactone 25 mg daily, low sodium diet and daily weights. 2. Acute on chronic hypoxic hypoxic respiratory failure secondary to COPD. 3. AKI (acute kidney injury) is improving, creatinine is 1.6 today. R65's hospital discharge summary dated 07/08/24 at 12:09 PM documents: primary discharge diagnosis: pneumonia of lower lobe due to infectious organism, unspecified laterality and heart failure exacerbation (probably right heart). (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 08/14/24 at 2:15 PM, V6 (LPN) stated if she had a resident that had a 71% SPO2, she would get a hold of V5 (Nurse Practitioner/NP) after she bumped up the oxygen, and see if she wanted the resident sent out. When R63 had the SPO2 of 71%, she contacted V5, and she gave an order for an in house x-ray on 07/03/24. The company that does the in-house x-ray is supposed to be same day, but now they are taking 2 to 3 days to get to the facility. (V5) is aware of the x-rays taking that long to be done. Usually, (R63's) oxygen will come back up. All the SPO2 levels are documented on the MAR. On 08/15/24 at 10:18 AM, V24 (family) stated she took R63 out to the ER (emergency room) on 07/05/24. V24 stated she came to visit and R63 was struggling to breathe; she had more shortness of breath than usual, she was a grayish color, and her feet were so swollen they would not fit into her shoes, and she has loose fitting sandals. A CNA (Certified Nurse Assistant) asked if she wanted R63 to see V5 because she was in the building, but she stated, no, she thought she needed to go to the hospital. V5 had not done anything yet, and R63 was having problems. V24 stated R63 came to the facility after being in the hospital with pneumonia and edema. It was the hospital that she was in prior to this facility that identified the heart concerns and gave her Lasix. She does not understand why they discontinued her Lasix. Then when they prescribed the Lasix again around the beginning of July, it was at half the dose she was on. On 08/15/24 at 12:58 PM, V6 (Licensed Practical Nurse/LPN) stated when V5 (Nurse Practitioner) gave the new orders after R63 was discontinued from hospice, she believes that could be when the Lasix was discontinued. She would not have been given a reason why it was discontinued. She is not sure how to look for the old orders, so that would just be her guess. On 08/19/24 at 2:12 PM, V47 (LPN) stated she can see where the order for Ipramtropium-albuterol was put in on 06/30/24, but it is not on the MAR for June, and she does not see where she received any in July, but the start date was 07/08/24. On 08/19/24 at 2:13 PM, V6 stated she has Ipramtropium-albuterol on the cart. She does not remember ever giving R63 the medication. V6 stated she can see the order from 06/30/24, but it is not on the June MAR. She does see the order on the July MAR, and the start date is 07/08/24. She believes it has a start date that is different than expected because the order was not confirmed; the order will not show up on the MAR until the order is confirmed. On 08/15/24 at 4:15 PM, V1 (Administrator) stated, From looking at (R63's) order sheet from when her hospice medications were discontinued, it appears the medications that were discontinued have a line through them. The Lasix order does not have a line through it, so following the pattern I see, I do not know why the Lasix order was discontinued; it does not appear it should have been. On 08/19/24 at 1:22 PM, V8 (CNA) stated she kind of remembers R63 in that timeframe before she went out to the hospital; she remembers her looking grayish. On 08/19/24 at 2:16 PM, V1 (Administrator) stated, If we had a resident that had a low oxygen saturation rate and her oxygen was increased and she was still feeling bad, especially at 71%, I would expect they would be sent out. V1 stated she would expect if an order for a chest x-ray was put in, stat, it would be done in 4 to 6 hours; a standard x-ray would be a day or two, so it would depend on the way the x-ray was ordered. V1 stated she does not know why the start date for the duoneb is not 06/30 for R63. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 08/20/24 at 3:35 PM, V5, Nurse Practitioner, stated she does not know anything about R63's Lasix being discontinued, or why it would be. She did not discontinue R63's medications after she was discontinued from hospice care, that would be V48 (Physician). V5 stated she did not get notified of R63 having a SPO2 of 71%; they could have notified the Nurse Practitioner on call. V5 stated she did not give the order for ipratropium-albuterol; it must have been one of the Nurse Practitioners on call. On 08/21/24 at 10:10 AM, V35 (Licensed Practical Nurse/LPN) stated she worked on 06/30/24. She stated someone came and got her from the dining room and told her, it's an emergency. She assessed R63, who was a gray blue color. V35 stated she took her SPO2 (oxygen level) and it was 88% with no oxygen. (R63) has COPD (Chronic Obstructive Pulmonary Disease); she has oxygen and a nebulizer in her room. V35 had an order for the duoneb (nebulizer treatment) before, so I called (V5) to get an order for the medication and gave it to her. If her SPO2 did not come up right away, I would have sent her out. On 08/21/24 at 1:26 PM, V48 (Physician) stated he does not have any notes from the end of May to July. Nothing in his notes is indicating that he discontinued the Lasix after R63 came off of hospice care. V48 stated, I am looking at her hospital notes and her creatinine was up a bit, but not bad, her CO2 runs in the high 30s typically with her history of smoking and COPD, so a CO2 of 42 would not be that alarming. (R63) does not have great kidney function, so we have to watch how much Lasix (R63) is given. I did not realize in house x-rays took that long, most of my facilities can get an x-ray on the same day, or at the latest the next morning. If I was only given the information of: a resident's oxygen saturation was 71% with 3 L of oxygen and it was raised to 5 L and the resident was still feeling bad, I would say they should have been sent out, without having any follow up oxygen saturations or information on status. On 08/21/24 at 1:40 PM, V2 (Assistant Director of Nursing/ADON) stated he would expect if the nurses had a resident that had a low oxygen saturation to apply oxygen or increase oxygen, and contact the Nurse Practitioner. V2 stated if the condition persists, he would expect the nurse to call 911. He would expect if the Nurse Practitioner was contacted, staff would document that they were contacted and what the response was. In the situation with R63, he would expect that a Nurse Practitioner would have been contacted, but he would not know that for sure without a progress note. On 08/21/24 at 3:25PM, V6 stated she did notify V5 via text message on 07/03/24 of R63's oxygen level. V6 stated V5 did respond back later to her, and ordered a chest x-ray. V6 stated V5 never ordered for a recheck of R63 oxygen saturation. V6 stated she was working two halls on that day and didn't have a lot of time. V6 stated she did check on R63, but didn't chart it, because she didn't have time, was short of staff, and was working two halls. V6 stated she put a late entry in today regarding R63 on 07/03/24. V6 stated she didn't have proof on her phone of the text message. V6 stated she erases all her messages daily. 49907 2. R68's face sheet documents R68 was admitted to the facility on [DATE], with diagnoses that include: unilateral primary osteoarthritis, left knee, pain in right knee, unspecified injury of right lower leg, sequela, polyneuropathy, morbid (severe) obesity due to excess calories, and unspecified abnormalities of gait and mobility. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	R68's MDS (Minimum Data Set), dated 5/01/2024, documents a BIMS (Brief interview for Mental Status) score of 15, indicating R68 is cognitively intact. Section GG-Functional Abilities and Goals documents V68 is dependent on staff for toileting hygiene, showering, and bathing. V68 is listed as partial/moderate assist for personal hygiene. R68's current Care Plan documents Care Areas of: R68 has skin impairment with risk for pressure injury development related to: Immobility. R68's interventions include: Administer treatments as ordered, monitor for effectiveness. Assess/record/monitor wound healing weekly. Measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Monitor for infection. Report improvements and declines to the MD. Needs assistance to turn/reposition approximately every 2 hours, more often as needed or requested. A document in R68's medical record, dated 07/18/2024, titled Specialty Physician Wound Evaluation & Management Summary, documents a skin tear to the right thigh and a rash to the right thigh. The wound to the right thigh was described as a skin tear, a surgical excisional debridement procedure was performed, and the following dressing treatment plan was ordered: Primary Dressing(s)-Alginate calcium apply once daily for 30 days; Collagen powder apply once daily for 30 days; Silver sulfadiazine, apply once daily for 30 days. Secondary Dressing(s)-Gauze Island with boarder apply once daily for 30 days. The rash to the right leg was diagnoses as Candidiasis rash of the right leg. The following treatment plan was ordered. Fluconazole 150mg orally. Repeat dose in 7 days, clotrimazole 1% as directed. A document in R68's medical record, dated 07/25/2024, titled Specialty Physician Wound Evaluation & Management Summary, documents a follow up for wound to the right thigh. It further documents the wound is resolved. There is no mention anywhere on this document about the rash to the right leg. R68's July Medication Administration Record (MAR) and the Physician's Order Sheet reveals the order for Fluconazole 150mg orally. Repeat dose in 7 days was not started or administered to R68. R68's July Treatment Administration Record (TAR) and Physician's Order Sheet reveals the order for the treatment to the skin tear to the right thigh and rash was not started or administered to R68. R68's shower sheets document she received a shower on 07/18/24, when areas of skin alteration were noted. R68 received a shower or bed bath on 07/22, 07/25, 08/01 and 08/12, and no areas of skin alteration were noted. On 08/13/2024 at 12:45 PM, V3 (LPN/Infection Prevention Nurse) stated V2 (Assistant Director of Nursing/ADON) takes care of wound rounds. V3 stated R68 last treatment orders that ended on 06/13/2024; her only current order was for Nystatin powder. V3 stated it would be her expectation the staff that receives these orders to put them in and start them. V3 stated she would immediately assess V68's skin today, and contact the doctor if there were any concerns. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 08/14/24 at 12:00 PM, V37 (Certified Nurse's Assistant/CNA) was providing incontinence care for R68. An area was observed on R69's right hip that was scabbed over with brown/red eschar; no signs of infection noted on surrounding tissue. R68 stated she wasn't sure how it got there, and then said she thought she got it from her wheelchair. R68 asked V37 to please wipe the area on her leg because some people forget to clean it when they provide care, and it burns. V37 lifted R68's right leg into the air and used a wipe to wipe what appeared to be a macerated/abrased area on upper inner thigh area. R68 stated staff aren't doing any current treatments to the area on her right leg, it has been there 3-4 weeks and the nurses were putting some kind of cream and a band aid on it at one time. R68 was not sure what the actual treatment was or exact dates of the treatment. On 08/20/2024 at 1:42 PM, V1 (Administrator) stated it is the responsibility of the DON (Director of Nursing) or ADON (Assistant Director of Nursing) in the DON'S absence to follow up on wound rounds and orders. V2 stated it is also the responsibility of all the nurses; the wound doctor informs the floor nurses of what the plan of care is. 48356 3. R100's Face Sheet documents an admitted [DATE], with diagnoses of UTI (Urinary Tract infection), Enterocolitis due to clostridium difficile, type 2 diabetes mellitus, and neuromuscular dysfunction of the bladder. R100's Minimum Data Set (MDS), dated [DATE], documents a BIMS (Brief Interview for Mental Status) score of 15, which indicates R100 is cognitively intact. R100's MDS also documents substantial/maximal assist with toileting, showers, and dressing. R100's Care Plan, dated 06/19/24, documents a Focus area of a foley catheter related to: urinary retention, neurogenic bladder. Interventions include in part, monitor/record/report to MD (Medical Doctor) for s/sx (signs and symptoms): pain, burning blood tinge urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp (temperature), urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, or change in eating pattern. There is no care plan related to history or risk of Urinary Tract Infections. R100's local hospital discharge summary documents an admitted [DATE], and a discharge date of [DATE], which documented in part under Active Issues requiring Follow-up Jardiance stopped due to fungal UTI (Urinary Tract Infection)/chronic foley. Hospital course documented R100 also had leukocytosis, Candida UTI, foley catheter exchange following admission. Home Jardiance discontinued. Treat with oral fluconazole. Under Discharge Medications the following is new medications are documented: Fluconazole 200 mg (milligrams), oral, daily, for Candida UTI: Quantity 11 tablets and Vancomycin 125 mg capsules 1 capsule two times a day orally, every 6 hours scheduled: Quantity 28 capsules. Stopped medications: Jardiance 25mg tablets. R100's current Physician Orders documents no fluconazole order. On 08/10/24, a new order was documented for Jardiance oral tablet 25mg give 1 tablet by mouth in the morning for DM (Diabetes Mellitus). (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 08/14/24 at 12:10 PM, V4 (Licensed Practical Nurse/LPN) stated R100 was not on fluconazole and he was never started on it when he came back from the hospital on 08/07/24. V4 said the Jardiance was stopped on return from the hospital, but was restarted on 08/10/24. V4 said there was no note in the progress notes to say why the Jardiance was restarted. On 08/14/24 at 12:43PM, V3 (Infection Preventionist) stated since she looked at the discharge summary today, she noticed R100 did have an order for fluconazole, and an order to stop the Jardiance. V3 said V4 (Licensed Practical Nurse/LPN) told her R100 had orders that didn't get transferred over when he returned on 08/07/24. V3 stated R100 should have been started on fluconazole for his UTI. V3 said it does say to stop the Jardiance related to the UTI. V3 stated it was stopped on 08/07/24, but was restarted on 08/10/24. V3 stated she does not know why the Jardiance was restarted. V3 said there is no progress notes stating why the Jardiance was restarted. V3 said she would have expected a progress note stating why the Jardiance was restarted. V3 stated R100 was in the hospital for a UTI from 08/02/24, until returning on 08/07/24. V3 stated she doesn't know why they missed the other orders because they did start the vancomycin that was ordered on the discharge summary. V3 stated because they did not start the fluconazole for R100, which was ordered for his urinary tract infection, it could have caused problems or even harm to R100, because he did not get the treatment for his UTI as ordered. V3 stated she was going to call V5 (Nurse Practitioner) to see what she wanted the facility to do, since they missed the new order from the hospital for fluconazole for R100's UTI. R100's Progress notes, dated 08/14/24 at 1:34 PM, documented, New order per V5. UA (Urinalysis) with culture if indicated. R100 agrees with new orders. R100's Urinalysis with Culture collected on 08/15/24. The Final Report, completed on 08/18/24, documented urine culture with Mixed Urogenital Flora. V5 (Nurse Practitioner) signed off on Urinalysis with culture on 08/19/24 with no new orders. On 08/20/24 at 1:40 PM, V48 (Medical Doctor) said, (R100) is in pretty bad shape. I was not aware that the facility did not follow the discharge instructions to start fluconazole for (R100's) UTI and to discontinue Jardiance. (R100) should have been started on the fluconazole when he returned from the hospital. I don't know why (R100) did not start the fluconazole. The medication would have been beneficial to treat (R100's) Urinary Tract Infection. I did see that the facility did a Urinalysis with culture for (R100) on 08/15/24. The final culture of the urinalysis and the results showed Mixed urogenital flora. V48 said he does agree no treatment is needed at this time related to the current urine culture. V48 said he saw on the hospital discharge they wanted to stop the medication Jardiance. V48 said he understands why the hospital would have wanted that medication stopped, because it removes the glucose from your body in your urine. V48 said the Jardiance should have been stopped until the urinary tract infection was resolved, then re-started, because Jardiance has a lot of other benefits such as cardiac benefits. V48 said he is glad R100 was restarted back on Jardiance, but it should have been at a later time. V48 said he agrees with the Nurse Practitioner starting him back on Jardiance. V48 said the vancomycin would not have altered the culture results of the urinalysis. (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 08/29/2024

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

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 08/20/24 at 3:52PM, V5 (Nurse Practitioner) said she was made aware of the order for fluconazole on 08/15/24, when one of the nurses told her the order got missed from the 08/07/24 discharge summary. V5 said she ordered a urinalysis to be done on 08/15/24 to see if R100 still had a UTI, and if he still needed the fluconazole or another medication. V5 stated the fluconazole should have been given as ordered from the hospital, but the nursing staff missed it. V5 said R100 needed the fluconazole for his UTI. V5 said when she found out R100 didn't get the fluconazole, they did a repeat UA with Culture, if indicated. V5 said they did get the urine back with the final culture and it showed Mixed urogenital flora. V5 said she did not order for R100 to have any new medication. V5 said the UTI did clear up. V5 said she did restart the Jardiance on 08/10/24. V5 said she wasn't made aware the reason the Jardiance was stopped, but she believes he needed the Jardiance for its other benefits. V5 said she wasn't given the full (hospital) discharge summary when R100 got back to the facility to know they stopped the Jardiance related to his Urinary Tract Infection. V5 said since R100's UTI is cleared, she would prefer that R100 continue the Jardiance. The facility policy titled Admissions to the Facility, revised 12/2006, documents the following under Physician Admission Orders: Prior to or at the time of admission, the resident's attending physician must provide the facility with information needed for the immediate care of the resident, including orders covering at least, B. Medication orders, including (as necessary) a medical condition or problem with each medication. 4. R100's Care Plan, dated 06/19/24, with a Focus area of, (R100) has altered skin integrity and/or risk for pressure injury development related to disease process impaired mobility, weakness. Interventions for this focus area include in part: Weekly skin check. Notify nurse immediately of any new areas of skin breakdown: redness, blisters, bruises, or discoloration noted during bathing or daily care. R100's Progress notes document on 08/05/24 at 6:38AM, R100 is currently in the hospital. Progress note, dated 08/07/24 at 7:15PM, documents R100 returned from hospital. No skin assessment was noted on readmission from the hospital in R100's progress notes. R100's Specialty Physician Wound Evaluation and Management Summary, dated 08/08/24, documents under History chief complaint, (R100) has wounds on his sacrum, right groin, left foot, right elbow, left hand, right dorsal hand, right foot. At the request of the referring provider. A thorough wound care assessment and evaluation was performed today. On 08/15/24 at 11:30 AM, V21(Licensed Practical Nurse/LPN) and V41(LPN) were performing treatments to R100, when V21 stated all treatments were completed. Three dressings were noted to R100's left upper mid back that appeared older with exudate on them. V21 stated she was not aware of any treatment to R100's left upper mid back. V21 removed all three dressings, which had exudate on the dressings. All three dressings were dated 08/06/24, with no initials. V21 said she was not aware of any open areas to left mid upper back. V21 stated R100 does not have any treatment to those areas. R100's Physician Orders documents a order on 06/18/24 Skin checks every day shift every Mon (Monday), Thu (Thursday). An order, dated 06/18/24, skin assessment on shower days every day shift every Mon, Thu. No treatment order for upper left back was noted in Physician orders. R100's Bath and Skin Report Sheet for August 2024 documents on 08/08/24, a bed bath was given, with no new skin areas documented. 08/15/24 Bed bath documented with no new skin areas documented. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 08/20/24 at 1:06 PM, V21 stated after she discovered the three areas to R100's left upper mid back, she did call the wound doctor. V21 stated the wound doctor said he would come in and look at the new areas and decide what treatment is needed, if any. V21 said the wound doctor is aware R100 has a diagnosis of bullous pemphigoid. V21 said R100 gets blisters often. V21 said the wound care doctor did come in and evaluate the three areas to R100's left upper mid back, and did not want treatment started at this time, because the areas were drying up. The facility policy titled Pressure Ulcers/Skin Breakdown, dated 8/2008, documents the nurse shall assess and document/report the following: Full assessment of skin condition including but not limited to location, stage or partial/full thickness, length, width, and depth, presence of exudates or necrotic tissue.

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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 - Minimal harm or potential for 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** 32765 Based on observation, interview, and record review, the facility failed to ensure newly identified pressure areas were assessed including measurements and descriptions of the area, and interventions were implemented for 1 (R27) of 7 residents reviewed for pressure ulcers in the sample of 51. Findings Include: R27's Admission Record documents R27 was admitted to the facility on [DATE], with diagnoses that include diabetes, hypertension, chronic kidney disease, muscle wasting, and cognitive communication deficit. R27's Minimum Data Set (MDS), dated [DATE], documents R27 has a Brief Interview for Mental Status (BIMS) score of 12, which indicates a moderate cognitive deficit. This same MDS documents R27 requires partial to moderate assist for bed mobility and transfers, is at risk of developing pressure ulcers, and has a pressure reducing device for his chair and bed. R27's Braden Assessment, dated 7/1/24, documents R27 is at Very High Risk of skin breakdown. R27's current Care Plan documents a Focus area of, Has (specify: stage) pressure injury or risk for pressure injury development related to: Impaired mobility. 8/5/24 impaired skin to scrotum, 8/12/24 area to right outer thigh. Date Initiated: 07/02/24. The interventions documented for this Focus area are, Administer treatments as ordered and monitor for effectiveness. Date Initiated: 08/14/2024.Encourage/assist to float heels while in bed. Date Initiated 08/16/24. LAL (low air loss) mattress to bed. Date Initiated 08/16/2024.Monitor nutritional status. Serve diet as ordered, monitor intake and record. Date Initiated: 7/2/24. Needs assistance to turn/reposition approximately every 2 hours, more often as needed or requested. Date Initiated: 07/02/2024 Obtain and monitor lab/diagnostic work as ordered. Report results to MD (Physician) and follow up as indicated. Date Initiated: 7/2/24.Provide pressure reducing pad to wheelchair. Date Initiated: 08/16/2024. Weekly skin check. Notify nurse immediately of any new areas of skin breakdown: redness, blisters, bruises, or discoloration noted during bathing or daily care. Date Initiated: 7/2/24. On 08/12/24 at 12:02 PM, V31 (Family Member) stated R27 had a couple of bed sores that he got at the facility. V31 stated R27 was admitted on [DATE] for care while his wife had surgery. V31 stated R27 slept on an air mattress at home, and she had asked the facility about one last week; they said maintenance would have to bring one in, and he still doesn't have one. There was no air mattress observed on R27's bed on the date and time of this interview. R27's Progress Notes, dated 8/12/24, documents, Note Text: Resident has a darken area to right hip, new orders for betadine every shift, Daughter aware. R27's medical record does not document an assessment, measurements, or description of the area. R27's Order Summary Report with active orders as of 8/16/24 includes the following orders, Betadine External Solution 10% (Povidone-Iodine) Apply to Right hip topically every shift for pressure. R27's medical record was reviewed and does not document an initial skin assessment. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R27's Treatment Administration Record (TAR), dated 7/1/24 to 7/31/24, documents weekly skin assessments with skin documented as intact. R27's TAR dated 8/1/24 to 8/31/24 documents a W for wound on 8/5/24. On 08/15/24 at 1:39 PM, V21 (Licensed Practical Nurse/LPN) administered treatments to R27's pressure area. V21 cleaned R27's right hip with wound cleanser and applied betadine. R27 appeared thin and the bone was very prominent under the pressure area. There was a scabbed area approximately the size of a silver dollar and the surrounding tissue was red/purplish in color. There was an air mattress observed on R27's bed and V21 stated it was put in place not even an hour ago. V21 stated they put it in place because of R27's hip and R27 not liking to lay on his left side. On 08/15/24 at 3:58 PM, V3 (Infection Preventionist/LPN) stated when a new area is identified, the nurse calls the wound specialist and gets orders for the area, and then the wound specialist comes in and does his assessment. V3 stated the nurses should document a progress note with an assessment and their notification of the physician. V3 stated she didn't see any assessments of the area and no admission skin assessment. V3 stated the pressure ulcer was acquired after R27 was admitted to the facility. V3 stated she wasn't aware an air mattress had been requested. The facility Pressure Ulcers/Skin Breakdown -Clinical Protocol policy, dated 8/2008, documents under Assessment and Recognition, 1. Document an individual's significant risk factors for developing pressure sores .2. In addition, the nurse shall assess and document/report the following: z. Full assessment of skin condition including but not limited to location, stage or partial/full thickness, length, width and depth, presence of exudates or necrotic tissue 3. Examine the skin of a new admission for skin conditions or indications of a Stage 1 pressure area that has not yet ulcerated at the surface

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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

Deficiencies at this level require more than one deficient practice statement.

A. Based on interview and record review, the facility failed to ensure residents assessed as being at risk for elopement were supervised and interventions were implemented to prevent elopement for 2 of 3 (R96 and R162) residents reviewed for accidents and supervision in the sample of 51. This failure resulted in R96, who had a history of elopement, and was assessed as being at risk of elopement, exiting the facility when a visitor entered, without staff knowledge, walking half the length of the facility and re-entering through the kitchen door that is located at the end of the facility, and R162 exiting the facility through a window, crossing a busy highway, and walking approximately 1.3 miles without staff knowledge.

These failures resulted in an Immediate Jeopardy, which was identified to have begun on 8/3/24 when R96 exited the facility without staff knowledge. On 8/3/24 when a visitor entered the facility through the front door, R96 exited the facility without staff knowledge. R96 walked half the length of the facility and re-entered through the kitchen door. On 8/9/24, R162 left the facility through a window, without staff knowledge. The local police notified the facility R162 was at a local business located across a busy highway and approximately 1.3 miles from the facility.

V1 (Administrator) was notified of the Immediate Jeopardy on 08/20/2024 at 1:18 PM. The surveyors confirmed by observations, interview, and record review, the Immediate Jeopardy was removed on 08/12/2024, but the noncompliance remains at Level Two due to additional time needed to evaluate implementation and effectiveness of training.

Findings Include:

1. R96's Admission Record, with a print date of 8/16/24, documents R96 was admitted to the facility on [DATE], with diagnoses that include dementia, anxiety disorder, weakness, cognitive communication deficit, conduct disorder, delirium, major depressive disorder, and insomnia.

R96's MDS (Minimum Data Set), dated 7/12/24, documents a BIMS (Brief Interview for Mental Status) score of 04, which indicates a severe cognitive deficit.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R96's current Care Plan documents a Focus area of, Is an elopement risk/wanderer related to: Disoriented to place, History of attempts to leave facility unattended, Impaired safety awareness. Date Initiated: 07/01/2024. This Focus area documents the following interventions: (electronic monitoring device) (wandering) management system at all times. Date Initiated: 07/01/2024 .Resident to be seen by Geri-psych (geriatric psychiatry). Date Initiated: 07/31/2024. Psych NP (Psychiatric Nurse Practitioner) to do med review (medication review) and medication adjustment one on one care till (until) able to rest and sleep. Date Initiated: 07/15/2024.Initiate monitoring of change of behaviors after family visits. Date Initiated: 07/18/2024. Implement one to one observation anytime resident begins wandering hallways, displaying anxiety after family visits and attempts exit seeking. Date Initiated 07/16/24. Front door to remain locked, and sign posted for visitors to ring doorbell and visitors can now only enter with staff assistance. Date Initiated: 08/08/24. Sign to be posted at front and back entrance for all staff and visitors to look behind them before opening door and re-direct (R96) away from doorway before entering or exiting. Date Initiated: 08/08/2024.Check (electronic monitoring device) battery function weekly and PRN (as needed). Date Initiated: 07/01/2024.Check (electronic monitoring device) placement every shift and PRN (as needed). Date Initiated: 07/01/2024. Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Date Initiated: 07/01/2024.Monitor for fatigue and weight loss. Date Initiated: 07/01/2024. Offer a warmed blanket. Date Initiated: 07/01/2024.Offer reassurance appropriate to the concern. Dated Initiated: 07/01/2024. Offer to take to a scheduled or planned activity. Date Initiated: 07/01/2024.Offer to take to the toilet or assist with continence care. Date Initiated: 07/01/2024. Provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures, and memory boxes. Date Initiated: 07/01/2024 .Redirect resident when wandering or exit seeking. Date Initiated: 07/01/2024. Resident is to be one on one anytime the resident starts to wander, and exit seek. Resident is to remain one on one until behavior resolves. One on One is to be implemented every time this behavior occurs. Date Initiated: 8/15/2024. Return to bed for additional rest or comfort. Date Initiated: 07/01/2024. Scan (electronic monitoring device) every shift for battery percentage, ensure placement and skin integrity. Location: LLE (left lower extremity). Date Initiated 08/05/2024. Use distraction to change thought pattern. Date Initiated: 07/01/2024. R96's Elopement Evaluation, dated 7/10/24, documents a score of 04, indicating R96 is at risk of elopement. R96's Elopement Evaluation, dated 8/6/24, documents a score of 08, which indicates R96 is at risk of elopement. R96's Elopement Evaluation, dated 8/14/24, documents a score of 09, which indicates R96 is at risk of elopement. R96's Progress Notes, dated 8/3/24, documents, (V21, LPN/Licensed Practical Nurse) advises resident had left the building and no alarm sounded. Found the (electronic monitoring device) was malfunctioning r/t (related to) placement and extra socks. Contacted ADON (Assistant Director of Nurses - V2 RN/Registered Nurse) and reported resident leaving the building. Awaiting further direction at this time. POA (Power of Attorney) aware. One on one direct supervision with resident directly after occurrence until confirmed wanderguard placement and activation. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A Facility Incident Report regarding R96, dated 8/3/24, documents, IDT (Interdisciplinary Team) met and reviewed incident. Complete head count was conducted. NP (Nurse Practitioner) and POA (Power of Attorney) notified. Investigations immediately conducted. Staff, resident and visitor interviews conducted. (R96) was seen ambulating the long-term care hallways on video camera. Then (R96) was seen at (name) nursing station with (V32, CNA/Certified Nursing Assistant). At 3:15 pm a visitor was entering front entrance facility when (R96) exited the facility. Visitor told (R96) she is not supposed to be outside. (R96) told visitor 'well I am going outside'. Visitor proceeded down to his father's room and did not inform the facility staff that a resident had exited the facility. (R96) walked out the front entrance and immediately re-entered the facility through the dietary door. The dietary staff took the resident to the (name) nurse station and informed the nurse that (R96) came into the dietary exit door from outside the facility. When the staff started checking (R96) (electronic monitoring device) the visitor stated I forgot to tell you that she went outside when I was coming in. (R96) (electronic monitoring device) transmitter was checked, and the red light was blinking. Blinking light indicates transmitter is active. When the transmitter was checked with the transmitter tester it indicated the transmitter was active. All resident (electronic monitoring device) transmitters were checked for the red blinking light, checked with transmitter tester and at each exit door and all alarms sounded. All staff was in-serviced with elopement policy, checking transmitters for red blinking light and checking with transmitter tester. Visitors inserviced upon entering facility not to let residents out and to immediately notify staff if it occurs. Medication review was completed, NP (Nurse Practitioner) and POA (Power of Attorney) updated, Care Plan Updated. Front door was locked, and sign posted for visitors to ring doorbell and visitors can not only enter with staff assistance. 15 minute safety checks were initiated. NP and POA updated. Care Plan updated. On 8/14/24 at 10:01 AM, V21 (Licensed Practical Nurse/LPN) stated she didn't recall what happened on 8/3/24 when R96 left the facility without staff knowledge. R96's progress note, dated 8/3/24, was reviewed with V21 and she stated, No., when asked if she could recall the events. On 8/14/24 at 10:03 AM, V31 (CNA/Certified Nursing Assistant) stated she was in with another resident, and when she came out, a nurse (V21) was walking with R96, and stated the kitchen staff just let R96 in the back door. V31 stated she never heard the alarm sound. V31 stated they kept R96 with them after that, because they do 15-minute checks when R96 has elopement behaviors. V31 stated she was walking with a visitor to let them out the front door, when the visitor said R96 got out the door when they came in. V31 stated the visitor tried to stop R96, but she said she was going. V31 stated that is when they started locking the front door. When asked if the door alarm should sound even if it was opened by a visitor, V31 stated it should, and they had checked R96's (electronic monitoring device) and it was on, and the battery level was working. V31 stated she didn't know why the alarm didn't sound. V31 stated they have a little box they hold up to the bracelet, and it will say if it is on and check the battery level. V31 stated there is also a blinking light on the bracelet, and if it is blinking, it means the bracelet is working. When asked if there was a way to see if the alarm would sound, V31 stated they took R96 to the door to see if would sound. V31 stated she wasn't there when it was checked. V31 stated they check the bracelet daily, and have always checked placement, and if the light on the bracelet was blinking. V31 stated she had forgotten they could check the battery level with the box. V31 stated they were shown how to check it after R96 eloped on 8/3/24. V31 stated R96's wanderguard was working, and they have no idea what happened. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 08/14/24 at 12:28 PM, V33 (Dietary Aid/Cook) stated she was working on 8/3/24 between 3:00 and 3:30 PM, when R96 came into the kitchen. V33 stated they thought it was V30 (Dietary Manager) coming in the door, but when it opened it was R96. V33 stated the door she entered is down by the dumpsters, near the stop sign on the south side of the facility. V33 stated she took R96 to the unit, and she was unable to locate the nurse. V33 stated once she found V21 (LPN), she (V21) got an attitude and then came back into the kitchen and told them to mind their own business; she had gotten R96 another (electronic monitoring device). V33 stated she never heard an alarm sound. On 8/14/24 at 10:05 PM, V35 (Anonymous) stated she was down the hall doing treatments, when V21 stated to her the kitchen staff said R96 was outside, and knocked on the Dietary door. V35 stated V21 walked R96 up to the front door to see if the door would alarm, and it didn't. V35 stated R96 was then placed on one to one, and V21 left the floor. V35 stated she thought V21 was calling to report the elopement to management, but she didn't. V35 stated she called V2 (Assistant Director of Nursing/ADON) to report it. V35 stated she later found out, R96 pushed past a visitor that was entering the facility and was let outside. V35 stated R96 was placed on one to one after the incident. V35 stated she didn't go with V21 when she walked R96 to the front door to see if the alarm would sound. When asked why it wouldn't alarm, V35 stated it may be an equipment malfunction. V35 stated they had training after the incident on how to check the battery and how to check for placement. V35 stated they placed a new (electronic monitoring device) bracelet on R96 after the incident, and they verified everyone else's (electronic monitoring device)were working. V35 stated she knows now how to check the bracelets. V35 stated they have a device that checks the battery. V35 stated she didn't have any idea how to use it before the incident, but now she does. When asked if she was aware they could check the battery's prior to this incident, V35 stated, No, not a clue. V35 stated prior to this incident where they documented the checks, it said to check placement. V35 stated so they were checking placement, not to make sure it was working properly. On 8/14/24 at 1:56 PM, V34 (Plant Operations Manager) stated they check the (electronic monitoring device) weekly, and staff check each day. V34 stated maintenance checks all the door alarms, but doesn't check the individual bracelets. V34 stated the nurses check the individual bracelets. V34 stated the nurses have a tester on the med cart, and it reads the warranty date, serial number, and tells if the battery is good. V34 stated if the battery is not good, it says it is zero, and to replace it. V34 stated they should be tested daily. V34 stated he is sure it is a manufacturer recommendation. V34 stated they are getting ready to enhance the system they have. When asked why the alarm didn't sound, V34 stated they called him and he in-serviced everyone, but R96's alarm was functioning properly. V34 stated they figured out staff had put the code in for another resident, and there is a 30 second delay on the door alarm, and before that 30 seconds was up the visitor let R96 out. The (electronic monitoring device) manufacturer recommendations were provided by V34, and they document the following, Testing Tags Accutech Tags operate by internal battery. Over the course of normal operations, Tags (wanderguards) eventually lose battery power and the Tags will need to be replaced. The Tag battery is not replaceable. For maximum protection of residents or assets, Accutech recommends that tags be tested on a weekly basis. There are many ways that you can test Tags: Enter a monitored zone, With an S-TAD, the Keypad's Auxiliary LED (Yellow) will light when a Tag is detected (Optional: additional wire required). Check Visual Pulse LED if present. (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 08/29/2024

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 0689

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

On 8/14/24 at 4:40 PM, V1 (Administrator) stated on 8/3/24, she got a call at home telling her R96 eloped, and they didn't know how she got out. V1 stated R96 left out the front door and came in the Dietary door. V1 stated she came to the facility and when she got there, they went through the entire building because the staff were all questioning the alarm system. V1 stated apparently a visitor came in, and R96 was trying to leave. V1 stated the visitor told R96 he didn't think she was supposed to leave, and she did anyway. V1 stated the visitor said he forgot to tell anyone she left, until he heard staff talking about it. V1 stated she checked the cameras, and R96 was seen wandering the hallway by the time clock around 3:00 PM. V1 stated R96 was with V32 (CNA) at the nurse's station and then the visitor was coming in around 3:15 PM. V1 stated based on when kitchen staff take their lunch breaks, R96 entered the kitchen right before 3:30 PM. V1 stated they took R96 to the nurse and she was assessed. V1 stated no one remembers hearing an alarm. V1 stated the facility staff checked R96's (electronic monitoring device) and told her it was working, and then took R96 to the door, and no alarm sounded. V1 stated they first checked the alarm by the blinking light that indicates it was working, then they checked it against the door once, and it didn't work and then again, and it did work. V1 stated they got a different (electronic monitoring device) bracelet for R96, and it alarmed as it should. V1 stated they checked every resident's bracelet against all three doors, and they all alarmed as they should. V1 stated she decided they needed to lock the doors because they can't have visitors letting people outside and staff not know they are gone. V1 stated it may have been a delay on the alarm after the code was put in for someone else, but they can't say for sure that is what happened. V1 stated before this incident, staff were checking placement and to ensure the red light was blinking on the bracelet. V1 stated after this incident, the staff were educated to use the tester to make sure the battery was full. V1 stated they didn't use the tester on R96's bracelet until she came into the facility, and when she checked it with the tester, it was working as it should. V1 stated she had R96 assessed by the psychiatric nurse, and they did medication adjustments. V1 stated she was diagnosed with a urinary tract infection, but it wasn't a bad one. V1 stated after the elopement on 8/3/24, R96 was placed on one to one.

R96's Resident Safety Checks reviewed, and do not document safety checks were being done on 8/3/24.

2. R162's Admission Record, with a print date of 8/16/24, documents R162 was admitted to the facility on [DATE], with diagnoses that include unspecified dementia, altered mental status, anxiety disorder, cognitive communication deficit, weakness, insomnia, and suicidal ideations.

R162's MDS, dated [DATE], documents a BIMS score of 09, which indicates a moderate cognitive impairment.

R162's Elopement Evaluation, dated 7/31/24, documents a risk for wandering/elopement was identified.

R162's Elopement Evaluation, dated 8/9/24, documents a score of 07, which indicates R162 is at risk for elopement.

(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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R162's current Care Plan documents a Focus area of, Is an elopement risk/wanderer related to: Impaired safety awareness, dementia with mood disturbance. Date Initiated: 08/01/2024. The interventions documented for this Focus area are Check (electronic monitoring device) battery function weekly and PRN (as needed). Date Initiated: 08/01/2024. Check (electronic monitoring device) placement every shift and PRN. Date Initiated: 08/01/2024 .Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Resident prefers watching television and being able to go out to smoke every couple of hours. Date Initiated: 08/01/2024 .Identify pattern of wandering: Is wandering purposeful, aimless, or escapist? Is resident looking for something? Does it indicated the need for more exercise: Intervene as appropriate. (R162) wanders purposefully looking for her family and wandering (sic) why she is here. Date Initiated: 08/01/2024. Offer a warmed blanket. Date Initiated 08/01/2024. Offer food or snacks. Date Initiated: 08/01/2024. Offer to take to a scheduled or planned activity. Date Initiated: 08/01/2024. Redirect resident when wandering or exit seeking. Date Initiated: 08/01/2024. Resident is to be one on one due to elopement out of the window. Date Initiated: 08/16/2024. Resident to be one to one at all times due to exit seeking behaviors. Date Initiated 08/16/2024. Use distraction to change thought pattern. Date Initiated: 08/01/2024. (electronic monitoring device) to be applied at all times. Date Initiated: 08/01/2024. R162's Facility Incident Report Form, dated 8/9/24, documents, Investigation conducted. IDT met and reviewed incident. Resident and staff interviews conducted. A visitor came to visit (R162) when it was discovered that (R162) could not be located. A full facility head count was conducted and determined (R162) was not in the building. All other residents were accounted for. Facility and facility grounds searched with no findings of (R162). While search was in process a staff member was notified by phone from the (local) Police department that (R162) was at the (name of business) on (name of road). Staff members then got into vehicle and went to collect (R162). (R162) was found safe with no injuries or any signs of distress. MD (physician) and Family member notified of resident elopement and safe entry back into the facility. Nurse completed full body assessment and vital signs upon reentry to facility with no abnormal findings. Safety checks initiated and (R162) was placed 1:1 at this time. (R162) admitted to kicking out the window screen and jumping out the window during interview which resulted in the alarm not sounding. Staff then assisted to check windows or any other possible site of exit. It was found on a closed Memory unit that a window was open with screen bent and had been kicked out. Upon these findings immediate interventions placed with placing a sign on the closed memory unit and placing an alarm on the closed doors that will sound anytime the doors are opened. Upon further investigation and interview with (R162) it is noted that (R162) was complaining of bilateral knee pain. Call placed to NP (Nurse Practitioner) (V5) with new orders for bilateral knee X-ray and UA (urinalysis) with culture if indicated. All labs and Xray results with negative findings. Staff continues to monitor resident for any changes in mood, status, or behavior. No changes noted. MD and family member updated on findings of investigation. Care plan updated. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 8/15/24 at 1:00 PM, V10 (Certified Nursing Assistant/CNA) stated she was working when R162 eloped. V10 stated R162 had called the police earlier that day. V10 stated she was working in the dining room, and everyone had been fed. V10 stated R162's family member came into the facility around 12:45 or 1:00 PM looking for R162 and they couldn't find her. V10 stated they searched each room and down the unit R162 lived on. V10 stated she didn't see R162 had opened a window. V10 stated V38 (MDS Coordinator) said the local police had pinged R162's phone and got her location. V10 stated they went to get her, and she was inside a place of business drinking water. V10 stated R162 was disoriented and confused. V10 stated she offered R162 a cigarette and told her they would call her family. V10 stated prior to his incident, R162 had never succeeded in eloping. V10 stated the window R162 went out was on the closed memory unit, and all the staff but one person was in the dining room, and that one person was passing meal trays. On 8/15/24 at 2:32 PM, V36 (CNA) stated she noticed right after lunch R162 was gone. V36 stated they looked through the whole building and outside, and there was a window on the closed memory unit that was open, and the screen was bent. V36 stated they assumed R162 went out the window because she was wearing a (electronic monitoring device) and no alarm went off. V36 stated they looked for approximately 20 minutes and was not able to locate R162. V36 stated R162 had been calling 911 all day that day. V36 stated V38 (MDS Coordinator) told her and V10 that R162 was on a nearby road. V36 stated then they got a call R162 was at a local business. V36 stated once they got to R162, she told them she went out a window. V36 stated R162 was very emotional, not angry or combative, just really sad. V36 stated they did a skin check when they got back to the facility. V36 stated she wasn't aware of R162 exiting the facility prior to this incident. V36 stated R162 had a (electronic monitoring device) on, and the light was blinking indicating that it was working. On 8/15/24 at 2:56 PM, V21 (Licensed Practical Nurse/LPN) stated she was working on the day R162 eloped, but she had no information related to it. V21 stated she knows nothing. On 08/15/24 at 4:05 PM, V3 (Infection Preventionist/Licensed Practical Nurse/LPN) stated she was working in the conference room, and sometime around 2:00 PM, she heard a page overhead that they needed a facility head count. V3 stated unknown staff told her R162 was missing. V3 stated they completed the head count and did not locate R162. V3 stated they had people searching outside the building and down the road. V3 stated they found an open window on the closed memory unit, with the screen bent, where it had been kicked out. V3 stated she thought V38 got a phone call stating they had R162 at a local business. V3 stated staff offered to go pick R162 up and bring her back to the facility. V3 stated R162 is a newer admission, they did an elopement risk assessment on her, and she was assessed as being at risk for elopement. V3 stated she wasn't aware of that risk prior to admission she thought she just had behavior/psychiatric issues. V3 stated when R162 got back to the facility they did an assessment, checked her vital signs, and called their corporate team, who had them place her on one to one observation. V3 stated she took R162's statement, and she was confused and didn't remember leaving. V3 stated she spoke with her later on and she said her knee was hurting. V3 stated when she asked her what she did to her knee, R162 stated it was probably when she kicked that thing out so she could escape. V3 stated they also placed an alarm on the closed memory units door so they would know if anyone entered the unit. When asked if she knew how long R162 had been gone, V3 stated she had been seen 30 minutes prior to them realizing she was missing. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 08/15/24 at 4:41 PM, V37 (CNA) stated around 11:30 AM, right before lunch, R162 came out of the activity room and handed her phone to her. V37 stated it was the local police, and R162 had called them and asked for help. V37 stated she explained to the police R162 was a confused resident. V37 stated R162 was sitting in the activities room. V37 stated she left and went to the dining room. V37 stated about 20 or 30 minutes later, after lunch the announcement went out for a head count. V37 stated she went out the back door with another CNA to look for R162. V37 stated she was checking windows, but didn't think to look on the closed memory unit. V37 stated her boyfriend, who also works at the facility, came to pick her up, so it was probably closer to 2:00 PM when they were looking for R162. V37 stated then the police called and said they had located R162. On 8/16/24 at 11:51 AM, V38 (MDS Coordinator) stated she was making rounds when V37 (CNA) came up to her and said R162 hadn't been seen for 15 minutes. V38 stated she paged for a head count and directed two CNA's to go out the back door to look, and her and the Business Office Manager started out the front door. V38 stated on her way out the door, the local police called and said they had one of the residents at a local place of business. V38 stated V10 and V36 (CNA's) went to pick her up. V38 stated R162 was sitting on a couch with a few workers, was in no distress, and had no injuries. V38 stated R162 said she had escaped V38 stated they placed R162 on one to one when they got her back to the facility, and moved her to a different room where the window goes out to the courtyard instead of outside. V38 stated R162's (electronic monitoring device) was in place and working when they got her, but because she went out a window, it didn't alarm. V38 stated R162 was leaving in two days because family had someone in place to provide 24-hour care at home. On 8/16/24 at 2:43 PM, V39 (LPN) stated she was working on the day R162 eloped. V39 stated R162 was agitated earlier in the day. V39 stated she was in the dining room when an unknown CNA came in and said R162 had called 911, and they heard her tell them we were holding her hostage. V39 stated about 20 minutes later, R162's family member brought her clothes, and they weren't able to find her. V39 stated she had checked R162's (electronic monitoring device) earlier in the day, and it was working and in place. V39 stated the police found her at the (place of business) a little over a mile from the facility. V39 stated R162 said she had jumped out of the window. V39 stated R162 complained of knee pain after she returned to the facility, and they x-rayed it with no findings. On 8/19/24 at 9:29 AM, V44 (Family Member) stated R162 went on a walkabout and when she got back to the facility, they placed her on one to one. V44 stated prior to admission to the facility, R162 had a history of wandering away. V44 stated when she left the facility, R162 made it to the gas station on the main corner in town. V44 stated someone from the nursing home called the police and they found her. On 8/19/24 at 12:55 PM, V1 (Administrator) stated on the day R162 eloped, she was out of state, and wasn't involved in the incident. V1 stated the facility did notify her R162 had left the facility. V1 stated she was told R162 kicked out a window and was gone 10-15 minutes. V1 stated once R162 was back in the facility, she said she hurt her leg kicking out the window. According to Google Maps, it would take the average person approximately 27 minutes to walk from the facility to the place of business she was located at. According to the website https://www.wunderground.com/history/daily/us/il/[NAME]/KMWA/date/2024-8-9., the temperature between 12:45 PM and 2:45 PM was 79 degrees Fahrenheit. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility Elopement and Search (Code Amber) Policy, dated 1/2023, documents, Policy: To establish methods for protecting residents who are at risk for elopement and for conducting an organized search for a resident who cannot be located. Policy Specifications: 1. All nursing personnel are responsible for: a. Knowing the whereabouts of residents for which they are assigned. b. Department Supervisors are responsible for conducting resident rounds. C. Staff are responsible for keeping the nurse informed of a resident's whereabouts .5. Residents who have been identified as cognitively impaired and who have been assessed as an elopement risk will be provided with an elopement prevention device (arm or ankle bracelet) or be placed in an area of the facility that has a door alarm device with audible sound, or on a secured/locked unit. 6. Bracelets will be observed for placement and checked for function daily. Facility exit door alarms are checked daily for function. All personnel are responsible for promptly reporting/replacing malfunctioning elopement prevention devices. Maintenance is responsible for fixing/replacing any exit doors that do not alarm. 7. All personnel are responsible for promptly going to the location and determining the cause of the activated audible door alarm. 8. When a resident makes repeated/continuous attempts to leave the building, the resident will be visibly observed every fifteen (15) until the behavior is resolved. In the event the resident continues to attempt to leave the building, a staff member will be assigned to provide one/one supervision and the physician notified. The resident will remain on one/one supervision until the behavior resolves or alternative interventions are initiated (i.e. elopement prevention device, secured/locked unit, or placed in an area of the facility that has a door alarm device). 9. In the event a resident cannot be located the following procedure is to be implemented: a. The charge nurse of the missing resident will announce CODE AMBER (name of the floor/unit of the missing resident) over the paging system. b. The Administrator and the Director of Nursing will immediately be notified. c. All available staff will immediately report to the nursing floor/unit of the CODE AMBER to be informed of the identity of the missing resident. The nurse should provide staff a description of what they look like, what they are wearing, etc.). d. The charge nurse will assign available staff to search each of the following areas including: i. Each floor/nursing unit/hallway. The resident rooms should be searched including the bathrooms and closets. ii. Gathering areas such as lounges, dining rooms, therapy rooms, shower rooms. iii. Offices, equipment rooms, utility rooms. Even rooms that are locked should be unlocked and searched. iv. Outside building grounds including the parking lot, storage sheds, ponds, wooded areas, patio, etc. v. Some staff members should also be immediately assigned to start searching off facility premises such as streets, surrounding areas containing woods, ponds, railroad tracks within close proximity of the facility, etc. vi. Notify the police department to assist in the search if resident is not promptly found. (Authorities should be called early enough to avoid police canines loss of tracking ability, if needed). vii. Notify additional off-duty personnel for search assistance as needed. viii. Notify the attending physician and authorized legal representative. ix. Assign one individual to gather and have available for reference: information to identify the resident, such as general description, picture, clothing being worn, etc 10. When the resident is found a licensed nurse will: a. Announce CODE AMBER ALL CLEAR over the paging system. b. Perform a clinical assessment of the resident's skin and functional status and dete[TRUNCATED]

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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 0692

Level of Harm - Actual harm

Residents Affected - Few

Provide enough food/fluids to maintain a resident's health.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 41610

Based on observation, interview, and record review, the facility failed to provide nutritional supplements, monitor weights, and implement interventions for 2 (R53 and R100) of 8 residents reviewed for nutrition in a sample of 51. This failure resulted in R53, who only weighed 76 pounds and had a recent 23% weight loss in 6 months, not receiving the ordered nutritional supplements to be able to maintain a healthy weight.

Findings include:

1. R53's Face Sheet documents R53 is a female resident with diagnoses including: unspecified dementia unspecified severity with mood disturbance, anemia, chronic embolism and thrombosis of unspecified axillary vein, essential hypertension, underweight, tremor, cognitive communication deficit, acute embolism and thrombosis of unspecified deep veins of left lower extremity, acute embolism and thrombosis of right subclavian vein, and portal vein thrombosis.

R53's Minimum Data Sheet (MDS), dated ,d+[DATE], documents no BIMS (Brief Interview for Mental Status) was conducted due to resident is rarely/never understood. R53's MDS documents R53 is dependent for eating.

R53's Order summary report documents a dietary order of regular diet with pureed texture, nectary consistency, offer fortified foods at all meals. Super cereal at breakfast, double eggs at breakfast, and offer thickened nutritional shakes TID (three times a day) use a straw with all drinks for nutrition, with an order date of 03/19/2024, and a start date of 03/19/2024, with no end date documented.

R53's care plan documents a focus area, dated 09/06/24, of: R53 has potential nutritional problem (weight loss) related to: poor intake, underweight, dementia and interventions listed as: monitor wts (weights) as ordered dated 06/30/23, monitor/document/report to MD (Medical Doctor) PRN (as needed) for s/sx (signs/symptoms) of dysphagia: pocketing, chocking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat, or appears concerned during meals dated 05/31/23, monitor/record/report to MD PRN s/sx of malnutrition: emaciation (cachexia), muscle wasting, significant weigh loss: >5% in 1 month, >7.5% in 3 months, > 10% in 6 months with a date initiated of 05/31/23, provide and serve diet as ordered. Monitor intake and record q (every) meal (03/19/24) pureed, nectar consistent fluids, fortified foods all meals, super cereal with breakfast double eggs at breakfast, ice cream @ (at) supper, use straws with all drinks dated 03/20/2024, provide and serve supplements as ordered with an initiated date of 06/05/23, and RD to evaluate and make diet change recommendations PRN, with a date initiated of 05/31/23.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	R53's progress note: dietary note, dated 07/16/24 at 10:40 AM, documents: RD (Registered Dietician) WT (weight)/wound note. (R53) has 23% weight loss for 6 months. (R53's) ht (height) is 67 inches and has a wt (weight) of 76 # (pounds) on July 2nd with a BMI (body mass index): of 12%. On June 11 (R53's) wt was 79 #, in April 82 pounds, and in January 99 #. (R53) has variable meal intakes as reported. (R53) is fed/assisted at meals. (R53) has severe dementia. She has treatments to wound on lt (left) buttock and skin tear lt sacrum. She is receiving MVI (multivitamin), Vit (vitamin) C, Zinc, (liquid protein medical food) and (arginine supplement drink) BID (twice a day) to help with healing. Continue pureed-NTL (nectar thick liquids) diet, fortified foods, SC (super cereal) at B (breakfast), double eggs at B (breakfast), thickened health shakes TID/(with) meals. Noted Res (resident) has been medically declining. Offering additional cals (calories)/pro (protein). Encourage intakes. Include extra [NAME] (margarine)/butter all meals. Monitor skin, WTs (weights) and further needs. R53's progress note: dietary note, dated 06/16/24 at 9:47 PM, documents: note text: RD WT/wound note. Res (R53) with 25% wt loss/6 months. Ht: 67 inches, June 11 wt:79# BMI: 12, March wt: 83#, Dec (December) wt: 106#. Variable meal intakes as reported. Res (R53) fed/assisted at meals. Has severe dementia. Tx: wound (lt) lat buttock/chronic ulcer and ABTX - cellulitis (Rt) elbow. receiving MVI, Vit C, Zn, (liquid protein medical food) and (arginine supplement drink) BID to help with healing. Continue pureed-NTL diet, fortified foods, SC at B, double eggs at B, thickened health shakes TID/meals. Noted Res (R53) has been medically declining. Offering additional cals/pro. Encourage intakes. Offer snacks between meals. Monitor skin, Wts, further needs. R53's progress note by V5 (Nurse Practitioner), dated 07/22/24, documents a visit date of 07/11/24, and a diagnosis of failure to thrive in adult, dated 07/22/24. On 08/12/24 at 12:16 PM, R53 did not receive a health shake with her lunch; she only had a glass with thickened water. R53 was being assisted by a staff member. On 08/13/24 at 12:14 PM, R53 did not receive a health shake with her lunch; she had one glass of an opaque thickened liquid in front of her. On 08/13/24 at 12:42 PM, V11 (Certified Nurse Aide/CNA) who was assisting R53 stated R53's drink was thickened water. On 08/14/24 at 8:04 AM, R53 did not receive a health shake with her breakfast; she had a thickened cranberry juice. She did not receive a double portion of eggs. There were no eggs observed on R53's meal tray. On 08/14/24 at 12:18 PM, R53 did not receive a health shake with her lunch. On 08/14/24 at 12:18 PM, V11, who was assisting R53, stated R53's only drink was thickened water. V11 stated, (R53) can eat good some days, and sometimes she will turn her head. On 08/15/24 at 8:01 AM, R53 did not receive a health shake with her breakfast or a double portion of eggs; she had one glass of thickened cranberry juice. On 08/15/24 at 8:07 AM, V9 (CNA) who was assisting R53, stated, (R53) had the hot cereal with the extra butter and sugar and stuff put in it, pureed sausage, and pureed pancakes, with thickened cranberry juice. (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 08/29/2024
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 0692 Level of Harm - Actual harm Residents Affected - Few	On 08/15/24 at 12:11 PM, R53 did not receive a health shake with her lunch; she had one glass of thickened cranberry juice with lunch. On 08/15/24 at 1:16 PM, V9 (CNA) who was assisting R53 stated she has not seen R53 with a health shake, that would probably be a good thing for her because she drinks better than she eats. On 08/15/24 at 4:17 PM, V12 (Dietary manager) stated, If (R53) is ordered to have a health shake, she should have received a health shake, and she should have received it three times a day if that is what is ordered for her. The kitchen puts them in a pan to give out to the residents that are supposed to receive them. (R53) should have received the double eggs with every breakfast. They put thickener on the carts for every dining room, so the CNA's can thicken the drinks that need to be thickened. The fortified foods are made with powered milk, brown sugar, white sugar, or butter. On 08/19/24 at 2:44 PM, V30 (Registered Dietitian) stated R53 is about 77 pounds; she does not know if she has been over a 100 pounds; she would have to be able to see her chart. V30 stated she has ordered the health shakes three times a day for her to hope to maintain her weight; she does not know if she would gain weight. V30 stated she would expect her to be receiving all three health shakes a day and the double eggs for protein. She would expect all residents that she recommends health shakes or other supplements for to receive them. At this facility, the fortified foods are considered whole milk. On 08/20/24 at 3:35 PM, V5 (Nurse Practitioner) stated, (R53) should receive the supplements and diet as recommended by (V30). 48356 2. R100's Face Sheet, dated 08/15/24, documents an admitted [DATE], with diagnoses of acquired absence of other toes, Enterocolitis due to clostridium difficile, type 2 diabetes mellitus, urinary tract infection, heart failure, iron deficiency anemia, gastrointestinal hemorrhage, and dysphagia. R100's Minimum Data Set (MDS), dated [DATE], documents in Section C a BIMS (Brief Interview for Mental Status) score of 15, which indicates R100 is cognitively intact. Section GG documents independent with eating and substantial/maximal assist with toileting, showers, R100's Progress note, dated 08/13/24 at 1:48PM from V30 (Registered Dietitian), documents, (R100) reported 20% WT (Weight loss)/1 mo. (Month). July 5 WT (Weight): 176# (Pounds) June WT: 221#. (R100)readmitted to facility with DX (Diagnosis) C-diff (clostridium difficile), UTI (Urinary Tract Infection), continue with previous recommendations. Monitor WT's closely. Refer prn (as needed). On 08/14/24 at 12:45 PM, R100's tray was sitting on his bedside table covered with aluminum foil along with thickened cranberry juice and thickened water; both were also covered with saran wrap. R100 was sitting in bed. R100 stated he wasn't hungry and didn't want to eat. On 08/15/24 at 10:40 AM, R100 stated he has had a significant weight loss. R100 said he doesn't like the food at the facility. R100 said they don't ever offer him an alternative, but he doesn't ask for one either. R100 said he does like the oatmeal at breakfast, but that usually is one of the main meals he eats. R100 said the food they usually serve him he doesn't eat. R100 said he believes this is why he has lost so much weight because he doesn't like a lot of the food they serve him. (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 0692 Level of Harm - Actual harm Residents Affected - Few	On 08/19/24 at 8:40 AM, R100 had his plate in front of him with oatmeal and toast. R100 said he feels like he ate better this weekend then he usually does. R100 said the food was a little better this weekend, and he did not ask for an alternative. On 08/18/24 at 8:50 AM, V40 (Speech Language Pathologist) stated she feels like R100 does good with his thickened liquids and mechanical soft diet. V40 stated R100 is not coming out of his room into the dining room to be monitored right now because he is on contact isolation related to c-diff. V40 said R100 really didn't come out much when he wasn't on contact isolation, but he did come out on occasion. V40 said R100 said he doesn't like a lot of the things they serve at the facility. On 08/18/24 at 1:00 PM, R100's room tray had sauerkraut with polish sausage and vegetables, and one glass of cranberry juice thickened to honey constituency. R100 consumed his glass of cranberry juice and maybe 25% of his meal. R100 stated he fed himself a little bit, but didn't eat much. On 08/18/24 at 3:00 PM, V30 (Registered Dietitian) stated R100 could not have super cereal related to him being a diabetic. V30 said she knows R100 is on a supplement for wound healing. V30 stated she is not done reviewing charts for weight changes yet this month. V30 said next week she will look at R100's weight changes. V30 said she does remember charting on R100 on 08/13/24, and she said she knows R100 did have c-diff from his recent hospital stay. V30 said she didn't realize R100's weight loss was the month prior to him having c-diff. V30 said next week, she will look at adding double eggs and whole milk to R100's diet. V30 was not aware =R100 had the 20% weight loss from June to July until R100 notified her of the weight loss. V30 said nobody notified her of significant weight changes all the time. V30 said its hit and miss; usually when they do notify her, it's about a resident on a tube feeding or resident on dialysis. V30 said no one notified her of R100 having any weight loss. V30 said if they would have notified her sooner, it would of had an impact on the weight loss. V30 would have been able to start interventions earlier. V30 said with that much of a weight loss, he should have been added to daily weights, not monthly. V30 said she does have focus groups she works on; she runs a report when she comes in to see what all residents have had weight losses. V30 said when she notices a significant weight change, she sends a note to the Director of Nursing with recommendations she would recommend to help with the weight loss. V30 said the 20% weight loss on R100 should have been sent to her immediately. V30 said she does know]R100 is on a supplement for his pressure ulcers. V30 said]they did add a nutritional supplement with a vitamin supplement for his wounds. V30 said]if they would have notified her sooner, she could have done more to help prevent further decline in weight and would have created a fax of recommendations to send to the medical director and director of nursing. (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 0692 Level of Harm - Actual harm Residents Affected - Few	On 08/21/24 at 12:03 PM, V12 (Dietary Manager) stated she was not aware of R100 having over a 20% weight loss in one month. V12 said she used to get a weight log monthly, or every other week, about who lost or gained weight. V12 said she hasn't got a weight log for resident who lost or gain in a long time. V12 doesn't even know who gained or lost anymore. V12 said V30 is usually pretty good about finding out who has gained or lost weight and will let her know. V12 said she thinks now maybe V30 did tell her recently about R100 saying he had a weight loss, but that she forgot about it. V12 said all residents should be offered alternatives, but that most of the time the CNA's (Certified Nurse Assistants) say no resident wants the alternative. V12 said she needs to go down and talk to R100 to see what is going on,and why he is losing weight. V12 said if she knew R100 had lost weight earlier,she might be able to prevent him from losing any more weight. V12 said she was not aware R100 had pressure ulcers or wounds,either. V12 said they should have given her a list of residents who have wounds as well, but they don't do that either. V12 said anyone with wounds need extra protein and more nutritional needs for wound healing. V12 said she thinks all the staff does not communicate as much as they used to about all areas of care. On 08/20/24 at 1:40 PM, V48 (Medical Doctor) stated he was not aware of R100 having over a 20% weight loss in one month. V48 said that R100 is in pretty bad shape. On 08/20/24 at 3:52 PM, V5 (Nurse Practitioner) said she wasn't aware of R100 having more than a 20% weight loss in one month. V5 said R100 did tell her he doesn't like the food at the facility much. V5 said she thinks this was about a week ago, so she recommended for him to have a nutritional supplement, because he needed the extra nutrients related to him having pressure ulcers and wounds. V5 said she did see him on 08/13/24. V5 said she knows his diet got changed to mechanical soft diet with honey thickened liquids. V5 stated she recommended for R100 to get the nutritional supplement three times a day. The facility policy,dated 08/2008, titled, Nutrition (Impaired)/Unplanned Weight loss - Clinical Protocol documents: 1. Monitor and document the weight and nutritional status of residents in a format which permits readily available month-to-month comparisons. Assess the individual's current nutritional status and identify individuals with anorexia, recent weight loss, and significant risk for subsequently impaired nutrition: for example, high risk residents with acute symptoms such as vomiting, diarrhea, fever, and infection, or those taking medications that may be causing or increasing the risk of anorexia or weight loss. 2. The physician will help identify conditions (cancer, renal disease, depression, dental problems, etc.) and medications that may be causing weight loss or increasing weight loss risk.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32765 Based on interview and record review, the facility failed to ensure narcotics were available and administered as ordered to prevent pain for 1(R157) of 2 residents reviewed for pain in the sample of 51. Findings Include: 1. R157's Admission Record, with a print date of 8/16/24, documents R157 was admitted to the facility on [DATE], with diagnoses that include gangrene, cellulitis, diabetes, peripheral vascular disease, atrial fibrillation, and edema. R157's Minimum Data Set (MDS), dated [DATE], documents a Brief Interview for Mental Status (BIMS) score of 14, which indicates R157 is cognitively intact. R157's current Care Plan documents the following Focus area of, Has .pain related to: Osteoarthritis, Peripheral vascular disease, Wounds. Date Initiated 7/29/24 The interventions for this Focus area initiated 7/29/24 are, Administer analgesia as per orders . Anticipate need for pain relief and respond to complaints of pain .Is able to call for assistance when in pain, reposition self, ask for medication, tell you how much pain is experienced, tell you what increases or alleviates pain Monitor/record pain characteristics and PRN (as needed): quality (e.g. sharp, burning) severity (1 to 10 scale), anatomical location, onset, duration (e.g. continuous, intermittent), aggravating factors, and relieving factors. Record pain with vitals Monitor/record/report to Nurse resident complaints of pain or requests for pain treatment Monitor/report to nurse any s/sx (signs/symptoms) of non-verbal pain: changes in breathing (noisy deep/shallow, labored, fast/slow), vocalizations (grunting, moans, yelling out, silence), mood/behavior (changes, more irritable, restless, aggressive, squirmy, constant motion), eyes (wide open/narrow slits/shut, glazed, tearing, no focus), face (sad, crying, worried, scared, clenched teeth, grimacing), or body (tense, rigid, rocking, curled up, thrashing) Notify physician if interventions are unsuccessful or if current complaint is a significant change from residents past experience of pain . R157's progress notes document the following: *7/26/24 at 8:52 PM, Note Text: Resident arrived via EMS (Emergency Medical Services) on stretcher. Placed into room . He immediately started refusing care. He did allow for us to obtain his vitals and weight. When it was time to reposition and examine wounds and skin, he screamed and said stop and leave me the hell alone. He was left alone and reapproached and continued to refuse any type of care. He believes being a DNR (Do Not Resuscitate) means that we will leave him lay and not preform (sic) care. When I educated him on the DNR, that either way he choose (sic), care still needed done, that he was here for us to help him and leaving him lay on wet, urine soaked linen was not caring for him. He continued to refuse. PCP (Primary Care Physician) will be notified by this nurse tomorrow morning. (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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*7/27/24 at 12:13 AM, Note Text: Resident has multiple wounds hospital reported over 30 wounds, He currently has wound vacs (vacuums) to both feet that are not hooked up and refuses for them to be changed and hooked up. PICC (peripherally inserted central catheter) line to left upper arm that was changed on 7-23-24. *7/27/24 at 3:58 PM, Late Entry: Note Text: resident refused all care from staff this shift except for medicine. Would not allow cna's (Certified Nursing Assistants) to turn, check, change, or reposition him. refused wound care. stated 'i hurt too much and i do not want to be touch (sic).' this nurse spoke to son on residents phone at time of wound care refusal and notified him of above. sons response was okay. (V5-Nurse Practitioner/NP) notified and gave order to start norco (sic) 5/325 mg (milligrams) one po (by mouth) q6h (every 6 hours) prn (as needed). *7/27/24 at 9:24 PM, Note Text: resident states he is in severe pain and refuses tx (treatment) or to move. Resident refuses and verbalizes understanding of potential harmful outcomes up to and including death. *7/27/24 at 11:05 PM, Note Text: refuses for wound vac to be placed. *7/27/24 at 11:10 PM, Note Text: Resident has stated he is refusing care r/t (related to) being in pain, (V5/NP) notified and gave new orders for Norco 5-325 Q6 hr. resident stated that won't do anything, why did you even try to help. R157's Order Review Report, with a print date of 8/28/24, documents a physician order for Norco 5-325 milligrams one by mouth every six hours as needed for pain, with a start date of 07/27/24. R157's Medication Administration Record (MAR), dated 7/1/24 to 7/31/24, documents a physician order for Norco 5-325 milligrams, one tablet by mouth every 6 hours as needed for pain. This same MAR documents a dose of Norco was administered on 7/28/24 at 9:46 AM. There is no documentation on this MAR of Norco being administered prior to this dose. R157's Controlled Drug Receipt/Record/Disposition Form, dated 7/28/24, documents on 7/28/24 at 8:30 AM, R157 was administered 1 Norco 5/325 mg. On 08/12/24 at 11:50 AM, R157 stated his pain medications are given too early and when they do the treatments, he has pain. R157 was discharged prior to this surveyor noting there was a delay in starting his pain medication, so R157 was not able to be interviewed related to the delay. On 8/20/24 at 3:30 PM, V21 (Licensed Practical Nurse/LPN) stated R157 would refuse care because he would say it would hurt, but then he would refuse his pain medication because he would say if you just don't move me it won't hurt. V21 stated he did like to have lotion on his legs and his back rubbed, and she would do those things. When asked why there was an order for Norco on 7/27/24 at 3:58 PM and the first dose wasn't administered until 7/28/24 at 8:30 AM, V21 stated she wasn't sure why there was a delay in starting the pain medication. On 08/21/24 at 9:39 AM, V41 (LPN) stated she gave R157 the Norco on 7/28/24 at 8:30 AM. V41 stated she probably administered it during medication pass after asking R157 if he was in pain. When asked if she knew why R157 didn't get the pain medications sooner, V41 stated they could have filled it from the emergency kit if the pharmacy hadn't delivered them. (continued on next page)

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	146036	A. Building B. Wing	08/29/2024

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

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/12/24 at 1:12 PM, R157's MAR, narcotics sign out log, and progress notes were reviewed with V1 (Administrator) and asked why there was a delay in administering R157's Norco after they received the order for it. V1 stated it may not have been delivered from the pharmacy, and if it wasn't, the staff may have pulled it from the emergency kit to administer. V1 stated if they did pull it from the emergency kit, it may not have been documented on the MAR, and wouldn't have been documented on the narcotics sign out log. V1 contacted the pharmacy to determine if any narcotics had been pulled from the emergency kit for R157, and stated the pharmacist was not able to find that any narcotics had been administered to R157 from the emergency kit. V1 stated she was going to interview the nursing staff to determine why there was a delay in starting R157's pain medication. The facility undated Pain Management Program policy documents in part, Purpose: to establish a program that can effectively manage pain in order to remove adverse physiologic and physiologic effects of unrelieved pain and to develop an optimal pain management plan to enhance healing and promote physiological and psychological wellness. Policy: It is the policy of the facility to facilitate resident independence, promote resident comfort, preserve, and enhance resident dignity and facilitate life involvement. The purpose of this policy is to accomplish the goals through an effective pain management program 12. The resident's physician will be notified of the resident's complaints of pain which are not relieved by comfort measure, including pain medication. 13. Pain control will be assessed during routine medication passes .

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48356 Based on observation, interview, and record review, the facility failed to ensure staffing in adequate numbers to meet the needs of the residents. This failure has the potential to affect all 99 residents who currently reside at the facility. Findings Include: The facility untitled resident roster, dated 8/11/24, documents 99 residents currently reside at the facility. 1.R21's Face sheet, dated 08/22/24, documents an admitted [DATE] with diagnoses of unspecified dementia, type 2 diabetes mellitus, hypothyroidism, depression, anxiety, history of falling, weakness, muscle wasting, and atrophy. R21's Minimum Data Set (MDS), dated [DATE], documents in Section C a Brief Interview for Mental Status (BIMS) score of 10, which indicated moderately impaired cognition. Section GG documents partial/moderate assistance with toileting and transfers. R21's Care Plan, dated 06/06/24, with a Focus area of, (R21) requires assist with ADL's (Activities of Daily Living) r/t (related to) activity intolerance, dementia, impaired balance, pain, psychotropic med use. Interventions for this focus area included provide ample time and toileting requires one assist. On 08/13/24 at 1:12 PM, R21 stated the facility does not have enough staff. R21 said she has to wait long periods of time just to get assistance to go to the bathroom. R21 said by the time staff finally gets to her, she has already had an accident, and she has had to sit wet for a long period of time. R21 said they never answer the call lights in a timely manner and the weekends are even worse. R21 said, It is embarrassing to wet yourself and not be able to do anything about it. On 08/19/24 01:24 PM, V63 (Registered Nurse/RN) stated the facility is always short of staff; that is nothing new. V63 stated they absolutely do not have enough staff to adequately care for all the residents at the facility. V63 said the facility does have a big staffing shortage problem. 2. R259's Face sheet documents an admitted [DATE], with diagnoses of unspecified dementia, severe with agitation, altered mental status, anxiety disorder, unspecified osteoarthritis, benign prostatic hyperplasia with lower urinary tract symptoms, insomnia, acute cystitis with hematuria, and atherosclerotic heart disease of native coronary artery without angina pectoris. R259's MDS, dated [DATE], documented a BIMS score of 00, which indicates severely impaired cognition. This MDS also documented R259 was dependent with eating, oral hygiene, toileting, and dependent with transfers. Under Fall History, R259's MDS documented on Admission/Entry or Reentry: R259 has had a fall within the last month. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R259's Fall Risk Evaluation, dated 08/11/24, documents a score of 15, which indicated R259 was at risk for falls. R259's untitled Fall reports document falls on 08/11/24 and 8/16/24; no injuries noted. R259's Care plan, dated 07/31/24, documents a focus area of, (R259) is at risk for falls related to: confusion, deconditioning, incontinence, psychotropic drug use, unaware of safety needs, dementia with agitation. Interventions for this focus area include: 07/31/24 be sure call light is within reach and encourage to use it for assistance as needed. Needs prompt response to all requests for assistance, 07/31/24 ensure wearing appropriate footwear when transferring or mobilizing in w/c (wheelchair), 07/31/24 keep furniture in locked position, 07/31/24 keep needed items, water, etc, in reach, 07/31/24 maintain a clear pathway in room, free of obstacles, 07/31/24 monitor position in wheelchair to prevent sliding, 08/01/24 transfer require max assist of two. There were no further fall prevention interventions added after 08/01/24. On 08/19/24 at 1:38 PM, V38 (New MDS/Care Plan Nurse) stated she doesn't see any new fall prevention interventions put in place for R259 after his recent falls on 08/11/24 and 08/16/24. V38 said that has been one of the problems at the facility lately; there hasn't been new interventions put in place for anything. V38 said she was getting ready to take over the Minimum Data Set (MDS) position. V38 said no one at the facility gets trained correctly on their positions and this is a problem because no one knows what they are supposed to be doing. On 08/19/24 at 2:05 PM, V50 (MDS/Care Plan Nurse) stated there have been no new fall prevention interventions put in place for at least 2-3 weeks. V50 said they usually have a fall meeting to talk about causative factors and put new interventions in to place on all falls, but they have been busy with surveys, and over half of the IDT (Interdisciplinary team) have been working on the floor or just not showing up to work. V50 said the floor nurses don't usually put any fall interventions in to place. V50 said she doesn't feel like they have enough staff right now to be able to care for the residents properly. V50 said she was usually notified of any new falls, wounds, elopements, and any abuse. V50 said since they have been short of staff, she thinks it has caused a negative impact on residents with them having increased behaviors. The Facility Policy titled Falls- Clinical Protocol documents under Treatment/Management 1. Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling. If underlying causes cannot be readily identified or corrected, staff will try various relevant interventions, based on assessment of the nature of category of falling, until falling reduces or stops or until a reason is identified for its continuation. (for example, if the individual continues to try to get up and walk without waiting for assistance). 49907 3. R68's Face Sheet documents R68 was admitted to the facility on [DATE], with diagnoses that include: unilateral primary osteoarthritis, left knee, pain in right knee, unspecified injury of right lower leg, sequela, polyneuropathy, Morbid (severe) obesity due to excess calories, unspecified abnormalities of gait and mobility. (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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R68's MDS, dated [DATE], documents a BIMS score of 15, indicating R68 is cognitively intact. Section GG-Functional Abilities and Goals documents R68 is dependent on staff for toileting hygiene, showering and bathing. R68 is listed as partial/moderate assist for personal hygiene. R68's current Care Plan documents a focus area of: R68 has skin impairment with risk for pressure injury development related to: Immobility. R68's interventions include: Needs assistance to turn/reposition approximately every 2 hours, more often as needed or requested. R68's Care Plan also has a focus area of Assist with ADL's (Activities of Daily Living) related to Activity Intolerance, Pain Impaired Mobility with an intervention of Bathing requires max (maximum) assist (assistance). Prefers day shift showers. R68's shower sheets document she is to receive showers on Mondays and Thursdays. R68's shower sheets document she received a shower on 07/18/24, a bed bath on 07/22/24, a shower on 07/25/24, a bed bath on 08/01/24 and shower 08/12/24. R68's shower sheet documents no showers were given on 7/29/24, 8/5/24 and 8/8/24, and no refusals were documented on these dates. On 08/12/2024 at 10:07 AM, R68 who is alert to person, place, and time, stated she has a few concerns. R68 stated there should be a CNA (Certified Nursing Assistant) on each hall on her wing, and one in between both halls. R68 stated at times there is one person covering both halls, and with the halls combined, it is approximately 45 residents to one CNA. R68 stated there are times she will wait one to two hours after hitting her call light to get changed. R68 stated sometimes they tell her there are this many people in front of her, or offer some kind of explanation, and sometimes they do not even acknowledge her. R68 stated not long ago, she did not shower for two weeks because they tell her they do not have the staff to help them get her up, because she uses a mechanical lift that requires two people to transfer her. R68 stated they will give her a bed bath, but that's just not the same as getting a shower and said she felt very unclean. R68 stated she has had sores on her bottom before from not being changed, and it took her over a year to be seen by the wound doctor, and she stated she felt like it took forever for them to heal. R68 stated she understands that second shift staffing is terrible and that sometimes things happen, and she stated she knows she isn't the only person here, but she feels like she is always waiting for hours. 4.R2's Face Sheet documents an admitted [DATE], which includes the following diagnoses: sepsis, unspecified intracranial injury with loss of consciousness, unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, muscle weakness, and abnormal posture. R2's MDS, dated [DATE], documents a BIMS was not completed. Section GG-Functional Abilities and Goals documents that R2 is dependent for oral hygiene, toileting hygiene, showering, bathing, dressing, and personal hygiene. R2's current Care Plan documents the following focus area; R2 has an Activities of Daily Living (ADL) self-care deficiency related to: R2 has a long history of traumatic brain injury (TBI). R2 has contractures of bilateral lower extremities. Dependent for Bathing requires assist of (2), Dressing, for Grooming and hygiene, and Toileting. Provide oral hygiene every AM, PM and PRN. Provide oral hygiene every shift. On 08/14/2024 at 08:48 AM, R2 appeared to have not received oral care recently. His teeth were covered in debris; he had a thick yellow film on his tongue, and his lips were flaky. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 08/15/2024 at 09:51 AM, R2's teeth were again covered in debris, with thick yellow film on his tongue, and his lips were flaky. On 08/15/2024 at 11:12 AM, it appeared oral care had been performed on R2. On 08/15/2024 at 11:15 PM, V26 (CNA) stated she provided oral care to R2 after breakfast, and she always tries to ensure those things get done. V26 stated she knows sometimes they are short staffed, and it may not get done timely by other staff. On 08/13/2024 at 3:35 PM, V37 (CNA) stated there is just not enough of us to go around to meet everyone's needs or to take the time we should to do the little things these residents need and deserve. On 08/15/24 at 2:32 PM, V36 (CNA) stated they don't have enough staff to meet the needs of the residents. V36 stated two aides to take care of 30 residents with behaviors isn't enough. V36 stated they can't give oral care, weights, vitals, showers aren't done timely, turning and positioning, and incontinence care can't be provided timely with the staffing they have. 32765 4. On 08/19/24 at 1:45 PM, V38 (MDS Coordinator) stated she was working as Social Services, Activities, and Business Office Manager from November 2023 until May 8th 2024. V38 stated in May 2024, she added Marketing and Admissions to the positions she was working. V38 stated from May 2024 to the end of July 2024, she was the facilities Social Services Director, Business Office Manager, Marketing, and Admissions, and helped in Activities. V38 stated the facility started cutting hours in November 2023. V38 stated they started with floor staff, Dietary, Housekeeping, and then management. V38 stated they had two CNA's working on Dream and Sleepy, and that isn't enough to meet the needs of the residents. The facility daily schedules reviewed and document on 7/8/24 -2-10 PM, 7/14/24 - 6 AM-2 PM, 7/19/24 - 2 PM to 10 PM, and 8/10/24 - 2 PM to 10 PM only two CNA's were working on Dream and Sleepy units. On 8/29/24 at 8:58 AM, V1 (Administrator) stated they have enough staff, but if there are call ins, then they have to pull administrative staff to cover the shift. V1 stated they now have agency they can use, and the regional corporate team will also help out. V1 stated, But if there is a call in, it is usually too late to cover the shift using agency, and the administrative staff will cover the shift, and then they are pulled from their duties.' This surveyor reviewed with V1 the schedules that documented one CNA each on Dream and Sleepy, and V1 stated they have more than one most of the time.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32765 Based on observation, interview, and record review, the facility failed to develop/revise and implement interventions to ensure preventative measures were consistently implemented for pica (ingesting non-food items) behavior for 1 (R45) of 1 resident reviewed for behavioral health services in the sample of 51. Findings Include: R45's Admission Record, with a print date of 8/20/24, documents R45 was admitted to the facility on [DATE], with diagnoses that include diabetes, dysphagia, osteoarthritis, brief psychotic disorder, delusional disorder, mild cognitive impairment, and depression. R45's MDS (Minimum Data Set), dated 8/20/24, documents R45 has a Brief Interview for Mental Status (BIMS) score of 10, which indicates a moderate cognitive impairment. R45's current Care plan documents a Focus area of, Resident has been caught eating cigarette butts, eating pages out of her bible, & and eating dirt. Resident may display episodes of eating other non-food items. The Focus area documents 10/19/2020 [NAME] DX (diagnosis).10/2/2023 tears pages from books in library in order to chew on them. Resident has a behavior of going into people's rooms and taking their snacks or other items. When asked she has the behavior of denying and hiding what she has taken, Date Initiated: 10/16/2020. This Focus area documents the following interventions, Allow her to keep a few snacks in her room. Date Initiated: 10/20/2023.Allow resident to sit at nurse's station for monitoring (ensure resident is wearing mask) Date Initiated: 02/18/2021. Anticipate and meet needs. Date Initiated: 10/16/2020. Encourage participation in activities of interest Date Initiated: 02/18/2021. If reasonable, discuss behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable. Date Initiated: 10/16/2020.Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes. Date Initiated: 10/16/2020 .Offer a piece of candy, Date Initiated: 02/18/2021 .Offer a piece of gum Date Initiated: 02/18/2021.Offer a snack Date Initiated: 02/18/2021.Praise any indication of progress/improvement in behavior. Date Initiated: 10/16/2020. Snack box to be at nurses station to include various snacks that resident can choose from between smoke breaks and meals, Date Initiated: 02/18/2021. R45's Documentation Survey Report, dated July 2024, under Intervention/Task- putting non-food items in mouth documents R45 attempted to ingest non-food items on 7/3-7/7, 7/9, 7/10, 7/17-7/21, 7/25, and 7/31/24 (6 AM to 2 PM); 7/1, 7/3, 7/5, 7/7-7/9, 7/14, 7/17-7/21, 7/26, and 7/27/24 (2 PM to 10 PM); 7/2 and 7/18/24 (10 PM to 6 AM). R45 did not attempt to ingest non-food items on 7/1, 7/2, 7/8, 7/13, 7/15, 7/16, 7/22, and 7/26-7/29/24 (6 AM to 2 PM); 7/4, 7/6, 7/12, 7/16, 7/23, and 7/30/24 (2 PM to 10 PM); 7/1, 7/3, 7/4, 7/6- 7/9, 7/13-7/15, 7/17, 7/20, 7/22, 7/24-7/27, and 7/29-7/31/24 (10 PM to 6 AM). R45 was unavailable 7/10/24- 2 PM to 10 PM, 7/11/24- all three shifts, 7/12/24- 6 AM to 2 PM and 10 PM to 6 AM. There is no documentation for the other days and shifts. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R45's Documentation Survey Report, dated Aug-24, under Intervention/Task- putting non-food items in mouth documents, R45 attempted to ingest non-food items on 8/1-8/7, 8/9, 8/14-8/16, and 8/22 (6 AM to 2 PM), 8/1, 8/4, 8/5, 8/7-8/12, 8/14-8/16, 8/21-8/23 (2 PM to 10 PM), and 8/1, 8/4, 8/8, and 8/10/24 (10 PM to 6 AM). R45 did not attempt to ingest non-food items on 8/3 24 (2 PM to 10 PM), and 8/3, 8/5, 8/6, 8/11-8/14, 8/16, 8/17, 8/21-8/23, and 8/25/24 (10 PM to 6 AM). R45 was unavailable 8/17/24- 2 PM to 10 PM and 10 PM to 6 AM, 8/18/24 - 6 AM to 2 PM and 2 PM to 10 AM, 8/19/24- all three shifts, 8/20/24- 6 AM to 2 PM, 8/21/24- 6 AM to 2 PM and 10 PM to 6 AM, and 8/25/24- 6 AM to 2 PM. There is no documentation for the other days and shifts. R45's POC (point of care) Response History, with a print date of 8/26/24, documents the following narratives related to R45's behavior tracking; 8/1/24 11:47 PM, resident is constantly taking things off carts to eat, also taking cups to eat. 8/4/24 8:26 PM, plastic paper 8/4/24 11:22 PM, paper and plastic and 8/5/24 8:51 PM, chewing on paper and gloves- redirected but unable to stop behavior. R45's Progress Note, dated 7/25/24 at 9:08 AM, documents, Note Text: Res (resident) was observed by (V8), CNA (Certified Nursing Assistant) chewing on mircro (sic) kill bleach wipes. (V8) took the wipes away from res and instantly reported the incident to this nurse (V6-Licensed Practical Nurse/LPN) and (V1), Administrator. This nurse called poison control to inform them of the incident and to see what further action should be taken. Per poison control: make sure the res drinks some fluids and eats a snack. Monitor res for dermological (sic) s/s (signs/symptoms) to her hands and face such as a small rash, burning, itching, irritation. Keep res at your facility at this time. No need to send her to the hospital. Call us back in 1 hour to give us an update on how res is doing. (V8), CNA washed res hands and face. Res is currently drinking a soda and eating a snack. No s/s of skin irritation, upset stomach, or nausea. (V5), NP (Nurse Practitioner) notified. Res daughter notified. Will continue to monitor res. R45's Progress Note, dated 7/25/24 at 10:30 AM, documents, Note Text: This nurse spoke c (with) poison control again to update them on res status. Res is showing no s/s of upset stomach, skin irritation, or feeling sick in any way. Res is at her normal baseline. Poison control said thank you for the update and that res should be completely fine then. R45's Progress Notes, dated 8/17/24 at 12:52 PM, documents R45 was transferred to the local hospital for evaluation after a syncopal episode and with abnormal vital signs. R45 was admitted to the hospital for evaluation. R45's Progress Notes document on 8/21/24 at 1:24 PM, RN (Registered Nurse) at (name of local hospital) called to give report. Report as follows: Pt (patient) was admitted to us c (with) syncope. Head CT (computerized tomography) negative. She has had a few hypoglycemic episodes since being here, so we changed her insulin orders. She had a mild UTI (urinary tract infection) that we treated c (with) Rocephin. She will not be coming back on an ATB (antibiotic). Her B/P (blood pressure) has slightly been elevated. Her last BM (bowel movement) was today. Staff observed what looked to be a plastic bag slightly protruding out of her anus. General surgery was consulted but pt was able to pass it c (with) the help of laxative. It ended up being a (name brand) bag. No new med orders except to stop Glipizide. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R45's local hospital records, dated 8/17/24, documents R45 was evaluated at the local emergency room after a syncopal episode at the facility. The hospital records document R45 was admitted for evaluation and treatment for diagnosis of urinary tract infection. R45's hospital records documents on 8/18/24 under Hospitalist Cross Cover Note, Alerted by RN (Registered Nurse) to patient voicing need for bowel movement with PCT (patient care technician) observed suspected rectal FB (foreign body) that looks like a plastic bag Pt (patient) seen and assessed .remains confused. Unreliable historian. On external exam, stool noted however no visible FB. No abdominal tenderness. No bleeding . Response: KUB (kidney, ureter, bladder x-ray), trial lactulose, RN to monitor for bowel movement, Will consult surgery in AM, if FB observed by nursing staff does not pass with BM (bowel movement) may need surgical evaluation. R45's hospital records document under Acute Care Surgery Progress Note, dated 8/20/24, (R45) admitted after a syncopal episode. General surgery was consulted due to concern for rectal foreign body. Overnight RN reported patient voiced need to have a BM and observed what appeared to look like a plastic bag protruding from her rectum at times. Patient is a poor historian due to underlying dementia. RN at bedside reports patient has attempted to eat telemetry leads and IV (intravenous) tubing during admission .Interval HPI (history of present illness) Pt (patient) up in chair. Had bowel movement overnight which resulted in passing plastic foreign body, appeared similar to a (name brand) sandwich bag. Per PCT, pt seems hungry, asking about meals. VSS (vital signs stable) no acute events reported overnight Assessment/Plan Surgery service consulted for rectal FB. Pt passed foreign with stool overnight .Will obtain repeat imaging as pt ahs (sic) hx (history) of PICA, unable to give history No acute surgical intervention Rectal FB- passed plastic (name brand) baggie. No FB palpable on rectal exam Bowel regimen, Resume regular diet, Con't (continue) sitter and environment modifications to reduce ingestion of FB . R45's Progress Notes, dated 8/21/24 at 2:22 PM, documents R45 arrived back to the facility on [DATE] via ambulance. On 8/22/24 at 8:39 AM, V36 (Certified Nursing Assistant/CNA) stated R45 has PICA, and eats books and tried to eat the bandage off her roommate's wounds. V36 stated R45 has tried to eat the stuffing out of her adult brief and they have to take it from her. V36 stated they try to keep an eye on R45. V36 stated R45 has started eating (white foam) cups now, so they don't give them to her anymore. On 8/22/24 at 12:44 PM, this surveyor walked to R45's room, R45 was not in the room. Located in R45's hall, this surveyor observed a cart with linens, a (white foam) cup with straw, and gloves on top of the cart. Next to the open cart was a three-drawer stand. V62 (Activities Director) opened the drawers for this surveyor and noted activities of daily living supplies including toilet paper, rubber bands, razors, denture cleaner, room deodorizer, depends, and other care supplies. The nurses station desk located on R45's hall had several boxes of gloves on the counter. On 8/22/24 at 1:24 PM, V61 (CNA) stated R45 eats all types of paper, toilet paper, paper towels, and plastic. V61 stated R45's daughter brings in snacks in (name brand) bags and she has attempted to eat the bag, gloves, and adult diapers. When asked what they do to prevent R45 eating non-food items, V61 stated they take everything from her pockets, and ask her to remove items from her mouth. V61 stated she wasn't sure when R45's daughter had last visited, since she had recently had surgery and wasn't able to come to the facility. V61 stated every time R45 goes back to her room, they have to empty her pockets. V61 stated R45 is constantly chewing on stuff. On 8/22/24 at 1:24 PM, this surveyor walked with V61 to R45's room, and looked through the drawers on her bedside table and they were empty. V61 stated she heard R45 had a bleach wipe, but she wasn't working and wasn't sure how R45 got it. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/22/24 at 1:30 PM, V8 (CNA) stated anytime she sees R45 with a non-food item, she takes it away. V8 stated she was supervising R45 while smoking today (8/22/24), and she attempted to eat a cigarette, but she was able to stop her. V8 stated R45 puts the cigarette out, breaks it apart, and eats the tobacco and paper that is on the outside of the tobacco. V8 stated they had to call poison control a while back (date unknown) for her eating a bleach wipe someone had left on the handrail near her room. V8 stated she hadn't seen R45 eat plastic, but she had heard about the hospital report, and when they give R45 snacks at night they are in a bag, and she would almost guarantee that is where R45 got it. On 8/22/24 at 2:45 PM, V56 (Family Member) stated the hospital called (8/21/24) and told her R45 was returning to the facility. V56 stated R45 has been eating non-food items for a while now. V56 stated R45 moved to the facility over two years ago and it started after she was admitted . When asked if she knew what the facility did to prevent R45 from ingesting non-food items, V56 stated they watch her. V56 stated they don't let her have paper, but she will sneak and get stuff. V56 stated she had to stop bringing her cookies in a bag. V56 stated she thought the last time she brought something to her, something happened because they called her and asked her not to bring things in bags. V56 was not able to remember the exact date but stated it had been a while. V56 stated R45 had never gotten choked, but the hospital told her she had eaten plastic when they called her (8/21/24). On 8/22/24 at 4:16 PM, V1 (Administrator) stated she had heard about R45 ingesting a plastic bag. V1 stated they catch R45 eating paper multiple times a day, and when they do, they offer R45 a snack or a piece of gum. V1 stated R45 is care planned for eating non-food items. V1 stated she caught her today (8/22/24) trying to rip papers out of the books in the library and asked her if she was hungry and offered her a snack. V1 stated she wasn't aware of R45 eating plastic bags before, but was aware of her having bleach wipes in her mouth. V1 stated they called poison control when they found she had them in her mouth. V1 stated bleach wipes are not supposed to be accessible to the residents. V1 stated she went around and asked everyone how they were left out and no one could tell her. V1 stated they also checked all the medication carts which is where they keep them. V1 stated she wasn't sure if she documented what she did. When asked if they did anything else, V1 stated they checked the halls to make sure there weren't any more out. V1 stated V6 (LPN) was working at the time and stated R45 hadn't ingested the bleach wipes. V1 stated she asked V6 where R45 got them, and V6 didn't know. The Summary provided to this surveyor on 8/26/24 documents on 7/25/24, R45 was chewing on micro kill bleach wipes. Under Resident Interviews the Summary documents, (R45) 7/25/24 Asked (R45) where she got the wipes from, and she stated 'Over there' and pointed down the hall toward the nurse's station. Asked (R45) why she was chewing on the wipe. She stated 'I don't know'. Asked (R45) if she swallowed what she was chewing on and she stated no. Asked (R45) if she was hungry or wanted a snack. She stated no. Asked (R45) if she wanted anything to chew on, she stated no. Under Final Summary/conclusion the Summary documents, Called Poison control and NP (Nurse Practitioner). No new orders from NP. Followed Poison control directions. (V38 - MDS Coordinator) and this writer (V1) also went down al (sic) hallways and nursing station and looked for any chemicals or bleach wipes accessible to residents. All medication carts where bleach wipes are located were locked. Clean supply room was also locked. Checked (R45) room for any bleach wipes or chemical in room. None Found. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/24/24 at 11:25 PM, V59 (CNA) stated she provided care to R45 at times. V59 stated she had caught R45 chewing on paper towels, tissue, gloves, and would ask her to spit them out. V59 stated she never saw R45 eating anything else. V59 stated she would attempt to redirect R45 if she found anything in R45's possession. V59 stated they take any excess paper towels and toilet paper out of the adjoining bathrooms. On 8/24/24 at 11:30 PM, when asked if she had ever witnessed R45 eating non-food items, V58 (LPN) stated, All the time. V58 stated they stop R45 and take things away from her. V58 stated they are vigilant about taking things away and making sure R45 doesn't ingest unsafe things. When asked what they do to prevent R45 from ingesting non-food items, V58 stated, It is less of prevent and more try to stop before it makes it to her mouth. V58 stated she wasn't aware of R45 ingesting plastic. V58 stated it is mostly paper, paper towels, and cardboard from the boxes of gloves. V58 stated snacks are served in bags and R45 prefers sandwiches and graham crackers. V58 stated a couple of times, R45's family has brought in something in cardboard containers, but she had never seen R45 with a (name brand) bag. The bags the facility snacks are served in are the kind that fold over, not zip. V58 stated when she gives R45 snacks, she makes sure she takes them out of the wrapping first. On 8/24/24 at 11:37 PM, V60 (CNA) stated she had witnessed R45 eat non-food items. V60 stated it was usually paper towels, stuff off their carts, boxes of gloves, (white foam) cups, trash bags, and trash. When asked what they did to prevent R45 from ingesting non-food items, V60 stated they try to keep paper towels and the trash can out of the bathroom. V60 stated it is a constant battle with R45. V60 stated R45 tries to ingest items off their carts, and they try to get to her as quickly as possible. V60 stated R45 is quick, and she does it all night. V60 stated they have to keep the snacks in the med room because R45 will grab them. V60 stated they have sandwiches, vanilla wafers, and graham crackers. V60 stated it is all prepackaged, other than the sandwiches and vanilla wafers. V60 stated she hadn't seen R45 attempt to ingest plastic but said, I wouldn't put it past her. V60 stated she had never seen R45 eat plastic bags, but she had seen her eat gloves. On 8/26/24 at 9:33 AM, V6 (LPN) stated she didn't think R45 ingesting non-food items was being behavior tracked. V6 stated they have on the medication administration to offer her snacks at certain times. V6 stated they offer R45 food, drinks, and activities if they see her attempting to ingest non-food items. When asked what they do to prevent R45 from ingesting non-food items, V6 stated they have taken the trash can out of her bathroom and there are no paper towels in her bathroom. V6 stated there really is no preventing it. V6 stated R45 will go to the library and rip pages out of books. V6 stated they also follow her down the hall when they see her walking, which is another prevention they implement. V6 stated she was working when R45 got the bleach wipe. V6 stated (V8/CNA) reported R45 was chewing on it. V6 stated she called poison control and then talked with them again about an hour later. V6 stated she didn't know where R45 got the wipe. V6 stated R45 had no negative outcomes. V6 stated the snacks are served from the kitchen and depending on what the snack is, it may be served on a plate or in a bag. V6 stated she takes R45's snacks out of the bags if it is served in one. (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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/26/24 at 4:18 PM, when asked what the facility does to prevent R45 from ingesting non-food items, V2 (Assistant Director of Nursing/ADON) stated he knows they watch her when she goes to the library because she rips the papers out of the books and puts them in her pockets. V2 stated he watched R45 on Friday (8/23/24) put the napkin off her silverware in her pocket. V2 stated R45 will eat the paper off the nurse's station desk. V2 stated before R45 pilfers something off the linen cart she will look around to see if anyone is watching. V2 stated R45 will eat wipes and tell the staff she doesn't have anything in her mouth when they can clearly see it. When asked what they do to prevent her from ingesting non-food items, V2 stated he would check her medical record. V2 stated he would check her chart because he didn't know what they had in place at the moment. V2 stated, I honestly think she needs 1:1 care because she is going to end up eating something and hurting herself. I feel like it is only a matter of time. V2 stated R45 always wants to be in her room or out smoking. V2 stated if R45 isn't being monitored in her room, she would eat the wrapper if they gave her a snack to eat in her room. This surveyor reviewed R45's hospital notes with V2 related to R45 passing a (name brand) bag in her stool. V2 stated they leave snacks out at night, and it is possible R45 grabbed a snack and went to her room, and she could have eaten the bag the snack was wrapped in. V2 stated he didn't know how long it would take a bag to pass through the gastrointestinal system. This surveyor reviewed with V2 the items observed on R45's hall, and asked if there was any intervention related to ensuring items R45 had attempted to ingest were not readily available to her, and V2 stated he didn't know. V2 stated when staff are complaining about R45 he tells them to bring the linen cart to the other hall. V2 did not know where R45 got the bleach wipes she attempted to ingest. V2 stated maybe behind the nurse's station, because he knows she goes back there looking for items. When asked what his expectation would be for R45's care, V2 stated, I have asked to have a 1:1 for her. It was my concern on Friday or the day she got back. Because I literally watched her like five times having stuff in her pockets and trying to eat stuff in her room. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/26/24 at 4:33 PM, V1 (Administrator) stated R45 was diagnosed with [NAME] (ingesting non-food items) a few years ago. V1 stated she didn't remember if they did any labs when she was first diagnosed . V1 stated she recently asked for lab work, and she knows R45 had a full iron work up when she was in the hospital (8/17/24-8/21/24), and it was normal. V1 stated she reviewed the care plan with the Psychiatric Nurse Practitioner (V68), and the only thing she could think of was to do a pica basket and use it as a praise system. V1 stated they had tried the nicotine patch in the past, but then R45 started eating those. V1 stated nurses will take R45 with them when they do medication pass, because if they don't, R45 will be going into other resident rooms and going through their belongings and their garbage. V1 stated no one admitted to leaving the bleach wipes out. When asked if she had ever considered not having items R45 had ingested readily available on her hall, V1 stated she wasn't aware R45 was attempting to eat other items until recently. V1 stated she didn't know R45 was eating gloves, cups, and all that until she pulled the behavior tracking narratives for this surveyor today, 8/26/24. V1 stated they are going to do something different now. V1 stated the only thing facility staff reported R45 was attempting to ingest to her was the paper, cigarettes, and bags her daughter brought snacks in. When asked about the snacks the facility provides, V1 stated they are delivered to the nurses station. V1 stated staff told her they gave her the snacks to eat at the nurse's station. V1 stated if that is going to be an issue, then they will have to go back to locking the snacks up in the employee break room. When asked if she knew where R45 got the (name brand) bag she passed while at the hospital, V1 stated she would have to call V56 (Family Member) and see when she brought R45 something in a (name brand) bag. When asked when V56 last visited R45, V1 stated the last time she spoke with V56 on 8/16/24, V56 told her she had surgery and wouldn't be in for a while. V1 stated she believes it is a true [NAME] behavior and as far as she knows R45 has never choked on anything. V1 stated R45 used to smoke three packs of cigarettes a day, and the family asked them to reduce the amount she smoked due to the cost, and that is when R45 began eating cigarettes and paper. On 8/26/24 at 4:06 PM, V5 (Nurse Practitioner) stated she didn't know how long it would take a (name brand) bag to pass through the gastrointestinal system. V5 stated she didn't know what the cause of R45's [NAME] was, but she thought it was probably behavioral. V5 stated R45 always gets all kinds of lab work done at the facility, and there is no specific lab to do for Pica. When asked if there was any possible negative impact from attempting to ingest a bleach wipe, V5 stated she wasn't aware R45 was chewing on a bleach wipe. V5 stated unless R45 was vomiting or something, then there really isn't anything to do other than monitor her. When asked what her expectations would be to prevent R45 from ingesting non-food items, V5 stated the only thing they can do is offer R45 other things such as frequent snacks or suckers. V5 stated R45 is ambulatory, so they can't really chase her around the building. V5 stated she knew they did an iron work up at her last admission to the hospital (8/17-8/21/24) and it was normal. On 8/27/24 at 6:01 PM, V1 (Administrator) stated the facility did not have a pica policy.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49907 Based on observation, interview, and record review, the facility failed to develop/implement individualized, person-centered interventions to attain the highest practicable physical, mental, and psychosocial well-being for 5 of 7 residents (R15, R25, R49, R74, R96) reviewed for dementia care treatment and services in a sample of 51. Findings include: 1. R96's Face Sheet, dated 08/16/24, documents an admitted [DATE], with diagnoses of unspecified dementia, unspecified severity, with agitation, anxiety disorder, cognitive communication deficit, altered mental status, delirium due to known physiological condition, major depressive disorder, single episode, and insomnia. R96's Minimum Data Set/MDS, dated [DATE], documents a BIMS score of 03, which indicates R96 has severely impaired cognition. Section GG documents partial/moderate assistance with toileting, shower, and lower body dressing. R96's Care Plan, with a review date of 07/01/24, documents a Focus area of, Has impaired cognitive function/dementia of impaired thought processes related to: dementia, impaired decision making, psychotropic drug use, short term memory loss. Interventions listed for this focus area include communicate with resident/family/caregivers regarding resident's capabilities and needs as indicated, initiated on 06/21/24, communication identify yourself at each interaction. When speaking and make eye contact. Reduce any distraction-turn off tv (television), radio, close door, etc. resident understands consistent simple, directive sentences, provide R96 with the necessary cues- stop and return if agitated-date initiated 06/21/24, engage in simple, structured activities that avoid overly demanding tasks-date initiated 06/21/24, monitor/document/report to MD (Medical Doctor) any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, or mental status as indicated-date initiated 06/21/24, needs supervision/assistance with all decision making-date initiated 06/21/24, and provide a homelike environment: visible clocks, a Calender, low glare light, consistent care routine, familiar objects, and reduced sensory noise- date initiated 06/21/24. There were no person-centered interventions listed specific to R96 regarding structured activities. R96's Physician Orders document an order, dated 08/12/24, for Lorazepam 1mg by mouth three times a day related to unspecified dementia unspecified severity with agitation; an order, dated 06/13/24, for Celexa 20mg 1 tablet by mouth in the morning for depression/anxiety; an order, dated 08/08/24, for Quetiapine fumarate 50mg 1 tablet by mouth twice a day for mood take 2 tablets 100mg by mouth at bedtime for mood; an order, dated 06/12/24, of Mirtazapine 15mg 1 tablet at bedtime for depression; an order, dated 07/24/24, for Buspirone 15mg by mouth two times a day for anxiety. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/14/24 at 3:00 PM, V42 (Maintenance/Family Member) stated R96 has never had any mental health diagnosis of any kind. V42 said the only diagnosis R96 has had is dementia and some depression. V42 stated most of R96's behaviors are from her dementia. V42 said R96 started forgetting things and not acting not like herself around 4-5 years ago. V42 said R96 used to wander when she was at home. V42 said R96 would forget that she is married and they have been married for over [AGE] years. V42 said R96 was never like this until she got dementia. R96's progress notes, dated 08/16/24 authored by V1 (Administrator) at 8:09PM, documents, This writer received a call from (Name of local hospital) ER (emergency room) (Name ER Physician) stating 'Just so you know, we evaluated (R96) and we sent her right back to you because we do not feel she needs to be evaluated by a psychiatric doctor. Her behavior is just part of her dementia. So, just wanted you to know that if you send her back to be seen we will just send her right back to you.' This writer stated 'Well I was thankful that the resident attacked me and not another resident. So when we think our resident are atrisk (sic) of harm to self or others then we have to have them evaluated for their safety and the safety of others. This writer also called (Name of Geriatric Psych Nurse Practitioner) to inform her of the situation and she gave a one time order of Haldol injection if (R96) becomes aggressive and may send back out to hospital if resident remains a harm to self or others. On 08/20/24 at 3:10 PM, R96 was in her room folding clothes while V65 (Activities/Transportation Aide) was sitting outside her door in a chair. R96 said that she loves to fold clothes and that she has to clean her room up, it was a mess. On 08/20/24 at 3:15 PM, V65 was observed sitting outside of R96's door. V65 stated she was doing one on ones with R96. V65 said they have been doing one on one for over a week due to R96 having increased behaviors and elopement attempts. V65 said they make sure R96 does not try to elope outside of the facility without supervision. V65 said they do activities with R96 to try to prevent her from having behaviors or trying to elope. V65 said staff will often take R96 to the dining room and do puzzles with her. V65 said staff is very good about trying different interventions with R96 to prevent her from getting agitated, or to try & stop her from eloping. V65 said she was waiting for someone to take over watching R96. V65 said they don't have a lot of help, and they are trying to find people to do one on ones with R96. V65 said she was waiting on V21 (Licensed Practical Nurse/LPN) to take over one on one with R96. On 08/20/24 at 3:20 PM, V21 (LPN) stated they always do all kinds of things with R96. V21 said they take R96 to activities, do puzzles with her, they braid R96's hair, and let her fold her own laundry because she loves to fold. V21 said R96 will go out to the courtyard and do some gardening with her. V21 said R96 has been on one on one's for over a week. V21 said if the Certified Nurse Assistants are the ones doing one on ones, they do routine care with R96 and make sure all her ADL (Activities of Daily Living) needs are taken care of. V21 said R96's granddaughter comes to visit, and her son works at the facility. V21 said they always try to get R96 involved in things to help her behaviors or elopement before they get worse. V21 said she was working the floor today and didn't think she was the one that was taking over one on ones with R96, and she was going to find someone to take over one on ones with R96. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/20/24 at 3:40 PM, V50 (MDS Coordinator) said she hasn't made any updates to R96 dementia care plan. V50 said she knows that they do extra stuff for R96, but haven't had time to care plan all the things they do to help R96 with her dementia. V50 said the main thing they focus on is R96's elopement. V50 said she knows she should have updated R96's dementia care plan to make it more person centered, but she just hasn't had time to do that. V50 said they have a lot of pre-written interventions that they select for a lot of the dementia care residents but that R96's dementia care plan is not person centered it's mainly a pre-selected template. 2. R74's face sheet documents an admitted [DATE], with the following diagnoses of unspecified dementia, Parkinson's disease with dyskinesia and cognitive communication deficit. R74's Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 02, indicating R74 is severely cognitively impaired. R74's Care Plan, with a review date of 04/26/2024 documents a focus area of (R74) is an elopement risk/wanderer AEB (as evidenced by) Resident wanders aimlessly with interventions of Distract (R74) from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Resident prefers: (Resident preferences are left blank.) Initiated on 07/28/2023. Redirect resident when wandering or exit seeking initiated on 11/02/2023. In the focus area of I have (R74) has impaired cognitive function/dementia or impaired thought processes r/t (related to) Dementia with interventions including, keep routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion, initiated on 07/28/2023. (R74) needs (Specify: supervision/assistance, this was left blank) with all decision making, initiated on 07/28/2023. In the focus area titled (R74) has episodes of bladder incontinence related to: Dementia when he needs to go to br (bathroom) he will seek different doors throughout building with the following intervention initiated on 08/23/2023, Assist and direct to br (bathroom) when seeking different doors. The focus area of (R74) has a behavior problem r/t forcefully handing silverware over to staff when asked. (R74) has a behavior problem with kissing a peer on the cheek unwanted. Interventions include, Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. Initiated on 09/05/2023. We will offer a distraction for (R74) if we see him wandering towards a peer. He likes snacks we will offer him a seat and a snack. Initiated on 09/18/2023. Another focus area documents (R74) a behavior problem related to urinating in trash cans and hallways he does have episodes of grabbing, hitting at, and wandering. refusing medication and showers at times, this was initiated on 10/16/2023 and the following interventions were initiated on the same date Anticipate and meet needs for toileting. Praise any indication of progress/improvement in behavior. On 07/14/2024 more interventions were added including Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes. A facility document titled POC Response History question 1, behavior symptoms, with a start date of 07/19/2024 through 08/15/2024. Documents R74 displayed wandering behaviors on 07/20 at 06:14AM, 07/21 at 02:32PM, 07/22 at 07:10AM, 07/24 at 07:55AM, 07/30 at 08:25PM, 07/31 at 06:23AM, 08/05 at 01:59PM, 08/09 at 08:44PM and 11:49PM, 08/12 at 11:37PM, 08/14 at 12:46AM and 09:23AM. Facility abuse investigations for the past six months were reviewed. There were five resident to resident abuse investigations involving allegations of R74 striking another resident. Incidents investigated on 05/06, 05/10, and 08/16 were witnessed by staff. Incidents investigated on 04/28 and 08/18 were unwitnessed. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/12/2024 at 10:30AM, R74 was observed standing above the chair in common area urinating on it. No staff were observed to be redirecting or implementing R74's care plan interventions at this time. On 08/12/2024 at 01:15PM, R74 was observed standing up front by the front door alone watching the door. No staff were observed to be redirecting or implementing R74's care plan interventions at this time. On 08/12/2024 at 03:30PM, R74 was observed upfront in the common area wearing only one sock, stacking the chair cushions in the chair. No staff were observed to be redirecting or implementing R74's care plan interventions at this time. On 08/13/2024 at 01:02PM, R74 was observed eating off of another resident's plate. No staff were observed to be redirecting or implementing R74's care plan interventions at this time. On 08/13/2024 at 02:45PM, R74 was observed standing by the front door with a fork in his hand and silverware in his pocket. No staff were observed to be redirecting or implementing R74's care plan interventions at this time. On 08/15/2024 at 09:49AM, R74 was observed sitting at the front of the building near the entrance, sleeping in a chair with silverware in his hand. No staff were observed to be redirecting or implementing R74's care plan interventions at this time. On 08/15/2024 at 02:20PM, R74 was observed standing in the corridor by the front door holding a plastic cup, a (white foam) cup, and two pieces of silverware. No staff were observed to be redirecting or implementing R74's care plan interventions at this time. On 8/15/24 at 2:32 PM,V36 (Certified Nurse's Assistant/CNA) stated they don't have enough staff to meet the needs of the residents. V36 stated two aides to take care of 30 residents with behaviors isn't enough. V36 stated they can't give oral care, weights, vitals, showers aren't done timely, turning and positioning, and incontinence care can't be provided timely with the staffing they have. V36 stated R74 has behaviors frequently. V36 stated she tries to redirect R74 as much as she can, but there is only so much she can do. V36 stated R74 is always wandering, but he gets aggressive with staff and other residents often. V36 stated she has reported R74 to administration more than once for hitting other residents. 3. R15's Face Sheet documents an admitted [DATE], and includes the following diagnoses: cerebral infarction, traumatic subdural hemorrhage without loss of consciousness, and unspecified dementia. R15's MDS, dated [DATE], documents a BIMS score of 02, indicating R15 is severely cognitively impaired. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R15's current Care Plan, with a review date of 06/22/2024, documents the following focus area: (R15) has impaired cognitive function/dementia or impaired thought processes r/t Dementia, Difficulty making decisions, Disease Process (specify), impaired decision making, short termmemory loss with interventions including: (name) requires approaches that maximize involvement in daily decision making and activity limit choices, use cueing, task segmentation, written lists, instructions (Initiated on 10/01/2022). Keep (R15) routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion. (Initiated on 01/01/2024). There were no person-centered interventions listed specific to R15's focus area for dementia care. 4. R49's Face Sheet documents an admitted [DATE], with the following diagnoses in part hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, vascular dementia, unspecified severity with other behavioral disturbance. R49's MDS, dated [DATE], documents a BIMS score of 00, indicating R49 is severely cognitively impaired. R49's current Care Plan, with a review date of 05/27/2024, documents a focus area of, Has impaired cognitive function/dementia or impaired thought processes related to: Dementia & Cerebral infarction with the following interventions initiated on 4/22/21: Keep routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion. Provide a program of activities that accommodates abilities. An intervention of: Encourage activities participation that promote brain engagement at her level was initiated on 09/12/2022. There were no person-centered interventions listed specific to R49's focus area for dementia care. 5. R25's Face Sheet documents an admitted [DATE], with diagnoses including unspecified dementia, moderate, without behavioral disturbance, Psychotic disturbance, mood disturbance, anxiety, and Major depressive disorder. R25's MDS, dated [DATE], documents a BIMS score of 08, indicating R25 is moderately cognitively impaired. R25's Care Plan documents the following focus area: (R25) has impaired cognitive function/dementia or impaired thought processes r/t (related to)Dementia. The following interventions were documented as initiated on 01/19/2023: Engage (R25) in simple, structured activities that avoid overly demanding tasks. Keep (R25's) routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion. Provide a program of activities that accommodates (R25's) abilities. There were no person-centered interventions listed specific to R25's focus area for dementia care. On 08/19/24 at 1:38PM, V38 (Registered Nurse/RN) stated that has been one of the problems at the facility lately; there hasn't been new interventions put in place for anything. V38 stated she was getting ready to take over the Minimum Data Set position. V38 stated she was working as Social Services, Activities, and Business Office Manager from 11/2023, and in May, they added Marketing and Admissions. V38 stated from May to the end of July 2024, she was Social Services, Activities, Business Office Manager, Marketing and Admissions. V38 stated she was not trained in any of the positions. V38 stated they started cutting hours starting with floor staff, then Dietary, Housekeeping, then management. V38 said no one at the facility gets trained correctly on their positions, and this is a problem because no one knows what they are supposed to be doing. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/19/24 at 2:05PM, V50 (Minimum Data Set Coordinator /Care Plan Nurse) stated they usually have IDT (Interdisciplinary team) meetings more frequently to discuss falls, wounds, abuse, etc. but they have been so busy with surveys, and over half of the IDT (Interdisciplinary team) have been working on the floor or just not showing up to work. V50 stated she doesn't feel like they have enough staff right now to be able to care for the residents properly. On 08/20/24 at 3:40PM, V50 (Minimum Data Set Coordinator\Care Plan Nurse) said she hasn't made any updates to dementia care plans. V50 said they have a lot of prewritten interventions they select for a lot of the dementia care residents. 48356 The facility policy titled Dementia-Clinical Protocol, dated 4/2007, documents under assessments Identify individuals who have been diagnosed as having dementia or otherwise irreversibly impaired cognition. The treatment/management includes For the individual with confirmed dementia, the staff and physician will identify a plan to maximize remaining function and quality of life.

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 08/29/2024
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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48356 Based on record review and interview, the facility failed to ensure the attending physician documented a specific diagnosis in the medical record for the use of a psychotropic medication for 1 of 5 residents (R96) reviewed for unnecessary medications in the sample of 51. The findings include: R96's Face Sheet, dated 08/16/24, documents an admitted [DATE], with diagnoses of unspecified dementia, unspecified severity, with agitation, anxiety disorder, cognitive communication deficit, altered mental status, delirium due to known physiological condition, major depressive disorder, single episode, and insomnia. R96's Minimum Data Set (MDS), dated [DATE], documents a Brief Interview for Mental Status (BIMS) score of 03, which indicates that R96 has severely impaired cognition. Section GG documents partial/moderate assistance with toileting, shower, and lower body dressing. R96's Care Plan, with a review date of 07/01/24, documents a Focus area, Uses psychotropic medications (specify medication) related to: Behavior management. Interventions for this focus include in part: Consult with pharmacy, MD (Medical Doctor) to consider dosage reduction when clinically appropriate. R96's Physician Orders documents an order, dated 08/12/24, for Lorazepam 1mg by mouth three times a day related to unspecified dementia unspecified severity with agitation; an order, dated 06/13/24, for Celexa 20mg 1 tablet by mouth in the morning for depression/anxiety; an order, dated 08/08/24, for Quetiapine fumarate 50mg 1 tablet by mouth twice a day for mood take 2 tablets 100mg by mouth at bedtime for mood; an order, dated 06/12/24, of Mirtazapine 15mg 1 tablet at bedtime for depression; an order, dated 07/24/24, for Buspirone 15mg by mouth two times a day for anxiety. Review of document titled Note to Attending Physician/Prescriber, printed 06/24/24, documents to Physician/Prescriber, V48 (Medical Doctor), to please clarify supporting indication for use of Seroquel (Quetiapine Fumarate) Note Behavioral disturbance entered on the PO (Physician Orders)/MAR (Medication Administration Record) is not a FDA (Federal Drug Association) labeled indication. An antipsychotic medication should generally be used only for the following indication/diagnoses. Please check the appropriate indication for the use of this agent, acute and maintenance of treatment of schizophrenia, bipolar 1 disorder manic episodes, or bipolar disorder with depressive episodes. No diagnosis box was checked. Under Physician/Prescriber F32.9 Major depressive disorder, single episodes was typed in on 07/01/24. (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 08/29/2024
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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/14/24 at 3:00 PM, V42 (Maintenance), who is R96's son, stated R96 has never had any mental health diagnosis of any kind. V42 said the only thing diagnosis R96 has had is dementia and some depression. V42 stated most of R96's behaviors are from her dementia. V42 said R96 started forgetting things and not acting not like herself around 4-5 years ago. V42 said R96 used to wander when she was at home. V42 said R96 would forget she is married, and they have been married for over [AGE] years. V42 said R96 was never like this until she got dementia. On 08/14/24 at 3:00 PM, V43 (Pharmacist) stated she did send a recommendation for an appropriate FDA approved diagnosis for the use of Quetiapine Fumarate, which is a antipsychotic medication. V43 stated the diagnosis of F32.9 Major Depressive Disorder, single episode, is not a FDA approve diagnosis for the use of the antipsychotic Quetiapine Fumarate. V43 said that she changed regions and did not know F32.9 Major Depressive Disorder, single episode, was the diagnosis they listed for R96's Quetiapine Fumarate antipsychotic medication use diagnosis. V43 said they should not be using Quetiapine Fumarate for the diagnosis they listed. The facility policy titled Psychotropic Medication Policy, dated 11/2017, documents under definitions: Antipsychotic drug: Neuroleptic drug that is helpful in treatment of psychosis and has a capacity to improve thought disorders. Policy specifications list under 2. Resident shall not be given antipsychotic drugs unless antipsychotic drug therapy is necessary to treat a specific or suspected condition as diagnosed and documented in the clinical record or to rule out the possibility of one of the conditions listed in guidelines of recognized external review agencies. Procedural specifications list under 2. The drug regimen will be reviewed during scheduled visitation by both the physician and the consultant Pharmacist. Section G list Use of Antipsychotic Drugs Antipsychotic drugs should not be used unless the clinical record documents that the resident has one of the following specific conditions Conditions other than Dementia: Schizophrenia, Schizo-Affective disorder, delusional disorder, Mood disorder (e.g. Bipolar disorder, severe depression refractory to other therapies and/or with psychotic features), Schizophreniform disorder, Tourette's disorder, Huntington Disease, nausea and vomiting associated with cancer or chemotherapy, hiccups (not induced by other medications), Medical Illnesses with psychotic symptoms (E.g. neoplastic disease or delirium) and/or treatment related to psychosis or mania (e.g. high-dose steroids) Section Behavioral or Psychological Symptoms of Dementia (BPSD) list in part Antipsychotic medications in persons with dementia should not be used if one or more of the following is/are the only indication: wandering, poor self-care, restlessness, impaired memory, and mild anxiety.

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	146036	A. Building B. Wing	08/29/2024

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49907 Based on observation, interview, and record review, the facility failed to provide all items noted on the daily menu and ensure availability of substitutions for 4 (R73, R43, R31 and R7) of 4 residents reviewed for menus meeting resident choices in a sample of 51 . Findings include: 1. R73's Face Sheet documents an admitted [DATE], and includes diagnoses of peripheral vascular disease, hyperlipidemia and gastro-esophageal reflux disease. R73's Minimum Data Set (MDS), dated [DATE], documents a Brief Interview for Mental Status (BIMS) score of 15, indicating R73 is cognitively intact. R73's Physician Order Sheet documents a regular diet, regular texture, regular consistency with directions of: double protein portions all meals, with an order date of 07/16/24, and an end date of indefinite. The facility document titled, Diet Spreadsheet, dated Day: 9 - Monday documents: lunch: 3 oz (ounces) herb roasted chicken, 4 oz creamy noodles, 4 oz Brussel sprouts, and a substitution of strawberry ice cream for dessert. On 08/12/2024 at 12:25 PM, the meal posted on the wall in the dining room was herb roasted chicken, creamy noodles, brussel sprouts, creamed corn, dinner roll/margarine, and strawberry ice cream. The substitution was BBQ (barbeque) beef and potato wedges. No butter was observed to be served to residents unless requested. On 08/12/2024 at 12:41 PM, R73 stated he usually prefers the alternative meal and requests it often, but almost never gets it. R73 stated sometimes the meal isn't even what is posted on the menu. R73 stated they do not get butter unless they ask for it. The facility document titled, Diet Spreadsheet, dated Day: 10 - Tuesday documents: lunch: 3 oz + gvy (gravy) pork chop with gravy, 1 potato + 2 Tbsp (tablespoon) + 2 tsp (teaspoon) Baked potato w (with)/sour cream & margarine, 4 oz vegetable medley, 1 ea (each)/1 tsp dinner roll/margarine, and 3 (inch) x (by) 2-1/2 crispy rice dessert bar. On 08/13/2024 at 12:10 PM, the meal posted on the wall in the dining room was Pork Chop with gravy, baked potato with sour cream and margarine, vegetable medley, and Rice Krispy treat. On 08/13/2024 at 12:30 PM, residents were observed having to ask for butter for the rolls and baked potato. R73 also asked for sour cream, and was told that they were out of it. The facility document titled, Diet Spreadsheet, dated Day: 11 - Wednesday documents: Lunch: fiesta hamburger steak 3oz, Spanish rice #8 dip (1/2 cup), chuckwagon corn 4 oz spdl, cinnamon baked apples 4 oz spdl, and beverage 8 oz. (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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/14/2024 at 12:19 PM, R73 was given fiesta hamburger steak. R73 requested the substitute, which was Cheesy Sausage Bake, but stated he could not eat that, as it hurts his stomach. Dietary staff was called over to his table and they offered him a bowl of Cream of Celery Soup and crackers. R73 declined the crackers, but was served a single bowl of soup. R73 was not offerred a different substitute for the protein, even though he is ordered to receive double protein at meals. 2. On 08/12/2024 at 12:41 PM, R43 presented as alert and oriented, and stated a policy had recently come down from corporate, stating they were no longer allowed to be given menus before meals. R43 stated the menu is to be posted on the wall in the dining room, but sometimes it isn't even updated. R43 stated they do not ask residents anymore what they would prefer for a meal. R43 stated the only way you can get the alternative is if you check the menu on the wall and go tell the kitchen yourself, or sometimes the Certified Nursing Assistants/CNA's will write it down for you, but even then, you aren't guaranteed to get it. R43 stated they do not get butter unless they ask for it. R43 stated he usually prefers the alternative meal and requests it often, but he almost never gets it. R43 stated sometimes it isn't even what is posted on the menu, if you don't verbally ask for it, you won't get it. On 08/13/2024 at 12:10 PM, the meal posted on the wall in the dining room was Pork Chop with gravy, baked potato with sour cream and margarine, vegetable medley and Rice Krispy treat. On 08/13/2024 at 12:30 PM, residents were having to ask for butter for rolls and baked potato. R43 asked for sour cream, and was told that they were out of it. 3. On 08/12/2024 at 12:43 PM, R31 presented as alert and oriented and stated they do not receive any kind of printed menu. R31 stated half the time, what is on the wall either isn't updated or they aren't served what is posted for the day. R31 stated they aren't offered choices. R31 stated they are never offered butter with their rolls; they have to ask for it, if they even get a roll. 4. On 08/14/2024 at 12:14 PM, R7 presented as alert and oriented, and stated they took away their right to have a choice when they took away the papers where they get to choose their meals. R7 stated sometimes, if you aren't served first, you do not get a choice (for the alternative). On 08/20/2024 at 1:42 PM, V1 (Administrator) stated V12 (Dietary Manager) is really bucking about the corporate menu process. V12 has really struggled. V1 stated the way it works is that the facility uses a new program. V1 stated the program rotates menus per season, and there is a 4-week menu that rotates until the season is over. V1 stated the menu must be posted in all the dining rooms. V1 stated according to V12, the problem is when something doesn't come in on the truck, the menu must be changed, and that doesn't always happen. V1 stated the paper menus were supposed to have been gone a long time ago. V1 stated she was told by a family before Dietary staff told them they did not have the substitute. V1 questioned Dietary staff and they stated they were out of it, and V1 advised them to make something else. V1 stated she wasn't sure there was a specific policy regarding substitutions.

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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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32765 Based on observation, interview, and record review, the facility failed to provide thickened liquids as ordered by the physician for 1 (R86) of 9 residents reviewed for diets prepared meet individual resident needs in the sample of 51. Findings Include: R86's Admission Record, with a print date of 8/16/24, documents R86 was admitted to the facility on [DATE], with diagnoses that include other symptoms and signs concerning food and fluid intake, and chronic respiratory failure with hypoxia. R86's Minimum Data Set (MDS), dated [DATE], documents a Brief Interview for Mental Status (BIMS) score of 05, indicating R86 has a severe cognitive deficit. This same MDS documents R86 requires a Mechanically altered diet-require change in texture of food or liquids (e.g., pureed food, thickened liquids). R86's current Care Plan documents a Focus area, dated 6/28/24, of, Has nutritional problem or potential nutritional problem (specify) related to: poor intake, hospice care in place. The interventions documented on this same care plan for this Focus area are: Monitor/document/report to MD (Physician) PRN (as needed) for s/sx (signs/symptoms) of dysphagia: pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat, or appears concerned during meals. Date Initiated 06/28/24 . Monitor/record/report to MD PRN s/sx of malnutrition: Emaciation (Cachexia), muscle wasting, significant weight loss .Date Initiated: 06/28/24 .Provide and serve diet as ordered. Monitor intake and record q (every) meal Date Initiated 06/28/24 RD (Registered Dietitian) to evaluate and make diet change recommendations PRN .Date Initiated 06/28/24 . Weigh (specify: frequency). Date Initiated: 06/28/24 . This same Care Plan documents a Focus area dated 6/28/24 of is at risk for dehydration or risk for fluid deficit related to: Poor intake, hospice care . The interventions documented for this Focus area all dated 6/28/24 are: Encourage to drink fluids of choice .Ensure access to (specify: type and consistency fluids i.e. cold water, thickened apple sauce) whenever possible . R86's current Care Plan does not document R86's specific diet orders. R86's hospice admission orders includes the order, Diet as tolerated. R86's IDG (Interdisciplinary Group) Report, dated 8/1/24, does not document any information related to R86's dietary needs. R86's Progress Notes, dated 7/16/24, documents, Note Text: RD (Registered Dietitian) Admit note. Completed nutritional assessment Level 3. Hospice Care. Continue Pureed-NTL (nectar thick liquids), monitor intakes/WTs.(weights) Refer prn (as needed). R86's Order Summary Report, active orders as of 8/16/24, document a physician order dated 6/28/24, regular diet, pureed texture, nectar consistency liquids, comfort/pleasure feedings as tolerated per (initials of hospice provider) for diet. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/12/24 at 12:40 PM, R86 was sitting at a table in the dining room. R86 ate ice cream and drank all but a quarter cup of chocolate milk that did not appear thickened. There was a cup of water sitting on the table near R86 that appeared to be thickened. This surveyor asked V16 (Licensed Practical Nurse/LPN) if R86's chocolate milk was thickened, and V16 picked the cup up, swirled it around, and said they don't thicken the chocolate milk. On 8/13/24 at 7:55 AM, R86 was in the dining room feeding herself a pureed diet and drinking chocolate milk. On 8/13/24 at 12:13 PM, R86 was served 2 cups of chocolate milk that was not thickened. On 8/13/24 at 12:17 PM, V28 (Certified Nursing Assistant) stated R86 was admitted to the facility with an order for thickened liquids, but she thought hospice gave an order for thin liquids. V28 stated R86 was served chocolate milk, and it wasn't thickened. On 8/13/24 at 12:26 PM, V29 (Assistant Cook) checked R86's diet card and stated R86's liquids should be thickened to a nectar consistency. On 8/13/24 at 12:28 PM, V12 (Dietary Manager) checked the liquids R86 had been served, and stated the liquids were not thickened, and they should have been. The facility Thickened Liquids policy, dated 2022, documents, Indications For Use: Thickened Liquids are often needed for individuals with difficulty swallowing. The individual is evaluated by a Speech Language Pathologist (SLP) and, after evaluation, the SLP orders the appropriate diet consistency and liquid consistency as needed If liquids are to be thickened by nursing or Dining Service staff, proper training on the use of the thickening product and specific product instruction should be conducted by the Dining Services Manager, Speech Language Pathologist or Registered Dietitian. Proper preparation of thickened liquids improves acceptance and safety for individuals requiring thickened liquids.

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F 0808

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 41610

Based on interview, observation, and record review, the facility failed to provide diets as ordered for 2 (R67 and R73) of 14 residents reviewed for therapeutic diets in a sample of 51.

Findings include:

1. R67's Face Sheet documents an admitted [DATE], with diagnoses including: essential hypertension, chronic pain, type 2 diabetes mellitus without complications, vitamin D deficiency, and difficulty in walking.

R67's Minimum Data Set (MDS), dated [DATE], documents a Brief Interview for Mental Status (BIMS) score of 15, indicating R67 is cognitively intact. R67's MDS section GG documents R67's eating abilities as independent.

R67's Physician Order Sheet documents a dietary order of: regular diet, regular texture, regular consistency with directions of: double portions all meals for diet with a start date of 12/15/2021 and an end date listed as indefinite.

The facility document titled, Diet Spreadsheet, dated Day: 9 - Monday documents: lunch: 3 oz (ounces) herb roasted chicken, 4 oz creamy noodles, 4 oz Brussel sprouts, and a substitution of strawberry ice cream for dessert.

On 08/12/24 at 11:50 AM, R67 received one 3 oz piece of chicken, 4 oz creamy noodles, 4 oz Brussel sprouts and strawberry ice cream with his lunch. R67 did not receive double portions with his lunch.

The facility document titled, Diet Spreadsheet, dated Day: 10 - Tuesday documents: lunch: 3 oz + gvy (gravy) pork chop with gravy, 1 potato + 2 Tbsp (tablespoon) + 2 tsp (teaspoon) Baked potato w (with)/sour cream & margarine, 4 oz vegetable medley, 1 ea (each)/1 tsp dinner roll/margarine, and 3 (inch) x (by) 2-1/2 crispy rice dessert bar.

On 08/13/24 at 12:05 PM, R67 received one pork chop 3 oz, 1 baked potato with butter, 4 oz of vegetable medley, dinner roll and crispy rice dessert bar. R67 did not receive double portions at lunch.

The facility document titled, Diet Spreadsheet, dated Day: 11 - Wednesday documents: breakfast: assorted juice 6oz, breakfast fruit of the day 4 oz, choice of hot or cold cereal 4 oz spdl (spoodle) hot or 6 oz spdl cold, scrambled eggs #16 dip (1/4 cup), sausage patty 1 each, toast 1 slice, margarine/jelly 1 each, milk/beverage 8 oz. Lunch: fiesta hamburger steak 3oz, Spanish rice #8 dip (1/2 cup), chuckwagon corn 4 oz spdl, cinnamon baked apples 4 oz spdl, and beverage 8 oz.

On 08/14/24 at 12:02 PM, R67 received one portion of 3 oz hamburger steak, #8 dip of Spanish rice, 4 oz of chuckwagon corn, and 4 oz of cinnamon baked apples. R67 did not receive double portions at lunch.

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F 0808

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

On 08/14/24 at 12:02 PM, R67 stated his lunch looks the same size as usual, he doesn't remember getting two pieces of chicken or two pieces of hamburger or anything like that.

The facility document titled, Diet Spreadsheet, dated Day: 12 - Thursday documents: breakfast: assorted juice 6 oz, breakfast fruit of the day 4 oz, choice of hot or cold cereal 4 oz spdl (spoodle) hot or 6 oz spdl cold, sausage patty 1 each, pancakes 2 each, margarine/syrup 1 tsp/1oz, milk/beverage 8 oz.

On 08/15/24 at 7:57 AM, R67 received one glass of juice, 4 oz of fruit, 4 oz of hot cereal, and 1 sausage patty and 2 pancakes. R67 did not receive double portions for breakfast.

R67's Care Plan documents a focus area of: R67 has potential nutritional problem (wt (weight) loss) related to: pain, dated 12/06/2022, with an intervention of: provide and serve diet as ordered, monitor intake and record q (every) meal with a date initiated of 12/16/2021.

2. R73's Face Sheet documents an admitted [DATE], with diagnoses including: chronic systolic heart failure, paroxysmal atrial fibrillation, peripheral vascular disease, type 2 diabetes mellitus with diabetic nephropathy, essential hypertension, hypotension, atherosclerotic heart disease of native coronary artery without angina pectoris, hyperlipidemia, gastro-esophageal reflux disease without esophagitis, hypothyroidism, muscle wasting and atrophy, non-pressure chronic ulcer of other part of left foot with fat layer exposed, and pneumonia.

R73's MDS, dated [DATE], documents a BIMS score of 15, indicating cognitively intact. R73's MDS section GG documents R73's eating abilities as independent.

R73's Physician Order Sheet documents a regular diet, regular texture, regular consistency with directions of: double protein portions all meals, with an order date of 07/16/24 and an end date of indefinite.

The facility document titled, Diet Spreadsheet, dated Day: 9 - Monday documents: lunch: 3 oz (ounces) herb roasted chicken, 4 oz creamy noodles, 4 oz Brussel sprouts, and a substitution of strawberry ice cream for dessert.

On 08/12/24 at 12:17 PM, R73 received one 3 oz piece of chicken, 4 oz creamy noodles, 4 oz Brussel sprouts and strawberry ice cream with his lunch. R73 did not receive another protein source or a double portion of chicken with his lunch.

The facility document titled, Diet Spreadsheet, dated Day: 10 - Tuesday documents: lunch: 3 oz + gvy (gravy) pork chop with gravy, 1 potato + 2 Tbsp (tablespoon) + 2 tsp (teaspoon) Baked potato w (with)/sour cream & margarine, 4 oz vegetable medley, 1 ea (each)/1 tsp dinner roll/margarine, and 3 (inch) x (by) 2-1/2 crispy rice dessert bar.

On 08/13/24 at 12:13 PM, R73 received one pork chop 3 oz, 1 baked potato with butter, 4 oz of vegetable medley, dinner roll, and crispy rice dessert bar. R73 did not receive a second protein source or a double portion of the pork chop at lunch.

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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 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility document titled, Diet Spreadsheet, dated Day: 11 - Wednesday documents: breakfast: assorted juice 6oz, breakfast fruit of the day 4 oz, choice of hot or cold cereal 4 oz spdl (spoodle) hot or 6 oz spdl cold, scrambled eggs #16 dip (1/4 cup), sausage patty 1 each, toast 1 slice, margarine/jelly 1 each, milk/beverage 8 oz. Lunch: fiesta hamburger steak 3oz, Spanish rice #8 dip (1/2 cup), chuckwagon corn 4 oz spdl, cinnamon baked apples 4 oz spdl, and beverage 8 oz. On 08/14/24 at 12:26 PM, R73 received one portion of 3 oz hamburger steak, #8 dip of Spanish rice, 4 oz of chuckwagon corn, and 4 oz of cinnamon baked apples. R73 did not receive a second protein source or a double portion of the hamburger steak at lunch. The facility document titled, Diet Spreadsheet, dated Day: 12 - Thursday documents: breakfast: assorted juice 6 oz, breakfast fruit of the day 4 oz, choice of hot or cold cereal 4 oz spdl (spoodle) hot or 6 oz spdl cold, sausage patty 1 each, pancakes 2 each, margarine/syrup 1 tsp/1oz, milk/beverage 8 oz. On 08/15/24 at 8:01 AM, R73 received one glass of juice, 4 oz of fruit, 4 oz of hot cereal, 1 sausage patty, and 2 pancakes. R73 he did not receive a second source of protein or a double portions of the sausage patty. R73's Care Plan documents a focus area of: R73 is at risk for nutritional problem or potential nutritional problem (wt loss) related to: psychotropic med (medication) use, and dysphagia with a date of 12/07/2022 and interventions of: provide and serve diet as ordered. Monitor intake and record q meal dated 06/23/22 and RD (Registered Dietitian) to evaluate and make diet change recommendations PRN (as needed) with a date of 06/23/2022. On 08/15/24 at 2:45 PM, R73 stated his meals are about what they have been this week; he receives one serving of the meat, it looks the same as everyone else's plate; he does not receive double protein. On 08/15/24 at 3:30 PM, V12 (Dietary Manager) stated if any residents are supposed to receive double proteins or double portions they should receive them. On 08/19/24 at 2:44 PM, V30 (Registered Dietitian) stated she would expect residents with fortified foods to receive whole milk with meals and super cereal with breakfast if they are not diabetic. She would expect all residents that are recommended supplements, health shakes, double portions, ice cream, whole milk, or whichever to receive those supplements. V30 stated she recommends them for weight loss, wound healing, or weight maintenance. On 08/22/24 at 4:10 PM, V1 (Administrator) stated they do not have a policy for following a diet order.