

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6008528	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/28/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SHAWNEE SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 1901 13TH STREET HERRIN, IL 62948
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Facility Reported Incident of June 15, 2024 II174860	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.1210 c) 300.1210 d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.	S9999		

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Electronically Signed

TITLE

(X6) DATE
07/18/24

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6008528	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/28/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SHAWNEE SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 1901 13TH STREET HERRIN, IL 62948
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 1</p> <p>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.</p> <p>d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:</p> <p>6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.</p> <p>These requirements are not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to prevent an accident for 1 (R2) of 3 residents reviewed for accidents in the sample of 9. This failure resulted in R2 receiving a 2 cm (centimeter) laceration to the right side of the forehead and being sent to the emergency room requiring 2 sutures.</p> <p>Findings Include:</p> <p>R2's Admission Record documents R2 was admitted to the facility on 11/14/19, and is 94 years old. R2's Admission Record documents diagnoses including but not limited to Diagnoses: Transient cerebral ischemic attack, unspecified, vascular dementia, unspecified severity, with other behavioral disturbance, other idiopathic peripheral autonomic neuropathy, chronic pain syndrome, unspecified glaucoma, unspecified macular degeneration, legal blindness, fibromyalgia, chronic pulmonary embolism, long term (current) use of anticoagulants, abnormal posture, weakness, and history of falling.</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6008528	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/28/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SHAWNEE SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 1901 13TH STREET HERRIN, IL 62948
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 2</p> <p>R2's Minimum Data Set (MDS), with Assessment Reference date of 3/25/24, documents a Brief Interview for Mental Status (BIMS) score of 09, which indicates R2 has moderate cognitive impairment. R2's MDS for Functional Abilities and Goals documents R2 uses a manual wheelchair and was coded as dependent for the ability to wheel 50 feet with 2 turns or to wheel 150 feet in a small corridor or similar space. (Dependent is defined as the helper does all of the effort...resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity).</p> <p>R2's Care Plan includes a focus area documenting R2 is at risk for falls related to: Weakness/Recent Infections, Dementia, Hx (history) of falls at home, self transfers initiated on 11/15/19 and revised on 7/23/23. Interventions include 4/12/14 High Back w/c (wheelchair) initiated on 4/25/24 and 6/15/24 bilateral foot pedals to w/c initiated on 6/21/24.</p> <p>The State of Illinois - Illinois Department of Public Health Long Term Care Facility Serious Injury Incident Report submitted by the facility documented R2 sustained a fall with physical harm or injury on June 15, 2024 at 11:30 AM. The incident report documented the following under Detailed Incident Summary: "Resident (R2) is alert with intermittent confusion. BIMS: 10 severe cognitive impact. Diagnosis: TIA (transient ischemic attack) vascular dementia, blindness, neuropathy. Resident transfers with assist x (times) 2, may use hooyer lift when weak. Requires assistance with long distance ambulation using high back wheelchair. On 6-15-2024 at approximately 11:30, CNA (Certified</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6008528	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/28/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SHAWNEE SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 1901 13TH STREET HERRIN, IL 62948
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 3</p> <p>Nursing Assistant) was assisting resident with ambulation in w/c (wheelchair) when she unexpectedly put her feet down, causing her to become entangled and fall forward out of chair. Resident does not remember the incident so is unable to say why she put her feet down while being assisted in the wheelchair. Resident propels self short distances and has not required foot pedals until this incident. Previously, she was able to hold legs up without difficulty. A laceration was noted to right side of forehead. First aid applied. Resident neuro checks WNL (within normal limits), vital signs stable, resident unable to provide statement as to what happened. Neurochecks initiated, NP (Nurse Practitioner) and resident's daughter notified. Resident sent to ER (Emergency Room) for evaluation via EMS (Emergency Medical Service). 6-15-2024 at 15:55 (3:55 PM) resident returned from ER to facility via EMS. All CT's (computed tomography) are negative, two stitches to right forehead. Bruising to right side of head. Resident can have extra strength Tylenol for pain and was put on Macrobid 100mg BID (twice daily) x 5 days for UTI (urinary tract infection). Interventions include Med (medication) review, ABX (antibiotic) therapy for UTI and bilateral foot pedals. IDT (interdisciplinary team) met, Physician, POA (Power of Attorney), and care plan updated."</p> <p>R2's local hospital records include an ED (Emergency Department) Provider Note, dated 6/15/24, and documented "Pt (patient) brought by EMS from (name of nursing facility). EMS states "the staff was pushing her in the wheel chair and she fell forward and hit her head. She has this circular puncture wound noted to the right side of his forehead. They said there was nothing there that could have caused it." The ED Provider Note further documents a Clinical Impression of: Fall,</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6008528	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/28/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SHAWNEE SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 1901 13TH STREET HERRIN, IL 62948
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 4</p> <p>initial encounter, Laceration of forehead, initial encounter, and Acute cystitis without hematuria. An ED Procedure Note documents a Laceration Repair to R2's forehead, laceration lengh of 2 cm (centimeters), repair type was sutures and number of sutures was documented as 2. New Prescriptions given were Acetaminophen 500 mg (milligram) 1 tablet as needed every 6 hours for pain and Nitrofurantoin Macrocrystalmonohydrate (Macrobid) 100 mg by mouth two times a day for 5 days.</p> <p>On 6/25/24 at 2:00 PM, V7 (Certified Nurse Aide/CNA) stated he was pushing R2 to the dining room for lunch and she put her feet down and fell forward. V7 said he tried to grab her to keep her from falling, but that didn't work. V7 said he did not have any foot rests on the wheelchair when he was pushing R2. V7 said it happened so fast. V7 said R2 had been able to hold her feet up prior to the incident, but after the incident, a couple of other CNA's told him that she would put her feet down at times. V7 stated he felt really bad.</p> <p>On 6/27/24 at 3:00 PM, V2 (Director of Nurses/DON) stated she did the reportable incident on R2. V2 said R2 did self propel short distances and was good about keeping her feet up on longer distances, but that day she just put her feet down and fell forward.</p> <p>The facility's Fall Policy titled Falls - Clinical Protocol documents a section of "Assessment and Recognition" which includes the following: 4. The staff will document risk factors for falling in the resident's record and discuss the resident's fall risk. a. Risk factors for subsequent falling include lightheadedness or dizziness, multiple</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6008528	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/28/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SHAWNEE SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 1901 13TH STREET HERRIN, IL 62948
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 5 medications, musculoskeletal abnormalities, peripheral neuropathy, gait and balance disorders, cognitive impairment, weakness, environmental hazards, confusion, visual impairment, and illnesses affecting the central nervous system and blood pressure. 5. The physician will identify medical conditions affecting fall risk (for example, a recent stroke or medications associated with increased falling risk) and the risk for significant complications of falls (for example, increased fracture risk in someone with osteoporosis or increased risk of bleeding in someone taking an anticoagulant). (B)	S9999		