STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0056028	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHAWNEE SENIOR LIVING	1901 13TH STREET , HERRIN, Illinois, 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) COMPLETION DATE
S0000	Initial Comments Facility Reported Incident of 7/11/25/2561559 Facility Reported Incident of 7/11/25/2561533 Facility Reported Incident of 7/11/25//2561485	S0000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) Section 300.3210t) 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		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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S9999	Continued from page 1 Section 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. These requirements were not met as evidenced by: Based on interview and record review, the facility failed to ensure residents were free from physical abuse for 2 of 4 residents (R1, R2) reviewed for abuse in the sample of 4. This failure resulted in R1 stabbing R2 in the back multiple times with an ink pen and both R1 and R2 being sent to the Emergency Room for evaluations. This past noncompliance occurred between 7/11/25 and 7/12/25. The findings include: R1's Admission Record documented an Admission Date of 5/30/24 and listed diagnoses including Unspecified Dementia, Major Depressive Disorder, and Anxiety Disorder. R1's Minimum Data Set (MDS) dated 5/27/25 documented a Brief Inventory for Mental Status (BIMS) Score of 8, indicating R1 has moderate deficits in cognition. R1's Care Plan dated 6/9/25 documented a problem area, "(R1) has been the recipient and aggressor of verbal and physical aggression related to dementia, and continual reorganization of personal belongings and environment." R2's Admission Record documented an Admission Date of 6/26/24 and documented diagnoses including Epilepsy and Cerebral Palsy. R1's MDS dated 4/29/25 documented a BIMS score of 13, indicating R2 has minimal deficits in cognition. R2's Care Plan dated 5/21/25 documented a problem area, "(R2) has been the recipient and aggressor of verbal and physical aggression related to poor coping skills." A Facility Incident Report Form dated 7/6/25 at 9:20 AM, authored by V1, Administrator, documented, "Altercation reported to Abuse Coordinator by nursing staff. (R1) and (R2) were arguing in the hall over a jacket. (R2) called (R1) a curse word and attempted to take the jacket away from (R1) resulting in (R1)'s arm being scratched. Both residents were immediately separated and the jacket was taken to determine who the jacket belonged to. Residents were assessed. (R1)'s	S9999		

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S9999	Continued from page 2 scratch was cleansed and treatment [sic] as ordered. No other signs of injury or pain were noted. Notified Power of Attorney and Nurse Practitioner of incident for both residents. Investigation begun." A Facility Incident Report Form dated 7/11/25 at 8:30am, authored by V1 documented, "(R2) reported that (R1) stabbed her in the back with a pen. (R1) was assessed and multiple puncture marks were visualized on (R1)'s back. (R1) and (R2) both were sent to the hospital for evaluation. (Local Police Department) (was) notified. Geriatric Psychiatry and Family Practice Nurse Practitioners notified. Power of Attorney/Family notified for both residents. Investigation begun." A Facility Incident Report Form dated 7/11/25 at 10:30am, authored by V1 documented, "During investigation of previous incident (7/11/25 at 8:30am), (R1) informed (V1) that (R1) had a bruise on her forehead. (R1) stated she did not report the bruise or incident to anyone. Both residents are separated. Both residents sent to ER (Emergency Room) for evaluation. (Local Law enforcement), Geriatric Psychiatry and Family Practice Nurse Practitioners notified. Power of Attorney/Family notified for both residents. Investigation begun." R1's "History of Present Illness" from the local ER dated 7/11/25 documented," (R1) is a 79 year old female brought to ER for a mental health exam following stabbing another patient at a local nursing home. She reports an incident at her nursing home where she used a ballpoint pen to defend herself against another resident who she describes as, 'feisty,' and, 'argumentative.' This documentation goes on to state, "She mentions a bruise on her forehead, which she attributes to being hit by the same resident two days ago. Review of Systems: Psychiatric: She exhibits impaired recent memory. Patient does seem to have appropriate judgement, but lost control after repeated offenses from the fellow resident she stabbed. Medical decision making: Urinalysis is slightly positive for infection. Patient was started on Ceftin. Patient will be returned to the nursing home. Nursing home staff will need to take appropriate measures to keep the two residents apart. I do not have concern patient will attack anyone else outside of being attacked herself." R2's "History of Present Illness" from the local ER dated 7/11/25 documented, "The patient was stabbed at her facility with a pen by another patient, in her right upper back. 10 total superficial wounds noted to right shoulder and back. Patient states, "I was	S9999		

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S9999	Continued from page 3 visiting my friend and another person who wasn't supposed to be in the room stabbed me with a pen in the back." Resident is alert and oriented to person, place, time, and purpose. There were no signs of infection, but I will put her on Bactrim for infection prevention." There was no documentation in the ER records as to R2 causing a bruise on R1's forehead, or any evidence of a psychiatric evaluation being done on R2. On 7/15/25 at 8:55am, R1 was alert only to herself. R1 was observed to be on one to one observation with CNA (Certified Nursing Assistant) staff. R1 was noted to have a large healing bruise to the left forehead. When asked about the bruise, R1 stated, "She did that to me. It was another resident." R1 stated she could not remember the other residents name, but referred to her with feminine pronouns. R1 stated this resident, date unknown, saw R1 in the hall and accused R1 of stealing her jacket, which R1 denied. R1 stated that was all she remembered about that incident, but stated the other resident must have stayed mad about the jacket, because at some point after, she came into R1's room and punched R1 on the forehead. R1 stated R1 then stabbed the other resident in the back with an ink pen, "In self- defense. I was trying to get her off me." R1 stated she did not remember anything about going to the hospital. R1 stated she did not know what, if anything, the facility did in response, and could not remember if she told any of the staff about getting punched in the forehead. On 7/15/25 at 9:05am, R2 was alert and oriented to person, place, and time. R2 was observed to be under one to one observation from CNA staff. R2 was observed to have ten pinprick sized scabs over her upper back. R2 stated R1 has a habit of coming into R2's room, taking R2's clothing items, leaving the room with them, and then throwing them away. R2 stated "a few days ago" R1 was in another residents room and she didn't belong in there, so R2 told R1 to get out, which R1 refused to do. R2 stated at that point, R1 began "sticking her in the back with an ink pen." R2 stated R2 left the room and was then going down the hallway and R2 was crying, which one of the nurses noticed. R2 stated she told the nurse what happened, and the nurse examined her and saw the marks made by the ink pen. R2 stated she was sent to the ER to be examined and was given an antibiotic in case the areas became infected. R2 stated she did not recall any incidents between her and R1 over a jacket. R2 denied ever hitting R1 on the forehead or scratching R1's arm. R2 stated after the incident, staff moved R1 to the other side of the building, and R1 has one to one at all times with CNA staff, "To protect her from	S9999		

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S9999	Continued from page 4 (R1)." On 7/15/25 at 9:38am, V1 stated on 7/11/25, V2, Director of Nurses, brought R2 to her to report what happened with R1. V1 stated she interviewed R2 who said R2 asked R1 to leave the other resident's room, and R1 started poking R2 in the back with a pen. V2 stated she then interviewed R1, who showed V1 a bruise on R1's forehead and indicated it was caused by R2 punching R1 in the head. V1 stated she was unaware of the bruise to R1's forehead until that time and of R1's report that it was caused by R2. V2 stated both residents were sent to the ER, and V1 requested they both receive a psychiatric evaluation, which the ER did not do. V1 stated when both residents returned to the facility on 7/11/25, both were immediately placed on one to one staff supervision. V1 stated there have been no further interactions between R1 and R2. V1 stated R1 was moved to a room at the farthest part of the building away from R2. V1 stated neither R1 nor R2 have any history of assaulting peers. On 7/15/25 at 11:40am, V1 stated she was notified immediately about the incident with R2 scratching R1 in the hallway, and an immediate investigation was initiated. V1 stated through the investigation it was determined that R2 scratched R1 accidentally while attempting to take the jacket from R1. The facility's Abuse Prevention Program Policy dated October 2022 documented, "Federal and state laws and regulations mandate that a nursing home resident has the right to be free from verbal, sexual, physical, and mental abuse, exploitation, corporal punishment, and involuntary seclusion." Prior to the survey date, the facility took the following actions to correct the non-compliance: 1. On 7/11/25, the Quality Assurance Committee developed a Plan of Correction for the 7/11/25 incident. 2. On 7/11/25, (R1) and (R2) were sent to ER for evaluation and the facility requested both residents receive a psychiatric evaluation. 3. On 7/11/25, V1 called local law enforcement to report the incident on 7/11/25. 4. On 7/11/25, V1 contacted both residents Primary Care Nurse Practitioner and Psychiatric Nurse Practitioner to complete medication reviews. A new order was given to give R1 the as needed antianxiety medication already	S9999		

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S9999	Continued from page 5 on file. A new order was received to start R2 on an antihistamine for the treatment of anxiety as needed for 14 days. 5. On 7/11/25, V1 educated staff on the Abuse Prevention Policy. 6. On 7/11/25, R2 returned to the facility, and R2's Care Plan was updated to include one to one supervision during waking hours and 1 hour safety checks while asleep. 7. On 7/11/25, R1 returned to the facility and R1's Care Plan was updated to include one to one supervision all weekend, with reassessment 7/14/25. R1's room was moved to the other end of the building (away from R2). 8. On 7/12/25, V1 and V2 completed Abuse Risk Assessments on all residents. 9. Starting on 7/12/25, V1 or designee will audit all residents that are high risk of abuse weekly for 4 weeks to ensure care plan interventions are in place and are being followed. 10. The Quality Assurance Committee will continue to monitor the facility's performance to ensure the corrective actions are effective. 11. On 7/12/25, all the above systemic changes were completed. "B" PNC	S9999		