

Illinois State Department of Health

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 10/22/2025	
NAME OF PROVIDER OR SUPPLIER SHAWNEE SENIOR LIVING				STREET ADDRESS, CITY, STATE, ZIP CODE 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		S0000				
	Facility Reported Incident of October 10, 2025/IL 2645848						
S9999	Final Observations		S9999				
	STATEMENT OF LICENSURE VIOLATIONS:						
	300.610a)						
	300.1210b)						
	300.1210d)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.						
	d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be						

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 practiced on a 24-hour, seven-day-a-week basis: 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. THESE REQUIREMENTS WERE NOT MET EVIDENCED BY: Based on interview and record review the facility failed to safely transfer a resident with a mechanical lifting device for 1 of 3 (R1) residents reviewed for accidents in a sample of 3. This failure resulted in R1 sustaining an impacted fracture of the right humeral neck. This past noncompliance occurred from 10/10/25 to 10/16/25. R1's "Admission Record" documents an admission date of 1/29/21, with diagnoses including unspecified sequelae of cerebral infarction, hemiplegia and hemiparesis following other nontraumatic intracranial hemorrhage affecting right dominant side, unspecified fracture of upper end of right humerus, initial encounter for closed fracture, muscle wasting and atrophy, not elsewhere classified, other lack of coordination. R1's Minimum Data Set (MDS) dated 9/17/25, documents a Brief Interview for Mental Status (BIMS) of 9, indicating R1 is moderately cognitively impaired. Section GG-Functional Abilities documents that R1 is "Dependent - 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" for transfers. R1's current Care Plan documents that R1 is at risk for falls related to impaired mobility, with a history of falls, suprapubic catheter, and a history of cerebral vascular accident with hemiplegia. The focus area documents R1 is dependent on staff with lower body dressing, putting on/taking off footwear, transfers and toilet hygiene, with interventions including, transfers require a sling lift, with an initiation date of 6/17/2024. The same Care Plan also documents that R1 requires assist with all ADLs (Activities of Daily Living) related to impaired mobility and right sided weakness with interventions including "Bed mobility requires ext (extensive) assist of 2" with an		S9999				

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S9999	Continued from page 2 initiation date of 10/21/19. R1's Physician's Order Sheet with a print date of 10/21/25 documents an order for R1 to be transferred via sling lift, with an initiation date of 6/17/24. R1's "Injury Investigation Summary" with an incident date of 10/10/25, that was completed by V2 (Director of Nursing/DON) states in the "final summary/conclusion" "On 10/10/25 R1 was being transferred with a sit to stand by R5 (CNA) when she experienced a syncopal episode and was then lowered back to wheelchair...the employee who performed the transfer was given 3-day suspension, coaching on Kardex and provided further transfer training." R1's final "Serious Injury Incident and Communicable Disease Report" documents an incident date and time of 10/10/25 at 8:07pm. Under detailed incident summary documents "(R1) is... dependent upon staff for transfers and ambulation and requires max assist for most ADL's. On 10/10/25, (R1) was being transferred with the sit to stand when she experienced a syncopal episode then lowered back to wheelchair. Resident was assessed by nurse and no obvious injuries were noted. Resident complained of right shoulder pain and heat pack applied. (V8 Nurse Practitioner) notified and ordered stat imaging. In house imaging showed impacted fracture of the humeral neck with no significant displacement...Resident was sent to (local hospital) ER (Emergency Room) for further evaluation..." R1's Progress Notes document on 10/10/25 at 9:19pm, "X-ray performed and results of x-ray faxed to facility. Res. (resident) has possible Fx (fracture) to Right humeral head. X-ray results show impacted transverse Fx of the humeral neck with no significant displacement. Per results, clinical correlation is requested to determine the age of the fracture. POA (Power of Attorney) notified of x-ray results and POA stated he was made aware of incident that possibly caused fracture earlier on this date. POA requesting res. be sent to hospital for further evaluation/tx (treatment.) Resident made aware of x-ray results and POA request and thanked this nurse for update. Res. stating she is in constant pain and hopes the hospital will help with the pain." R1's Progress Notes document on 10/10/25 at 11:13pm, "Late entry: (local) EMS (Emergency Medical Services) arrive at approx. (approximately) 2130 (9:30PM) for transport resident to hospital." R1's ED (Emergency Department) Provider Notes from the		S9999				

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S9999	Continued from page 3 local hospital with a date of service of 10/10/25 at 10:12pm documents that R1 presented to the Emergency department for a right humerus fracture. This document states that R1 fell at the facility out of a sit to stand lift. On 10/20/25 at 10:34am, R1 stated she could not remember how she was injured. On 10/21/25 at 11:16am, V1 (Administrator) stated on 10/11/25 they identified a failure with the incident that occurred the evening of 10/10/25 involving R1. V1 stated they immediately started an investigation as soon as they were notified of the incident and the Quality Assurance Committee immediately started to develop a plan of correction. On 10/22/25 at 12:37pm, V5 (Certified Nursing Assistant/CNA) states that R1 needed to go to the bathroom. V5 stated he was unsure how R1 transferred, so he asked her, and she told him the sit to stand. V5 stated that she transferred to the toilet with the sit to stand without incident. V5 stated when he lowered her back into her chair, it appeared she passed out. V5 stated he immediately alerted the nurse. V5 stated he was suspended while investigated, he was trained on how to find out what someone's transfer needs were and general training on transfers. On 10/22/25 at 1:03pm, V3 (Licensed Practical Nurse/LPN) stated she did not witness the incident that occurred on 10/10/25, but she was R1's nurse that day and assessed her immediately after. V3 stated that V5 had transferred R1 with the sit to stand lift, and stated she passed out when transferring her back to the wheelchair. V3 stated that R1 had no visible injuries but complained of right shoulder pain. V3 stated she immediately contacted the physician and R1's power of attorney. V3 stated pain relief and stat x-rays were ordered and R1 was sent out later when Xray results were received. V3 stated she was under the impression that everyone in the facility knew that R1 was to be transferred using a sling lift. V3 stated that R1 had right side paralysis. V3 stated if someone is unsure of how someone is to be transferred, they can reference the Kardex or they can always ask a nurse, as they can find it in the chart. On 10/21/25 at 11:14am, V2 (DON) stated if staff is unsure how to transfer a resident, they can utilize the Kardex to find the information. V2 also stated the information is in the residents' medical record in a few different places, the nursing staff can access that information.		S9999				

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S9999	Continued from page 4 The facility policy titled, "Safe Lifting and Movement of Residents" with a revision date of August 2008, states in the section for the use of mechanical lifts; "Mechanical lifting devices shall be used for any resident needing a two person assist. Except during emergency situations or unavoidable circumstances, manual lifting is not permitted." Prior to the survey date, the facility took the following actions to correct the noncompliance: 1. The facility held a meeting with Quality Assurance Committee on 10/11/25 with V1 (Administrator) and V2 (DON) to develop a plan of Correction for the 10/10/25 incident. 2. On 10/10/25 R1 was transferred with a sit to stand by V5 (CNA). V3 (LPN) called V8 (Nurse Practitioner/NP) with resident complaints of shoulder pain. Hot pack, Tylenol and x-rays ordered. 3. On 10/10/25 V4 (LPN) received x-ray results, notified V8 and R1 was sent to the emergency room for evaluation for determination of age of fracture. 4. On 10/11/25 R1 returned to the facility with sling to right shoulder, Norco for pain and follow-up with orthopedics. 5. On 10/11/25 V5 (CNA) was suspended pending investigation. 6. On 10/16/25 V5 was reinstated and received additional training on reviewing Kardex, Hoyer lift, sit to stand and having two people while using a mechanical lift. 7. Starting on 10/16/25 Administrator or designee will conduct daily audits of "high risk rounding form", resident Kardex, Care Plans and staff/resident transfers to ensure correct transfers lift and practice are being followed. 8. QAPI (Quality Assurance and Performance Improvement) committee will continue to monitor the facilities' performance to ensure corrective actions are effective. 9. Completion date systemic changes will be completed: 10/16/25. (B)			S9999			