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 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. (continued on next page)

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

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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)

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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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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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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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	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 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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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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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 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)

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

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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 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.