STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145581	A. Building B. Wing	08/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Meadows of Cahokia	2 Annable Court Cahokia, IL 62206

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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50628 Based on observation, interview, and record review, the facility failed to provide adequate supervision to prevent residents from wandering into other resident's rooms for 1 of 3 resident's (R8) reviewed for wandering in a sample of 16. Findings include: R8's Face Sheet, with an admitted [DATE], documented R8 has diagnoses of but not limited to vascular dementia, unspecified severity, with other behavioral disturbance and wandering in diseases. R8's Minimum Data Set (MDS), dated [DATE], documented R8 is severely cognitively impaired and requires assistance with all his activities of daily living (ADL). R8's Care Plan, with an admitted [DATE], documented R8 is an elopement risk/wanderer related to (r/t) impaired cognition and poor safety awareness. Interventions were but not limited to If wander guard is noted to be removed/missing, put Resident on frequent face checks or 1:1, provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures, and memory boxes, and distract him from wandering by offering pleasant diversions, structured activities, food, conversation, television, ambulating. R8's Wandering/Elopement Assessment, dated 08/01/24, documented R8 is a high risk with a score of 15. R8's Progress Notes, dated 8/2/2024 at 1:29 PM, documented Behavior Note: Resident has been wandering within the facility this morning. Resident constantly redirected. Resident noted walking into other Resident's room in which he was seen by Staff pulling covers back trying to get in bed with another Resident. Resident redirected again. This writer notified Administrator and she is aware of the matter. Resident has refused all meds offered to him. Multiple attempts made. R8's Progress Notes, dated 8/2/2024 at 4:14 PM, documented Social Services Note R8 was admitted into facility on 08/01/2024. He is here as a long-term resident with no discharge plans. R8 has a diagnosis (dx) of Vascular Dementia. Resident is alert and oriented (A&O) times (X) 1. He wanders throughout the facility aimlessly. He does not focus when being spoken to. His expression would be considered as flat affect. A wander guard has been placed on him. (continued on next page)

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

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R8's Progress Notes, dated 8/3/2024 at 3:36 PM, documented 15:46 Health Status Note: Unable to redirected verbally at this time. Resident up ambulating going from room to room. Attempting to get into to bed with peers. Running at times when trying to verbally redirect. Does not responding to touch will pull away. Staff continue to let resident monitor to prevent falling or altercation with fell ow peer. R8's Progress Notes, dated 8/7/2024 5:05 PM, documented Health Status Note: Attempted to exit facility thru fire door. Resident was assisted back per staff member. Ambulate with staff member with slow and steady gait. Staff member state resident lost footing in grass dropping to knees. Resident assisted self-up at that time. Unable to give passive range of motion (PROM) due to confusion. Unable to verbally redirect. Continue to ambulate ad-lib. On 08/13/24 at 01:05 PM, R8 was observed walking out of his room and going down the 600-hallway. He was observed walking into one of the rooms on the 600 hallway and then back out. R8 then proceeded to walk down the 100 hallway and into one of the rooms on that hall and then back out. When R8 came out of the room located on the 100-hallway staff were observed to be present and redirected him. On 08/14/24 at 10:30 AM, V8, Certified Nursing Assistant (CNA) stated that it depends who is working on how well the residents who wander are supervised. On 08/14/24 at 01:55 PM, R6 was asked how he felt about resident's wandering into his room. He stated that he tells them to leave that they are in the wrong room and hopes the resident will listen to him because they are invading his space. On 08/14/24 at 02:00 PM, R2 was asked how he felt about resident's wandering into his room. R2 state he just tells them to get out. He said he doesn't want them to steal his stuff and he feels disappointed the staff don't do their job and keep the residents who wander supervised. On 08/14/24 at 03:15 PM, V1, Administrator and V2, Director of Nursing (DON) stated they would expect the staff to redirect the residents who wander into other resident's room to redirect them out of the other resident's room. V2 stated they should safely remove the wandering resident and try to prevent the occurrence of that situation. The facility's policy, Behavioral Assessment, Intervention, and Monitoring, revision date of December 2016, documented Policy Interpretation and Implementation General Guidelines 1. Behavior is the response of an individual to a wide variety of factors. The factors may include medical, physical, functional, psychosocial, emotional, psychiatric, or environmental causes. 2. Behavior is regulated by the brain and is influenced by past experiences, personality traits, environment, and interactions with other people. Behavior can be a way for an individual in distress to communicate unmet needs, indicate discomfort, or express thoughts that cannot be articulated. It further documents Monitoring 3. Interventions will be adjusted based on the impact on behavior and other symptoms, including any adverse consequences related to treatment.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50628 Based on observation, interview, and record review, the facility failed to monitor blood sugars regularly and administer insulin as ordered for 1 of 11 residents (R2) reviewed for medications in the sample of 16. Findings include: R2's Admission Record, with admitted [DATE], documented R2 has diagnoses of but not limited to cerebrovascular accident (CVA), acquired absence of left and right leg below the knee, Type II diabetes mellitus, peripheral vascular disease (PVD), atrial fibrillation, chronic kidney disease (CKD), hypertension (HTN), phantom limb syndrome. R2's Minimum Data Set (MDS), dated [DATE], section C documented resident is cognitively intact with a Brief Interview Mental Status (BIMS) of 15. Section GG documents impairment on both lower extremities and requires a wheelchair. He requires setup assistance with eating, oral hygiene, partial assistance with upper body dressing, substantial assistance with showering, lower body dressing, and personal hygiene and dependent with toileting hygiene. Section H stated that he is always continent of both bowel and bladder. R2's Care Plan, dated 5/28/24 documented interventions for emotional, intellectual, and social needs from staff, Activities of Daily Living (ADL) self-care deficit, limited physical mobility, cardiac risk, bilateral leg pain risk, oral/ dental pain risk, fall risk, fatigue risk, infection risk, Gastrointestinal (GI) bleed risk, mood fluctuation risk with repeated threats to sue the facility, and skin breakdown risk. R2's Physician's Orders, with an order date of 05/10/24, documented R2 was to receive Humalog Insulin (Lispro) 5 units Subcutaneous (SQ) three time a day (TID). R2 was also to receive Humalog Insulin per sliding scale SQ three time a day as indicated along with the scheduled does of Humalog insulin. R2's Physician's Order, with start date of 07/18/24, documented R2 was to receive 24 units of Glargine Insulin SQ at bedtime. R2's Medication Administration Record (MAR), from August 1st through August 13th regarding his Humalog insulin (Lispro) 5 units TID order, documented R2 did not receive his scheduled 7:00 AM 5 units of Humalog insulin on 08/01/24, 08/02, 08/03, 08/04, 08/07, 08/08, 08/10, and 08/11/24. R2 did not receive his 11:00 AM scheduled 5 units on 08/01/24, 08/02, 08/03, 08/04, 08/05, 08/06, 08/07, 08/09, 08/10, 08/11, 08/12, 08/13, and 08/14/24. R2 did not receive his 4:00 PM scheduled 5 units on 08/01/24, 08/02, 08/03, 08/04, 08/05, 08/06, 08/07, 08/08, and 08/09/24. R2's MAR for the month of August 2024 was reviewed and documented the following. From the dates of August 1, 2024, through August 13, 2024, he did not receive his scheduled 24 units of Glargine insulin 08/01/24 through 08/11/24. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/13/24 at 9:20 AM, during R2's interview he stated he doesn't take scheduled medications by mouth because he doesn't think the staff know what the medications, they are giving him are for. R2 stated that he was supposed to have his blood sugar checked four times per day and that last weekend it was not checked all day Saturday, Sunday, or Monday morning. On 08/13/24 at 1:00 PM, follow up interview with R2 was conducted and R2 was asked if he ever refused his medication and he stated, I refuse all of them except for insulin and Tylenol. When asked if he refuses his accucheck testing, R2 stated that he does not. R2's Progress Notes were reviewed and no documentation of notification to the physician as to why R2's scheduled Humalog and Glargine insulin was held. During this investigation during continuous direct observation from 10:00 AM to 12:00 PM on 08/14/24 was made with no nursing professionals observed entering R2's room or talking with him. On 08/14/24 at 11:25 AM, Review of R2's electronic medical record (EMR) and MAR was conducted. R2's MAR documented he had refused his blood glucose check at 11:00 AM on 08/14/24. On 08/14/24 at 11:50 AM, R2 was questioned by surveyor if his nurse had asked him if he wanted his accucheck preformed prior to lunch, R2 stated he was not asked, and he did not receive an accucheck. On 08/14/24 at 1:10 PM, Interview with V9, Pharmacist at facility's pharmacy, clarified orders for R2s Humalog and Lantus. V9 stated that the Humalog is ordered for 5 units three times per day routinely plus an additional Humalog sliding scale insulin depending on R2's blood sugar. A scenario was provided to V9 asking if R2's accucheck was 178, he (R2) should receive Humalog 5 units routine plus 2 units sliding scale? To which V9 said if that had not been given, she would consider that a medication error. This surveyor also reviewed the order for R2's Lantus 24 units every night. V9 said this should be given routinely. If the nurse has a question regarding medication being given based on a blood sugar reading, she should notify the physician with her concerns for any other orders. V9 said if the Lantus was not given as ordered she would consider this a medication error. On 08/14/24 at 2:02 PM, V1, Administrator stated she would expect the nurses to follow the physician's orders, if the resident refuses medication she would expect them to reattempt to give it and educate the resident on what could happen if they don't take the medication. The facility's policy Medication Administration General Principles, with a revision date of 01/14/2020, documents Policy: Medications will be administered in a safe, efficient and accurate manner to residents for whom they are prescribed in accordance with current acceptable nursing practice. It further documents Policy Guidelines and interpretation: 5. Where applicable (e.g. physician's orders) vital signs should be obtained prior to the administration of medications whose indications require these measures.