

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145581	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER Autumn Meadows of Cahokia		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34964</p> <p>Based on interview and record review, the facility failed to prevent employee to resident physical abuse by a staff member for 1 of 3 residents (R2) reviewed for abuse in the sample of 4. This failure resulted in R2 sustaining a bloody lip causing him to be upset and having pain.</p> <p>Findings include:</p> <p>On 10/22/24 at 3:15 PM R2 was sitting outside on patio. He stated a CNA (Certified Nursing Assistant) hit him about a week ago. He stated they were talking stuff to each other and she hit him one time in the mouth with her fist. He stated it hurt.</p> <p>On 10/23/24 at 12:20 PM R2 stated when V4, CNA, hit him in his mouth with her fist he was very upset. He stated it hurt a lot. He stated V4 got a wet cloth and wiped the blood off his lips.</p> <p>The facility's Illinois Department of Public Health (IDPH) Notification Form dated 10/13/24 at 10:00 PM documents, under description of Accident, Causes, Injuries and Action taken by Establishment as a result of Accident: Reported to Administrator at 10:00 resident told family member CNA hit him in the mouth. CNA sent home. Investigation ongoing. R2 was identified as the resident referred to in the report. The form documents the police were not informed at time of the report. It documents the type of incident is alleged physical abuse.</p> <p>The facility's Final Report of the Abuse Investigation dated 10/18/24 at 8:38 AM documents, 10/16/24 I (V1, Administrator) called (V4, CNA) this AM and ask she come in as the investigation has been completed and we need to speak to her about the results. (V4) arrived at 11:08; she arrived to speak with myself and (V2, Director of Nursing (DON) in the multipurpose room. I presented the termination paperwork and reasoning being the investigation and camera review provided substantial evidence and it was believed this incident probably did happen. She refused to sign the termination paper. When she exited the building, she walked around to the back of the building then drove around; that's when the (local) police department blocked her in, she parked her car and (local) police department took her into custody.</p> <p>The facility's document labeled, (V4) Resident Abuse Incident 10/13/24 Video Investigation documents a timeline of what V15, the facility's IT director observed on the camera footage minute by minute as he reviewed the footage. It documents, 7:25:50 Employee appears to be punching at resident.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/22/24 at 1:30 PM the facility's video camera coverage dated 10/13/24 between 7:15 AM and 7:26 AM was observed with V1 Administrator. The camera footage showed the inside of R2's room with his feet and legs visible. On the footage V4 is observed entering R2's room and standing at the foot of his bed. V4 then grabs R2's sheets/blankets in her hands and pulls but it appears he is pulling against her and keeping sheet/blanket pulled up. V4 lets go of the sheet/blanket and raises her arms with hands fisted and thrusts both fists towards area where R2's torso and head would be located. Unable to see if she makes contact with R2 or not, but then V4 stops and closes the door to R2's room with her on the inside.</p> <p>On 10/23/24 at 9:43 AM V8, Licensed Practical Nurse (LPN) stated she heard about R2's allegation that a CNA had hit him in the mouth when staff were talking about it around her. She stated she did not do anything at the time because they were not talking directly to her, they were just talking around her. She stated it was about 6:30 PM and it was halfway through her shift, and they said it happened on day shift, so she thought it had already been reported. She stated she thinks she notified (V2), DON and (V13), Assistant Director of Nursing (ADON) at that time just to make sure they were aware. She stated she had talked to R2 at the beginning of her shift, and he had not said anything to her about a CNA hitting him at that time. V8 stated around 9:30 PM R2's sister, (V11) came walking out of the dining room and was irate, wanting to know what was going to happen to the CNA who hit R2. V8 stated she went and looked at R2's lip and had to pull it up to see the mark on it. She stated it was small area, described it as you could cover it with the tip of your finger, and was white, like it was old, not red or bleeding. V8 stated she had tele-messaged the DON and ADON earlier and told the sister it would be addressed tomorrow. V8 stated she did not notify the administrator because she did not know she was supposed to. She stated she was not aware the administrator is over the DON, so she messaged the DON and ADON.</p> <p>On 10/23/24 at 10:29 AM V2 stated the first he heard about the incident regarding R2 being hit in the mouth by V4, CNA was on 10/13/24 around 8:30 PM from V12, R2's niece. V2 stated he did not know if (V8) had sent him a message earlier that evening and stated he could not find the message on his phone. V2 stated he sometimes has problems with his phone, so he doesn't know if she tried to message him or not. V2 stated he did not call and talk to staff after R2's niece called him. He stated he came in the next day and talked to R2 and assessed him. V2 stated R2 didn't seem to remember the incident and did not have any marks or bleeding on his lip when he assessed him. He stated he would have expected V8 to assess the resident as soon as she heard about it to check for injuries and ask what happened, and to report it to the administrator.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/23/24 at 12:15 PM V11, R2's sister/POA (Power of Attorney) stated R2 had called her around 11:30 AM on Sunday, October 13, 2024, and told her he wanted her to come up and see him. She stated he did not say anything about the CNA hitting him, he just said he wanted her to come, so she did not get in a hurry to get up to the facility. V11 stated when she got to the facility it was around 4:30 PM and R2 was not in his room so she went and found him in the dining room. She stated he was eating dinner, and she noticed his left side of his mouth was swollen and she asked him what happened, and he told her (V4) got mad at him that morning because he did not want to get out of bed, and they were talking shit and she hit him in the mouth. V11 stated she looked in his mouth and his gums were bloody, and he had a little piece of meat (skin) hanging from him left upper lip. She stated he was complaining of pain while he was eating. V11 stated she went and asked the nurse (V8) that had just come on duty on the afternoon shift what had happened, and she stated she did not know anything about it and V11 stated she told her what (R2) had told her about the CNA hitting him in the mouth that morning. V11 stated she could not remember the nurse's name but stated She is here today. V11 walked up to the nurse's station and identified V8 as the nurse she spoke to on Sunday, October 13, 2024, about R2 stating he had been hit in the mouth by V4. V11 stated on that Sunday when she reported the incident to V8, V8 told her she would need to do a report and report it to the DON. V11 stated this conversation and V8's observation of R2's mouth happened in the hall after he left the dining room and was on the way back to his room at about 4:45 PM. V11 stated she did talk to V8 again because V8 thought R2 was talking about a different CNA but R2 clarified to V8 that it was V4, CNA who had hit him. V11 stated she and V8 both asked him why he did not tell staff what happened, but he didn't really have a reason. V11 stated she is upset because it is a resident's right to stay in bed a little longer if they want and he should not have been abused just because he didn't want to get up when V4 wanted him up.</p> <p>On 10/23/24 at 12:46 PM V14 Social Service Director (SSD) stated she did see R2 on Monday morning before lunch the day after V4 had allegedly hit him. She stated she did not see any active bleeding, but he did have a piece of meat hanging on his left upper lip. She stated he did complain of pain to his mouth.</p> <p>On 10/23/24 at 2:16 PM V10, CNA Supervisor, stated she did not work on Sunday, October 13, 2024, but she did work on the next day, and she saw R2 in the dining room where she helps pass breakfast trays. She stated he was acting his usual self, and she did see he had marks on his upper and lower lips that looked like impressions from his teeth. She stated she looked closer at his lips because she had seen some dried blood on his lips around that area.</p> <p>On 10/23/24 at 1:10 PM V1, Administrator, stated it would never be acceptable for a staff to hit a resident. V1 stated she had not reported V4 to the Department of Professional Regulations yet because she was waiting for the police report to send to them. She stated she did not immediately terminate V4 but did suspend her because she wanted to make sure the police got what they needed so she wouldn't get away with what she did. She stated the police viewed the camera footage on Monday afternoon and decided to press charges against V4 for assaulting R2.</p> <p>R2's Face Sheet documents his diagnoses to include Chronic Obstructive Pulmonary Disease, Unspecified, Chronic Kidney Disease, Stage 3B, Type 2 Diabetes Mellitus with Diabetic Neuropathy, Other Seizures, Chronic Systolic (Congestive) Heart Failure, Schizophrenia, Need for Assistance with Personal Care, Peripheral Vascular Disease, Hypertension, Cerebral Infarction, and Generalized Anxiety Disorder.</p> <p>(continued on next page)</p>		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	<p>R2's Order Summary Report dated 10/22/24 documents his medications include Xarelto 15 milligrams (mg), a blood thinner which he takes daily.</p> <p>R2's Minimum Data Set (MDS) dated [DATE] documents his Brief Interview for Mental Status Score (BIMS) is 12, which indicates he is moderately cognitively impaired, and he requires substantial to maximal assist to perform bed to chair and chair to bed transfers.</p> <p>R2's Care Plan initiated on 2/22/22 and revised on 10/17/24 documents, (R2) is at risk for making repeated inappropriate sexual comments/gestures towards staff, verbal/physical/sexual abuse and threats/accusations against staff r/t (related to) impulsiveness, impaired cognition. The goal for this care plan documents, He will refrain from making inappropriate sexual comments and/or suggestions toward staff. He will not touch female staff in a sexually suggestive manner. This care plan was updated on 10/13/24 with the intervention: Monitor open area to lip for s/s (signs and symptoms) of infection. Notify Psyche NP (Nurse Practitioner) of incident. Offer comfort and reassurance as indicated. Per the care plan these interventions were initiated on 10/16/24.</p> <p>R2's Care Plan initiated on 12/21/21 and revised on 10/16/24 documents, (R2) is at risk for skin breakdown and injury related to incontinence, decreased mobility, poor safety awareness and renal disease. 10/13/24 Open area to lip (nosocomial)). Intervention added on 10/16/24 documents, Monitor open area to lip for s/s of infection. Administer pain medications as indicated / requested.</p> <p>The facility's document, Personnel Action Form, dated 10/15/24 documents V4 was terminated for inappropriate conduct. Description of Action or Event documented: 10/13/24 at 7:25 AM Resident complained a CNA hit him in the mouth with a closed fist. Investigation and camera review shows a reasonable probability that this did occur. Police plan to press charges. Action taken: Termination.</p> <p>The facility's policy, Abuse Prevention Program, revised 2/2023, documents, This facility affirms the right of our residents to be free from abuse (verbal, mental, sexual or physical), neglect, misappropriation of resident property, exploitation, corporal punishment, involuntary seclusion and physical and chemical restraints that are not required to treat a resident's medical symptoms. this facility therefore prohibits acts of mistreatment, neglect, abuse and/or crimes from being committed against its residents. This facility desires to establish a resident sensitive and resident secure environment.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>34964</p> <p>Based on interview and record review, the facility failed to immediately report an allegation of employee physical abuse to the administrator and notify the local law enforcement for 1 of 3 residents (R2) reviewed for reporting of abuse allegations in the sample of 4.</p> <p>Findings include:</p> <p>On 10/23/24 at 12:20 PM R2 stated when V4 hit him in his mouth with her fist he was very upset. He stated it hurt a lot. He stated V4 got a wet cloth and wiped the blood off his lips.</p> <p>The facility's Illinois Department of Public Health (IDPH) Notification Form dated 10/13/24 at 10:00 PM documents, under description of Accident, Causes, Injuries and Action taken by Establishment as a result of Accident: Reported to Administrator at 10:00 resident told family member CNA hit him in the mouth. CNA sent home. Investigation ongoing. R2 was identified as the resident referred to in the report. The form documents the police were not informed at time of the report. It documents the type of incident is alleged physical abuse.</p> <p>The facility's Final Report of the Abuse Investigation dated 10/18/24 at 8:38 AM documents, 10/16/24 I (V1, Administrator) called (V4, CNA) this AM and ask she come in as the investigation has been completed and we need to speak to her about the results. (V4) arrived at 11:08; she arrived to speak with myself and (V2, Director of Nursing (DON)) in the multipurpose room. I presented the termination paperwork and reasoning being the investigation and camera review provided substantial evidence and it was believed this incident probably did happen. She refused to sign the termination paper. When she exited the building, she walked around to the back of the building then drove around; that's when the (local) police department blocked her in, she parked her car and (local) police department took her into custody. The final report documented that the police were notified on 10/14/24 at 7:45 AM.</p> <p>The facility's document labeled, (V4) Resident Abuse Incident 10/13/24 Video Investigation documents a timeline of what V15, the facility's IT director observed on the camera footage minute by minute as he reviewed the footage. It documents, 7:25:50 Employee appears to punching at resident.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/23/24 at 9:43 AM V8, Licensed Practical Nurse (LPN) stated she heard about R2's allegation that a CNA had hit him in the mouth when staff were talking about it around her. She stated she did not do anything at the time because they were not talking directly to her, they were just talking around her. She stated it was about 6:30 PM and it was halfway through her shift, and they said it happened on day shift, so she thought it had already been reported. She stated she thinks she notified (V2), DON and (V13), Assistant Director of Nursing (ADON) at that time just to make sure they were aware. She stated she had talked to R2 at the beginning of her shift, and he had not said anything to her about a CNA hitting him at that time. V8 stated around 9:30 PM R2's sister, (V11) came walking out of the dining room and was irate, wanting to know what was going to happen to the CNA who hit R2. V8 stated she went and looked at R2's lip and had to pull it up to see the mark on it. She stated it was small area, described it as you could cover it with the tip of your finger, and was white, like it was old, not red or bleeding. V8 stated she had tele-messaged the DON and ADON earlier and told the sister it would be addressed tomorrow. V8 stated she did not notify the administrator because she did not know she was supposed to. She stated she was not aware the administrator is over the DON, so she messaged the DON and ADON.</p> <p>On 10/23/24 at 10:29 AM V2, Director of Nursing, stated the first he heard about the incident regarding R2 being hit in the mouth by V4, CNA was on 10/13/24 around 8:30 PM from V12, R2's niece. V2 stated he did not know if (V8) had sent him a message earlier that evening and stated he could not find the message on his phone. V2 stated he sometimes has problems with his phone, so he doesn't know if she tried to message him or not. V2 stated he did not call and talk to staff after R2's niece called him. He stated he came in the next day and talked to R2 and assessed him. V2 stated R2 didn't seem to remember the incident and did not have any marks or bleeding on his lip when he assessed him. He stated he would have expected V8 to assess the resident as soon as she heard about it to check for injuries and ask what happened, and to report it to the administrator.</p> <p>On 10/23/24 at 11:10 AM V2 provided a copy of the tele-message from R2's Electronic Medical Record (EMR) that was dated 10/13/24 at 8:32 PM sent by V8 marked Secure Conversations that documented, the resident's sister stated he was struck in the mouth by an aid this morning for refusing to get out of bed and also that his shoes are missing and the resident stated that his roommate brother took them. V2 stated he would not have seen this communication until he was back in the facility on his computer. He stated if there is something important to report to him, staff would need to call him on his cell phone directly.</p> <p>The facility's document, Personnel Action Form, dated 10/14/24 documents V8 was given a disciplinary/corrective action for event that happened on 10/13/24 at 5:35 PM which was described as, Not following Abuse Policy and failing to notify administrator of alleged abuse, which is not following policy. Per this form, expectations for employee are: Report alleged abuse to administrator immediately. Under Employee's comments on this document, V8's handwritten response documented, The incident occurred on a prior shift. I was unaware that it wasn't reported due to the nurse on the prior shift contacting the family for the resident, but I did reach out and tele-messaged the DON/ADON during my shift to see if they were aware of the incident at 6:30 PM when the family member asked me what action was being taken about it and stated she wanted the CNA who was responsible fired. Unaware that I was supposed to contact the administrator.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/23/24 at 12:15 PM V11, R2's sister/POA (Power of Attorney) stated she arrived at facility around 4:30 PM and R2 was not in his room so she went and found him in the dining room. She stated he was eating dinner, and she noticed his left side of his mouth was swollen and she asked him what happened, and he told her (V4) got mad at him that morning because he did not want to get out of bed, and they were talking shit and she hit him in the mouth. V11 stated she went and asked the nurse (V8) that had just come on duty on the afternoon shift what had happened, and she stated she did not know anything about it and V11 stated she told her what (R2) had told her about the CNA hitting him in the mouth that morning. V11 stated she could not remember the nurse's name but stated She is here today. V11 walked up to the nurse's station and identified V8 as the nurse she spoke to on Sunday, October 13, 2024, about R2 stating he had been hit in the mouth by V4. V11 stated on that Sunday when she reported the incident to V8, V8 told her she would need to do a report and report it to the DON. V11 stated this conversation and V8's observation of R2's mouth happened in the hall after he left the dining room and was on the way back to his room at about 4:45 PM. V11 stated she did talk to V8 again because V8 thought R2 was talking about a different CNA but R2 clarified to V8 that it was V4, CNA who had hit him. V11 stated she and V8 both asked him why he did not tell staff what happened, but he didn't really have a reason.</p> <p>On 10/23/24 at 1:10 PM V1, Administrator, stated it would never be acceptable for a staff to hit a resident. V1 stated she had not reported V4 to the Department of Professional Regulations yet because she was waiting for the police report to send to them. She stated the police were notified on 10/14/24 and viewed the camera footage on Monday afternoon and decided to press charges against V4 for assaulting R2. V1 stated she should have been notified immediately with a phone call when staff were first aware of R2's allegation that V4 had hit him. V1 stated tele-messages are not appropriate to notify her of abuse because they are not monitored all the time when management is not in the facility.</p> <p>The facility's document, Personnel Action Form, dated 10/15/24 documents V4 was terminated for inappropriate conduct. Description of Action or Event documented: 10/13/24 at 7:25 AM Resident complained a CNA hit him in the mouth with a closed fist. Investigation and camera review shows a reasonable probability that this did occur. Police plan to press charges. Action taken: Termination.</p> <p>The facility's policy, Abuse Prevention Program, revised 2/2023, under the section Policy Guidelines and Interpretation documents, 1. All covered individuals are required to immediately report any occurrences of potential mistreatment, abuse, neglect, mistreatment, including injuries of unknown source, adverse events, exploitation, theft, or crimes committed against a resident that they observe, hear about, or suspect to the administrator or to an immediate supervisor who must then immediately report it to the administrator. In the absence of the administrator, reporting can be made to an individual who has been designated to act as administrator in the administrator's absence. Under Federal law covered individuals are required to report suspicions that a crime has been committed against a resident to the Department and local law enforcement as described below. 2. For crimes that result in serious bodily injury as defined above a covered individual must report by phone or facsimile within two (2) hours of the formulation of a reasonable suspicion.</p>		