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	11/15/2024

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33110 Based on interview, record review and observation the facility failed to prevent resident to resident abuse for 3 of 5 residents (R2, R3, R5) reviewed abuse in the sample of 5. Findings Include: 1. R2's MDS dated [DATE] documents R2 is cognitively intact. R2's Electronic Health Record documents R2 has diagnoses of Cerebrovascular Disease, Acquired Absence of right and left leg below the knee, Atrial Fibrillation, Chronic Kidney Disease, and Non compliance with Medications. R3's MDS dated [DATE] documents R3 is moderately cognitively impaired. R3's Electronic Health Record documents R3 has in part the diagnoses of Post Traumatic Stress Disorder, Anxiety Diosrder, Violent Behavior, and Bipolar Disorder. R3's Care Plan dated 3/22/24 documents (R3) has a history of severe abuse, neglect, and confinement. She has a heightened level of fear especially anxiety and mistrust of others Goal: safety will be maintained. [NAME] doe will be placed on her door instead of her name. Information concerning (R3) can only be given to (V3) (V1 or V2) to be notified if anyone calls for her. (R3's) care plan dated 5/9/24 also document increase in behaviors non-compliance verbal and physical aggression paranoia, hallucinations and delusions Goal: she will not have an increase in behaviors. Observe and report increase in behaviors. R2's Nurse's Note dated 10/5/24 documents Activity worker notified (this) writer that this resident (R2) grabbed the back of a female resident's (R3) chair and pushed it extremely hard causing female resident (R3) to roll into the wall really hard. Residents (R2 and R3) were separated resident (R2) was asked why he pushed the other resident (R3) he (R2) stated to activity worker he was tired of her running into his damn chair. DON (Director of Nursing notified along with Administrator. On 11/14/24 at 10:30 AM, R3 was inside the nurses station with staff, and she was cursing the staff. (continued on next page)

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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/15/24 at 9:35 AM, V9 Activity Aide stated, I was doing an activity game. They play multiple games according to their own level. It was at 10:00 AM. The smokers kept coming into the room asking about smoke break. (R3) asked about smoke break I told her (R3) I would be there in a minute. She (R3) accidently bumped into R2's chair. (R2) then pushed her chair hard into this white thing that is near the wall. (R3) began crying, but she was not hurt. I (V9) immediately called the nurse. V9 was asked who she should have reported it to she said the nurse and the nurse called the DON. She was unsure it the administrator was actually notifed. On 11/15/24 9:40 AM, V8, LPN (Licensed Practical Nurse) stated, yes they came to the desk and told me that (R2) had pushed (R3's) chair into the wall. (R2) told me that he was tired of (R3) running into his chair. On 11/15/24 at 10:02 AM, V1, Administrator stated they did not have an investigation for this resident to resident altercation. 2. R5's MDS dated [DATE] documents R5 is moderately cognitively impaired. R5's Electronic Health Records Diagnoses Cerebral Infarction, Hemiparesis, Hemiplegia, HTN, Repeated Falls, Slurred Speech R5's Nurses Note dated 10/23/24 documents staff made this writer aware that a female resident (R3) hit this resident (R5). Resident (R5) states she hit me right here in the face and pointed at his chin. Resident (R5) unclear as to why he was hit, or what caused her(R3) to hit him (R5). Resident (R5)states it does not hurt, and there is no bruising nor discoloration noted to the area. MD (Medical Doctor) made aware, NNO (No New Orders) at this time. Resident's (R5) sister/POA (Power of Attorney) contacted and made aware. She voices no concerns. Resident (R5) currently sitting in his wheelchair watching tv (television), no s/s (signs or symptoms) of distress noted. Plan of care ongoing. R3's Nurses Note dated 10/23/24 documents writer was notified by staff that resident (R3) was physically abusive towards another resident (R5). Staff stated this resident (R3) punched another resident in the face multiple times. This resident (R3) was removed from area by other staff members and placed at nurses station. Writer notified the Administrator (V1) along with DON (V2) began an investigation IDPH Notification form dated 10/23/24 documents (R3) was witnessed striking (R5), while at the table residents separated and no injuries. Families and physician notified staff and other residents were interviewed. No issues with the investigation was found The facility policy Abuse Prevention Program dated 2/2023 documents this facility affirms the right of our residents to be free from abuse (verbal, mental, sexual, or physical.) Abuse means physical, mental, or sexual assault inflicted upon a resident other than accidental means in a facility.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33110 Based on interview, record review, and observation the facility failed to investigate resident to resident abuse for two of five residents (R2, R3) reviewed for abuse in the sample of 5. Findings Include: The facility policy Abuse Prevention Program dated 2/2023 documents this facility affirms the right of our residents to be free from abuse (verbal, mental, sexual, or physical.) Abuse means physical, mental, or sexual assault inflicted upon a resident other than accidental means in a facility. R2's MDS dated [DATE] documents R2 is cognitively intact. R3's MDS dated [DATE] documents R3 is moderately cognitively impaired. R2's Nurse's Note dated 10/5/24 documents Activity worker notified (this) writer that this resident (R2) grabbed the back of a female resident's (R3) chair and pushed it extremely hard causing female resident (R3) to roll into the wall really hard. Residents (R2 and R3) were separated resident (R2) was asked why he pushed the other resident (R3) he (R2) stated to activity worker he was tired of her running into his damn chair. DON (Director of Nursing notified along with Administrator. On 11/15/24 at 9:35 AM, V9, Activity Aide stated, I was doing an activity game. They play multiple games according to their own level. It was at 10:00 AM. The smokers kept coming into the room asking about smoke break. (R3) asked about smoke break I told her (R3) I would be there in a minute. She (R3) accidently bumped into R2's chair. (R2) then pushed her chair hard into this white thing that is near the wall. (R3) began crying, but she was not hurt. I (V9) immediately called the nurse. V9 was asked who she should have reported it to she said the nurse and the nurse called the DON. She was unsure it the administrator was actually notifed. On 11/15/24 9:40 AM, V8, LPN (Licensed Practical Nurse) stated, yes they came to the desk and told me that (R2) had pushed (R3's) chair into the wall. (R2) told me that he was tired of (R3) running into his Chair. On 11/15/24 at 10:02 AM, V1, Administrator stated they did not have an investigation for this resident to resident altercation.