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	12/17/2024

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 - 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** 49494 Based on interview and record review the facility failed to provide services per current standards of practice, rising to the level of neglect with R2 sustaining a femur fracture on an unknown date, with the femur bone ultimately penetrating through the skin after 15 days of documented continued pain and extremity abnormality. This failure resulted in R2 being hospitalized with an open femur fracture requiring surgical intervention which caused pain and suffering. Findings include: R2's face sheet, print date of 12/16/24, documented R2 has diagnoses of unspecified fracture of right femur, unspecified severe protein-calorie malnutrition, Alzheimer's disease, atherosclerosis, paranoid schizophrenia, drug induced dyskinesia, contractures, history of cerebral infarction, cognitive communication deficit, osteoporosis, and functional quadriplegia. R2's MDS (Minimum Data Set), dated 12/4/24, documented R2 is moderately cognitively impaired, is non-ambulatory, and is dependent on staff for transfers. R2's hospice aide visit note, dated 11/15/24 at 8:45 AM, documented patient's right foot swollen and bruised. Case manager updated on new concerns. R2's radiology results report, dated 11/17/24, documented reason for study: localized swelling, mass and lump, right lower limb. Findings: views of the knee show mild joint space loss and subchondral sclerosis compatible with osteoarthritis. No acute fracture or dislocation is seen. No significant joint effusion is noted. Conclusion: Mild osteoarthritis, without fracture. R2's EMR (Electronic Medical Record) progress note dated 11/22/24 at 3:12 AM documented patient right knee is very swollen and c/o (complaining of) pain. Medicated for pain. R2's EMR progress note dated 11/26/24 at 10:26 PM documented .she is complaining of pain in her knee and foot. R2's hospice aide visit note, dated 11/29/24 at 8:30 AM, documented right leg, knee, and foot swollen. Case Manager and in house nurse updated on new concern and visit. (continued on next page)

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	R2's hospice nurse visit note, dated 11/29/24 at 10:30 AM, documented patient continues to have some increased swelling to her right foot and leg up to her knee at a +2 edema. R2's hospice nurse triage notes, dated 12/1/24 at 7:43 AM, documented patient's right knee is swollen and painful to touch. Advised to give patient pain medication. It continues, patient's right knee is more swollen than a week ago. R2's EMR progress note dated 12/1/24 at 11:13 AM documented aide notified nurse of resident right knee looking abnormal. Upon assessment resident knee was swollen with minimal pain to touch. MD notified and stated to refer resident to orthopedic surgeon as outpatient f/u (follow up). DON (Director of Nursing) notified, and hospice nurse will leave message for regular nurse to follow up with resident. R2's EMR progress note dated 12/4/24 at 11:33 AM documented per nursing documentation R2 had c/o right knee pain during look back. 11/29 NOR (new order received) for Tylenol TID (3 times per day). R2's hospice aide visit note, dated 12/6/24 at 9:00 AM, documented patient has blister on right knee. Case Manager and in house nurse updated. R2's hospice nurse notes, dated 12/6/24 at 12:20 PM, documented our HHA (hospice health aide) found a small blister on her right knee today while bathing. It continues, treatment orders - cover blister with 3x3 foam dressing daily and prn (as needed). Increased pain related to blister. New orders received: tramadol 25mg BID (two times a day) and q4hrs PRN. Education provided to sign on the new order that was giving in order to help control R2's pain better. R2's EMR progress note dated 12/6/24 at 1:45 PM documented resident knee continues to be monitored; hospice nurse was consulted to look at patient knee. Upon evaluation the knee swollen, and red. Writer asked hospice nurse for an order for pain medication for her pain. Tramadol was ordered TID and PRN (as needed). On 12/16/24 at 11:35 AM V21 CNA (Certified Nurse Assistant) stated she was assigned to R2's hall on 12/7/24 and that she made her first rounds at 6:30 AM, checked on R2 and could see R2's bone tightly up against the skin near right knee. Stated she informed day nurse V11 LPN and the night nurse. V21 stated these two nurses went and looked at R2's knee shortly after she told them. V21 stated when she checked on R2 around lunch time the bone was through the skin and there was blood on the sheets. On 12/16/24 at 11:50 AM V11 LPN (Licensed Practical Nurse) stated she was R2's nurse on 12/7/24 on the day shift. V11 stated she and the night nurse went and looked at R2's leg at approximately 6:30 AM on 12/7/24 and R2's right leg was swollen, red, and it appeared bone was up against the skin. R2 stated the night nurse had given R2 pain medication. V11 stated she did not notify R2's doctor at this time because prior x-rays were negative and that she did send her out once the bone came through the skin around noon. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	R2's EMR progress note dated 12/7/24 at 1:40 PM documented this nurse was informed by nursing that resident was noted to have something sticking out of her knee. Upon assessment this nurse noted an area to her right knee to look like bone sticking out of knee with clear and red fluid flowing from area. Vitals WNL (within normal limits). Emergency services contacted. MD/hospice made aware. Phoned POA (power of attorney) to inform. No answer. Admin notified. Ambulance in route. R2's hospice progress note, dated 12/7/24 at 1:43 PM documented patient bones popped through skin. Facility MD sent patient out. R2's EMR progress note dated 12/7/24 at 1:56 PM documented EMS (Emergency Medical Services) here to transport resident to hospital. R2's regional hospital emergency medicine notes dated 12/7/24, documented R2 presents to ED (Emergency Department) for evaluation of right leg deformity. Per EMS, patient was found in bed at her nursing home when staff found blood on her sheets and on further investigation noticed a deformity to the patients right distal femur with a poke hole oozing blood. Nursing home staff is unaware of any fall or when the trauma may have occurred. Patient has dementia so further history is limited secondary to patient mental acuity. Imaging notable for open fracture of the right distal femur. Orthopedics consulted. Given fracture and belief that had the patient fallen she would not have been able to get herself back into bed without staff being aware of her injury, will consult social work for concern of elder abuse. Will also get trauma scans and consult trauma surgery. R2's regional hospital orthopedic trauma surgery notes, dated 12/7/24, documented x-rays of right femur knee and tib-fib taken in the ED reviewed by me demonstrates right distal femur fracture with significant lateral displacement of the right proximal femur fragment. CT scan of the right knee taken in the ED and reviewed by me demonstrates right distal femur fracture with lateral displacement of the proximal femur fragment, appears to have significant callus formation around the fracture site indicating a nonacute fracture. There is gas tracking from open wound. It continues, given CT scan imaging showing callus formation around the fracture would lean towards this not being an acute fracture. Per son she has had no injury and was found in her bed today by nursing facility staff with open wound. Given also none reported injury to the right ankle 2 to 3 weeks ago cannot rule out NAT (Non-Accidental Trauma). R2's trauma admission history and physical dated 12/7/24 documented this is an [AGE] year-old female presenting as a level 3 - consult trauma following suspected fall/elder abuse. Concerns with safety at NH (nursing home). Son open to finding new establishment. R2's regional hospital operative progress notes, dated 12/9/24, documented this is an elderly woman who is very infirm and demented. Recently, the nursing home noted a small gradual ulcer and sore over the anterolateral distal femur, which actually was an open fracture. She apparently had a fracture of the distal femur, which was unrecognized; however, on presentation to regional hospital with the open wound, x-rays and CT (computed tomography) scan noted a significantly displaced comminuted but healed distal third femur fracture with significant malunion. Distal lateral spike from proximal segment was quite sharp and prominent and had eroded the skin and now was protruding approximately a center through the skin with skin breakdown, essentially an open delayed fracture. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 12/10/24 at 3:38 PM V7 LPN stated that she had been off work a week back in November and when she returned to work the CNAS told her R2's knee was swollen, bruised, warm, and red. V7 stated she thinks maybe R2's leg was broken around 11/17/24. V7 stated she told V2 DON that the in-house x-ray company they use may have missed the fracture on the x-ray. On 12/10/24 at 3:45 PM V8 CNA stated she took care of R2 last Thursday, 12/5/24, and that she told the nurses that R2's bone was broken in her leg because you could see the bone poking through the skin. V8 then demonstrated how the bone looked under the skin by sticking her hand partially in a disposable glove and pressing a finger tightly up and out against the glove. V8 stated R2 was in severe pain and R2's knee was warm and swollen. V8 stated she reported this to R2's nurse V7 and to another nurse on 12/5/24 and that they both said it was arthritis according to the x-ray. On 12/11/24 at 11:42 AM V7 LPN stated I think one of the CNAS did tell me last week that R2's bone looked like it was popping through the skin, so she went and looked at R2's leg and did not think it looked like the bone was coming through. V7 stated she did call hospice at this time and got an order to increase R2's tramadol for her increase in pain. On 12/11/24 at 11:50 AM V10 LPN stated when she worked two weekends ago an agency nurse asked her to go down and look at R2's leg because the agency nurse thought the leg appeared fractured. V10 stated R2 grimaced when she touched R2's leg. R2 stated that the agency nurse informed her she called R2's hospice nurse and updated hospice on R2's leg but that she does not recall what hospice did about the nurse's concerns. On 12/11/24 at 11:57 AM V11 LPN stated she has been R2's nurse a few times over the past few weeks and that R2's right leg was red and swollen. On 12/11/24 at 1:00 PM V13, Hospice RN, stated Oh my God, a few days prior, she (R2) had a small blister that had formed that looked like a pressure injury. V13 stated he was notified by V14 Hospice CNA, around 11/15/24, that R2 had bruising to the bottom of her ankle with swelling, the facility ordered an x-ray. V13 stated he notified V12, R2's son and he (V13) and V12 thought it was weird that she would have bruises and swelling since R2 barely moved and was either in the reclining wheelchair or her bed. V13 stated he assessed R2, and Tylenol and Lasix were ordered, the next week when V13 returned the leg was swollen, going up the calf and towards the knee and the knee had started to swell. V13 stated he reported this to the facility and V14, reported that she had also notified the facility. V13 stated the following week, there was a small area of redness that appeared to be a pressure injury from R2 being contracted and her knees rubbing together. V13 stated skin prep was ordered. The next time he was notified he was told that R2's bone was sticking out of her leg. V13 stated in his opinion, that type of an injury could have only occurred during a transfer or something of that nature because R2 didn't move, and she was either in the reclining wheelchair of the bed. V13 stated he was never notified of any of the changes in R2 by the facility only by V14. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 12/11/24 at 1:55 PM V14, Hospice CNA, stated approximately 3 weeks ago, she noticed bruising from the bottom R2's heel and swelling in the foot. V14 stated when she would touch the heel, leg or foot, R2 would jump, make noises and grimace. V14 stated she told V10, LPN, and she took V14 along with two other nurses, unsure of names, to look at R2's foot. When V14 stated she comes to bathe R2 on Thursdays, except the week of Thanksgiving and she came that Friday. V14 stated when she came the week of Thanksgiving, R2's entire leg and knee was huge, swollen, and went up the entire leg. V13, stated she notified R2's nurse, unsure of name. V13 stated there was a blistered area to the knee that was white in the center, and it looked like bone. V13 stated she then called V13 to notify him. On 12/12/24 at 8:26 AM V18 LPN stated she was R2's nurse on 11/17/24 and that she contacted V19 R2's primary physician because R2's right knee was swollen. V18 stated she did not notice any bruising nor an increase in R2's pain symptoms V18 stated she notified V19 through the secure message system in PCC. V18 stated she is an agency nurse, so she does not work regularly and when she worked on 12/1/24 the CNAS informed her they were not getting R2 out of bed because it looked like something was protruding from the side of R2's knee and it was hard. V18 stated she looked at R2's knee and the protrusion was hard. V18 stated she reported this to the DON (Director of Nursing) V2, and he instructed her to get an order for x-rays of R2's knee. V18 stated she notified V19 through the secure messenger system and sent V19 a photo of R2's knee. V18 said V19 replied that it looked like water under the knee, no x-ray ordered but did order a referral to an outpatient orthopedic doctor. V18 stated this occurred on a Sunday and she thinks she put in an order for the referral and passed it on in report, but she does not know if the appointment was ever set up. V18 stated she called the hospice nurse on 12/1/24 about R2 and that hospice said don't send R2 to the hospital and just keep her comfortable. V18 stated outpatient referral need to be approved by hospice but she did not inform the hospice nurse about V19 ordering the outpatient orthopedic referral. V18 stated she does not know if V19 was informed of the ongoing issues with R2's knee because she is just agency. V19 stated she messaged him on 11/17/24 and 12/1/24. R2's progress notes do not document any physician notification on 11/17/24. On 12/12/24 at 9:06 AM V1 (Administrator) stated no order for the outpatient orthopedic consultation was put into R2's record nor did the facility arrange an appointment for R2 to see an orthopedic surgeon, although acknowledging a referral had been made. On 12/12/24 at 9:25 AM V19 R2's primary physician stated he had received notifications from the facility regarding R2's edema via the secure message system. V19 stated he would have to check his records to see when and how many times he was notified. V19 stated he was notified from time to time on her. V19 stated he was not aware that the facility did not put in an order in the EMR for the orthopedic referral he gave on 12/1/24 nor was he aware of the facility not setting up this appointment. V19 stated that for R2's bone to come through her skin it had to be caused by trauma and that a pathological fracture would not cause this. V19 stated he would have expected the facility to immediately initiate an investigation on 11/15/24 when the EMR documented an injury to R2's right foot. On 12/12/24 at 11:19 V19 (R2's physician and facility Medical Director) stated he is not able to view secure messages from the facility nurses beyond 12/4/24 because the system deletes them after a week. On 12/7/24 he was notified bone was sticking through the skin and he had R2 sent to the ER. V19 stated the facility contacted him again on 12/9/24 that R2 was admitted to the hospital with a femur fracture and that he requested more information from the facility of how the fracture happened, and he has not heard back from the facility. V19 stated he does not recall being told by the nurse on 12/1/24 that R2's bone appeared to be protruding under the skin. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 12/16/24 at 11:25 AM V1 stated the facility should have reported and investigated R2's right leg injury when it was first found on 11/15/24. V1 stated the facility nurses should have been closely assessing R2's leg and should have updated R2's primary physician of R2's right leg condition changes. On 12/16/24 at 11:27 AM V20 Regional Director stated R2's leg injury should have been investigated when it was first noted on 11/15/24, R2's leg should have been closely monitored, and that R2's attending physician should have been updated of the ongoing changes of R2's condition. Review of R2's Clinical Record documented despite multiple continued reports of pain, abnormal extremity presentation without signs of healing, and specific reports of a bone appearing the facility initiated no further diagnostic testing to evaluate and treat. R2's Clinical Record documents the only x-ray's R2 received following the initial bruising, in which a possible injury was suspected was on 11/16/24 and 11/17/24, both in the facility. The facility Abuse Prevention Program policy, revision date of 2/2023, documented 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. It is the policy of this facility to develop a mechanism to reduce the risk of abuse, neglect, misappropriation of resident property and/or crimes from being committed against the residents of this facility. It continues, neglect as defined at 483.5, means the failure of the facility, its employees or service providers to provide goods and services to a resident a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49494 Based on interview and record review, the facility failed to immediately investigate a resident injury of unknown origin for 1 of 4 residents (R2) reviewed for injuries of unknown origin and abuse. This failure resulted in R2 experiencing increased pain and swelling from 11/15/24 until 12/7/24 when R2 was admitted to a regional hospital. R2's leg injury of unknown origin was first documented on 11/15/24 and R2's unknown injury investigation was not initiated until 12/9/24 two days after R2's fracture femur penetrated through her skin. This failure has the potential to affect all 88 residents residing in the facility. Findings include: R2's face sheet, print date of 12/16/24, documented R2 has diagnoses of unspecified fracture of right femur, unspecified severe protein-calorie malnutrition, Alzheimer's disease, atherosclerosis, paranoid schizophrenia, drug induced dyskinesia, contractures, history of cerebral infarction, cognitive communication deficit, osteoporosis, and functional quadriplegia. R2's MDS, dated [DATE], documented R2 is moderately cognitively impaired, is non-ambulatory, and is dependent on staff for transfers. R2's care plan, undated, documented R2 requires a mechanical lift for all transfers. R2's resident care flow sheet, undated, documented R2 is assist of 1 for transfers. R2's EMR (Electronic Medical Record) progress note dated 11/15/24 at 10:16 AM documented slight discoloration to right posterior foot observed, appears to be injury, green in color and edema to right foot, origin unknown, no incident reported, facial grimacing observed when palpated, NP (Nurse Practitioner) notified, and hospice nurse notified. R2's incident report, dated 11/15/24 at 10:06 AM, documented incident description: slight discoloration to R (right) posterior foot, appears to be injury green in color and edema to R foot. Resident unable to give description. Predisposing Situation Factors: during transfer. R2's EMR progress note dated 11/20/24 at 8:48 AM documented writer was notified that resident's knee was very swollen, and she has a black bruise on her left and right coccyx. Wound nurse was notified to take a look at the area. MD (Medical Doctor) is already aware of the situation, there was an x-ray performed. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/11/24 at 9:37 AM Surveyor requested incident investigation from V1 for R2's injury that was documented in R2's progress notes on 11/15/24. V1 replied I don't see any incidents for that date, oh there is an incident report for that date in risk management, I am responsible for investigating and reporting incidents, but I didn't, and I don't know why it was not done. V1 stated that the facility does not have any staff statements nor any investigation notes for R2's unknown injury that was documented on R2's 11/15/24 incident report form. V1 stated that she does consider R2's injury that was documented on R2's 11/15/24 incident report to be an unknown injury. V1 stated that no staff notified her of R2's injury that was documented on 11/15/24 and that if she would have known about it then she would have investigated it. Surveyor asked V1 for more information regarding the statement V1 documented on R2's injury investigation that was initiated on 12/9/24, V1 documented V9 CNA usually works the front half of 600 so hasn't cared for her in some time but stated when she did work the back half of 600 1 time, she left R2 in bed due to the swelling. She stated that another CNA had spoken to her and told her that R2 had a fall. Surveyor asked V1 if she identified who the staff member was that told V9 that R2 had a fall and V1 stated I don't know who the CNA was because V9 could not recall the CNAS name. V1 stated she became aware of R2's injury on Saturday, 12/7/24 and reported the incident/unknown injury to IDPH on 12/9/24 after she was told by one of the facility's nurses that R2 had a femur fracture. V1 stated that she is the one who usually investigates the incidents since the facility terminated the QA nurse back in September of this year. V1 stated R2's injury to her right foot that was documented on 11/15/24 should have been investigated. R2's EMR progress note dated 12/7/24 at 1:40 PM documented this nurse was informed by nursing that resident was noted to have something sticking out of her knee. Upon assessment this nurse noted an area to her right knee to look like bone sticking out of knee with clear and red fluid flowing from area. Vitals WNL (within normal limits). Emergency services contacted. MD/hospice made aware. Phoned POA to inform. No answer. Admin notified. Ambulance in route. R2's regional hospital emergency medicine notes dated 12/7/24, documented R2 presents to ED (Emergency Department) for evaluation of right leg deformity. Per EMS, patient was found in bed at her nursing home when staff found blood on her sheets and on further investigation noticed a deformity to the patients right distal femur with a poke hole oozing blood. Nursing home staff is unaware of any fall or when the trauma may have occurred. Patient has dementia so further history is limited secondary to patient mental acuity. Imaging notable for open fracture of the right distal femur. Orthopedics consulted. Given fracture and belief that had the patient fallen she would not have been able to get herself back into bed without staff being aware of her injury, will consult social work for concern of elder abuse. Will also get trauma scans and consult trauma surgery. The facility's investigation notes of R2's right leg injury, dated 12/7/24, documented V1 Administrator was informed of R2 being sent to the ER (emergency room) on 12/7/24 for evaluation of a possible knee injury. It continues, 12/9/24 I (V1) was informed by V7 LPN (Licensed Practical Nurse) this AM at approximately 8:45 AM that R2 had a femur fx (fracture). I submitted the reportable injury. On 12/16/24 at 11:25 AM V1 stated the facility should have reported and investigated R2's right leg injury when it was first found on 11/15/24. V1 stated the facility nurses should have been closely assessing R2's leg and should have updated R2's primary physician of R2's right leg condition changes. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/16/24 at 11:27 AM V20 Regional Director stated R2's leg injury should have been investigated when it was first noted on 11/15/24, R2's leg should have been closely monitored, and that R2's attending physician should have been updated of the ongoing changes of R2's condition. On 12/17/24 at 9:40 AM V1 Administrator stated she did not investigate R2's coccyx bruising that was documented in R2's progress notes on 11/20/24. V1 stated that she was notified by R2's nurse on Saturday, 12/7/24 that R2's right leg bone came through her skin. V1 stated she did not initiate an investigation on 12/7/24 because she was out of town, nor did she delegate any members of the facility management team to go into the facility and initiate the investigation. V1 stated she started the investigation on Monday 12/9/24. The facility Abuse Prevention Program policy, revision date of 2/2023, documented 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. Policy: It is the policy of this facility to develop a mechanism to reduce the risk of abuse, neglect, misappropriation of resident property and/or crimes from being committed against the residents of this facility. This will be done by implementing the following systems and/or practices: It continues; Injuries of Unknown Source are defined by as an injury of unknown source when both of the following conditions are met: The source of the injury was not observed by any person or the sources of the injury could not be explained by the resident; and the injury is suspicious because of the extent of the injury or the location of the injury. It continues, Serious Bodily Injury is defined by the Elder Justice Act 2011(19)(A) as an injury involving extreme physical pain; involving substantial risk for death; involving protracted loss or impairment of a bodily member, organ, or mental faculty; or requiring medical intervention such as surgery, hospitalization , or physical rehabilitation. It continues, 5. Facility staff will investigate and report any allegations of abuse within timeframes required by Federal law. The facility's Reporting of Abuse, Neglect, Theft and Crimes policy, dated 2/23, documented It is the policy of this facility to establish internal reporting guidelines for facility staff in the event they become aware or formulate a reasonable suspicion that abuse, neglect, mistreatment, including injuries of unknown source, exploitation, theft, or a crime has been committed against a resident of the facility. Policy Guidelines and Interpretation: 1. Internal Reporting: a. 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. b. All covered individuals are required to immediately report any adverse event that results in the death or serious injury of a resident to the facility 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 an administrator in the administrator's absence. (continued on next page)

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	145581	A. Building B. Wing	12/17/2024

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Abuse, Neglect, Theft and Crimes Investigations policy, dated 2/23, documented this facility does not condone any form of resident abuse. This facility will take all reports of abuse, neglect, mistreatment, including injuries of unknown origin, against its residents seriously and will attempt to investigate allegations with the intent of detecting any wrongdoing, determining causative factors and when indicated, implementing corrective actions to prevent reoccurrence. Policy Guidelines and Interpretation: 1. The Administrator will immediately suspend any employee who has been accused of resident abuse pending the outcome of the investigation. 2. The facility will immediately implement investigative pathways associated with the event including the preservation of the scene, evidence, and the identification of witnesses. Resident Protection Investigation Paths, Injuries of Unknown Source, complete an incident report, if one has not been generated, include in investigative file. Do a full body exam, check range of motion, consult with physician, pull schedules, staffing pattern worksheets, and resident room rosters from at least 24 hours prior to the alleged event or injury and at the time the injury was noted to generate a list of individuals that will need to provide statement or be interviewed. Continue physical assessments and obtain vital signs at least every shift for the next 72 hours. The CMS 671 Form dated 12/17/2024 documents there are 88 residents residing at the Facility.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49494 Based on interview and record review the facility failed to assess, monitor, and provide timely treatment for R2's knee pain. This failure resulted in when R2 had continued pain and swelling from 11/15/24 until 12/7/24 at which time her femur bone was protruding through her skin. R2 was hospitalized with an open femur fracture requiring surgical intervention which caused pain and suffering, with an increased risk for infection, vascular issues, and subsequently could have resulted in death. The failure to provide ongoing assessment, monitoring, and treatment for R2's ongoing knee pain led to R2's undiagnosed femur fracture to develop into an open fracture. The Immediate Jeopardy began on 11/15/24 when R2's right foot injury was noted, and the facility failed provide ongoing assessment, monitoring, and timely treatment for R2's ongoing symptoms including an increase in swelling and pain. The facility did not seek treatment for R2's ongoing symptoms until R2's femur fracture penetrated through her skin on 12/7/24. On 12/13/24 at 12:40 PM V1, Administrator, was notified of the Immediate Jeopardy. The surveyors confirmed through interview and record review that the Immediate Jeopardy was removed on 12/15/24, but noncompliance remains at Level two because additional time is needed to evaluate the implementation and effectiveness of the in-service training and quality assurance. Findings include: R2's Face Sheet, print date of 12/16/24, documented R2 has diagnoses of unspecified fracture of right femur, unspecified severe protein-calorie malnutrition, Alzheimer's disease, atherosclerosis, paranoid schizophrenia, drug induced dyskinesia, contractures, history of cerebral infarction, cognitive communication deficit, osteoporosis, and functional quadriplegia. R2's Minimum Data Set, MDS, dated [DATE], documented R2 is moderately cognitively impaired, is non-ambulatory, and is dependent on staff for transfers. R2's Care Plan, undated, documented R2 requires a mechanical lift for all transfers. R2's Resident Care Flow Sheet, undated, documented R2 is assist of 1 for transfers. R2's Electronic Medical Record, EMR, Progress Note dated 11/15/24 at 10:16 AM documented slight discoloration to right posterior foot observed, appears to be injury, green in color and edema to right foot, origin unknown, no incident reported, facial grimacing observed when palpated, NP (Nurse Practitioner) notified, and hospice nurse notified. R2's Incident Report, dated 11/15/24 at 10:06 AM, documented incident description: slight discoloration to R (right) posterior foot, appears to be injury green in color and edema to R foot. Resident unable to give description. Predisposing Situation Factors: during transfer. R2's EMR Progress Note, dated 11/15/24 at 12:35 PM documented call return for the hospice nurse, made aware that NP (Nurse Practitioner) would give an order for x-ray to foot if hospice approved, V13 hospice Registered Nurse, RN agreed to x-ray. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R2's hospice aide visit note, dated 11/15/24 at 8:45 AM, documented patient's right foot swollen and bruised. Case manager updated on new concerns. R2's radiology results report, dated 11/16/24, documented reason for study: pain, right foot. Findings: There is mild osteopenia. There is mild degenerative joint disease seen. There is no fracture, dislocation, or soft tissue swelling. No osteomyelitis is seen. There is a plantar heel. Conclusion: Mild degenerative joint disease; otherwise, no fracture or dislocation seen. R2's radiology results report, dated 11/17/24, documented reason for study: localized swelling, mass and lump, right lower limb. Findings: views of the knee show mild joint space loss and subchondral sclerosis compatible with osteoarthritis. No acute fracture or dislocation is seen. No significant joint effusion is noted. Conclusion: Mild osteoarthritis, without fracture. R2's EMR Progress Note, dated 11/20/24 at 8:48 AM documented writer was notified that resident's knee was very swollen, and she has a black bruise on her left and right coccyx. Wound nurse was notified to take a look at the area. MD (Medical Doctor) is already aware of the situation, there was an x-ray performed. R2's EMR Progress Note, dated 11/22/24 at 3:12 AM, documented patient right knee is very swollen and c/o (complaint of) pain. Medicated for pain. R2's EMR Progress Note, dated 11/22/24 at 2:19 PM, documented writer was notified by CNA that resident only ate about 20% of her meal. CNA stated that she is having difficulty eating and drinking. R2's EMR Progress Note, dated 11/26/24 at 10:26 PM, documented resident remains on hospice. No s/s of distress. She is complaining of pain in her knee and foot. R2's hospice aide visit note, dated 11/29/24 at 8:30 AM, documented right leg, knee, and foot swollen. Case Manager and in house nurse updated on new concern and visit. R2's hospice nurse visit note, dated 11/29/24 at 10:30 AM, documented patient continues to have some increased swelling to her right foot and leg up to her knee at a +2 edema. There are no Progress Notes in R2's medical record from the facility from 11/26/24 through 12/1/24 regarding the condition or further assessment of R2's knee. R2's hospice nurse triage notes, dated 12/1/24 at 7:43 AM, documented patient's right knee is swollen and painful to touch. Advised to give patient pain medication. It continues, patient's right knee is more swollen than a week ago. R2's EMR Progress Note dated 12/1/24 at 11:13 AM documented aide notified nurse of resident right knee looking abnormal. Upon assessment resident knee was swollen with minimal pain to touch. MD notified and stated to refer resident to orthopedic surgeon as outpatient f/u (follow up). DON (Director of Nursing) notified, and hospice nurse will leave message for regular nurse to follow up with resident. R2's EMR Progress Note, dated 12/4/24 at 11:33 AM documented per nursing documentation R2 had c/o right knee pain during look back. 11/29 NOR (new order received) for Tylenol TID (3 times per day). (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R2's hospice nurse notes, dated 12/6/24 at 12:20 PM, documented our HHA (hospice health aide) found a small blister on her right knee today while bathing. It continues, treatment orders - cover blister with 3x3 foam dressing daily and prn (as needed). Increased pain related to blister. New orders received: tramadol 25mg BID (two times a day) and q4hrs PRN. Education provided to sign on the new order that was giving in order to help control R2's pain better. R2's EMR Progress Note dated 12/6/24 at 1:45 PM documented resident knee continues to be monitored; hospice nurse was consulted to look at patient knee. Upon evaluation the knee swollen, and red. Writer asked hospice nurse for an order for pain medication for her pain. Tramadol was ordered TID and PRN (as needed). R2's hospice aide visit note, dated 12/6/24 at 9:00 AM, documented patient has blister on right knee. Case Manager and in house nurse updated. R2's EMR progress note dated 12/7/24 at 1:40 PM documented this nurse was informed by nursing that resident was noted to have something sticking out of her knee. Upon assessment this nurse noted an area to her right knee to look like bone sticking out of knee with clear and red fluid flowing from area. Vitals WNL (within normal limits). Emergency services contacted. MD/hospice made aware. Phoned POA to inform. No answer. Admin notified. Ambulance in route. R2's hospice progress note, dated 12/7/24 at 1:43 PM documented patient bones popped through skin. Facility MD sent patient out. R2's EMR Progress Note dated 12/7/24 at 1:56 PM documented EMS (Emergency Medical Services) here to transport resident to hospital. R2's EMR Progress Note dated 12/9/24 at 5:27 PM documented writer received an update on resident, she was admitted for a right femur fracture. Administrator, DON, and MD notified. R2's Regional Hospital Emergency Medicine Notes dated 12/7/24, documented R2 presents to ED (Emergency Department) for evaluation of right leg deformity. Per EMS, patient was found in bed at her nursing home when staff found blood on her sheets and on further investigation noticed a deformity to the patients right distal femur with a poke hole oozing blood. Nursing home staff is unaware of any fall or when the trauma may have occurred. Patient has dementia so further history is limited secondary to patient mental acuity. Imaging notable for open fracture of the right distal femur. Orthopedics consulted. Given fracture and belief that had the patient fallen she would not have been able to get herself back into bed without staff being aware of her injury, will consult social work for concern of elder abuse. Will also get trauma scans and consult trauma surgery. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R2's regional hospital orthopedic trauma surgery notes, dated 12/7/24, documented x-rays of right femur knee and tib-fib taken in the ED reviewed by me demonstrates right distal femur fracture with significant lateral displacement of the right proximal femur fragment. CT scan of the right knee taken in the ED and reviewed by me demonstrates right distal femur fracture with lateral displacement of the proximal femur fragment, appears to have significant callus formation around the fracture site indicating a nonacute fracture. There is gas tracking from open wound. It continues, given CT scan imaging showing callus formation around the fracture would lean towards this not being an acute fracture. Per son she has had no injury and was found in her bed today by nursing facility staff with open wound. Given also none reported injury to the right ankle 2 to 3 weeks ago cannot rule out NAT (Non-Accidental Trauma). R2's trauma admission history and physical dated 12/7/24 documented this is an [AGE] year-old female presenting as a level 3 - consult trauma following suspected fall/elder abuse. Concerns with safety at NH (nursing home). Son open to finding new establishment. R2's regional hospital x-ray results of right knee and right femur, dated 12/7/24, documented open fracture distal femoral shaft. R2's regional hospital trauma surgery progress notes, dated 12/8/24, documented right ankle pain, right knee pain, (moans to pain) right lower extremity in ace wrap to knee. R2's regional hospital physician progress note, dated 12/9/24, documented femoral shaft fracture, chronic - spoke to nursing home who stated swelling was first noted to leg/knee on 11/15/24 and this worsened along with surrounding erythema in the last few days leading up to admission. When noticed, hospice was notified prompting x-ray. R2's regional hospital operative progress notes, dated 12/9/24, documented this is an elderly woman who is very infirm and demented. Recently, the nursing home noted a small gradual ulcer and sore over the anterolateral distal femur, which actually was an open fracture. She apparently had a fracture of the distal femur, which was unrecognized; however, on presentation to regional hospital with the open wound, x-rays and CAT scan noted a significantly displaced comminuted but healed distal third femur fracture with significant malunion. Distal lateral spike from proximal segment was quite sharp and prominent and had eroded the skin and now was protruding approximately a center through the skin with skin breakdown, essentially an open delayed fracture. On 12/10/24 at 2:20 PM V2, Director of Nursing, DON, stated that he does not manage the resident incidents for the facility. V2 stated that the previous nurse who was in charge of investigating resident incidents and unknown injury investigations was terminated a while back and V4 (Licensed Practical Nurse, LPN)/Restorative Nurse/QA (Quality Assurance) is now in charge of incidents. V2 stated V4 started in this position 2 weeks ago. On 12/10/24 at 2:24 PM V4 stated she just started in this position a little over a week ago and is now following up on falls in the facility's risk management EMR. V4 stated she is not aware of any unknown injuries occurring since she started in this position. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/10/24 at 2:33 PM V1, Administrator, stated she is the one that is in charge of reporting and investigating unknown injuries. V1 stated R2 was admitted to the hospital this past Saturday, 12/7/24 with a femur fracture. V1 stated she spoke to R2's family and they told her the hospital physician stated that R2's femur fracture is 3-4 weeks old. V1 stated R2's knee was x-rayed in November and the x-ray was negative for any fracture. V1 stated she is still investigating R2's unknown injury/femur fracture. On 12/10/24 at 3:09 PM V5, Care Plan Coordinator, CPC, stated that she was putting interventions in for the resident falls/incidents in the time frame when the facility did not have a QA Nurse but that she did not investigate the fall/incidents during this time. On 12/10/24 at 3:30 PM V6, Certified Nurse Assistant, CNA, stated she is not aware of how R2 sustained the femur fracture. V6 stated she did report to R2's nurse that R2 as having a lot of leg pain and that it was swollen. V6 stated she does not recall when this was and that she does recall a nurse looking at R2's leg when she informed the nurse of R2's pain. V6 stated R2 is transferred via a mechanical lift with 2 assists. On 12/10/24 at 3:38 PM V7, Licensed Practical Nurse, LPN stated that she had been off work a week back in November and when she returned to work the CNAs told her R2's knee was swollen, bruised, warm, and red. V7 stated she thinks maybe R2's leg was broken around 11/17/24. V7 stated she told V2 that the in-house x-ray company they use may have missed the fracture on the x-ray. On 12/10/24 at 3:45 PM V8 stated she took care of R2 last Thursday, 12/5/24, and that she told the nurses that R2's bone was broken in her leg because you could see the bone poking through the skin. V8 then demonstrated how the bone looked under the skin by sticking her hand partially in a disposable glove and pressing a finger tightly up and out against the glove. V8 stated R2 was in severe pain and R2's knee was warm and swollen. V8 stated she reported this to R2's nurse, V7, and to another nurse on 12/5/24 and that they both said it was arthritis according to the x-ray. V8 stated that R2 should be transferred with a mechanical lift but staff just pick her up because she is 90 pounds and that is why she thinks someone dropped R2. V8 then presented a resident care flow sheet with a list of the residents' names on the hall that R2 resides on and stated look at this, it says R2 is to be transferred with an assist of one. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/11/24 at 9:37 AM Surveyor requested incident investigation from V1 for R2's injury that was documented in R2's progress notes on 11/15/24. V1 replied I don't see any incidents for that date, oh there is an incident report for that date in risk management, I am responsible for investigating and reporting incidents, but I didn't, and I don't know why it was not done. V1 stated that the facility does not have any staff statements nor any investigation notes for R2's unknown injury that was documented on R2's 11/15/24 incident report form. V1 stated that she does consider R2's injury that was documented on R2's 11/15/24 incident report to be an unknown injury. V1 stated that no staff notified her of R2's injury that was documented on 11/15/24 and that if she would have known about it then she would have investigated it. Surveyor asked V1 for more information regarding the statement V1 documented on R2's injury investigation that was initiated on 12/9/24, V1 documented V9 CNA usually works the front half of 600 so hasn't cared for her in some time but stated when she did work the back half of 600 1 time, she left R2 in bed due to the swelling. She stated that another CNA had spoken to her and told her that R2 had a fall. Surveyor asked V1 if she identified who the staff member was that told V9 that R2 had a fall and V1 stated I don't know who the CNA was because V9 could not recall the CNAS name. V1 stated she became aware of R2's injury on Saturday, 12/7/24 and reported the incident/unknown injury to IDPH on 12/9/24 after she was told by one of the facility's nurses that R2 had a femur fracture. V1 stated that she is the one who usually investigates the incidents since the facility terminated the QA nurse back in September of this year. V1 stated R2's injury to her right foot that was documented on 11/15/24 should have been investigated. V1 stated the Therapy Department determines how residents should be transferred and then the Medical Records staff update the transfer flow sheets at the nurse's station. V1 stated the CNAs transfer the residents according to the flow sheets. On 12/11/24 at 11:35 AM V9 stated she believes another CNA mishandled R2 during a transfer. V9 stated when she came in last week on day shift, maybe on Wednesday but not for sure, a night shift CNA told me R2's leg was swollen when she was giving me report that morning and this CNA said she was told that someone dropped R2 causing the leg injury. V9 stated she could not recall the name of the CNA that told her this nor did the CNA name the employee who allegedly dropped R2. V9 stated R2's leg was 3 times the size of her other leg last week. V9 stated R2 is very small so the CNAS can transfer R2 with one assist with the mechanical lift. V9 stated she assumes that is why the facility's care sheet has R2 down as a 1 assist with transfers. On 12/11/24 at 11:42 AM V7 LPN stated she thought one of the CNAs did tell her last week that R2's bone looked like it was popping through the skin, so she went and looked at R2's leg and did not think it looked like the bone was coming through. V7 stated she did call hospice at this time and got an order to increase R2's tramadol for her increase in pain. On 12/11/24 at 11:50 AM V10 LPN stated when she worked two weekends ago an agency nurse asked her to go down and look at R2's leg because the agency nurse thought the leg appeared fractured. V10 stated R2 grimaced when she touched R2's leg. R2 stated that the agency nurse informed her she called R2's hospice nurse and updated hospice on R2's leg but that she does not recall what hospice did about the nurse's concerns. On 12/11/24 at 11:57 AM V11 LPN stated she has been R2's nurse a few times over the past few weeks and that R2's right leg was red and swollen. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/11/24 at 12:20 PM V12 (R2's son) stated he received a call from R2's hospice nurse last Saturday on 12/7/24 and told him that the nursing home was sending his mom to the emergency room because she had a bone coming out of her right leg. V12 stated R2 then was transferred to a regional hospital and that the orthopedic surgeon told him R2's right leg was fractured approximately 3 weeks ago and that R2 had to of been dropped to cause this type of fracture. V12 stated this surgeon told him not to take R2 back to that nursing home. V12 stated the surgeon was unable to fix the fracture but did shave the bone off, cleaned out the injury, and then stitched the leg back up. V12 stated that he has not received any notifications from the nursing home about R2's leg and that the only information he has received about R2 in the past two months has been from the hospice nurse. V12 stated R2 is going to a different facility when she is discharged from the hospital. On 12/11/24 at 1:00 PM V13, Hospice RN, stated Oh my God, a few days prior, she (R2) had a small blister that had formed that looked like a pressure injury. V13 stated he was notified by V14 Hospice CNA, around 11/15/24, that R2 had bruising to the bottom of her ankle with swelling, the facility ordered an x-ray. V13 stated he notified V12, R2's son and he (V13) and V12 thought it was weird that she would have bruises and swelling since R2 barely moved and was either in the reclining wheelchair or her bed. V13 stated he assessed R2, and Tylenol and Lasix were ordered, the next week when V13 returned the leg was swollen, going up the calf and towards the knee and the knee had started to swell. V13 stated he reported this to the facility and V14, reported that she had also notified the facility. V13 stated the following week, there was a small area of redness that appeared to be a pressure injury from R2 being contracted and her knees rubbing together. V13 stated skin prep was ordered. The next time he was notified he was told that R2's bone was sticking out of her leg. V13 stated in his opinion, that type of an injury could have only occurred during a transfer or something of that nature because R2 didn't move, and she was either in the reclining wheelchair of the bed. V13 stated he was never notified of any of the changes in R2 by the facility only by V14. On 12/11/24 at 1:55 PM V14, Hospice CNA, stated approximately 3 weeks ago, and she noticed bruising from the bottom R2's heel and swelling in the foot. V14 stated when she would touch the heel, leg, or foot, R2 would jump, make noises and grimace. V14 stated she told V10, LPN, and she took V14 along with two other nurses, unsure of names, to look at R2's foot. When V14 stated she comes to bathe R2 on Thursdays, except the week of Thanksgiving and she came that Friday. V14 stated when she came the week of Thanksgiving, R2's entire leg and knee was huge, swollen, and went up the entire leg. V13 stated she notified R2's nurse, unsure of name. V13 stated there was a blistered area to the knee that was white in the center, and it looked like bone. V13 stated she then called V13 to notify him. On 12/11/24 at 3:11 PM V16 LPN stated she is the nurse that completed the incident report on R2 on 11/15/24. V16 stated that R2's hospice CNA was giving R2 a bed bath and that the hospice CNA reported to her that R2 had bruises on her right lower extremity. V16 stated she assessed R2, gave R2 pain medicine because R2 had facial grimacing. V16 stated she did notify V1, V2, and R2's doctor of the injury of unknown injury on 11/15/24. V16 stated that she was concerned something may have happened during a transfer causing R2's injury. V16 stated the nursing staff are supposed to transfer residents according to the resident care flow sheets that are in a book at the nurse's station. (continued on next page)

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	145581	A. Building B. Wing	12/17/2024

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/12/24 at 8:26 AM V18 LPN stated she was R2's nurse on 11/17/24 and that she contacted V19 R2's primary physician because R2's right knee was swollen. V18 stated she did not notice any bruising nor an increase in R2's pain symptoms V18 stated she notified V19 through the secure message system in (electronic medical record system). V18 stated she is an agency nurse, so she does not work regularly and when she worked on 12/1/24 the CNAS informed her they were not getting R2 out of bed because it looked like something was protruding from the side of R2's knee and it was hard. V18 stated she looked at R2's knee and the protrusion were hard. V18 stated she reported this to the DON, and he instructed her to get an order for x-rays of R2's knee. V18 stated she notified V19, R2's Physician, through the secure messenger system and sent V19 a photo of R2's knee. V18 said V19 replied that it looked like water under the knee, no x-ray ordered but did order a referral to an outpatient orthopedic doctor. V18 stated this occurred on a Sunday and she thinks she put in an order for the referral and passed it on in report, but she does not know if the appointment was ever set up. V18 stated she called the hospice nurse on 12/1/24 about R2 and that hospice said don't send R2 to the hospital and just keep her comfortable. V18 stated outpatient referral need to be approved by hospice but she did not inform the hospice nurse about V19 ordering the outpatient orthopedic referral. V18 stated she does not know if V19 was informed of the ongoing issues with R2's knee because she is just agency. V19 stated she messaged him on 11/17/24 and 12/1/24. R2's progress notes do not document any physician notification on 11/17/24. On 12/12/24 at 8:53 AM V1 stated she is not able to pull the secure messages for R2 from the EMR because they only save for two weeks, and the nurses are supposed to document the messages in the resident's progress notes. On 12/12/24 at 9:06 AM V1 stated no order for the outpatient orthopedic consultation was put into R2's record nor did the facility arrange an appointment for R2 to see an orthopedic surgeon. On 12/12/24 at 9:25 AM V19 stated he had received notifications from the facility regarding R2's edema via the secure message system. V19 stated he would have to check his records to see when and how many times he was notified. V19 stated he was notified from time to time on her. V19 stated he was not aware that the facility did not put in an order in the EMR for the orthopedic referral he gave on 12/1/24 nor was he aware of the facility not setting up this appointment. V19 stated that for R2's bone to come through her skin it had to be caused by trauma and that a pathological fracture would not cause this. V19 stated he would have expected the facility to immediately initiate an investigation on 11/15/24 when the EMR documented an injury to R2's right foot. On 12/12/24 at 11:19 AM, V19 stated he is not able to view secure messages from the facility nurses beyond 12/4/24 because the system deletes them after a week. On 12/7/24 he was notified bone was sticking through the skin and he had R2 sent to the ER. V19 stated the facility contacted him again on 12/9/24 that R2 was admitted to the hospital with a femur fracture and that he requested more information from the facility of how the fracture happened, and he has not heard back from the facility. V19 stated he does not recall being told by the nurse on 12/1/24 that R2's bone appeared to be protruding under the skin. On 12/16/24 at 11:25 AM V1 stated the facility should have reported and investigated R2's right leg injury when it was first found on 11/15/24. V1 stated the facility nurses should have been closely assessing R2's leg and should have updated R2's primary physician of R2's right leg condition changes. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/16/24 at 11:27 AM V20 Regional Director stated R2's leg injury should have been investigated when it was first noted on 11/15/24, R2's leg should have been closely monitored, and that R2's attending physician should have been updated of the ongoing changes of R2's condition. The Hospice Services Agreement dated January 2009 states, The services provided by (Hospice Provider Name) and Nursing Facility under the terms of this Agreement shall be in addition to, and not a substitute for, the services routinely provided to residents by Nursing Facility according to its agreements with residents and applicable state and federal laws and regulations. The facility's Notification Changes in Condition, dated 2/20/23, documented it is the responsibility of licensed staff to contact the physician and the resident's responsible party whenever there is a change in the resident's physical, mental, or psychosocial status. Definitions: 1. Acute change in condition is a sudden, clinically important deviation from a patient's baseline in physical, cognitive, behavioral, or functional status that, without intervention, may result in complications or death. 2. Non-urgent change in condition is a deviation from a patient's baseline in physical, cognitive, behavioral, or functional status that is not reasonable expected to result in complications or death may be a persistent or intermittent result of the patient's diagnosed disease state. Policy guidelines and interpretation: 1. Upon identification of any change in condition licensed nursing personnel will contact the resident's attending physician/on-call physician/practitioner to notify him/her of the change. Acute changes in condition should occur immediately upon recognition while non-urgent changes should occur no later than 72 hours from the noted change. 2. All notifications should be preceded by an appropriate physical, mental, or psychosocial assessment to enable the physician to make adequate and appropriate treatment and/or transfer decisions. 3. Following notification of the physician, licensed nursing personnel will contact the resident's responsible party/emergency contact/family member/POA or Guardian to inform him/her of the change. For acute changes in condition this should occur immediately when practicable and after addressing the resident's immediate needs and for non-urgent changes in condition the notification should occur within 72 hours of the noted change. 4. All notifications should be documented and should include; a. The date and time of the notification; b. The name of the individual contacted; c. The specific reason for the notification; d. And any specific responses that were given by the person contacted. 5. All changes of condition require follow-up assessment and documentation of resident condition which should include, at a minimum: a. Vital signs b. Pain c. Orientation d. Any change from baseline status e. Status of any pending labs/diagnostics. The Immediate Jeopardy that began on 11/15/24 was removed on 12/15/24 when the facility took the following actions to remove the immediacy: A. Identification of Residents Affected or Likely to be Affected: 1. R2 was transferred to a hospital for treatment. R2 is no longer a resident of the facility. The facility has conducted an ongoing investigation into R2's injuries. 2. V2, Director of Nursing, or designee has assessed all residents, completed on 12/14/24, to identify any pain or injury of unknown origin not previously identified, assessed, reported, and treated. For any findings identified, the facility would follow its policy to ensure the pain/injury is reported, assessed, monitored, and treated timely. No residents with unreported/untreated pain or injuries identified. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 42636 Based on interview and record review, facility administration failed to direct and monitor the activities of the nursing department managers to identify nursing concerns/changes in condition. This failure has the potential to affect all 88 residents residing in the facility. Findings Include: R2's Progress Note, dated 11/15/24 at 10:16 AM, documents the following: slight discoloration to the right posterior foot observed, appears to be an injury, green in color and edema noted to the right foot. Origin unknown, no incident reported, facial grimacing observed when palpated. Nurse Practitioner (NP) notified; hospice nurse notified. R2's Progress Note, dated 11/20/24 at 8:48 AM, documents the following: writer was notified that R2's knee was very swollen. MD (Medical Doctor) is already aware of the situation, there was an x-ray performed. R2's Progress Note, dated 11/22/24 at 3:12 AM, documents the following: R2's right knee is very swollen and complains of pain, medicated for pain. R2's Progress Note, dated 12/1/24 at 11:13 AM, documents the following: Aide notified nurse of resident's right knee looking abnormal. Upon assessment the right knee was swollen with minimal pain to touch. MD notified and stated to refer resident to orthopedic surgeon as outpatient. DON notified. R2's Progress Note, dated 12/6/24 at 1:45 PM, documents the following: R2's right knee continues to be monitored. The hospice nurse was consulted to look at patient's knee. Upon evaluation the knee was swollen, and red. Writer asked hospice nurse for an order for pain medication. Tramadol was ordered TID (Three times daily) and as needed. R2's Progress Note, dated 12/7/24 at 12:7?24 at 1:40 PM, documents the following: Nurse was informed by nursing that resident was noted to have something sticking out of her knee. Upon assessment this nurse noted an area to her right knee that looked like bone sticking out of the knee with clear and red fluid flowing from the area. Vitals within normal limits. Emergency services contacted. MD/hospice made aware. POA phoned with no answer, Administrator notified. Ambulance in route. R2's Progress Note, dated 12/9/24, documents the following: Resident admitted to the hospital with a right femur fracture. Administrator, DON, and MD notified. On 12/11/24 at 9:37 AM, V1, Administrator, stated staff did not notify her of R2's injury that was documented on 11/15/24 and if she would have known about it, she would have investigated it. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 12/17/24 at 12:40 PM, V2, Director of Nursing, DON, stated he discusses with V1, Administrator, in the morning department head meeting, any concerns in the nursing department, falls, incidents, the 72 hour reports, etc. V2 stated he was notified by nursing staff 11/15/24 that R2's knee was swollen, they got x-rays, they were negative for fracture, showed a possible effusion and this was discussed in the department head meeting, unsure of date. V2 stated he was not notified by the nursing staff on R2 again until 12/7/24, when the bone was sticking out of the knee. V2 stated he told the nurse, unsure of whom, to notify the MD. V2 stated R2 was on hospice so normally when a resident is on hospice, they would notify hospice first, then notify the physician to verify the orders. V2 stated he was not notified by nursing of any changes or worsening with R2's leg from 11/5/24 until 12/7/24 and he would expect to be notified of any changes, concerns or anytime hospice was notified and then he would have discussed it with V1, Administrator, at the meeting. On 12/17/24 at 2:05 PM, V1, Administrator, stated she does not recall being notified by the nursing department or managers of any changes with R2, until 12/7/24 when R2 was sent to the hospital. V1 stated she would expect the nursing department managers to notify her of any changes. The Administrator Essential Duties and Responsibilities document the following: Direct and monitor the activities of department heads and provide management guidance and information to assure efficient operation and to adhere to organization policies and procedures. Assure quality of care is provided to residents in accordance with the current federal, state, and local standards, guidelines and regulations governing all areas. The Long-Term Care Facility Application for Medicare and Medicaid form, CMS 671, dated 12/17/24, documents there are 88 residents residing in the facility.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 42636 Based on interview and record review the facility failed to have a Quality Assessment and Assurance (QAA) meeting to identify concerns within the facility quarterly and with the required members in attendance. This failure has the potential to affect all 88 residents residing in the facility. Findings Include: The QAPI (Quality Assurance Performance Improvement) Sign-In Sheet documents the last QAA meeting was held on 1/25/24 with the MDS (Minimum Data Set)/CPC (Care Plan Coordinator), treatment nurse, restorative nurse, infection control nurse, DON (Director of Nurses) and administrator in attendance. There is no documentation that the medical director attended the meeting. On 12/17/24 at 11:25 AM, V1, Administrator, stated the last QAA meeting was held in January 2024, and they are supposed to be held quarterly. The Quality Assurance Process Improvement and Compliance (QAPIC) policy, dated 4/22/10, documents the following: The purpose of this plan is to provide a framework using common principles found in risk management, quality improvement and compliance methodologies for the development of structures and processes that supports the mission and values of our organization; that encourages a systems approach to performance assessment and improvement; that promotes high quality resident care; that protects facility assets; and that fosters a culture of compliance with all regulatory and ethical standards. With the support of the Governing Members this organization will establish a QAPIC committee made up of key administrative staff, the medical director, compliance officer/liaison, and other members as deemed appropriate by the Committee and/or Governing Members. The Long-Term Care Facility Application for Medicare and Medicaid form, CMS 671, dated 12/17/24, documents there are 88 residents residing in the facility.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 42636 Based on interview and record review the facility failed to ensure nurse aides completed the required 12 hours of education per year. This has the potential to affect all 88 residents residing in the facility. Findings include: The Learner Status report given by V1, Administrator, on 12/17/24, documents the following: V24, CNA (Certified Nursing Assistant), hire date of 5/30/23, documents V24 has completed 0% of education for the past year; V25, CNA, hire date of 4/5/23, documents V25 has completed 0% of education for the past year; V26, CNA, hire date of 2/8/17, documents V26 has completed 34.62% of education for the past year; and V27, CNA, hire date of 10/3/18, documents V27 has completed 0% of education for the past year. On 12/17/24 at 11:25 AM, V1, Administrator, stated the CNAs are supposed to have 15 hours of education per year. V1 stated they used to hold a blitz for education twice per year so the CNAs could get their education, they stopped doing that and changed over to an electronic education system, the managers have been pushing for the past year for them to get their education completed, but it isn't working. V1 stated herself, the Human Resource Director, and CNA Supervisor and responsible for monitoring their education. The Certified Nurse Aide policy, dated 3/15/23, documents they shall attend all mandatory in-services and maintain 12 hours of continuing education each year. Long Term Care Facility Application for Medicare and Medicaid form, CMS 671, dated 12/17/24, documents there are 88 residents residing in the facility.