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	09/22/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop and implement a person-centered plan of care for fall prevention for 1 of 3 residents reviewed for falls in a sample of 11. This failure resulted in R2 who was post right below the knee amputation attempting to self-transfer and R2 falling to the floor. The impact and trauma from the fall, re-opened the amputation surgical incision site, requiring urgent hospital treatment and surgical revision of the surgical site. Findings Include: R2's admission Sheet, with admission date of 07/25/25, documented R2 has diagnoses of but not limited to Peripheral vascular disease, Type II Diabetes Mellitus (DM), complete traumatic amputation at knee level, right lower leg, subsequent encounter, need for assistance with personal care, acquired absence of right leg below knee, and difficulty in walking. R2's Minimum Data Set (MDS), dated [DATE], documented R2 is cognitively intact with a Brief Interview for Mental Status (BIMS) of 15 out of 15 and he requires assistance of one with transfers. R2's Morse Fall Scale, dated 07/25/25 at 2:29 PM, documented R2 was a high risk for falling with a score of 50. Morse Fall Scoring is as follows: High Risk 45 and higher, moderate risk 25-44, and low risk 0-24. R2's Care Plan, date initiated for falls 08/19/25, documented R2 is at risk for falls. Gait/balance problems d/t (due to) a recent BKA (below the knee amputation). 08/17/25 Unwitnessed fall, reopened surgical BKA. Goal: The resident will be free of injury (r/t related to) falls. Interventions include but not limited to anticipate and meet the residents needs as needed, ensure the resident's call light is within reach and encourage the resident to use it for assistance as needed, and follow facility fall protocol. R2's Progress Notes, Effective date: 08/17/2025 at 22:45 (10:45 PM), Created by: V23, Assistant Director of Nursing, created date: 09/16/2025 at 13:46 (1:46 PM), documented Late Entry:Resident laying on floor in hallway his feet legs pointing into the doorway to his room with his head more centered towards the hallway. He was holding his recent surgical BKA. His surgical wound had opened up measuring 15 cm (centimeters) in length and 3 cm in height. A pain assessment as well as a complete body assessment were completed Resident was placed back into his W/C (wheelchair) after assessments completed. The open laceration was covered with ABD (abdominal) pads then wrapped to stop the bleeding. This was effective. Local ambulance service was notified of our need for transport to local hospital. POA (Power of Attorney)/Physician/DON (Director of Nursing) notified. Report called to local hospital. Nurses Note from V24, Licensed Practical Nurse (LPN). R2's Operative Note, dated 08/20/25 at 10:18 AM, documented R2 had depleted (used up) venous (vein) access and a suitable IV (Intravenous) could not be started. Instead, they had to place a triple lumen-catheter (a type of central venous catheter in his right femoral vein (in his right groin area) to be able to administer the general anesthesia. Under general anesthesia the right leg was prepped and draped. The patient had a complete dehiscence (is a surgical complication where a closed incision reopens, exposing internal tissues and potentially organs) of the right BKA closure site. There was a hematoma present. The incision was made along the previous closure site and the entire below-knee flap was taken down. There was evidence of some nonviable (incapable of life or living) muscle and traumatized muscle from the fall as well as a hematoma (localized collection of blood that pools outside of blood vessels) which was evacuated (removed). There was a large amount of fibrous tissue in the posterior flap. An excisional debridement was preformed of these fibrous tissues. A portion of the tibial bone was exposed in the wound. Proximally a cm of tibial bone was then excised using a power saw. All the posterior flap was viable with no evidence of necrosis or ischemia. The wound was irrigated with an antibiotic solution, the posterior flap was brought anteriorly, and the previous skin incision was reapproximated using interrupted vertical sutures. The leg was dressed with Adaptic gaze, fluff gauze, kerlix wraps and an ace wrap. R2's Progress Notes, dated 08/22/2025 at 4:00 PM, documented R2 returned to the facility at this time. On 09/17/25 at 11:45 AM, V19, Medical Director said he would deem R2 a fall risk and there should be a fall plan of care in place for him. V19 stated the fall R2 had has the potential to cause harm and he is sorry it happened. V19 said he thinks the facility failed in preventing R2's fall. He said no one was answering his call light, and his bed was broke that's a lot. He said yes, this incident has the potential for the resident to experience harm or death. He said it's unacceptable and he absolutely agrees the facility failed. The facility's Care Planning policy, effective date of 05/02/07, documented Comprehensive Care Plans The resident's comprehensive care plan is developed within seven (7) days of the completion of the resident's comprehensive assessment (MDS/RAI). Each care plan will be dated indicating the date in which it was implemented. Each resident's comprehensive care plan should be designed to: o Incorporate identified

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to 1) develop and implement a person-centered plan of care for fall prevention; 2) ensure proper working order of R2's bed for 1 of 3 residents reviewed for falls in the sample of 11. This failure resulted in R2 who was post right below the knee amputation attempting to self-transfer, R2's bed rolled away from him due to a malfunctioning locking mechanism, and with R2 falling to the floor. The impact and trauma from the fall, re-opened the amputation surgical incision site, requiring urgent hospital treatment and surgical revision of the surgical site. Findings Include:R2's admission Sheet, with admission date of 07/25/25, documented R2 has diagnoses of but not limited to Peripheral vascular disease, Type II Diabetes Mellitus (DM), complete traumatic amputation at knee level, right lower leg, subsequent encounter, need for assistance with personal care, acquired absence of right leg below knee, and difficulty in walking. R2's Minimum Data Set (MDS), dated [DATE], documented R2 is cognitively intact with a Brief Interview for Mental Status (BIMS) of 15 out of 15 and he requires assistance of one with transfers. R2's Morse Fall Scale, dated 07/25/25 at 2:29 PM, documented R2 was a high risk for falling with a score of 50. Morse Fall Scoring is as follows: High Risk 45 and higher, moderate risk 25-44, and low risk 0-24. R2's Care Plan, date initiated for falls 08/19/25, documented R2 is at risk for falls. Gait/balance problems d/t (due to) a recent BKA (below the knee amputation). 08/17/25 Unwitnessed fall, reopened surgical BKA. Goal: The resident will be free of injury (r/t related to) falls. Interventions include but not limited to anticipate and meet the residents needs as needed, ensure the resident's call light is within reach and encourage the resident to use it for assistance as needed, and follow facility fall protocol. R2's Progress Notes, dated 8/9/2025 at 10:13 PM, Administration Note: documented R2 had his staples removed from his right BKA. R2's Progress Notes, dated 8/16/2025 at 11:21 AM, Administration Note: documented R2's areas to his right BKA had healed over. R2's Progress Notes, Effective date: 08/17/2025 at 22:45 (10:45 PM), Created by: V23, Assistant Director of Nursing, created date: 09/16/2025 at 13:46 (1:46 PM), documented Late Entry:Resident laying on floor in hallway his feet legs pointing into the doorway to his room with his head more centered towards the hallway. He was holding his recent surgical BKA. His surgical wound had opened up measuring 15 cm (centimeters) in length and 3 cm in height. A pain assessment as well as a complete body assessment were completed Resident was placed back into his W/C (wheelchair) after assessments completed. The open laceration was covered with ABD (abdominal) pads then wrapped to stop the bleeding. This was effective. Local ambulance service was notified of our need for transport to local hospital. POA (Power of Attorney)/Physician/DON (Director of Nursing) notified. Report called to local hospital. Nurses Note from V24, Licensed Practical Nurse (LPN) R2' Progress Notes, dated 8/18/2025 at 5:16 AM, documented *Transfer to Hospital Summary Resident admitted to Local Hospital Admitting diagnosis (Dx): wound Dehiscence. R2's Operative Note, dated 08/20/25 at 10:18 AM, documented R2 had depleted (used up) venous (vein) access and a suitable IV (Intravenous) could not be started. Instead, they had to place a triple lumen-catheter (a type of central venous catheter in his right femoral vein (in his right groin area) to be able to administer the general anesthesia. Under general anesthesia the right leg was prepped and draped. The patient had a complete dehiscence (is a surgical complication where a closed incision reopens, exposing internal tissues and potentially organs) of the right BKA closure site. There was a hematoma present. The incision was made along the previous closure site and the entire below-knee flap was taken down. There was evidence of some nonviable (incapable of life or living) muscle and traumatized muscle from the fall as well as a hematoma (localized collection of blood that pools outside of blood vessels) which was evacuated (removed). There was a large amount of fibrous tissue in the posterior flap. An excisional debridement was preformed of these fibrous tissues. A portion of the tibial bone was exposed in the wound. Proximally a cm of tibial bone was then excised using a power saw. All the posterior flap was viable with no evidence of necrosis or ischemia. The wound was irrigated with an antibiotic solution, the posterior flap was brought anteriorly, and the previous skin incision was reapproximated using interrupted vertical sutures. The leg was dressed with Adaptic gaze, fluff gauze, kerlix wraps and an ace wrap. R2's Progress Notes, dated 08/22/2025 at 4:00 PM, documented R2 returned to the facility at this time.R2's Illinois Department of Public Health (IDPH) Final Report, dated 08/25/25, documented Diagnosis: Attention and concentration deficit, moderate protein-calorie malnutrition, peripheral vascular disease, unspecified, cognitive communication deficit, complete traumatic amputation at knee level, right lower leg, subsequent

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0908 Level of Harm - Actual harm Residents Affected - Few	Keep all essential equipment working safely. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0908 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure essential resident equipment was in good working condition for 1 of 1 resident reviewed for physical environment in a sample of 11. This failure resulted in R2 who was post right below the knee amputation attempting to self-transfer, R2's bed rolled away from him due to a malfunctioning locking mechanism, and with R2 falling to the floor. The impact and trauma from the fall, re-opened the amputation surgical incision site, requiring urgent hospital treatment and surgical revision of the surgical site. Findings Include: R2's admission Sheet, with admission date of 07/25/25, documented R2 has diagnoses of but not limited to Peripheral vascular disease, Type II Diabetes Mellitus (DM), complete traumatic amputation at knee level, right lower leg, subsequent encounter, need for assistance with personal care, acquired absence of right leg below knee, and difficulty in walking. R2's Minimum Data Set (MDS), dated [DATE], documented R2 is cognitively intact with a Brief Interview for Mental Status (BIMS) of 15 out of 15 and he requires assistance of one with transfers. R2's Progress Notes, Effective date: 08/17/2025 at 22:45 (10:45 PM), Created by: V23, Assistant Director of Nursing, created date: 09/16/2025 at 13:46 (1:46 PM), documented Late Entry:Resident laying on floor in hallway his feet legs pointing into the doorway to his room with his head more centered towards the hallway. He was holding his recent surgical BKA. His surgical wound had opened up measuring 15 cm (centimeters) in length and 3 cm in height. A pain assessment as well as a complete body assessment were completed Resident was placed back into his W/C (wheelchair) after assessments completed. The open laceration was covered with ABD (abdominal) pads then wrapped to stop the bleeding. This was effective. Local ambulance service was notified of our need for transport to local hospital. POA (Power of Attorney)/Physician/DON (Director of Nursing) notified. Report called to local hospital. Nurses Note from V24, Licensed Practical Nurse (LPN). The facility's Work Order/Maintenance request form, dated 08/18/25, documented V14, Maintenance Director per: Morning meeting that R2 needed his bed replaced due to bed/lock on old bed defective. On 09/11/25 at 1:25 PM, R2 said his bed was broke and his wheels on the bed wouldn't lock. He said he had his wheelchair beside the bed and when he was trying to get out of bed and into his wheelchair the bed rolled away from him, and he fell on the floor and busted his stump open. R2 said he put his call light on to get some help, but no one ever came so he crawled out into the hallway and yelled for help. R2 said two certified nursing assistants (CNAs) finally came down and helped him up off the floor, they put him in his wheelchair and wheeled him up to the nurse's station (NS) so the nurse could check him out. R2 said they sent him out to the hospital, and they put the sutures back in his leg and then sent him home on Sunday. On 09/16/25 at 11:52 AM, V16, Housekeeping said R2 did complain that his bed slides and he fell because of it. On 09/16/25 at 11:57 AM, V14, Maintenance Director said he isn't sure if R2 got a new bed or not and he would have to look it up. He then asked V15, Maintenance who was standing next to V14 if he remembered if R2 had gotten a new bed and V15 said yes, he did. This surveyor asked V14 and V15 if they could tell me why R2 received a new bed. V15 said because R2 complained his bed wouldn't lock. V14 then stated the locking mechanism on the bed wasn't working and when it doesn't work it will cause the bed to slide. On 09/17/25 at 2:41 PM, Follow up interview with R2. R2 said the incident happened around eight or nine in the evening. He said he went to get up on his own and the bed slid, he fell, and he put his call light after he fell. R2 said he waited for a long time, and no one came to assist him, so he crawled out into the hallway and yelled for help, and it still took the CNAs a while to come and help him. R2 stated the CNAs finally came and got him in his wheelchair and took him to the nurse's station for the nurse to assess. R2 said he was bleeding all over the place. There was a trail of blood from the bed to the hallway. He said there was so much blood they had to take towels and put on it to stop it from bleeding. R2 said it hurt bad, on a scale of 0-10 with 10 being the worst he said it was an 11. On 09/17/25 at 3:07 PM, V14, Maintenance Director stated he believes he found out R2's bed was broken from a work order then he stated no he made a note in the meeting about the bed. He said they have a meeting every morning with the department directors, and he made a note about the bed. He said he would have to look for the notes from that day because he wasn't sure what day it was on. V14 said they had to replace R2's bed because the locking mechanism did not work correctly, and the bed wouldn't lock, and was still able to move. On 09/18/25 at 10:40 AM, V1, Administrator stated she can't put a date on it when she was made aware of R2's bed not working properly. She said R2 came in and then he had the fall, and it was sometime during that time frame that she was made aware. V1 was questioned if was before or after the fall