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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145581 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/29/2026 |
| NAME OF PROVIDER OR SUPPLIER Autumn Meadows of Cahokia | | STREET ADDRESS, CITY, STATE, ZIP CODE 2 Annable Court Cahokia, IL 62206 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| <p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to prevent resident to resident abuse for 2 of 6 residents (R2 and R3) reviewed for abuse in a sample of 7. Findings Include: 1. R3's Face Sheet, original admission date of 12/26/22, documented R3 has diagnoses of but not limited to dementia, parkinsonism, bipolar disorder, and hypertension (HTN). R3's MDS (Minimum Data Set), dated 09/24/25, documented R3 is cognitively intact with a Brief Interview for Mental Status (BIMS) of 15 out of 15 and is independent with most of his activities of daily living (ADLs) and with walking 50 feet. R3's Care Plan, not dated, documented the following: R3 refuses to change rooms or be moved off the hall regarding recent altercation with another resident. Goal: R3 will not engage in an altercation until next review. Intervention: R3 was educated to not engage with the resident he recently had an altercation with. Staff will continue to redirect them and keep them apart in common areas. R3 is at risk for being verbally/physically inappropriate, abusive with staff and other residents' r/t being short tempered and having impaired cognition. R3 makes false accusations of staff during ADL care. R3 has been noted with clippers and attempts to cut other residents' hair. Goal: R3 will fewer behavioral episodes. Interventions include but are not limited to Encourage him to express feelings appropriately, Explain/reinforce why behavior is inappropriate and/or unacceptable to him, and report any claims of abuse/touching/kissing to the Administrator, Director of Nursing (DON), Medical Doctor (MD), Power of Attorney (POA), ensure the safety of those around him, and educate him on the importance of NOT kissing, touching other residents for any reason. R3 was physically aggressive with his peer's related to (r/t) Anger, Dementia, Depression, History of harm to others, Poor impulse control and diagnosis of bipolar disorder. R3 was physically aggressive on 7/6/25. Goal: R3 will seek out staff/caregiver when agitation occurs through the review date. Interventions include but are not limited to Analyze times of day, places, circumstances, triggers, and what de-escalates behavior and document, both residents separated immediately, full assessment completed by nursing staff, police and proper authorities notified resident sent to hospital for labs urinalysis (UA) and psych evaluation. R3 has potential to experience psychosocial/mental abuse. Goal: R3 will have no indications of psychosocial well-being problem by/through review date. Interventions include but are not limited to Consult with: Pastoral care, social services, Psych services, Other and when conflict arises, remove residents to a calm safe environment and allow to vent/share feelings. State surveying agency Final Serious Injury Incident and Communicable Disease Report, incident dated of 11/18/25 at 7:35 AM, documented the following: This is the follow up report to the 11/18/25 reportable for R3 and R2. R3 is a [AGE] year-old long term male resident with diagnosis of dementia, parkinsonism, hypertension, kidney disease, muscle weakness, history of falling, lack of coordination, and atherosclerosis. He has a BIMS of 15. R2 is a [AGE] year-old long term male resident with diagnosis of diabetes, schizophrenia, vascular disease, right below knee amputation, attention and concentration</p> <p>(continued on next page)</p> |

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

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>deficit, cognitive communication deficit, and muscle weakness. At approx. (approximately) 7:35 AM staff reported an alleged resident to resident altercation in the dining room. Residents were immediately separated. Both residents were assessed with no injury noted. Police, responsible parties and physician were notified. Investigation initiated per protocol. During the investigation, R3 was interviewed and stated that he was propelling himself through the dining room. R2 was also in the dining room and was in the path that R3 was taking. R3 asked him to move over, but R2 yelled out and pushed R3's wheelchair. R3 reached out to stop his wheelchair from moving when R2 made contact with him causing R3 to fall from his wheelchair. R2 was also interviewed. He stated that R3 was propelling through the dining room and wheeled next to him, into R2's personal space. R2 requested that R3 back up, but he refused. R2 made contact with R3, causing him to fall from his wheelchair. Local police were contacted. Police officer came to the facility but declined to interview the residents. Based on the resident's medical and psych diagnosis, there is no evidence of intentional abuse. Both residents have continued to do their routine with no mental anguish. Both care plans have been updated accordingly. Will continue to monitor for behaviors. Typed Interview from V11 (Former Business Office Manager/BOM), dated 11/18/25, documented the following: To whom it may concern, I V11, was on my way to the dining room this morning around 7:35 AM and as I was walking down the hallway to the dining room, I noticed a lot of staff running into the dining room. As I entered the dining room, I noticed a resident R3 on the floor trying to get up while nurses and CNAs (certified nursing assistants) were present. After entering the dining room, I found out R3 and R2 had gotten into a fist fight. The witnesses were stating that R3 was at the table cleaning it off, where another resident was sitting. R2 was sitting at a table near the kitchen area where he usually sits and went over to the table where he saw R3 wiping off the table and went over and said something to him and R3 hit him, and he hit R3 back and R3 fell on the floor. As I began speaking with R2, he began saying out loud, quote I hit him. I said to R2, we had a talk with you recently regarding trying to stay away from R3, and he began yelling, saying that we always defend R3 and let him do what he wants to do. That statement is not true. R3 and R2 were okay, but I did notice a small bruise under R3's chin. R3's Progress Notes were reviewed and there was no documentation regarding the resident-to-resident altercation with R2 on 11/18/25. R2's Progress Notes, dated 11/18/2025 at 15:49 (3:49 PM) documented the following Note Text: I heard arguing in the dining room and upon entering found this resident and another resident who was in the floor, hitting and kicking each other. They were separated and taken to their rooms. The Administrator and NP (Nurse Practitioner) were notified of occurrence. 2. R2's Face Sheet, original admission date of 07/25/25, documented R2 has diagnoses of but not limited to Schizophrenia, unspecified, Type II Diabetes Mellitus, and acquired absence of right leg below the knee. R2's Minimum Data Set, dated [DATE], documented R2 is cognitively intact with a BIMS of 15 out of 15, needs partial/moderate assistance with most of his ADLs, and with standing. R2's Care Plan, not dated, documented R2 is/has potential to be verbally and physically aggressive r/t Schizophrenia. Goal: R2 will demonstrate effective coping skills through the review date, R2 will not harm self or others through the review date, and the resident will seek out staff/caregiver when agitation occurs through the review date. Interventions include but are not limited to Analyze times of day, places, circumstances, triggers, and what de-escalates behavior and document, Assess and address for contributing sensory deficits, Monitor/document/report as needed (PRN) any signs and symptoms (s/sx) of resident posing danger to self and others, and Psychiatric/Psychogeriatric consult as indicated. It also documented R2 has potential to experience psychosocial/mental abuse. Goal: R2 will have no indications of psychosocial well-being problem by/through review date. Interventions include but not limited to When</p> <p>(continued on next page)</p> | | |

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| <p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>conflict arises, remove residents to a calm safe environment and allow to vent/share feelings. The state surveying agency Initial Serious Injury Incident and Communicable Disease Report, incident dated of 11/26/25 at 9:57 AM, documented the following: R3 is a [AGE] year-old long term male resident with diagnosis of dementia, parkinsonism, hypertension, kidney disease, muscle weakness, history of falling, lack of coordination, and atherosclerosis. He has a BIMS 15. R2 is a [AGE] year-old long term male resident with diagnosis of diabetes, schizophrenia, vascular disease, right below knee amputation, attention and concentration deficit, cognitive communication deficit, and muscle weakness. On 1/23/25, staff reported R3 was using a box cutter type tool to scrape the dirt from the dining room tables. Administrator and Social Service Director asked R3 to give up the tool as it was unsafe for a resident to have it. R3 refused. Local police were called and R3 gave the tool to the police without incident. On 1/26/25, at approximately 9:57am, R2 told staff that R3 had threatened R2 with the box cutter tool. Investigation was initiated. Follow up report will be sent. R2's Progress Notes were reviewed and have no documentation regarding the incident involving R2 and R3 on 1/23/26. R3's Progress Notes, dated 1/23/2026 15:47 (3:47 PM) documented Behavior Note Text: It was reported that R3 had a razor-sharp item in his possession. SSD (Social Service Director) explained to R3 that the item needed to be turned in so no one will get hurt. R3 refused to give the item to SSD or the Adm (Administrator). Calls were made to his son and his parole officer to see if it would encourage R3 to give the item up. R3 still refused to say no, he was not giving it to anyone. Local Police dept. (department) was called to retrieve the instrument. R3 gave it to one of the policemen. His parole officer will be coming to see him in early Feb. (February). On 01/28/26 at 9:45 AM, R3 is lying in bed in his room that had multiple boxes all over the floor and in his closet and one side of his closet was padlocked shut. He had needles and thread in the top drawer of his bedside table located over by his door, he had nail clippers laying on his bedside table, a disposable razor in a holder on his wheelchair, and a drill bit laying on another table in his room. On 1/26/2026 at 10:30 AM, R3 was asked about what had happened Friday with the box cutter, he stated the R2 was an as****e and he came down to the dining room and was just cussing in front of everyone, while I was scraping the tables with my box cutter because the tables are sticky. R2 continued to state that he told him to stop cussing in front of the children that were visiting. He didn't stop cussing so R3 told him to stop and that he would get him one way or another because (R2) don't think his s**t don't stink. R3 stated that the Social Services Director and the Activity Director came to him and tried to take it away, but they called the police on him, and he gave it to him. On 1/26/2026 at 11:45 AM, R2 stated that R3 threatened him with the box cutter while out in the dining last Friday (1/23/26). R2 stated that he told the staff the R3 had it and the staff attempted to take it away from him, but he wouldn't give it to them. R2 stated that staff asked R3 why he had it and R2 stated that R3 said it was for him (R2). R2 stated that he does not feel safe in the facility. R2 stated, when asked, if he reported it to the staff on Friday of what R3 said to him, he said yes, he did. On 1/26/2026 at 12:30 PM, R1 stated that R3 could have killed them or any of the staff with the box cutter and he does not feel safe living in the facility. R1 stated that R3 lives on the same hall as he does. On 1/26/2026 1:00 PM, R6 stated that she does not feel safe living in this facility because of the resident (R3) that has a box cutter, and he has threatened another resident. R6 also stated that she feels that V1 (Administrator) ignores their complaints and sweeps everything under the rug. On 01/27/26 at 11:35 AM, Follow up interview with R2. R2 said R3 threatened him with a box cutter on Friday and administration knew about it but they didn't do anything about it. He said he didn't see any police come to the facility and remove the box cutter from R3 and he (R3) has a lot more stuff in his room. R2 said he doesn't</p> <p>(continued on next page)</p> | | |

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| <p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>feel safe at the facility because of the incident with R3. R2 said he couldn't get up and walk and R3 could so he wouldn't be able to get away from R3. R2 said V8 (Social Services Director/SSD) asked R3 what the box cutter was for and R3 pointed to him (R2) and said it was for him. On 01/27/26 at 11:50 AM, V8 (SSD) said she can't remember who came and got her, but someone did. She said they told her R3 had something like a box-cutter/razor blade. V8 said she went down to the dining room area where R3 was at and asked him for the sharp object. She said she even begged, and he showed it to her, but he wouldn't give it to her. V8 said her and V1 (Administrator) both went down to R3 room with him trying to get the box-cutter from him, but he wasn't going to give it to them. V8 said V1 stayed with R3 while V8 went down to her office and called the police. She said the police came and retrieved the item from R3 with no issues. She said he wouldn't tell them where he got the box-cutter, but he did tell them he used it for his crafts and wanted to know how he was going to be able to use it now. She said she told him when he wanted to use sharp objects, he would have to use them with activities, and they would keep it locked up for him. V8 said a few days before this they had to take scissors away from R3 and lock them up. She said R3 shouldn't be allowed to have sharp objects due to his temperament is kind of bad. On 01/27/26 at 12:45 PM, V1 (Administrator) said yes, she stayed with R3 while V8 (SSD) went down and called the police. She said she stayed in the room with him because R3 had secured it (box-cutter) in his room, and he wouldn't give it over to them, so they didn't want him to get it out with no one being in the room. She said R3 told her he's had the box-cutter for years and she said you could tell it was old. V1 said the police came and R3 handed it right over to them. V1 said V8 had also taken scissors away from R3 and put them up. V1 said she visually looked around his room and didn't see anything but when his parole officer comes, they are going to do a sweep of his room to make sure he doesn't have anything else. V1 said R3 told her he would let her (V1) look around with his parole officer here. On 01/27/26 at 2:10 PM, R7 who is cognitively intact with a BIMS of 15 out of 15 stated he was in the dining room when the incident happened between R2 and R3. He said R3 had brought some type of razor knife to the dining room and was cleaning stuff off the tables with it. R7 said when R3 was asked why he had it (box-cutter) he said R3 stated it's for him and pointed to R2. R7 said R3 refused to give it to V1 (Administrator). R7 said he didn't see any police in the building that day after the incident. R7 stated today was the first day in a long time they had butter knives given to them at mealtime. He said he saw R3 out in the dining room using the butter knife to cut some fabric off one of the bibs. On 01/28/26 at 9:45 AM, Follow up interview with R3. R3 said he had a tool that had a razor blade like object on the end of it and he was using it to scrap off the tables in the dining room. He said R2 can't say a sentence without having cuss words in it and he doesn't like that kind of language being use exceptionally around little kids. R3 said R2 came in the dining room wanting to start something with him and he told him he wished he could put R2 back in the sewer, close the lid, flush it, and make sure he doesn't come back up. R3 said he has a wrench and other tools in his room, but the facility isn't aware he has them. On 01/28/26 at 10:25 AM, V3 (Licensed Practical Nurse/LPN) said she didn't see the incident between R2 and R3 and she didn't hear R3 threaten R2. She said R2 and R3 just don't get along. She said they will wheel past each other and both will mumble stuff under their breath, and it just goes from there and both will just get louder and louder. R3 only seems to argue with R2. On 01/28/26 at 10:35 AM, V6 (Certified Nursing Assistant/CNA) stated R3 had a box-cutter or something like it and he took it out in the dining room. He said he didn't see it, but he did have it. He said they had to call the police to come out and get it from R3. R6 said R2 and R3 just don't mix well, and they will say things to each other. He said you never know who really starts it. The facility's Abuse Prevention Program,</p> <p>(continued on next page)</p> | | |

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| <p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>last revision dated of 2/2023, documented Purpose: This facility affirms the right of our residents to be free from abuse (verbal, mental, sexual or physical), neglect, misappropriations of resident property, exploitation, corporal punishment, involuntary seclusion and physical and chemical restraints that are not required to treat a resident's medical symptoms. The 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 further documented Abuse: Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means in a facility. It also documented Physical Abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment. It also documented Willful as defined at 483.5 and as used in the definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.</p> | | |