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	02/25/2026

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to maintain a resident's right to secure and confidential personal and medical records for 2 of 2 residents (R4, R5) reviewed for resident rights in the sample of 9.The findings include: 1. R4's admission Record, dated 2/25/26, documents R4 was admitted to the facility on [DATE] and was discharged on 12/9/25 with diagnosis of Chronic Obstructive Pulmonary Disease (COPD), Respiratory Failure, Anemia, Obesity, Hyperlipidemia, Hypertension (HTN), and Falls.R4's Care Plan, dated 11/23/25, documents R4 is at risk for falls. R4 has oxygen therapy related to COPD, chronic respiratory failure. R4 has a mood problem. R4 is a smoker.R4's Minimum Data Set (MDS), dated [DATE], documents R4 is cognitively intact and is independent on activities of daily living (ADLs). R4 is always continent of both bowel and bladder.R4's Physician Order, dated 12/4/25, documents May discharge home with PT (physical therapy)/OT (occupational therapy)/HH (home health) services with nursing.R4's Nursing Note, dated 12/9/25 at 12:58 PM, documents Resident discharged home with medication and discharge instructions. Voiced understanding of all teachings. Transported via private vehicle by family. No concerns voiced. Denied pain and discomfort.On 2/25/26 at 9:14 AM, V20 (R4's Daughter) stated My mom gave me the prescriptions, and I took them to (name of pharmacy) and dropped them off. When I returned to get the medications, they didn't say anything to me about having the wrong prescriptions, they just gave me mom's meds. I didn't know anything about the wrong paperwork until the facility called us and told us. While on the phone with V20, R4 got on another phone and joined the conversation and stated I took the envelope home with me, and I gave the prescriptions to my daughter (V20) and she took them to (name of pharmacy). Then I threw the rest of the papers in the trash.2. R5's admission Record, dated 2/25/26, documents R5 was admitted to the facility on [DATE] and was discharged on 12/9/25 with diagnosis of Diverticulitis, Methicillin-Resistant Staphylococcus Aureus (MRSA), Morbid obesity, Respiratory. failure, COPD, Emphysema, Major depressive disorder, Atrial Fibrillation, Stenosis of bilateral carotid arteries, Cardiomegaly, Disc degeneration lumbar, Abdominal Aortic Aneurysm (AAA), Congestive Heart Failure (CHF), Hyperlipidemia, HTN, Cardiac pacemaker, Hernia, and anxiety disorder.R5's Care Plan, dated 11/6/25, documents R5 has no history of falls, and has been free from falls but is at risk for falls. 10/21/25: R5 has oxygen therapy.R5's MDS, dated [DATE], documents R5 is cognitively intact and is independent for her ADLs. R5 is always continent of bowel and bladder.R5's Physician Order, dated 12/2/25, documents May discharge with PT/OT/HH services with nursing.R5's Nursing Note, dated 12/9/25 at 1:23 PM, documents Daughter informed this nurse that her mother would be discharging immediately due to not being able to part with her Medicaid check. Assured this nurse that she has medication coverage and oxygen prepared for at home use. Social services offered home health services. Resident assisted by staff to discharge.R5's Discharge summary, dated [DATE] at 2:06 PM, documents (R5) discharged on the 9th of the month. Daughter said that she will be taking care of her mother in the home and do not want a health care company for PT and nursing. The reason being (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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	is that they do not work within her schedule. She prefers not to have one. V17 (R5's Daughter) said that she will be calling Dept (Department) on aging to see if she can get paid for helping her mother. (R5) goes to (name of hospital) to see physician. She will be seeing him within the two weeks of discharge. (V17) discharged her mother within a day. Therefore, SSD (Social Service Director) is still trying to get her a chore worker. SSD spoke with (V17) today and she said that her mother is doing ok. R5's Nursing Note, dated 12/9/25 at 2:11 PM, documents Resident discharged home with medication and discharge instruction. Transported by family via private vehicle. No concerns of pain or discomfort.On 2/23/26 at 9:06 AM, V17 stated My mother (R5) was in the facility for rehab after a lengthy hospital stay. I decided to take her home to care for her and upon her discharge from facility, they gave us a lot of papers, medications, and prescriptions in an envelope. I took the envelope and handed them to the pharmacy to get my mom's meds, and the pharmacist told me those were not my mom's prescriptions and were for someone else (R4). I called and let them know and the nurses then had to e-scribe the prescriptions to the pharmacy to get the correct meds. I was unsure what exactly was in the envelope but was upset because if we have someone else's information, then that other person must have my mom's.On 2/24/26 at 9:28 AM, V13 (Social Service Director) stated On 12/9/25, I had two residents leaving at the same time, (R4 and R5), and I gathered the discharge paperwork in a yellow envelope, unsealed, and accidentally gave each one the wrong envelope. I asked (R5 and her daughter/V17) if they would go over the paperwork with me before they left, and her daughter stated the paperwork was already put in (R5's) bag and she was not going to go get them to go over the paperwork. If she would have, they probably would have discovered the mistake. (R5's) daughter called and cursed me out about the mix up. I then called (R4) to explain to her family what happened, and they were fine and not upset about it.On 2/24/26 at 10:43 AM, V2 (Director of Nursing), stated During a resident's discharge, we normally do not give out paper prescriptions, we always give them a 30-day supply of the medications along with discharge paperwork. (R5's) daughter refused the 30-day supply of medications and insisted on the NP (Nurse Practitioner) to write paper prescriptions instead. The NP agreed to do so, and the paper prescriptions were place in (R5's) discharge paperwork envelope. I received a phone call from (R5's) daughter who began cursing at me from the start about the mix up of prescriptions. I asked them if they would bring the paperwork back, that I would give her the correct ones and (R5's) daughter refused. I had to ask the NP to send (R5's) prescriptions electronically to the pharmacy to get filled, which she did. We had a discharge Care Plan meeting with (R5), her daughter, and other managers and (R5's) discharge was discussed and planned at that time. That is when any discharge teaching is done to (R5) and her daughter, so the nurse doesn't have to take the time to do so upon discharge. The nurses get the paperwork and prescriptions, if on paper, together and gives them to Social Service Director, who will go through it with the resident and family. I never heard back from (R4) or her family, so I reached out to them. (R4) had her own medications and did not have to go to the pharmacy and her family were understanding and not upset about the situation.On 2/25/26 at 8:05 AM, V13 stated The paperwork that I go over with a resident who is getting discharged is any appointments they may have, the discharge instructions, home health and other agencies contact information and appointments that may be set up. I did go through the correct paperwork with (R4) and I remember putting them in a large envelope. I must have given them the wrong envelopes when they left. (R5) and her daughter did not want to go through the paperwork and just wanted their envelope so they could leave.On 2/25/26 at 8:40 AM, V1 (Administrator) stated We do not have copies of the paperwork that was given to (R4 and R5) upon discharge.On 2/25/26 at 11:55 AM, V1 stated I would expect the staff to maintain a resident's confidentiality at all times and to ensure that a resident (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	getting discharged has the correct paperwork to avoid any resident personal information be shared to others.The Facility's Resident Rights/Ombudsman Program Policy, dated 11/2028, documents in part You have a right to privacy and confidentiality of your personal and medical records. Your medical and personal care are private. Your facility may not give information about you or your care to unauthorized persons without your permission, unless you are being transferred to a hospital or to another health care facility.The Facility's HIPAA Compliance/HIPAA Administrative Requirements Policy, dated 9/2015, documents in part To help ensure that Facility implements and adheres to administrative, technical and physical safeguards in connection with PHI. Facility will implement intentional or unintentional administrative, technical and physical safeguards designated to protect against any use or disclosure of PHI in violation of the HIPAA Privacy Rule or these HIPAA Privacy Policies and Procedures. Facility will reasonably safeguard PHI to limit incidental uses or disclosures made pursuant to an otherwise permitted or required use or disclosure.

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the facility failed to do temperature readings on food cooked to maintain safe and appetizing temperatures for residents. This failure has the potential to affect all 84 residents residing in the facility.The findings include: On 2/23/26 at 11:30 AM, an observation was made on the facility's kitchen with V8 (Dietary Manager.)On 2/23/26 at 11:38 AM, V8 stated I did have a lot of complaints of cold food when I started, mostly from the residents who eat in their room. I think most of it came from the staff on the halls not delivering the trays to the rooms in a timely manner. I think we have been working on that. On 2/23/26 at 11:43 AM, V10 (Cook) was seen taking food out of oven and onto the steam table. V10 stated the menu today is meatloaf, sweet potatoes, cauliflower, and pineapple upside down cake. The temperature logbook was reviewed with no temperatures documented since 1/30/26. When asked about it, V10 stated I take the temps, I just forget to write them down.On 2/23/26 at 11:55 AM, V8 was advised that no temperatures were logged in the temp book. V8 stated I was not aware of this, and I would expect them to be documenting the temperatures with each meal.On 2/23/26 at 12:00 PM, V10 was seen checking temperatures of the food coming out of the oven or stove with a digital thermometer, when asked about calibrating the thermometer first, V10 stopped and wiped it off with alcohol pad and then proceeded to check temperatures without calibrating the thermometer. When food was at correct temperatures, V10 placed the food onto the steam table to be served.On 2/23/26 at 12:05 PM, The substitute menu item today was fish. V9 (Cook) was seen placing the fish on the steam table without checking temperature. When asked about the temperature, V10 stated No the fish temp was not checked.On 2/23/26 at 12:26 PM, The first plate of food made with V10 (Cook) plating the food. There was no rechecking of the food temperatures prior to serving. V10 was seen using a utensil to serve food to the plate, then would use his other hand to adjust the food on the plate. On 2/23/26 at 12:42 PM, A second pan of meatloaf was brought out of the oven and placed on steam table. There was no temperature check done prior to V10 plating the food from this pan.On 2/23/26 at 1:15 PM, The last plate/tray was made as the test tray and was walked down the hall with the last resident hall trays. The test plate was taken to the conference room and temperatures checked, and the food tasted. The meatloaf was at 163 degrees F. with a good appearance, good taste, and warm to taste. the corn was at 120 degrees F. with normal appearance, a bland taste with no seasoning, and was cold to the taste. The sweet potatoes were at 102 degrees F. and appeared dry, with a good taste, but was cold to the taste. The fish was at 108 degrees F. with good appearance, good taste, but cold to the taste. The cup of peaches was at 46 degrees F, with good appearance, good taste, and was cold to the taste.The Dietary's Food Temperature Log dated January 2026, documents temps checked each for meal except on 1/7/26, 1/8/26, and 1/31/26.The Dietary's Food Temperature Log dated February 2026, does not have any temperatures logged. From 1/31/26 until 2/23/26, there were no documented temperatures done.On 2/25/26 at 11:55 AM, V1 (Administrator) stated I would expect the dietary staff to check food temperatures for each meal and document the temps in the logbook. I would also expect the dietary staff to always maintain a clean and sanitary environment in the kitchen.The Facility's Dietary Cooking and Cooling Policy, dated 2016, documents in part Foods will be cooked thoroughly, reaching the appropriate internal temperature specific to each item. 2. A properly calibrated thermometer should be inserted into the thickest part of the food, and at least two readings should be taken in different places to ensure the proper temperature has been reached.The Facility's Dietary The Dining Experience Policy, dated 2016, documents in part Residents will have an exceptional dining experience that enhances their quality of life and provides attention to the individual resident's plan of care and dining wishes. 12. Resident meals will be served in a sanitary (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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	environment with proper food handling procedures.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to follow proper sanitation and food handling practices for safe food handling, and failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety. This failure has the potential to affect all 84 residents residing in the facility.The findings include: On 2/23/26 at 11:30 AM, an observation was made in the facility's kitchen with V8 (Dietary Manager.)On 2/23/26 at 11:43 AM, V10 (Cook), was seen taking food out of oven and onto the steam table. V10 stated the menu today is meatloaf, sweet potatoes, cauliflower, and pineapple upside down cake. The temperature logbook was reviewed with no temperatures documented since 1/30/26. When asked about it, V10 stated I take the temps, I just forget to write them down.On 2/23/26 at 11:45 AM, The stand-up fridge in the kitchen had a temperature reading of 41 degrees Fahrenheit (F.), digital reading from inside. The walk-in fridge did not have a thermometer in the fridge and no external temperature to read. Unable to check temp. There were cups of fruit seen lying on a tray that were uncovered and not labeled. The walk-in freezer did not have a thermometer and had no external temperature to read. There was a plastic bag with a container of crackers that were open to air and a container of dip that was not labeled and appeared to be brought in from an outside facility.On 2/23/26 at 11:55 AM, V8 was advised of no thermometers or temperatures taken. V8 stated They did have thermometers in there, not sure what happened to them. When advised that no temperatures were logged in the temp book, V8 stated I was not aware of this, and I would expect them to be documenting the temperatures with each meal.On 2/23/26 at 12:00 PM, V10 was seen checking temperatures of the food coming out of the oven or stove with a digital thermometer, when asked about calibrating the thermometer first, V10 stopped and wiped it off with alcohol pad and then proceeded to check temperatures without calibrating the thermometer. When food was at correct temperatures, V10 placed the food onto the steam table to be served.On 2/23/26 at 12:05 PM, The substitute menu item today was fish. V9 (Cook) was seen placing the fish on the steam table without checking temperature. When asked about the temperature, V10 stated No the fish temp was not checked.On 2/23/26 at 12:26 PM, The first plate of food made with V10 (Cook) plating the food. There was no rechecking of the food temperatures prior to serving. V10 was seen using a utensil to serve food to the plate, then would use his other hand to adjust the food on the plate. On 2/23/26 at 12:42 PM, A second pan of meatloaf was brought out of the oven and placed on steam table. There was no temperature check done prior to V10 plating the food from this pan.The Dietary's Food Temperature Log dated January 2026, documents temps checked each for meal except on 1/7/26, 1/8/26, and 1/31/26.The Dietary's Food Temperature Log dated February 2026, does not have any temperatures logged. From 1/31/26 until 2/23/26, there were no documented temperatures done.The Dietary Refrigerator Temperature Log does not indicate which refrigerator it is referring to. They have a walk-in fridge and a stand-up fridge. This log documents temps checked in August 2025, September 2025, October 2025, December 2025, and January 2026. There are no checks for November 2025 or for February 2026.The Dietary Freezer Temperature Log documents temperatures were checked August 2025 through January 2026. There are no temperature checks done for February 2026.On 2/25/26 at 11:55 AM, V1 (Administrator) stated I would expect the dietary staff to check food temperatures for each meal and document the temps in the logbook. I would also expect the dietary staff to always maintain a clean and sanitary environment in the kitchen. I would expect staff to label and store foods properly.The Facility's Dietary Cooking and Cooling Policy, dated 2016, documents in part Foods will be cooked thoroughly, reaching the appropriate internal temperature specific to each item. 2. A properly calibrated thermometer should be inserted into the thickest part of the (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	food, and at least two readings should be taken in different places to ensure the proper temperature has been reached.The Facility's Dietary The Dining Experience Policy, dated 2016, documents in part Residents will have an exceptional dining experience that enhances their quality of life and provides attention to the individual resident's plan of care and dining wishes. 12. Resident meals will be served in a sanitary environment with proper food handling procedures.The Facility's Dietary Food Storage Policy, dated 2026, documents in part Food shall be stored at appropriate temperatures and using appropriate methods to ensure the highest level of food safety. 1. General storage guidelines to be followed: a. All food items will be labeled. f. leftover contents of cans and prepared food will be stored in covered, labeled, and dated containers in refrigerators and/or freezers. 2. Refrigerated storage guidelines to be followed: a. Set refrigerators to the proper temperature. The setting must ensure the internal temperature of the food is 41 degrees F. or lower. Place hanging thermometer in the warmest part of the refrigerator. b. Conduct random temperature checks of food items. f. Never leave any food item uncovered and not labeled. 3. Frozen storage guidelines to be followed: b. Check freezer temperature regularly.