

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  04/05/2024
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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42636</p> <p>Based on interview, and record review facility failed to provide adequate supervision to prevent an elopement, investigate a fall and follow fall precautions in 4 of 8 residents, (R8, R15, R36, R78) reviewed for accidents/supervision, in a sample of 30.</p> <p>Findings include:</p> <p>1. R78's Progress Note, dated 3/24/2024 at 1:05 PM, documented, Resident eloped from building was spotted by the staff and brought back to facility. This nurse requested a shower and done a body assessment. Resident don't have any new open areas. And know has a wander guard on right wrist. Wife was notified and DON (Director of Nurses). Resident is safe.</p> <p>The Final Investigative Report, dated 3/28/24, documented that at 11:09 AM on 3/24/2024, V1, Administrator was notified that V11, Certified Nurse's Assistant (CNA), who had left for her 15-minute break, found R78 off the facility premises at 11:06 AM. No initial injuries were noted, R78 was placed in V11's car and returned to the facility carrying a bible. V11 stated at first, R78 didn't want to get into the car because it smelled like cigarettes. After some talking she was finally able to talk him into getting into the car and she was able to return him to the facility. The building, R78's room and windows were checked for failures and were cleared. The windows were intact. All alarmed exit doors were checked and all alarms sounded when opened. The nurse completed a full body assessment with no injuries, open areas or bruising noted. Wife was made aware of elopement. Wander Guard placed on right wrist. R78 is a VA (Veteran) resident who is also diagnosed with dementia, he is able to carry a conversation but information given is not always appropriate. V1 spoke with R78 this morning and he believed he and his wife were at a fishing lodge staying in a cabin, he asked what cabin V1 was staying in. V1 explained I'm up front with administrator on the door. I ask him to stop and speak to me prior to leaving with his wife. He also explained to me how he was roller skating last night. He is very pleasant to speak with however very confused. Maintenance performs audits and audio checks of door alarms on a frequent basis to ensure alarms are performing as we would expect them to do when the door is opened. Camera review shows R78 walking up the 100 hall towards the lobby then entering the multipurpose room for a couple minutes then walking up to the front desk standing next to a visitor who was speaking to the receptionist. R78 then turned to his right and exited the building through the front door at 11:03 AM.</p> <p>R78's Medical Diagnosis Listing, undated, documented that R78 has a diagnosis of Vascular Dementia, Cerebral Infarction and Wandering.</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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R78's Minimum Data Set (MDS), dated [DATE], documented that R78 has a BIMS (Brief Interview for Mental Status) score of 7, which is severe cognitive impairment.</p> <p>R78's Elopement Assessment, dated 3/9/24, documented that R78 has potential or low risk for elopement.</p> <p>R78's Elopement Assessment, dated 2/16/24, documented that R78 was at high risk for elopement.</p> <p>R78's Care Plan, dated 3/26/24, documented that R78 was an elopement risk/wanderer related to impaired cognition and poor safety awareness. R78's care plan fails to document R78's elopement risk or interventions to prevent elopement prior to 3/26/24.</p> <p>On 4/05/24 at 8:20 AM, V11, CNA, stated that she was not sure how R78 got out of the building. V11 stated that she lives right down the road from the facility and was heading home on her break around 11:00 AM to check things at her house. She continued to state that she saw R78 walking, picked him up and brought him back to the facility. V11 stated that R78 was not injured. V11 stated that R78 didn't say where he was going, he was just walking. V11 stated that R78 had not attempted to get out of the building before, he would wander throughout the building and go into other resident rooms.</p> <p>On 4/05/24 at 8:35 AM, V1, Administrator, stated that R78 had not attempted to elope from the facility prior to his elopement. V1 stated that R78 stayed in his room or around the nurse's station. V1 stated that R78 was in the military and flew a plane prior to the age of 18. V1 stated that R78 was busy so they contacted his wife to find out what kind of things R78 would do to keep him busy and she (R78's wife) said that when R78 wouldn't really do anything, if he was bored, he would go rent a plane to fly. V1 stated that R78's wife brought him in some books yesterday and they give him things to work on, i.e. wheelchairs, etc. V1 stated that when R78 eloped, he did not have a wander guard at that time and that it was implemented after he eloped. V1 stated that the facility camera showed R78 standing at the front entrance/receptionist area, there was a visitor at the receptionist desk talking to the receptionist, R78 was standing between the visitor and the wall, turned and walked out of the front door. V1 stated that V11, CNA, saw R78 walking and picked him up. V1 stated that R78 did not get hurt. V1 stated that R78 has the wander guard now and that they keep him busy with different activities.</p> <p>The Elopement Prevention Policy, dated 3/1/16, documented, The purpose of the policy is to establish guidelines ensuring that each resident is assessed to determine if they are at risk for elopement/flight and when determined to be at risk to ensure that they receive appropriate, individualized interventions to reduce that risk. Nothing in this policy is meant to provide assurances as to the ability of the facility to prevent an elopement from occurring. Elopement occurs when a resident leaves the facility without the expressed knowledge or approval of the facility or an authorized representative of the facility. Residents identified as being at risk will have an individualized plan of care developed and implemented that attempts to reduce their elopement or flight risk.</p> <p>45947</p> <p>2. R36's Face Sheet, documented that R36 was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis following cerebral infarction, type 2 diabetes mellitus, muscle weakness, need for assistance with personal care, and history of falling.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 4/2/24 at 1:40 PM, 4/3/24 at 12:18 PM, 4/3/24 at 4:02 PM, and 4/4/24 at 7:50 AM, R15 was lying in bed in her room with no floor mat beside her bed.</p> <p>On 4/3/24 at 4:02 PM, V18, CNA, stated that she did not think that R15 was a fall risk and was unaware of her requiring floor mats beside her bed.</p> <p>4. R8's Face Sheet, documented that R8 was admitted to the facility on [DATE] with diagnoses including chronic respiratory failure with hypoxia, morbid obesity with alveolar hypoventilation, schizoaffective disorder, left knee pain, muscle weakness, and stage 3 pressure ulcer to right buttock.</p> <p>R8's MDS, dated [DATE], documented that R8 was cognitively intact, dependent with rolling from left to right, and dependent with transfer.</p> <p>R8's Fall Risk Assessment, dated 8/9/23, documented that R8 was at high risk for falling.</p> <p>R8's Care Plan, initiated 6/8/22, documented that R8 was at risk for falls related to morbid obesity, weakness, and shortness of breath with exertion.</p> <p>The Facility's Fall Log, undated, documented that R8 had a witnessed fall on 11/24/23 at 11:03 AM.</p> <p>R8's Care Plan Intervention, dated 11/24/23 documented, Educate staff on the importance of not pulling resident back in her w/c (wheelchair) with pad to only adjust her in chair with (mechanical) lift.</p> <p>R8's Progress Notes, for the month of November 2023, did not contain any documentation regarding R8's 11/24/23 fall.</p> <p>On 4/3/24 at 2:00 PM, R8's 11/24/23 Fall Investigation was requested from V1, Administrator.</p> <p>On 4/4/24 at 10:10 AM, V12, Restorative LPN, stated that R8 did have a fall on 11/24/23, but she did not have a Fall Investigation. She continued to state that staff were transferring R8, and when they pulled back the pad in the chair to readjust her, she slipped to the floor. V12 stated that because of this, R8 is now only transferred with a mechanical lift.</p> <p>On 4/4/24 at 4:10 PM, V1, Administrator, stated that she expects fall investigations to be completed after each fall and that progressive interventions to be added and implemented at all times.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The Facility's Accidents and Incidents Policy, revised 2/20/23, documented, All incidents and accidents occurring at the facility will be reported, investigated, and tracked in accordance with the guidelines contained herein. It continues, An incident report must be initiated by the charge nurse or the nursing supervisor on the scene of the incident. It continues, Preliminary investigation is conducted by the first responders in conjunction with the charge nurse and/or department supervisor if department supervisor is on site. It continues, The Administrator or his/her designee will be responsible for assigning an investigator(s) to complete the investigation of an incident/accident. It continues, Unless otherwise specified, investigations should be initiated as soon as practicable however they should be completed with {sic} five (5) days of the event. It continues, The safety committee will review the incident report and preliminary investigation and implement new intervention(s) based on the environmental and/or resident conditions which may be the root cause of the accident, along with staff interview and MD (Medical Doctor) recommendation. It continues, If a fall or fall event continues despite new interventions, analysis will be performed to determine the appropriateness of the current interventions and implement new interventions or provide rationale as to why the current plan remains relevant. It continues, Ensure any new interventions have been entered on the resident's plan of care.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42636</b></p> <p>Based on observation, interview and record review, the facility failed to provide appropriate tracheostomy care for 1 of 3 residents (R136) reviewed for respiratory care, in a sample of 30.</p> <p>Findings include:</p> <p>On 4/04/24 at 12:10 PM, R136 was observed with light yellow drainage on the drain sponge around his tracheostomy site, V14, Certified Nurse's Assistant (CNA), asked V2, Director of Nurses (DON), to change the tracheostomy dressing. V2 removed R136's soiled dressing, did not cleanse the tracheostomy site prior to applying the clean drain sponge.</p> <p>R136's Medical Diagnosis Listing, undated, documented that R136 has a diagnosis of Acute and Chronic Respiratory Failure and Tracheostomy Status.</p> <p>R136's Minimum Data Set (MDS), dated [DATE], documented that R136 receives oxygen, suctioning and tracheostomy care.</p> <p>R136's Care Plan, dated 5/28/23, documents R136 is at risk for impaired oxygenation and difficulty breathing related to diagnosis of Respiratory Failure with placement of tracheostomy and to use universal precautions at all times.</p> <p>R136's Physician Order Sheet (POS), documented an order, dated 1/19/24, for tracheotomy/respiratory monitoring every shift related to Acute/Chronic Respiratory Failure and tracheostomy status.</p> <p>On 4/05/24 at 8:25 AM, V2, DON, stated that tracheostomy care utilizes sterile technique. V2 stated that staff are to perform hand hygiene, gel in, gel out. V2 stated that when doing a procedure, staff are to wash their hands, put gloves on, then when changing procedures, they are to wash their hands again and re-glove.</p> <p>The Tracheostomy Care policy, dated 8/2013, documented, Aseptic technique must be used. Sterile gloves must be used during aseptic procedures. Site and stoma care: apply clean gloves. Clean the stoma with two peroxide soaked gauze pads. Rinse the stoma with saline soaked gauze pads. Wipe with dry gauze. Disinfect the stoma with the antiseptic soaked gauze pads. Allow to air dry or wipe with clean, dry gauze. Apply a fenestrated gauze pad around the insertion site. Remove gloves. Wash hands.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>45947</p> <p>Based on observation, interview, and record review, the facility failed to ensure foods were stored in a manner that prevents foodborne illness. This has the potential to affect all 81 residents living in the Facility.</p> <p>Findings include:</p> <p>On 4/2/24 at 8:15 AM, in the standing refrigerator there were two pitchers containing a dark liquid that were not dated nor labeled. There were two individual cups with a brown creamy liquid inside that were dated 4-2 but did not document the contents inside. There were four sandwiches dated 3/31 that were not labeled. There were 24 individual cups with a clear liquid substance that were not labeled nor dated.</p> <p>On 4/2/24 at 8:17 AM, bowls were stored in a plastic bin on a rack next to the toaster. The bowls were not covered nor stored upside down, potentially allowing debris from the toaster area to fall inside.</p> <p>On 4/2/24 at 8:20 AM, the dry storage area had a pair of work boots in the corner of the room behind the can rack.</p> <p>On 4/2/24 at 8:25 AM, the walk in refrigerator had a plastic container of a white creamy substance that was not labeled. There was a cylindrical loaf of processed meat in a pan and a loaf of fresh, unprocessed meat in a pan that were not labeled.</p> <p>On 4/2/24 at 8:23 AM, the walk in freezer had a tray of nine individual bowls of rainbow sherbet that were not labeled nor dated. There was a plastic bag with meat patties and a plastic bag with ground meat that had been previously opened and resealed, but were not labeled nor dated. There was another tray with individual bowls of chocolate ice cream that were covered, but were not labeled nor dated.</p> <p>On 4/2/24 at 8:48 AM, V4, Dietary Manager, stated that the patties in freezer were pepper patties and the ground meat was sausage for pizza. He stated he will get labels on them and will have staff get labels on the chocolate ice cream and sherbet.</p> <p>On 4/2/24 at 4:10 PM, V1, Administrator, stated that she expects the facility to follow its food storage policies and label and date all foods.</p> <p>The Facility's Food Receiving and Storage Policy, revised 7/2014, documented, Foods shall be received and stored in a manner that complies with safe food handling practices. It continues, All foods stored in the refrigerator or freezer will be covered, labeled and dated (use by date).</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>The Facility's Refrigerators and Freezers Policy, revised 12/2014, documented, This facility will ensure safe refrigerator and freezer maintenance, temperatures, and sanitation, and will observe food expiration guidelines. All food shall be appropriately dated to ensure proper rotation by expiration dates.</p> <p>The Facility's Long-Term Care Facility Application for Medicare and Medicaid, dated 4/2/24, documented that there are 81 residents living in the facility.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42636</b></p> <p>Based on interview, observation and record review, the facility failed to follow infection control practices to prevent infection in 1 of 6 residents (R136) reviewed for infection control in the sample of 30.</p> <p>Findings include:</p> <p>1. On 4/04/24 at 12:10 PM, R136 was observed with light yellow drainage on the drain sponge around his tracheostomy site, V14, Certified Nurse's Assistant (CNA), asked V2, Director of Nurses (DON), to change the tracheostomy dressing. V2 had gloves on prior to being asked to change the dressing due to having to turn off R136's tube feeding for staff to perform catheter care on R136. V2 did not change gloves nor perform hand hygiene prior to providing care to the tracheostomy site. V2 took the new drain sponge, opened the package and sat it on R136's bed, still in the opened package. V2 then removed R136's soiled dressing, did not change gloves, perform hand hygiene or cleanse the tracheostomy site prior to applying the clean drain sponge.</p> <p>On 4/04/24 at 1:30 PM, V15, Licensed Practical Nurse (LPN), was observed suctioning R136's tracheostomy. V15 washed her hands, opened the suctioning kit, donned clean gloves, turned around, touched the suction machine, poured sterile water into an opened container that had been sitting out on R136's bedside stand (not a new sterile container). V15, then touched the suction catheter and began suctioning R136, after suctioning once, V15 then took the suction catheter, placed it in the container with the sterile water to clear any drainage from the catheter. V15 then proceeded to touch the outside of R136's tracheostomy tube while attempting to place it down the inner part of the tube. V15 did not maintain a sterile field while providing tracheostomy care, change gloves or perform hand hygiene when going from a clean to dirty field.</p> <p>R136's Medical Diagnosis Listing, undated, documented that R136 had a diagnosis of Acute and Chronic Respiratory Failure and Tracheostomy Status.</p> <p>R136's Minimum Data Set (MDS), dated [DATE], documented that R136 receives oxygen, suctioning and tracheostomy care.</p> <p>R136's Care Plan, dated 5/28/23, documented that R136 was at risk for impaired oxygenation and difficulty breathing related to diagnosis of Respiratory Failure with placement of tracheostomy and to use universal precautions at all time.</p> <p>R136's Physician Order Sheet (POS), documented an order, dated 1/19/24, for tracheotomy/respiratory monitoring every shift related to Acute/Chronic Respiratory Failure and tracheostomy status.</p> <p>On 4/05/24 at 8:25 AM V2, DON, stated that tracheostomy care utilizes sterile technique. V2 stated that staff are to perform hand hygiene, gel in, gel out. V2 stated that when doing a procedure, staff are to wash their hands, put gloves on, then when changing procedures, they are to wash their hands again and re-glove.</p> <p>(continued on next page)</p>		

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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)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Suctioning the Lower Airway policy, dated 10/2010, documented, The purpose of the policy is to remove secretions, maintain a patent airway, and prevent infection of the lower respiratory tract. Use sterile equipment to avoid widespread pulmonary and systemic infection. Suctioning of the lower airway is a sterile procedure. All equipment that comes into contact with the lower airway must be sterile. Procedure: Perform hand antisepsis. Put on gloves. Connect one end of suction tubing to suction unit and place the other end near the resident. Turn on suction unit and adjust to appropriate negative pressure. Remove Gloves. Open suction catheter kit. Place sterile drape across the resident's chest. Remove sterile cup, touching only the outside. Fill cup with 100 cc (cubic centimeters) sterile saline or sterile water. Apply sterile gloves. Holding the catheter in dominant hand and the tubing in the non-dominant hand, connect the catheter to the tubing. Suction a small amount of water from the cup to verify negative pressure. Rest catheter tip on sterile surface. Insert the catheter into airway without applying suction. Advance the catheter until resistance is med. Pull back 1-2 cm (centimeters). Apply intermittent suction and slowly withdraw catheter. Rinse catheter and tubing with sterile saline or sterile water until clear.</p> <p>The Tracheostomy Care policy, dated 8/2013, documented, Aseptic technique must be used. Sterile gloves must be used during aseptic procedures. Site and stoma care: apply clean gloves. Clean the stoma with two peroxide soaked gauze pads. Rinse the stoma with saline saline soaked gauze pads. Wipe with dry gauze. Disinfect the stoma with the antiseptic soaked gauze pads. Allow to air dry or wipe with clean, dry gauze. Apply a fenestrated gauze pad around the insertion site. Remove gloves. Wash hands.</p> <p>The Hand Hygiene policy, dated 9/2017, documented, Proper hand hygiene practices reduce the transmission of pathogenic microorganisms to residents, visitors, and other staff members.</p>