STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001317	A. BUILDING: _____ B. WING _____	C 06/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN MEADOWS OF CAHOKIA	2 ANNABLE COURT CAHOKIA, IL 62206

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint Investigation: #2244487/IL147774	S 000		
S9999	Final Observations Ststement of Licensure Violations 300.610a) 300.1210b) 300.1210c) 300.1210d)6 Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 resident to meet the total nursing and personal care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These Requirements were NOT MET as evidenced by: Based on interview and record review the facility failed to implement resident specific effective and progressive interventions to prevent falls for 2 of 3 residents (R6, R10) reviewed for falls in the sample of 10. This failure resulted in R10's fall sustaining a head laceration that required emergency department treatment of 5 staples. Findings include: 1. R10's Physician Order dated 05/20/22 documents "history of Falling" and "generalized muscle weakness." R10's Face Sheet, printed 6/10/22, documents R10 was admitted 5/20/22 with diagnoses to include history of falling, Alzheimer's Disease, restlessness and agitation.	S9999		

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S9999	Continued From page 2 R10's Minimum Data Set (MDS) dated 05/31/22 documents severe cognitive impairment, requires extensive assistance of two plus persons for transfer, bed mobility, is totally dependent on two plus persons for toileting, is not steady moving from seated to standing position only able to stabilize with staff assistance. R10's Care Plan dated 06/09/22 documents "(R10) is at risk for falls r/t (related to) weakness, impaired cognition and poor safety awareness." With the Goal to be free of injury r/t falls. Interventions include: "Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs. Ensure the resident's call light is within reach and encourage the resident to use it for assistance as needed. Mattress on floor alongside bed. Bolstered low air loss mattress." R10 fell on 06/01/22 and 06/03/22. No new intervention added to care plan. R10's Health Status Note dated 06/01/22 at 2:35 PM documents "Resident noted lying on floor on bedside pad on pillow. Awake and alert. Responding to name only noted bloody drainage to back of head with 5cm (centimeter) long laceration. Area cleansed with pressure dressing applied. PERRL (pupils equal and reactive to light) V/S (vital signs) 98.5 76 20 130/60 O2 (oxygen saturation) 97% ROM (range of motion) given x4 with no facial grimace. Facility Administration notified. 911 called RE: Questionable head injury and sutures need to laceration. MD (medical doctor) to be notified and family made aware. Hospice to be informed." R10's Care Plan was not updated with new interventions after this fall.	S9999		

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S9999	Continued From page 3 R10's Health Status Note dated 06/01/22 documents "Resident returned to facility via stretcher from (metropolitan) Hospital. Awake and alert. Transferred to bed with assist of two. Five staples to back of head at this with no drainage noted." R10's Nursing Note dated 06/03/22 at 9:35 AM documents "resident was observed laying on left lateral side at 9:20am. Blood was noted on the floor and sutures were noted to not be intact. All vitals were stable, and pupils were constricted. Hospice was contacted at 9:23 in which they agreed to send resident to hospital. Resident's wife has been contacted at 9:30am and informed of the resident being sent to the hospital. I also informed her that if resident is unable to be seen at VA (Veterans Administration) hospital, he will be sent to (metropolitan) ED (emergency department). Vitals are T (temperature): 96.9 BP (blood pressure): 143/83 O2: 98% on RA (room air) P (pulse):76" R10's Fall investigation dated 06/01/22 at 2:35pm documents "Resident noted lying on floor on bedside pad on pillow. Awake and alert. Responding to name only. Noted bloody drainage to back of head with 5 cm long laceration." R10's Care Plan was not updated with new interventions after this fall. On 06/10/22 at 10:15 AM, V10, CNA (Certified Nursing Aid) stated, "(R10) tries to get up on his own a lot. He tried to get up yesterday. That's why he has the mattress on the floor and bed in low position. He's very confused. Normally it takes one person to get him up unless he's combative then you need help." On 06/10/22 at 12:50 PM, V5, LPN (Licensed	S9999		

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S9999	Continued From page 4 Practical Nurse) stated, "If a resident falls, I do skin assessment, vital signs before we get them up, Range of motion. Let the doctor and family know. check to see what intervention are in place. Make sure their environment is clear, make sure they are wearing non-slip socks. Either the MDS coordinator or the doctor might tell us the intervention." On 06/10/22 at 2:30 PM, V2, Director of Nursing (DON) stated, (R10's) wife said he liked to walk on a treadmill at home. I'm having 2 staff walk with him in the evening. We are hoping it helps wear him out and keeps him from wanting to get up." On 06/10/22 at 2:53 PM, V1, Administrator, stated, "I couldn't find a fall policy." 2. R6's Physician Order dated 05/22/20 documents "NEED FOR CONTINUOUS SUPERVISION." R6's MDS dated 05/31/22 documents that resident has no cognitive impairment, requires extensive assistance of two plus persons for transfer, requires extensive assist of one person for toileting, is not steady, only able to stabilize with staff assistance from seated to standing position or moving on and off toilet. R6's Care Plan dated 06/22/21 documents "(R6) is at risk for falls r/t poor safety awareness, unsteady gait and weakness." It also documents R6 is at risk for Fainting/syncope (temporary loss of consciousness caused by a fall in blood pressure) related to hypotension. The Care Plan documents R6 has a diagnoses of Syncope and Collapse. Fall interventions include: remind R6 to watch for liquids on the floor; remind R6 to dangle	S9999		

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S9999	Continued From page 5 legs on side of bed for minute or two prior to standing, rise slowly when standing, drink plenty of water throughout the day, notify staff when light headed or dizzy; encourage to take breaks when fatigued/SOB (short of breath)/dizzy; notify nurse when weak, light headed, SOB; x1 assist with ambulation/transfers. R6 fell on 05/29/22 and 06/04/22. No new interventions added to care plan. R6's Fall investigation dated 05/29/22 at 5:30 PM documents "(R6) was noted on the floor in a seated position by staff. BM (bowel movement) noted on the floor up under the resident, he has a foley catheter for urine. The resident did complain of minor pain to his right arm that was relieved by Tylenol 650 mg. Fall protocol including neuro-checks." R6's Care Plan was not updated with new interventions after this fall. R6's Nursing Note dated 06/04/22 at 4:21 AM documents "Note Text: Resident was noted on room floor, head facing bathroom and feet under wheelchair. Shoes was on feet, foley intact. Resident pants pull down to ankle. Resident noted to have BM all over him and the floor. When ask, resident stated 'I WAS GOING TO THE BATHROOM AND FELL DOWN'. ROM performed, all in normal limits. No bruises or injuries sustained. 2 assist back to wheelchair. Neuros started. MD made aware. POA (power of attorney) and DON will be made aware." R6's Care Plan was not updated with new interventions after this fall. On 06/10/22 at 2:20 PM, V13, LPN (Licensed Practical Nurse) stated, "(R6) had a couple falls last month. He is unsteady. We had him start using a wheelchair. He wants to be independent	S9999		

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S9999	Continued From page 6 and take himself to the bathroom. He is non-compliant." (B)	S9999		