STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0039636	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN MEADOWS OF CAHOKIA	2 ANNABLE COURT , CAHOKIA, Illinois, 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) COMPLETION DATE
S0000	Initial Comments Investigation of Facility Reported Incident of October 5, 2025/IL2639773	S0000		10/27/2025
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.3210t) 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 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure residents were free from abuse in 2 of 3 residents (R2, R3) reviewed for sexual abuse in the sample of 6. This failure resulted in R2 crying, was “emotional” and “shaken up”. For a reasonable, rational person this would result in psychosocial distress.	S9999		10/27/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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S9999	Continued from page 1 Findings include: 1.) R1's Face Sheet documents R1 was admitted to the Facility on 12/11/24 with diagnoses including traumatic brain injury. R1's Minimum Data Set (MDS) dated 7/16/25 documented R1 was moderately cognitively impaired and ambulated by wheelchair. R1's Care Plan dated 8/5/25 documents R1 has a behavior problem of being sexually inappropriate. On 10/10/25 at 1:35 PM, V8 (Certified Nursing Assistant/CNA Supervisor) stated R1 has been on 15-minute checks since 8/22/25 for inappropriate behavior. On 10/14/25 at 9:10 AM, V14 (Nurse Practitioner) stated R1 has a history of sexual aggression and is monitored every shift. On 10/14/25 at 9:15 AM, V4 (Licensed Practical Nurse/LPN), stated R1 has inappropriately touched staff in the past and is on 15-minute checks for monitoring. On 10/14/25 at 9:53 AM, V16 (CNA) stated R1 has a history of inappropriately touching both staff and residents and requires redirection. 2.) R2's Face Sheet documents R2 was admitted to the Facility on 1/1/25 with diagnoses including intellectual disabilities. R2's MDS dated 9/3/25 documented R2 was moderately cognitively impaired and ambulated by wheelchair. R2's Care Plan dated 6/5/25 documents R2 is at risk of abuse due to impaired cognition. On 10/10/25 at 12:35 PM, R2 stated, "(R1) touched me down there (pointed to genital area)." "That's not good for me." "I don't like him touching me." The Facility's Initial Report sent to the state surveying agency on 10/5/25 documents R1 attempted to touch R2 on her private area at the nurse's station. R2's Progress Note by V7 (LPN) on 10/5/25 at 5:41 PM documents, "Resident stated she was touched on her private area by a male resident in the hallway by nurse station."	S9999		

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S9999	Continued from page 2 On 10/10/25 at 12:30 PM, V5 (Social Services Director/SSD) stated, “I know it happened. We believe her when she tells us it happened and took it (the allegation) seriously. This is not the first time (R1) has had inappropriate behaviors.” On 10/14/25 at 9:56 AM, V7 stated she was R2’s nurse when R2 reported the allegation to her. V7 saw R2 next to the nurse’s station while R1 was self-propelling his wheelchair down the hallway. V7 went to her medication cart, and a few minutes later R2 came and said R1 touched her. R1 was rolling himself back down the hallway at that time, and R2 was pretty “shaken up.” R2 was crying and pretty emotional. On 10/14/25 at 9:50 AM, V15 (Activities Director) stated she was about to take residents on an outing and R2 motioned for her to come over to her. R2 told V15 that R1 had touched her in the private area. The Facility’s Final Report and Conclusion of Incident also documents R2 reported R1 touched her private area while she was sitting at the nurse’s station. When interviewed by V1, R2 asked what the Facility was doing about it. R1 was interviewed about the incident and replied, “What is wrong with that?” 3.) R3’s Face Sheet documents R3 was admitted to the Facility on 1/30/25 with diagnoses including diabetes mellitus type two and muscle weakness. R3’s Minimum Data Set (MDS) dated 9/3/25 documented R3 was cognitively intact and required partial assistance with transfer. R3’s Care Plan does not address risk of sexual abuse. On 10/10/25 at 1:43 PM, R3 stated shortly after she was admitted here, she was at the nurse’s station when R1 grabbed her sweater and offered her ten dollars for a “bl** jo*.” On 10/10/25 at 2:50 PM, R3 stated she told staff who were working at the time of this allegation but does not recall their names. On 10/10/25 at 3:15 PM, V1 (Administrator) stated the Facility did not have any abuse investigations for R1 and R3. On 10/14/25 at 4:00 PM, V1 stated she does not understand how the incident between R1 and R3 could be considered sexual abuse, because there was no physical	S9999		

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S9999	Continued from page 3 touching. R1 was just asking R3 if she would be interested and does not feel that would be upsetting to people. On 10/14/25 at 1:47 PM, V1 stated she expects staff to follow its abuse policy. The Facility's "Abuse Prevention Program" Policy revised 2/20/25 documents the Facility affirms the right of our residents to be free from abuse (verbal, mental, sexual or physical). Abuse is defined as physical or mental injury or sexual assault inflicted upon a resident other than by accidental means in the facility. Sexual abuse includes but is not limited to unwanted intimate touching of any kind especially of breasts or perineal area. Mental abuse is the use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation or degradation. "B"	S9999		