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 12/17/2024

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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S 000	Initial Comments Complaint Survey: 244010065/IL182273 & 24410211/IL182557	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.690a) 300.690b) 300.1010h) 300.1210b) 300.1210d)3 300.3240a) 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 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident	S9999		

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AUTUMN MEADOWS OF CAHOKIA	2 ANNABLE COURT CAHOKIA, IL 62206

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S9999	Continued From page 1 affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. 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 resident to meet the total nursing and personal care needs of the resident. 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:	S9999		

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AUTUMN MEADOWS OF CAHOKIA	2 ANNABLE COURT CAHOKIA, IL 62206

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S9999	Continued From page 2 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These Requirements were NOT MET as evidenced by: Based on interview and record review the facility failed to assess, monitor, and provide timely treatment for R2's knee pain. This failure resulted in when R2 had continued pain and swelling from 11/15/24 until 12/7/24 at which time her femur bone was protruding through her skin. R2 was hospitalized with an open femur fracture requiring surgical intervention which caused pain and suffering, with an increased risk for infection, vascular issues, and subsequently could have resulted in death. The failure to provide ongoing assessment, monitoring, and treatment for R2's ongoing knee pain led to R2's undiagnosed femur fracture to develop into an open fracture. Findings include: R2's Face Sheet, print date of 12/16/24, documented R2 has diagnoses of unspecified fracture of right femur, unspecified severe protein-calorie malnutrition, Alzheimer's disease, atherosclerosis, paranoid schizophrenia, drug induced dyskinesia, contractures, history of	S9999		

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AUTUMN MEADOWS OF CAHOKIA	2 ANNABLE COURT CAHOKIA, IL 62206

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S9999	Continued From page 3	S9999		

cerebral infarction, cognitive communication deficit, osteoporosis, and functional quadriplegia.

R2's Minimum Data Set, MDS, dated 12/4/24, documented R2 is moderately cognitively impaired, is non-ambulatory, and is dependent on staff for transfers.

R2's Care Plan, undated, documented R2 requires a mechanical lift for all transfers.

R2's Resident Care Flow Sheet, undated, documented R2 is assist of 1 for transfers.

R2's Electronic Medical Record, EMR, Progress Note dated 11/15/24 at 10:16 AM documented slight discoloration to right posterior foot observed, appears to be injury, green in color and edema to right foot, origin unknown, no incident reported, facial grimacing observed when palpated, NP (Nurse Practitioner) notified, and hospice nurse notified.

R2's Incident Report, dated 11/15/24 at 10:06 AM, documented incident description: slight discoloration to R (right) posterior foot, appears to be injury green in color and edema to R foot. Resident unable to give description. Predisposing Situation Factors: during transfer.

R2's EMR Progress Note, dated 11/15/24 at 12:35 PM documented call return for the hospice nurse, made aware that NP (Nurse Practitioner) would give an order for x-ray to foot if hospice approved, V13 hospice Registered Nurse, RN agreed to x-ray.

R2's hospice aide visit note, dated 11/15/24 at 8:45 AM, documented patient's right foot swollen and bruised. Case manager updated on new

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AUTUMN MEADOWS OF CAHOKIA	2 ANNABLE COURT CAHOKIA, IL 62206

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S9999	Continued From page 4	S9999		

concerns.

R2's radiology results report, dated 11/16/24, documented reason for study: pain, right foot. Findings: There is mild osteopenia. There is mild degenerative joint disease seen. There is no fracture, dislocation, or soft tissue swelling. No osteomyelitis is seen. There is a plantar heel. Conclusion: Mild degenerative joint disease; otherwise, no fracture or dislocation seen.

R2's radiology results report, dated 11/17/24, documented reason for study: localized swelling, mass and lump, right lower limb. Findings: views of the knee show mild joint space loss and subchondral sclerosis compatible with osteoarthritis. No acute fracture or dislocation is seen. No significant joint effusion is noted. Conclusion: Mild osteoarthritis, without fracture.

R2's EMR Progress Note, dated 11/20/24 at 8:48 AM documented writer was notified that resident's knee was very swollen, and she has a black bruise on her left and right coccyx. Wound nurse was notified to take a look at the area. MD (Medical Doctor) is already aware of the situation, there was an x-ray performed.

R2's EMR Progress Note, dated 11/22/24 at 3:12 AM, documented patient right knee is very swollen and c/o (complaint of) pain. Medicated for pain.

R2's EMR Progress Note, dated 11/22/24 at 2:19 PM, documented writer was notified by CNA that resident only ate about 20% of her meal. CNA stated that she is having difficulty eating and drinking.

R2's EMR Progress Note, dated 11/26/24 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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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S9999	Continued From page 5	S9999		

10:26 PM, documented resident remains on hospice. No s/s of distress. She is complaining of pain in her knee and foot.

R2's hospice aide visit note, dated 11/29/24 at 8:30 AM, documented right leg, knee, and foot swollen. Case Manager and in house nurse updated on new concern and visit.

R2's hospice nurse visit note, dated 11/29/24 at 10:30 AM, documented patient continues to have some increased swelling to her right foot and leg up to her knee at a +2 edema.

There are no Progress Notes in R2's medical record from the facility from 11/26/24 through 12/1/24 regarding the condition or further assessment of R2's knee.

R2's hospice nurse triage notes, dated 12/1/24 at 7:43 AM, documented patient's right knee is swollen and painful to touch. Advised to give patient pain medication. It continues, patient's right knee is more swollen than a week ago.

R2's EMR Progress Note dated 12/1/24 at 11:13 AM documented aide notified nurse of resident right knee looking abnormal. Upon assessment resident knee was swollen with minimal pain to touch. MD notified and stated to refer resident to orthopedic surgeon as outpatient f/u (follow up). DON (Director of Nursing) notified, and hospice nurse will leave message for regular nurse to follow up with resident.

R2's EMR Progress Note, dated 12/4/24 at 11:33 AM documented per nursing documentation R2 had c/o right knee pain during look back. 11/29 NOR (new order received) for Tylenol TID (3 times per day).

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	IL6001317	A. BUILDING: _____ B. WING _____	C 12/17/2024

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AUTUMN MEADOWS OF CAHOKIA	2 ANNABLE COURT CAHOKIA, IL 62206

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S9999	Continued From page 6	S9999		

R2's hospice nurse notes, dated 12/6/24 at 12:20 PM, documented our HHA (hospice health aide) found a small blister on her right knee today while bathing. It continues, treatment orders - cover blister with 3x3 foam dressing daily and prn (as needed). Increased pain related to blister. New orders received: tramadol 25mg BID (two times a day) and q4hrs PRN. Education provided to sign on the new order that was giving in order to help control R2's pain better.

R2's EMR Progress Note dated 12/6/24 at 1:45 PM documented resident knee continues to be monitored; hospice nurse was consulted to look at patient knee. Upon evaluation the knee swollen, and red. Writer asked hospice nurse for an order for pain medication for her pain. Tramadol was ordered TID and PRN (as needed).

R2's hospice aide visit note, dated 12/6/24 at 9:00 AM, documented patient has blister on right knee. Case Manager and in house nurse updated.

R2's EMR progress note dated 12/7/24 at 1:40 PM documented this nurse was informed by nursing that resident was noted to have something "sticking out of her knee." Upon assessment this nurse noted an area to her right knee to look like bone sticking out of knee with clear and red fluid flowing from area. Vitals WNL (within normal limits). Emergency services contacted. MD/hospice made aware. Phoned POA to inform. No answer. Admin notified. Ambulance in route.

R2's hospice progress note, dated 12/7/24 at 1:43 PM documented patient bones popped through skin. Facility MD sent patient out.

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AUTUMN MEADOWS OF CAHOKIA	2 ANNABLE COURT CAHOKIA, IL 62206

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S9999	Continued From page 7 R2's EMR Progress Note dated 12/7/24 at 1:56 PM documented EMS (Emergency Medical Services) here to transport resident to hospital. R2's EMR Progress Note dated 12/9/24 at 5:27 PM documented writer received an update on resident, she was admitted for a right femur fracture. Administrator, DON, and MD notified. R2's Regional Hospital Emergency Medicine Notes dated 12/7/24, documented R2 presents to ED (Emergency Department) for evaluation of right leg deformity. Per EMS, patient was found in bed at her nursing home when staff found blood on her sheets and on further investigation noticed a deformity to the patients right distal femur with a poke hole oozing blood. Nursing home staff is unaware of any fall or when the trauma may have occurred. Patient has dementia so further history is limited secondary to patient mental acuity. Imaging notable for open fracture of the right distal femur. Orthopedics consulted. Given fracture and belief that had the patient fallen she would not have been able to get herself back into bed without staff being aware of her injury, will consult social work for concern of elder abuse. Will also get trauma scans and consult trauma surgery. R2's regional hospital orthopedic trauma surgery notes, dated 12/7/24, documented x-rays of right femur knee and tib-fib taken in the ED reviewed by me demonstrates right distal femur fracture with significant lateral displacement of the right proximal femur fragment. CT scan of the right knee taken in the ED and reviewed by me demonstrates right distal femur fracture with lateral displacement of the proximal femur fragment, appears to have significant callus	S9999		

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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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S9999	Continued From page 8	S9999		

formation around the fracture site indicating a nonacute fracture. There is gas tracking from open wound. It continues, given CT scan imaging showing callus formation around the fracture would lean towards this not being an acute fracture. Per son she has had no injury and was found in her bed today by nursing facility staff with open wound. Given also none reported injury to the right ankle 2 to 3 weeks ago cannot rule out NAT (Non-Accidental Trauma).

R2's trauma admission history and physical dated 12/7/24 documented this is an 80-year-old female presenting as a level 3 - consult trauma following suspected fall/elder abuse. Concerns with safety at NH (nursing home). Son open to finding new establishment.

R2's regional hospital x-ray results of right knee and right femur, dated 12/7/24, documented open fracture distal femoral shaft.

R2's regional hospital trauma surgery progress notes, dated 12/8/24, documented right ankle pain, right knee pain, (moans to pain) right lower extremity in ace wrap to knee.

R2's regional hospital physician progress note, dated 12/9/24, documented femoral shaft fracture, chronic - spoke to nursing home who stated swelling was first noted to leg/knee on 11/15/24 and this worsened along with surrounding erythema in the last few days leading up to admission. When noticed, hospice was notified prompting x-ray.

R2's regional hospital operative progress notes, dated 12/9/24, documented this is an elderly woman who is very infirm and demented. Recently, the nursing home noted a small gradual

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S9999	Continued From page 9	S9999		

ulcer and "sore" over the anterolateral distal femur, which actually was an open fracture. She apparently had a fracture of the distal femur, which was unrecognized; however, on presentation to regional hospital with the open wound, x-rays and CAT scan noted a significantly displaced comminuted but healed distal third femur fracture with significant malunion. Distal lateral spike from proximal segment was quite sharp and prominent and had eroded the skin and now was protruding approximately a center through the skin with skin breakdown, essentially an open delayed fracture.

On 12/10/24 at 2:20 PM V2, Director of Nursing, DON, stated that he does not manage the resident incidents for the facility. V2 stated that the previous nurse who was in charge of investigating resident incidents and unknown injury investigations was terminated a while back and V4 (Licensed Practical Nurse, LPN)/Restorative Nurse/QA (Quality Assurance) is now in charge of incidents. V2 stated V4 started in this position 2 weeks ago.

On 12/10/24 at 2:24 PM V4 stated she just started in this position a little over a week ago and is now following up on falls in the facility's risk management EMR. V4 stated she is not aware of any unknown injuries occurring since she started in this position.

On 12/10/24 at 2:33 PM V1, Administrator, stated she is the one that is in charge of reporting and investigating unknown injuries. V1 stated R2 was admitted to the hospital this past Saturday, 12/7/24 with a femur fracture. V1 stated she spoke to R2's family and they told her the hospital physician stated that R2's femur fracture is 3-4 weeks old. V1 stated R2's knee was x-rayed in

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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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S9999	Continued From page 10	S9999		

November and the x-ray was negative for any fracture. V1 stated she is still investigating R2's unknown injury/femur fracture.

On 12/10/24 at 3:09 PM V5, Care Plan Coordinator, CPC, stated that she was putting interventions in for the resident falls/incidents in the time frame when the facility did not have a QA Nurse but that she did not investigate the fall/incidents during this time.

On 12/10/24 at 3:30 PM V6, Certified Nurse Assistant, CNA, stated she is not aware of how R2 sustained the femur fracture. V6 stated she did report to R2's nurse that R2 as having a lot of leg pain and that it was swollen. V6 stated she does not recall when this was and that she does recall a nurse looking at R2's leg when she informed the nurse of R2's pain. V6 stated R2 is transferred via a mechanical lift with 2 assists.

On 12/10/24 at 3:38 PM V7, Licensed Practical Nurse, LPN stated that she had been off work a week back in November and when she returned to work the CNAs told her R2's knee was swollen, bruised, warm, and red. V7 stated she thinks maybe R2's leg was broken around 11/17/24. V7 stated she told V2 that the in-house x-ray company they use may have missed the fracture on the x-ray.

On 12/10/24 at 3:45 PM V8 stated she took care of R2 last Thursday, 12/5/24, and that she told the nurses that R2's bone was broken in her leg because you could see the bone poking through the skin. V8 then demonstrated how the bone looked under the skin by sticking her hand partially in a disposable glove and pressing a finger tightly up and out against the glove. V8 stated R2 was in severe pain and R2's knee was

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S9999	Continued From page 11	S9999		

warm and swollen. V8 stated she reported this to R2's nurse, V7, and to another nurse on 12/5/24 and that they both said it was arthritis according to the x-ray. V8 stated that R2 should be transferred with a mechanical lift but staff just pick her up because she is 90 pounds and that is why she thinks someone dropped R2. V8 then presented a resident care flow sheet with a list of the residents' names on the hall that R2 resides on and stated look at this, it says R2 is to be transferred with an assist of one.

On 12/11/24 at 9:37 AM Surveyor requested incident investigation from V1 for R2's injury that was documented in R2's progress notes on 11/15/24. V1 replied "I don't see any incidents for that date, oh there is an incident report for that date in risk management, I am responsible for investigating and reporting incidents, but I didn't, and I don't know why it was not done." V1 stated that the facility does not have any staff statements nor any investigation notes for R2's unknown injury that was documented on R2's 11/15/24 incident report form. V1 stated that she does consider R2's injury that was documented on R2's 11/15/24 incident report to be an unknown injury. V1 stated that no staff notified her of R2's injury that was documented on 11/15/24 and that if she would have known about it then she would have investigated it. Surveyor asked V1 for more information regarding the statement V1 documented on R2's injury investigation that was initiated on 12/9/24, V1 documented "V9 CNA usually works the front half of 600 so hasn't cared for her in some time but stated when she did work the back half of 600 1 time, she left R2 in bed due to the swelling. She stated that another CNA had spoken to her and told her that R2 had a fall." Surveyor asked V1 if she identified who the staff member was that told

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 12	S9999		

V9 that R2 had a fall and V1 stated "I don't know who the CNA was because V9 could not recall the CNAS name." V1 stated she became aware of R2's injury on Saturday, 12/7/24 and reported the incident/unknown injury to IDPH on 12/9/24 after she was told by one of the facility's nurses that R2 had a femur fracture. V1 stated that she is the one who usually investigates the incidents since the facility terminated the QA nurse back in September of this year. V1 stated R2's injury to her right foot that was documented on 11/15/24 should have been investigated. V1 stated the Therapy Department determines how residents should be transferred and then the Medical Records staff update the transfer flow sheets at the nurse's station. V1 stated the CNAs transfer the residents according to the flow sheets.

On 12/11/24 at 11:35 AM V9 stated she believes another CNA mishandled R2 during a transfer. V9 stated "when she came in last week on day shift, maybe on Wednesday but not for sure, a night shift CNA told me R2's leg was swollen when she was giving me report that morning and this CNA said she was told that someone dropped R2 causing the leg injury. V9 stated she could not recall the name of the CNA that told her this nor did the CNA name the employee who allegedly dropped R2. V9 stated R2's leg was 3 times the size of her other leg last week. V9 stated R2 is very small so the CNAS can transfer R2 with one assist with the mechanical lift. V9 stated she assumes that is why the facility's care sheet has R2 down as a 1 assist with transfers.

On 12/11/24 at 11:42 AM V7 LPN stated she thought one of the CNAs did tell her last week that R2's bone looked like it was popping through the skin, so she went and looked at R2's leg and did not think it looked like the bone was coming

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 12/17/2024

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
S9999	Continued From page 13	S9999		

through. V7 stated she did call hospice at this time and got an order to increase R2's tramadol for her increase in pain.

On 12/11/24 at 11:50 AM V10 LPN stated when she worked two weekends ago an agency nurse asked her to go down and look at R2's leg because the agency nurse thought the leg appeared fractured. V10 stated R2 grimaced when she touched R2's leg. R2 stated that the agency nurse informed her she called R2's hospice nurse and updated hospice on R2's leg but that she does not recall what hospice did about the nurse's concerns.

On 12/11/24 at 11:57 AM V11 LPN stated she has been R2's nurse a few times over the past few weeks and that R2's right leg was red and swollen.

On 12/11/24 at 12:20 PM V12 (R2's son) stated he received a call from R2's hospice nurse last Saturday on 12/7/24 and told him that the nursing home was sending his mom to the emergency room because she had a bone coming out of her right leg. V12 stated R2 then was transferred to a regional hospital and that the orthopedic surgeon told him R2's right leg was fractured approximately 3 weeks ago and that R2 had to of been dropped to cause this type of fracture. V12 stated this surgeon told him not to take R2 back to that nursing home. V12 stated the surgeon was unable to fix the fracture but did shave the bone off, cleaned out the injury, and then stitched the leg back up. V12 stated that he has not received any notifications from the nursing home about R2's leg and that the only information he has received about R2 in the past two months has been from the hospice nurse. V12 stated R2 is going to a different facility when she is discharged

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 12/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 14	S9999		

from the hospital.

On 12/11/24 at 1:00 PM V13, Hospice RN, stated "Oh my God, a few days prior, she (R2) had a small blister that had formed that looked like a pressure injury." V13 stated he was notified by V14 Hospice CNA, around 11/15/24, that R2 had bruising to the bottom of her ankle with swelling, the facility ordered an x-ray. V13 stated he notified V12, R2's son and he (V13) and V12 thought it was weird that she would have bruises and swelling since R2 barely moved and was either in the reclining wheelchair or her bed. V13 stated he assessed R2, and Tylenol and Lasix were ordered, the next week when V13 returned the leg was swollen, going up the calf and towards the knee and the knee had started to swell. V13 stated he reported this to the facility and V14, reported that she had also notified the facility. V13 stated the following week, there was a small area of redness that appeared to be a pressure injury from R2 being contracted and her knees rubbing together. V13 stated skin prep was ordered. The next time he was notified he was told that R2's bone was sticking out of her leg. V13 stated in his opinion, that type of an injury could have only occurred during a transfer or something of that nature because R2 didn't move, and she was either in the reclining wheelchair of the bed. V13 stated he was never notified of any of the changes in R2 by the facility only by V14.

On 12/11/24 at 1:55 PM V14, Hospice CNA, stated approximately 3 weeks ago, and she noticed bruising from the bottom R2's heel and swelling in the foot. V14 stated when she would touch the heel, leg, or foot, R2 would jump, make noises and grimace. V14 stated she told V10, LPN, and she took V14 along with two other nurses, unsure of names, to look at R2's foot.

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	IL6001317	A. BUILDING: _____ B. WING _____	C 12/17/2024

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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S9999	Continued From page 15	S9999		

When V14 stated she comes to bathe R2 on Thursdays, except the week of Thanksgiving and she came that Friday. V14 stated when she came the week of Thanksgiving, R2's entire leg and knee was "huge," swollen, and went up the entire leg. V13 stated she notified R2's nurse, unsure of name. V13 stated there was a blistered area to the knee that was white in the center, and it looked like bone. V13 stated she then called V13 to notify him.

On 12/11/24 at 3:11 PM V16 LPN stated she is the nurse that completed the incident report on R2 on 11/15/24. V16 stated that R2's hospice CNA was giving R2 a bed bath and that the hospice CNA reported to her that R2 had bruises on her right lower extremity. V16 stated she assessed R2, gave R2 pain medicine because R2 had facial grimacing. V16 stated she did notify V1, V2, and R2's doctor of the injury of unknown injury on 11/15/24. V16 stated that she was concerned something may have happened during a transfer causing R2's injury. V16 stated the nursing staff are supposed to transfer residents according to the resident care flow sheets that are in a book at the nurse's station.

On 12/12/24 at 8:26 AM V18 LPN stated she was R2's nurse on 11/17/24 and that she contacted V19 R2's primary physician because R2's right knee was swollen. V18 stated she did not notice any bruising nor an increase in R2's pain symptoms V18 stated she notified V19 through the secure message system in (electronic medical record system). V18 stated she is an agency nurse, so she does not work regularly and when she worked on 12/1/24 the CNAS informed her they were not getting R2 out of bed because it looked like something was protruding from the side of R2's knee and it was hard. V18 stated she

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 12/17/2024

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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S9999	Continued From page 16	S9999		

looked at R2's knee and the protrusion were hard. V18 stated she reported this to the DON, and he instructed her to get an order for x-rays of R2's knee. V18 stated she notified V19, R2's Physician, through the secure messenger system and sent V19 a photo of R2's knee. V18 said V19 replied that it looked like water under the knee, no x-ray ordered but did order a referral to an outpatient orthopedic doctor. V18 stated this occurred on a Sunday and she thinks she put in an order for the referral and passed it on in report, but she does not know if the appointment was ever set up. V18 stated she called the hospice nurse on 12/1/24 about R2 and that hospice said don't send R2 to the hospital and just keep her comfortable. V18 stated outpatient referral need to be approved by hospice but she did not inform the hospice nurse about V19 ordering the outpatient orthopedic referral. V18 stated she does not know if V19 was informed of the ongoing issues with R2's knee because she is just agency. V19 stated she messaged him on 11/17/24 and 12/1/24. R2's progress notes do not document any physician notification on 11/17/24.

On 12/12/24 at 8:53 AM V1 stated she is not able to pull the secure messages for R2 from the EMR because they only save for two weeks, and the nurses are supposed to document the messages in the resident's progress notes.

On 12/12/24 at 9:06 AM V1 stated no order for the outpatient orthopedic consultation was put into R2's record nor did the facility arrange an appointment for R2 to see an orthopedic surgeon.

On 12/12/24 at 9:25 AM V19 stated he had received notifications from the facility regarding R2's edema via the secure message system. V19 stated he would have to check his records to see

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	IL6001317	A. BUILDING: _____ B. WING _____	C 12/17/2024

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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S9999	Continued From page 17	S9999		

when and how many times he was notified. V19 stated he was notified from time to time on her. V19 stated he was not aware that the facility did not put in an order in the EMR for the orthopedic referral he gave on 12/1/24 nor was he aware of the facility not setting up this appointment. V19 stated that for R2's bone to come through her skin it had to be caused by trauma and that a pathological fracture would not cause this. V19 stated he would have expected the facility to immediately initiate an investigation on 11/15/24 when the EMR documented an injury to R2's right foot.

On 12/12/24 at 11:19 AM, V19 stated he is not able to view secure messages from the facility nurses beyond 12/4/24 because the system deletes them after a week. On 12/7/24 he was notified bone was sticking through the skin and he had R2 sent to the ER. V19 stated the facility contacted him again on 12/9/24 that R2 was admitted to the hospital with a femur fracture and that he requested more information from the facility of how the fracture happened, and he has not heard back from the facility. V19 stated he does not recall being told by the nurse on 12/1/24 that R2's bone appeared to be protruding under the skin.

On 12/16/24 at 11:25 AM V1 stated the facility should have reported and investigated R2's right leg injury when it was first found on 11/15/24. V1 stated the facility nurses should have been closely assessing R2's leg and should have updated R2's primary physician of R2's right leg condition changes.

On 12/16/24 at 11:27 AM V20 Regional Director stated R2's leg injury should have been investigated when it was first noted on 11/15/24,

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AUTUMN MEADOWS OF CAHOKIA	2 ANNABLE COURT CAHOKIA, IL 62206

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S9999	Continued From page 18	S9999		

R2's leg should have been closely monitored, and that R2's attending physician should have been updated of the ongoing changes of R2's condition.

The "Hospice Services Agreement" dated January 2009 states, "The services provided by (Hospice Provider Name) and Nursing Facility under the terms of this Agreement shall be in addition to, and not a substitute for, the services routinely provided to residents by Nursing Facility according to its agreements with residents and applicable state and federal laws and regulations."

The facility Abuse Prevention Program policy, revision date of 2/2023, documented this facility affirms the right of our residents to be free from abuse (verbal, mental, sexual, or physical), neglect, misappropriation of resident property, exploitation, corporal punishment, involuntary seclusion and physical and chemical restraints that are not required to treat a resident's medical symptoms. This 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 is the policy of this facility to develop a mechanism to reduce the risk of abuse, neglect, misappropriation of resident property and/or crimes from being committed against the residents of this facility. It continues, neglect as defined at 483.5, means "the failure of the facility, its employees or service providers to provide goods and services to a resident a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress.

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S9999	Continued From page 19 The facility's Notification Changes in Condition, dated 2/20/23, documented it is the responsibility of licensed staff to contact the physician and the resident's responsible party whenever there is a change in the resident's physical, mental, or psychosocial status. Definitions: 1. Acute change in condition is a sudden, clinically important deviation from a patient's baseline in physical, cognitive, behavioral, or functional status that, without intervention, may result in complications or death. 2. Non-urgent change in condition is a deviation from a patient's baseline in physical, cognitive, behavioral, or functional status that is not reasonable expected to result in complications or death may be a persistent or intermittent result of the patient's diagnosed disease state. Policy guidelines and interpretation: 1. Upon identification of any change in condition licensed nursing personnel will contact the resident's attending physician/on-call physician/practitioner to notify him/her of the change. Acute changes in condition should occur immediately upon recognition while non-urgent changes should occur no later than 72 hours from the noted change. 2. All notifications should be preceded by an appropriate physical, mental, or psychosocial assessment to enable the physician to make adequate and appropriate treatment and/or transfer decisions. 3. Following notification of the physician, licensed nursing personnel will contact the resident's responsible party/emergency contact/family member/POA or Guardian to inform him/her of the change. For acute changes in condition this should occur immediately when practicable and after addressing the resident's immediate needs and for non-urgent changes in condition the notification should occur within 72 hours of the noted change. 4. All notifications should be documented and should include; a.	S9999		

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AUTUMN MEADOWS OF CAHOKIA	2 ANNABLE COURT CAHOKIA, IL 62206

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S9999	Continued From page 20 The date and time of the notification; b. The name of the individual contacted; c. The specific reason for the notification; d. And any specific responses that were given by the person contacted. 5. All changes of condition require follow-up assessment and documentation of resident condition which should include, at a minimum: a. Vital signs b. Pain c. Orientation d. Any change from baseline status e. Status of any pending labs/diagnostics. (A)	S9999		