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 07/09/2025

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 Complaint Survey: 2545919/IL195510 & 2545928/IL195547	S0000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.3240a) 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,	S9999		

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

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S9999	Continued from page 1 signed and dated minutes of the meeting. 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. 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)	S9999		

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Continued from page 2

These Requirements were NOT Met as evidenced by:

Based on observation, interview, and record review, the facility failed to prevent mental abuse by denying access to visitors who abuse, exploits and harasses the residents residing in the facility. This failure has the potential to affect all 91 residents residing in the facility. This failure has caused mental and psychosocial harm, leading to residents feeling unsafe in the facility, which is their home. Due to the unknown reason of the men's intrusion into the facility, this could have caused physical, mental, and psychosocial harm to all residents, due to the incident that occurred and not knowing if the men had deadly weapons or what their intentions were. This failure has caused residents to feel unsafe in the facility.

Findings include:

On 6/18/25, at approximately 6:00 PM, the facility failed to prevent a group of men from entering the facility, smoking marijuana, saying/singing obscenities such as "sit your old a** down", f*** you n****, and swinging a leather belt around, while shooting a "music video" and included two residents (R1, R4), without their permission, in this video that was posted on social media, now showing over 67,000 viewers.

On 7/2/25 at 9:30 AM, R4 was observed in the hallway in his wheelchair. R4 stated he found out he was in a video without his permission. R4 stated he was in his room and must have fallen asleep because he was awoken by a loud noise, not a normal noise, and he saw a group of guys cursing, smelling like marijuana, yelling "F*** old people." R4 stated the lady at the front desk (V11, Receptionist) didn't try to stop them from coming in the building. R4 stated he called the police because he didn't know what the men were doing. R4 stated a couple of days later he was shown a video posted on social

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media and he saw CNAs (Certified Nursing Assistants) in the video "just walk by these guys and didn't say anything to them." R4 stated he isn't sure why this was allowed to happen and doesn't feel safe in the facility. R4 stated "I can't defend myself and neither can any of the other people that live here, they are sick and that is why they are here, these hooligans, I didn't know if they came in with guns, knives, or what their intentions were." R4 appeared anxious, nervous, and fearful when talking about the incident.

R4's Face Sheet, undated, documents R4 has the following diagnoses: Type 1 Diabetes, Neuropathy, Chronic Kidney Disease, Heart Disease, Traumatic Amputation of the Right Foot, Need for Assistance with Personal Care, and Traction Detachment of the Left Eye Retina.

R4's Minimum Data Set (MDS), dated 6/10/25, documents R4 has a BIMS (Brief Interview of Mental Status) score of 15, indicating R4 is cognitively intact.

R4's Care Plan, dated 7/14/25, documents R4 has Activities of Daily Living (ADL) self-care performance deficit and requires assistance with daily care needs.

On 7/3/25 at 2:35 PM, R1 stated he did not give permission to be videotaped or have the video posted on social media.

R1's Face Sheet, undated, documents R1 has the following diagnoses: Altered Mental Status, Schizophrenia, Type 2 DM, Pulmonary Hypertension, and Heart Disease.

R1's MDS, dated 4/24/25, documents R1 has a BIMS score of 10, indicating R1 has moderate cognitive impairment.

R1's Care Plan, dated 4/12/24, documents R1 has an ADL self-care performance deficit and requires assistance with daily care needs.

R1's Care Plan, dated 6/25/25, documents on 6/25/25, it was brought to staff's attention that R1 was in a video going around on social media that illegally recorded on the premises, violating R1's privacy. R1 will be

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S9999	Continued from page 4 removed from the common areas if door lock system fails. The facility doors will be locked 24/7 and will require either a code or staff permission to enter the facility, approved visitors only. R1's Progress Note, dated 6/25/25 at 4:32 PM, documents the following: About 12:00 PM, writer received notification from staff that a video was circulating on social media posted by a civilian. Apparently, the video had a glimpse of the resident in it. The facility was unaware of the video being recorded. Police were notified and took a report. Writer spoke with R1's POA (Power of Attorney) and made her aware of the video and advised the preventative measures that would be put into place moving forward. R1's Progress Note, dated 6/27/25 at 11:16 AM, documents the following: Resident is alert with periods of confusion. Resident has a diagnosis of Schizophrenia, Wandering, and Insomnia. Resident likes to hang out in the common areas. Resident witnessed an incident regarding some men running in the building. R1 stated he saw the event take place. He stated they were just young and confused. The facility's Final Investigation Report, dated 6/27/25, documents the following: On June 18th, 2025, a group of men entered into the building behind some employees. The receptionist asked them to sign in because they stated they were here to see their granny. Then the men proceeded to laugh and say they were just playing, then a few more men rushed behind him and ran through 100 halls. (V13 and V16) from the dietary department had asked the men to leave once they got down the hall. The men left and exited out the front door. Witnesses say they did have their phone in their hand but wasn't sure at the moment what they were doing or what they were possibly recording. Other staff and residents did witness the phone in their hand, and it seemed like they were recording themselves. Our resident (R4) called the police first and told the receptionist (V11) he called. The men were still hanging out in the parking lot. The DON and the police arrived simultaneously, and the men exited the parking lot. After the video surfaced on 6/25/25, staff notified the administrator that one of the residents (R1) appeared in the video. The video didn't mention any names or identify who theses residents were. They saw a small glimpse of (R4), but he claims he was telling the civilians to exit and stop causing commotion. (R4) is alert and oriented x 4 and he is his	S9999		

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S9999	Continued from page 5 own POA. Administrator notified the police again and called R1's family about the event. MD (Medical Doctor) is aware of the event. Residents were interviewed on the 100-hall, they had no concerns and advised they all feel safe. Social Service Assistant ensured them that their safety is our priority. Activity Director is conducting a resident council meeting advising all the residents that the doors will now be locked 24/7 and visitors must put in a code to enter, or the receptionist will have to manually let them in the building. Our HR (Human Resources) director also sent out a voice alert notifying families and staff our interventions. There was no harm done and no abuse substantiated, all residents have continued their daily routine with no mental anguish. (R1) has continued his daily routine as well with no mental anguish. The QAPI (Quality Assurance Performance Improvement) Action Plan, dated 6/27/25, documents the concern was video recording and invasion. The root cause analysis was unlocked doors, possible people hanging around parking lot, and ensure proper screening. Goals/Objectives are to keep the doors locked 24/7. Action items are to lock the doors 24/7, pending new cameras with a possible "buzz in" option, and spot checks of the parking lot. On 7/2/25 at 8:30 AM, V4, CNA (Certified Nursing Assistant), stated she saw a video that was circulating, some guys came in rapping, unsure of the date, the video was inappropriate, the men in the video kept saying "sit your old a** down." On 7/2/25 at 8:32 AM, V5, LPN (Licensed Practical Nurse), stated she saw the video on social media, it was inappropriate, there were young men rapping, she was unable to watch it fully and she is unsure of who's social media site it came from. On 7/2/25 at 8:35 AM, V6, CNA, stated she wasn't here when the video was made but it was all over social media, the video was inappropriate, there were young men running around singing "sit you old ass down." On 7/2/25 at 8:37 AM, V7, CNA, stated there was a video shot in the facility and that was inappropriate. V7 stated she isn't sure of who's social media page it was shared from. V7 stated it was from a gentleman that made the video, they were in the parking lot and	S9999		

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S9999	Continued from page 6 facility, there were residents in the video. On 7/2/25 at 8:40 AM, V9, RN (Registered Nurse), stated there was a video on social media, it was inappropriate, the individuals in the video don't work at the facility, it was disrespectful and not safe. V9 stated she didn't think there were any residents or staff that were affiliated with or knew the men in the video, it could be local people, but she isn't sure of who they were or any of their names. V9 stated she only saw it because someone else posted it, but she was unable to tell the surveyor who posted it. On 7/2/25 at 8:50 AM, V10, Dietary Manager, stated she was gone for the day when the incident with the video occurred on 6/18/25, but her evening dietary staff were here and wrote statements. V10 stated the video crossed the line and violated HIPAA (Health Insurance Portability and Accountability Act), the men were walking through the facility, she thinks there was one resident in the video. On 7/2/25 at 9:00 AM, V2, Director of Nurses (DON), there was a video of about "6-7 black men" in the facility. V2 stated he got a call from the facility on 6/18/25 in the evening about it and came immediately, when he arrived the men were standing outside of the facility, he is unsure of their names and doesn't believe they were affiliated or knew any of the staff or residents. V2 stated he asked the men what they were doing at the facility and what was their purpose of being there, one of the men, V14, Unidentified Male, told him that he had came in, gave the receptionist a phony name to distract her, while the other men snuck in the front door. On 7/2/25 at 10:15 AM, V12, R3's Family, stated R3 was in the hospital but has been transferred to another nursing home. V12 stated R3 didn't want to return because she didn't feel safe in the building because of the video that was made in the facility. On 7/2/25 at 10:37 AM, R7 stated he doesn't feel safe in the facility with those men coming through the door like that, smoking marijuana. On 7/2/25 at 10:40 AM, R8 stated he doesn't feel safe in the facility since the incident occurred.	S9999		

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On 7/2/25 at 3:35 PM, V18, CNA, stated she was here when the video incident occurred on 6/18/25. V18 stated she didn't see the men with the camera, but they were rapping in the hallway, there were a few residents in the hallway, can't recall who they were. V18 stated when this happened, she didn't feel safe because she didn't know who they were or why they were there.

On 7/2/25 at 4:19 PM, V13, Dietary Aide, stated she was here when the incident with the video occurred on 6/18/25, she was clocking out and noticed a group of men in the parking lot, she went to tell the receptionist, who was outside, then she went to the nurses station to let the staff know what was going on and then the men came through the front door and were coming down the hallway, so she told them to leave "because nobody else would." V13 stated this made her feel unsafe, the men came in smoking and doing all kinds of stuff.

On 7/2/25 at 4:25 PM, V17, CNA. stated on 6/18/25 she was on the 100-hall doing her rounds, she went to the nurse's station and noticed a group of men coming down the 100-hall, she thought it was a resident's family, but it wasn't. V17 stated a few of the other aides walked down the hallway, doesn't recall who the aides were, to see what was going on. V17 stated there were residents saying it made them feel uncomfortable, unable to recall who, just that there were a few.

On 7/2/25 at 4:50 PM, V11, Receptionist, stated on 6/18/25 around 6:00 PM, she was in the parking lot talking with a resident's family member and noticed a group of men in the parking lot, they were talking loudly, and she didn't think anything of it. V11 stated about that time a couple of the kitchen staff came from around the building and told her about the men. V11 stated she came back into the facility and 1 man came to the desk and about 6 or 7 men came in after the first male and proceeded to walk down the hallway, she asked them what they were doing and told them if they weren't here to see a loved one, they needed to leave. V11 stated the other men kept walking and the one man said they were there to film a video, and she told them they needed to leave, they could not do that here. V11 stated she didn't call the police while the man was at her desk because "she leaves the facility at 9 at night and didn't want to get shot, you'll get shot, I'm 61 years old." V11 stated one of the residents saw it and

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called the police. V11 stated the men did eventually leave the facility and were outside talking to V2, DON. V11 again stated she felt very unsafe, she was afraid she would get shot because "they will do that to you." V11 stated now the doors are kept locked and any visitors have to be let in. V11 stated she will feel much safer when they get the new things in place, they are supposed to install a camera at the receptionist desk and any visitors will have to be buzzed in. So, when a visitor comes, she will be able to see who it is, ask why they are here, and they won't be let in until it is verified who they are and that they are visiting a resident. V11 appeared upset and visibly shaken when talking about the incident and what could have happened.

On 7/3/25 at 2:40 PM, V1, Administrator, stated on 6/18/25, she received a phone call that some men were in the facility, one of the men distracted the receptionist by telling her he was here to see his granny, while the other men came into the facility and proceeded down the 100-hall. V1 stated staff did tell the men to leave and they did eventually. V1 stated R1 was the main resident in the video, he and his POA (Power of Attorney) were not concerned for him or his safety. V1 stated she isn't sure who the men were, but the "word is that the one singing could be a rapper with local connections." V1 stated there were no staff or residents that knew the men, and no one had given them permission to videotape in or outside the facility. V1 stated since the incident, they are keeping the front door locked at all times and anyone entering through that door has to be let in by the receptionist or staff.

On 7/8/25 at 10:25 AM, V29, Paramedic/Clinical Team Member for V28, FNP (Family Nurse Practitioner), stated an incident like this could cause mental and psychosocial harm. V28 stated staff needed to observe R4 for any signs of increased anxiety, acting out towards stimulation like what had occurred with the incident that could resemble PTSD (Post Traumatic Stress Disorder).

The Abuse Prevention Program policy, dated 6/2008, documents the 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

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S9999	Continued from page 9 medical symptoms. 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. 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. Examples include abuse that is facilitated or caused by nursing home staff taking or using photographs or recordings of any manner that would demean or humiliate residents. The Long-Term Care Facility Application for Medicare and Medicaid, CMS 671, dated 7/8/25, documents there are 91 residents residing in the facility. "B"	S9999		