Illinois Department of Public Health

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 12/12/2023

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 Survey: 2349862/IL167123	S 000		
S9999	Final Observations Statement of Licensure Violations 300.1210b) 300.1210d)6 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: 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:	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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S9999	Continued From page 1 Based on interview and record review, the Facility failed to perform a safe and appropriate transfer for 1 of 3 residents (R14) reviewed for falls in the sample of 28. This failure resulted R14 obtaining a gash to head and sent out to hospital. Findings include: R14's Face Sheet documents R14 was admitted to the Facility on 7/19/21 with diagnoses including traumatic brain injury, persistent vegetative state, chronic respiratory failure, tracheostomy status, multiple contractures, and bed confinement status. R14's Minimum Data Set (MDS) dated 9/15/23 documented R14 required total dependence with 2+ person assistance for bed mobility and transfer. R14's Care Plan initiated 8/17/21 documented R14 was dependent on staff for all ADL (Activities of Daily Living) needs related to suffering a closed head injury and remained in a non-verbal, vegetative state, responsive only to touch. The Care Plan documents R14 was at risk for fall and/or injury related to seizures. R14's Fall Risk Assessment dated 9/13/23 documented R14 was at "High Risk" for falls. The Facility's Fall Log documents R14 fell during staff assist on 11/27/23. R14's Fall Investigation by V13, (Licensed Practical Nurse/ LPN), on 11/27/23 at 2:06 PM documents V14's (CNA /Certified Nurse Aid) reported he fell out of bed during patient care and has a dash (gash) on his right forehead. The investigation documented R14 was unable to	S9999		

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S9999	Continued From page 2 respond and had a laceration to the top of his scalp. R14's Late Entry Progress Note dated 11/27/23 at 3:15 AM documents, "The cna (CNA) informed this nurse during patient care that the resident fell out of bed. Resident has a dash to the r/t (right) side of his forehead, resident unable to speak to determine any pain, resident was transported to (Hospital) via EMT (Emergency Medical Technician) around 3:15 pm for further eval (evaluation), vitals were taken and his POA (Power of Attorney) were notified." R14's Hospital Records from 11/27/23 admission document R14 had superficial lacerations to forehead and right parietal scalp. R14's Care Plan revision on 11/27/23 documents, "Educate staff that resident is 2 assist with patient care and transfers." On 12/5/23 at 10:20 AM, V3 (Social Services Director) stated R14 was usually lying in bed in the same position, and she had never seen him move about in his bed. On 12/5/23 at 10:39, V1 (Administrator), stated V14 (CNA) turned R14 over during incontinent care, and he rolled out of bed. On 12/5/23 at 10:42 AM, V13 (LPN) stated R14 should have had two people with him during care. On 12/5/23 at 11:05 AM, V11 (LPN) stated R14 has a brain injury and requires total care with two person assistance for turning, repositioning, and transfer. On 12/5/23 at 11:32 AM, V14 (CNA) stated she	S9999		

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S9999	Continued From page 3 was changing R14 by herself, and when she turned him onto his left side he started coughing really hard and just rolled off onto the floor. She stated she always performed care on R14 by herself in the past, but now he is a two person assist. On 12/5/23 at 11:45 AM, V2 (Director of Nursing /DON), stated V14 was cleaning R14, and R14 ended up on the floor. V2 stated he would have expected two CNA's to have been providing care to R14. On 12/5/23 at 1:30 PM, V1 stated she would expect two people to have been assisting R14 with care at the time of his fall. V1 stated the Facility does not have a policy regarding falls. (B)	S9999		