

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145581	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/20/2025
NAME OF PROVIDER OR SUPPLIER  Autumn Meadows of Cahokia		STREET ADDRESS, CITY, STATE, ZIP CODE  2 Annable Court Cahokia, IL 62206	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45947</b></p> <p>Based on interview and record review, the Facility failed to provide oxygen therapy as ordered for 1 of 3 residents (R2) reviewed for respiratory care in the sample of 4.</p> <p>Findings include:</p> <p>1. R2's Face Sheet documents R2 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD), obstructive sleep apnea (OSA), and chronic respiratory failure with hypoxia.</p> <p>On 3/19/25 at 8:34 AM, R2 stated the power went out on 3/14/25 and she had to go without oxygen for a couple of hours. She stated she begged for portable oxygen, but they never brought it. She was starting to feel a little short of breath before the power kicked back on.</p> <p>R2's 8/26/24 Physician Order documents if resident complains of or has signs and symptoms of shortness of breath when lying flat, ensure the head of bed is elevated and/or assist her with propping up pillows when in bed (except while providing care) at every shift.</p> <p>R2's Minimum Data Set (MDS) dated [DATE] documented R2 was cognitively intact, dependent with bed mobility and transfer, and received oxygen therapy.</p> <p>R2's Care Plan revised 1/16/24 documents R2 is at risk for impaired oxygenation, weakness, shortness of breath, fatigue, skin pallor (paleness), lightheadedness, dizziness and a fast heartbeat related to diagnosis of COPD and OSA.</p> <p>R2's March 2025 Medication Administration Record (MAR) documents blanks in the rows labeled SOB (Short of Breath) (Yes or No) and Administered for the evening shift on 3/14/25.</p> <p>R2's 10/2/24 Physician Order documents oxygen at 2 liters/minute per nasal cannula continuously and as needed while in bed for chest pain/shortness of breath.</p> <p>R2's March 2025 MAR does not document oxygen was provided on evening shift on 3/14/25.</p> <p>On 3/19/25 at 10:15 AM, V6, Registered Nurse (RN), stated R2 only uses oxygen as needed.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/19/25 at 3:05 PM, V9, Nurse Practitioner (NP), stated R2 is cognitively intact and is able to determine when she needs supplemental oxygen.</p> <p>On 3/19/25 at 2:30 PM, V1, Administrator, stated she does not have a policy regarding respiratory care, but she expects oxygen to be provided as ordered and documented in the MAR.</p>