

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  08/27/2025
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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review, the facility failed to provide monitoring of a resident requiring continues oxygen with a known history of having smoking materials in the room and failed to implement interventions to ensure a safe environment for 1 of 3 residents (R3) reviewed for smoking. This failure resulted in (R3) continuing to smoke inside room while wearing oxygen placing self and others at risk for safety concerns. Findings include: This failure resulted in an Immediate Jeopardy began on 8/5/2025 when R3 who requires continuous oxygen and suffers from Chronic Obstructive Pulmonary Disease and Dyspnea was found to have odors of smoke of mind altering substances in his room. The survey team validated the abatement on 8/26/25 at 3:27pm. The facility remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of policies and procedures and the in-service training. R3's Care Plan, dated 8/10/2025, documents that (R3) at for safety concerns r/t (related to) possession of smoking substance and using it in his room. The resident will not suffer injury from unsafe smoking practices. (R3) is instructed to get up every 2 hours to sit in his chair to have his room searched for drugs hidden. Instruct resident about smoking risks and hazards and about smoking cessation aids that are available. Instruct resident about the facility policy on smoking: locations, times, safety concerns. Notify charge nurse immediately if it is suspected resident has violated facility smoking policy. It also documents (R3) is at risk for safety concerns r/t having possession of smoking substances in his room while in use of O2 and not being supervised. The resident will not smoke without supervision. The resident will not suffer injury from unsafe smoking practices. Instruct resident about smoking risks and hazards and about smoking cessation aids that are available. Instruct resident about the facility policy on smoking: locations, times, safety concerns. Notify charge nurse immediately if it is suspected resident has violated facility smoking policy. Observe clothing and skin for signs of cigarette burns. R3's Minimum Data Set (MDS), dated [DATE], documents that R3 is cognitively intact. R3's Physician Order Sheet (POS), dated 5/20/2025, documents Oxygen 2LPM (liter per minute) per NC (nasal canula) continuous every shift. R3's progress Notes, dated 8/5/2025 at 3:24 AM, documents that Nursing Note (HC), Note Text: Writer has noted that resident was noted to have mind altering substance in his room. The smell of THC. Resident states he is aware of facility policy and will not do it again. Attendee to see resident today on rounds. R3's Progress Notes, dated 8/10/2025 at 10:34 AM, documents that Nursing Note (HC), Note Text: Day shift aide stated resident was in his room with door closed, when they opened resident door very strong smoke smell released from the room. Nurse educated resident on safety concerns while on oxygen and while in building as well facility smoking policies. On 8/11/2025 15:57 Nursing Note (HC) Note Text: room searched, sweep complete on room for smoking supplies. resident given copy of smoking policy, verbalized understanding of policy and verbalized understanding of education given by nurse V5 at time of smoking incident. will continue to f/u. On 8/20/2025 a review of R3's electronic health record documents no smoking assessment or contract. R3's Behavior Monitoring &amp; Interventions, dated 8/5/2025 to 8/25/2025, and MONITOR - Behavior Symptoms documents, dated 8/5/2025 to 8/25/2025, documents no refusals of care. On 8/21/2025 at 11:00 AM R3's Electronic Health Record (EHR) reviewed. R3's EHR documents no smoking assessment and no contract. At that time R3's smoking assessments and contracts requested. R3's EHR documents no monitoring of R3 for smoking in room from 8/5/2025 to 8/10/2025. R3's EHR documents no refusal to transfer from bed to chair from 8/12/2025 to 8/19/2025, 8/21/25 to 8/24/2025. As of 8/25/2025 at 3:00 PM the facility hadn't provided R3's smoking assessments or smoking contract. On 8/20/2025 at 10:01 AM V2, Director of Nurses, stated that the midnight CNA upon entering R3's room, noticed the smell. V2 stated that they asked if he was smoking and R3 denied. V2 stated that they did not complete an incident report or complete an investigation. V2 stated that they put in place to get R3 up during the day. V2 stated that R3 has behaviors of yelling and cursing the staff out. V2 stated that when this occurs the staff leaves the room and then he goes down to the room and talk with R3. V2 stated that they completed a room search of R3's drawers and did not find anything. V2 stated that they were not able to search R3's bed or person because R3 would not get out of the bed. On 8/20/2025 at 11:32 AM V5, LPN, stated that she was notified of the strong smoke smell coming from room by V16, CNA, and that R3 had offered to sell V16 some marijuana. V5 stated that V16 identified the smell as marijuana. V5 stated that she entered R3's room. V5 stated that she did not see R3 smoking but was able to smell the aroma. V5 stated that she spoke with R3 about smoking in his room and he said he wouldn't do it</p>		