

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145643	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/17/2024
NAME OF PROVIDER OR SUPPLIER Blessing Hospital Snu		STREET ADDRESS, CITY, STATE, ZIP CODE Broadway at 11th Street Quincy, IL 62301	

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>32875</p> <p>Based on observation, interview, and record review the facility failed to follow a physician's order for oxygen for one of one resident (R115) reviewed for oxygen therapy in the sample of 16.</p> <p>Findings include:</p> <p>The Oxygen Delivery policy dated 11/2023 documents Upon physician order, a licensed respiratory therapist (RT) or respiratory student working under a licensed RT will provide supplemental oxygen to adult, pediatric, and infant patients to treat or prevent hypoxia.</p> <p>R115's Physician Order dated 10/14/24 at 9:09 AM, documents 2 (two) liters of oxygen per cannula only at night.</p> <p>On 10/15/24 at 10:55 AM, 10/16/24 at 10:33 AM, and 10/17/24 at 12:13 PM, R115 was sitting in his room wearing oxygen.</p> <p>On 10/17/24 at 12:40 PM, V11/Registered Nurse stated that R115's oxygen order was for R115 to wear the oxygen at night only.</p> <p>On 10/17/24 at 12:40 PM, V12/R115's Power of Attorney stated that she was glad to hear that R115 did not need to be wearing the oxygen during the day because R115 did not like to wear it.</p> <p>On 10/17/24 at 1:05 PM, V2/Director of Nursing stated that respiratory therapy sets the oxygen supply up. The nurses are responsible for following the physician orders.</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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