

Illinois State Department of Health

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 08/27/2025	
NAME OF PROVIDER OR SUPPLIER AUTUMN MEADOWS OF CAHOKIA				STREET ADDRESS, CITY, STATE, ZIP CODE 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	Complaint Survey: 2547605/2588292		S0000			08/27/2025	
S9999	Statement of Licensure Violations Section 300.1210 General Requirements for Nursing and Personal Care 300.1210b) 300.1210c) 300.1210d)6 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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: 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:		S9999			08/27/2025	

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 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 5/26/2025, 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, "B"			S9999			

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S9999	Continued from page 2 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 & 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 anymore.		S9999				

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S9999	Continued from page 3 On 8/20/2025 at approximately 11:00 AM V1, Administrator, stated that she was aware of R3 smoking and the care plan had been updated to reflect interventions put in place. V1 stated that this is not a new problem for R3. V1 stated that this has been going on prior to V1 date of hire in March. V1 stated that she inherited this problem. On 8/20/2025 at 2:15 PM V13, MDS Coordinator, stated that she was made aware of R3's smoking in his room on a Sunday. V13 stated that the facility addressed, provided education, and put interventions in place. V13 stated that the interventions are not working due to R3 refusing to get up. V13 stated that they continue to educate R3, and interventions are in place. On 8/20/2025 at 2:30 PM V10, Wound Nurse, stated that she was present on August 10 when R3 was noted to have smoked. V10 stated that she was alerted by staff that there was an odor coming from R3's room. V10 stated that upon entering V10 smelled the smoke. V10 stated that R3 was lying in bed with oxygen on and in place. V10 stated that she informed R3 that he could not smoke in his room because it was dangerous. V10 stated that she educated him on the risk of smoking with his oxygen. V10 stated that R3's oxygen was on and in place. V10 stated that she was able to get the lighter from R3. V10 stated that she didn't find any smoking supplies. V10 stated that she asked R3 where it was? R3 stated that he didn't have any more he smoked it all. V10 stated that she educated R3 on not smoking and R3 stated that he would not do it anymore. V10 stated that she was concerned because R3 has oxygen, and it could ignite. V10 stated that she started working at the facility in April. V10 stated that she was told that this was a problem prior to her employment. On 8/21/2025 at 2:04 PM V17, Nurse Practitioner (NP), stated that it is a big concern of any resident to smoke when using oxygen. V17 stated that the concern would be causing fire, harm to the resident and others. V17 stated that she would expect herself or the rounding physician to be notified. V17 stated that it is dangerous, and she would expect the resident to be assessed, interventions put in place, an investigation to be conducted, and ongoing monitoring. On 8/21/2025 at 3:00 PM V15, NP, stated that it was a fire hazard for R3 to be smoking in his room. V15 stated that it is dangerous for R3 to smoke in his room. V15 stated that R3 is on continuous oxygen and that could ignite causing harm and injury to R3 and his roommate if he has one. V15 stated that she would expect to be notified of the incident. V15 stated that		S9999				

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S9999	Continued from page 4 she was not aware and not been notified of these incidents prior to this conversation. V15 stated that she would expect an investigation to be performed to find out how is R3 getting the items as he does not get out of the bed or leave his room. V15 stated that R3 health concerns could be a problem as well due to his COPD. On 8/25/2025 at 12:40 PM V16, CNA, stated that R3 showed her a small amount of substance in a bag. V16 stated that R3 identified it as marijuana and offered to sell it to her. V16 stated that she declined and reported it to her supervisor. V16 stated that she is unsure of the date. V16 stated that on a Sunday she came onto the hall and smelled a strong odor. V16 stated that she noticed that R3's door was closed. V16 stated that when she entered R3's room a cloud of smoke came out of the room. V16 stated that R3 was lying in bed with his oxygen on and in place. V16 stated that she asked R3 what was going on and R3 became upset and started cursing at V16. V16 stated that she explained to R3 that he can't smoke in his room because it is dangerous. V16 stated that she explained that he is putting her and all the residents on oxygen at risk for blowing up and catching on fire. V16 stated that R3 told her that he would not do it again. V16 stated that she texted V1 and informed her of what she found. V16 stated that V1 notified V10, and a room search was performed. V16 stated that interventions were put in place at that time. V16 stated that they were notified to get R3 out of the bed. V16 stated that R3 does not want to get out of bed and curses her and threatens to hit her in the head if she tries. On 8/25/2025 at 4:10 PM V1 stated that she was only aware of 1 incident of R3 smoking. On 8/26/2025 at 3:23 PM V18, Primary Physician, stated that it is a big concern with R3 smoking in his room with oxygen. V18 stated that R3 could blow the place up. V18 stated that he would expect that the facility would monitor this behavior. The facility Smoker's List 2025 documents All Cigarettes and Lighters must be returned into activity staff. All Smoking activities must be done in the designated area and with supervision. All residents that smoke must have a signed contract on file. No exceptions. The facility's Smoking Policy, dated 5/22/2017, This is a smoke free facility for staff. This facility allows direct supervised smoking by resident outside on patio in rear of facility. All resident cigarettes and	S9999					

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S9999	Continued from page 5 smoking paraphernalia will be maintained in a locked box. No resident shall have possession of these materials. Smoking is prohibited in front of the facility in resident rooms or compartment where flammable liquids, combustible gases or oxygen is in use or stored. It continues Oxygen containers are not allowed in smoking areas at any time. The facility's Drug and Alcohol Behavioral Contract, not dated, documents for any resident who appears to be under the influence of any illegal substance or alcohol, the physician will be notified and the resident will be tested immediately. 1. First offense: responsible party/guardian will be notified of the offense. Staff will discuss behavior with the resident and attempt to define why the action occurred. Care plan will be updated as indicated. Nursing will check room daily, at random times, for illegal substances or alcohol for an unspecified amount of time. 2. Second offense: responsible party/guardian will be notified of the offense. Staff will discuss behavior with the resident and attempt to define why the action occurred. Care plan will be updated as indicated. Nursing will check room daily, at random times, for illegal substances or alcohol for an unspecified amount of time. The resident will be sent to a chemical dependency/alcohol abuse program within or outside of the facility.		S9999				