STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146122	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Paul's Senior Community	1021 West E Street Belleville, IL 62220

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)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43794 Based on interview and record review the facility failed to ensure proper transfer techniques to prevent falls and injuries for one of 7 residents (R2) reviewed for supervision to prevent falls in the sample of 7. This failure resulted in an Immediate Jeopardy when V8, Certified Nurse's Aide (CNA) transferred R2 incorrectly causing R2 to sustain bilateral femur (thigh) fractures and expiring on 04/14/24. This past non-compliance occurred from 04/11/24 to 04/12/24. The Immediate Jeopardy began on 4/11/24, when V8 attempted to transfer R2 by herself, and R2 falling and sustaining bilateral femur fractures which lead to her death. On 4/17/24, at 2:17 PM, V1, Administrator, V25, Regional Corporation Nurse and V26, Director of Clinical Operations were notified of the Immediate Jeopardy. The surveyor confirmed by observation, interview, and record review, that the Immediate Jeopardy was removed, and the deficient practice was corrected, on 4/12/24, prior to the start of the survey and was therefore Past Noncompliance. Findings include: R2's Electronic Medical Record, EMR, undated documents R2 was admitted to the facility on [DATE]. R2's EMR, dated 05/29/19, documents R2 has a diagnosis of Alzheimer's Disease, unspecified. R2's EMR, dated 02/17/21, documents a diagnosis of chronic pain syndrome. R2's EMR, dated 10/01/22, documents a diagnosis of Vascular Dementia, unspecified severity, with agitation. R2's Care Plan dated 04/13/21 documents ADL (Activities of Daily Living): (R2) has an ADL Self Care Performance Deficit r/t (related to) limited mobility from her past left hip fracture, weakness and confusion. Alert, oriented to self. Incontinent of B&B (bowel and bladder). Able to feed self. Utilizes wheelchair for mobility. Hesitant in new environments and does not do well with too many options. Requires extensive assist and encouragement to complete most tasks. Has a stuffed, interactive cat that she often has nearby as a companion. R2's Care Plan Intervention, dated 03/10/22 documents TRANSFER: sit to stand using 2 assist. (continued on next page)

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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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	R2's Minimum Data Set, MDS, dated [DATE] documents a BIMS (Brief Interview of Mental Status) score of 99, which means the resident had severe cognitive impairment. The MDS documents that the resident required substantial/maximal assistance for roll left and right, sit to lying, and lying to sitting on side of bed. The MDS documents that the resident was dependent for sit to stand, chair/bed to chair transfer, toilet transfer, and tub/shower transfer. R2's Health Status Note dated 04/11/24 at 11:39 PM documents The resident was being transferred into the room by aide and the resident's weight shifted toward the aide making the aide fall backward the resident came down forward and once this nurse immediately arrived at the room it was observed that the resident down on one knee and the aide holding her up best, she could. Resident was immediately assessed for injuries. there was no open area to the knees, this nurse attempted ROM (Range of Motion) and upon review the left femur seems to have a deformity. The right thigh had some swelling and at this time the aide and nurse was not clear if this was normal muscular tight swelling or from the fall. So, EMS (Emergency Medical Services), MD (Medical Director) and family notified once EMS arrived and was given report was informed of all concerns of bilateral knees and femurs. Pt (patient) vitals were stable. pt did not hit her head and was sent to (local hospital). R2's Health Status Note dated 04/12/24 at 12:24 PM documents Resident admitted to (local hospital) due to BLE (bilateral lower extremities) fractures. R2's Radiology Report dated 04/12/24 documents Acute significantly displaced and comminuted fracture of the mid left femur. Acute significantly fracture of the mid right femur. R2's Health Status Note dated 04/12/24 at 1:43 PM documents Clarification note per Nurses note incident occurred at 21:00. Facility's Lift Transfer Past Non-Compliance form, dated 04/12/24 documents under problem On 4-11-24 patient (R2) was transferred with 1 person assist but care plan was for sit to stand using 2 assist. On 04/16/24 at 2:09 PM, V8, CNA (Certified Nursing Aide) stated that she was putting R2 in her bed and R2 fell on her. She stated that she yelled for help because R2 was on top of her, and she could not move. She stated that she noticed R2's leg was deformed. She stated that she told the nurse that something was not right with R2's leg. She stated that R2 is normally a 2 assist, but she has been working with her for months. She (V8) stated she has been transferring R2 by herself for a while. She stated that R2's legs are contracted, and she always has her legs crossed. She (V8) stated that lifted her (R2) with a gait belt and put her (V8's) leg between R2's legs. She (V8) stated that she stumbled and R2 fell on top of her. She (V8) stated that the unit was not short staffed. She (V8) stated that R2 fell between 9:00 PM and 9:30 PM. She (V8) stated that it took a long time for the ambulance to get there. She (V8) stated that the ambulance arrived around 10:30 PM. She (V8) stated that the nurse ordered x-rays instead of calling an ambulance. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On 04/16/24 at 2:27 PM, V9, Licensed Practical Nurse, LPN, stated that she was sitting at the nurses' station. V9 stated that she heard yelling down the hall. She (V9) stated she ran to see R2 with one knee on the floor kneeling and V8 holding R2 up with R2's back against the dresser. She (V9) stated that she was able to assist R2 into her wheelchair. She (V9) stated that she assessed R2 and noticed a bulging area on her right thigh. She (V9) stated that she ordered a STAT x-ray. She stated that she had another aide come look at R2's legs and that aide stated that her legs did not look that way before. She (V9) stated that instead of waiting on (mobile x-ray company), she called the ambulance. She (V9) stated that the hospital could get an x-ray quicker and that R2 had already been given her norco (pain medication) at 8:00 PM, so the ER (emergency room) could give her more pain meds. She (V9) stated that she did not see a gait belt or a sit to stand. She stated that V8 never asked her or the other CNA on the unit for help to transfer R2. On 04/17//24 at 12:47 PM, V21, ER Physician, stated that the resident (R2) had very severe osteopenia and never would have survived surgery. He (V21) stated that he is unsure if the fractures contributed to her death, but it did not help. On 04/17/24 at 2:08 PM, V19, Medical Director stated that in his professional opinion the bilateral femur fractures contributed to R2's death. Facility's Fall Prevention Policy (S.A.F.E.) dated 02/2021 documents The S.A.F.E. program promotes Safety, Assessment, Fall prevention and Education of both staff and residents. The Immediate Jeopardy and deficiency practice that began on 4/11/24 was corrected/removed on 4/12/24 after the facility took the following actions to correct the noncompliance prior to the start of current survey: 1. DON (V2) or Designee (V14) to provide 100% of nursing staff were educated on 2 person transfers with all lifts following the patient Kardex prior to their next assigned shift. Done 04/12/24. 2. DON or Designee will provide education to direct care staff on correct procedures for following the Kardex prior to allowing staff to work their next assigned shift. Done 04/12/24. 3. Staff will not be allowed to work and will be taken off the schedule until all education is completed. 4. Education will continue until all nursing staff have been educated, staff will not be allowed to return to work until the education has been provided. 5. All new nursing staff and agency will have the same information reviewed with them at the time of orientation. 6. AD HOC QAPI meeting was immediately held with the medical director on 04/12/24. 7. The DON or Designee will complete 5 lift educations a week for 8 weeks. 8. Any deficient practices will be corrected immediately. Patterns or trends will be reported to QA committee for further recommendations and follow-up. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	9. All resident's transfer status' reassessed and reviewed by V3, Assistant Director of Nursing, ADON on 04/12/24.