

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146122	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/10/2025
NAME OF PROVIDER OR SUPPLIER St Paul's Senior Community		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0550</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44967</p> <p>Based on interview, observation, and record review, the facility failed to maintain residents' pride and dignity for 3 of 5 residents (R1, R3, R5) reviewed for resident dignity in the sample of 5. This failure resulted in expressed feelings of embarrassment and frustration.</p> <p>The Findings Include:</p> <p>1. R1's Admission Record, dated 2/5/25, documents R1 was admitted to the facility on [DATE] with diagnoses of Chronic Obstructive Pulmonary Disease (COPD), Respiratory Failure, Malignant Neoplasm of bronchus or lung, Hypertension (HTN), Morbid Obesity, Diverticulosis, Sleep Apnea, Nicotine Dependence, Lymphedema, Pulmonary HTN, Congestive Heart Disease (CHF), and Peripheral Vascular Disease (PVD).</p> <p>R1's Care Plan, dated 1/24/25, documents R1 has COPD: Interventions: Give aerosol or bronchodilators as ordered, give oxygen therapy as ordered by the physician, monitor for difficulty breathing (Dyspnea) on exertion, remind resident not to push beyond endurance, monitor for signs/symptoms of acute respiratory insufficiency. It continues R1 has Oxygen (O2) Therapy related to shortness of breath (SOB). Interventions: The resident has O2 via nasal prongs/mask continuously, humidified, monitor for signs/symptoms of respiratory distress and report to Medical Doctor as needed (PRN). It continues R1 has altered respiratory status/Difficulty Breathing related to acute respiratory failure. Interventions: Administer medication/puffers as ordered, elevate head of bed (HOB). It continues R1 has bladder incontinence. Interventions: the resident uses disposable briefs, change (freq/frequent) and PRN, check the resident (freq) and as required for incontinence, wash, rinse, and dry perineum, change clothing PRN after incontinence episodes. R1 has bowel incontinence. Interventions: Provide bedpan/bedside commode, provide peri-care after each incontinent episode.</p> <p>R1's Minimum Data Set (MDS), dated [DATE], documents R1 is cognitively intact and is dependent on staff for Activities of Daily Living (ADLs). R1 is frequently incontinent of both bowel and bladder.</p> <p>On 2/6/25 at 8:40 AM, R1 was seen lying on her side with a strong odor of feces in the room. R1 stated I am very upset because I let the Certified Nursing Assistant (CNA) know that I had a Bowel Movement (BM) and was saturated about 30-minutes ago and was told that she would be right back. I have been lying in my BM since then, and no one has come in to take care of me yet this morning. I am usually out of bed by now.</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 0550</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/6/25 at 8:44 AM, V13, CNA, brought in R1's breakfast tray and set it on her bedside table. R1 stated 'You're bringing me my breakfast without even cleaning me up first?' V13 stated 'We already had this discussion. and walked out of the room. R1 stated 'Her discussion was 'You missed breakfast and now have to eat in your room.' Now my breakfast will be cold by the time I get to eat it. I am very messy and stinky. This has me very frustrated and embarrassed and it takes away my dignity and pride, and I have no control over it.</p> <p>On 2/6/25 at 8:52 AM, R1 was provided incontinence care by V13, CNA, and V16, CNA.</p> <p>On 2/6/25 at 9:20 AM, When asked if R1 notified her of being soiled this morning, V13 stated 'Yes, she did. She put her call light on, and I answered it and told her I would be right back. Then I was helping another resident and was going to go to her after that. When asked why she would bring her breakfast tray to her before cleaning her up, V13 stated 'I was given the cart of trays and told to deliver them to all the residents in the rooms and I didn't want all the food to get cold. What was I supposed to do?'</p> <p>2. R3's Admission Record, dated 1/5/25, documents R3 was admitted to the facility on [DATE] with diagnosis of Hypoglycemia, End Stage Renal Disease (ESRD), Dependence on Renal Dialysis, Cerebral Infarction, Aphasia, HTN, Spinal Stenosis Cervical, and Anemia.</p> <p>R3's Care Plan, dated 12/9/24, documents R3 has bladder incontinence. Interventions: The resident uses medium disposable briefs, change (freq) and PRN, check the resident every two Hours and as required for incontinence, wash, rinse and dry perineum, change clothing PRN after incontinence episodes. It continues R3 has bowel incontinence. Interventions: Check resident every two hours and assist with toileting as needed, observe pattern of incontinence, and initiate toileting schedule if indicated, provide bedpan/bedside commode, provide peri-care after each incontinent episode, take resident to toilet at same time each day resident usually has bowel movement. It continues R3 has an ADL Self-Care Performance Deficit. Interventions: The resident is totally dependent on staff for toilet use, requires two staff participation to use toilet.</p> <p>R3's MDS, dated [DATE], documents R3 has a moderate cognitive impairment and is dependent on staff for toileting and transfers, requires substantial/maximum assistance from staff for other ADLs. R3 is frequently incontinent of both bowel and bladder.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/5/26 at 1:56 PM, V11, R3's daughter, stated My mom (R3) called me on Saturday morning (2/1/25) around 7:30 AM. She told me she had to use the restroom and put her call light on, and no one is answering it. Mom said her call light has been on for an hour and half already. While I was on the phone with her, a CNA (V9) came in and told mom that she was the only one working the floor and that mom was a two-person assist and she could not get her to the restroom herself. The CNA told her to just go in her bed and to put her call light on and she will clean her up when she is done. When the CNA left, my mom said (V11), I don't sh** in my pants, what am I supposed to do. We waited about two minutes later, and I had mom turn on the call light to see if the CNA would come back and we waited 20 more minutes, and she never came back. At that point, I decided to come on in myself. It takes me a while to get there but I would say within an hour I was there, and mom's call light was still on, and no one had helped her. Mom did wet her pants but did not have a bowel movement. (V3, Assistant Director of Nursing/ADON) was here by then and told me that everyone called in and she was the one on-call, so she had to come in to assist. (V3) told me she was very sorry and that it was just her and one CNA working. She said she called (staffing agency) and they didn't have anyone. (V3) told me she called (V2, Director of Nursing/DON) five times and that (V2) did not answer her phone. (V2) never showed up to help the staff out. There was mom's physical therapist (V10, Physical Therapist Assistant/PTA) who happened to be visiting her family member and both of us were helping other residents get up and to the dining room to eat. I'm a Licensed Practical Nurse (LPN) so knew what needed to be done, however, I did not work as a nurse, more as a CNA, and (V3) allowed us to help everyone out. I have been working with (V1, Administrator) and the Social Service person to get mom out of there and I believe we are moving her this coming Friday (2/7/25).</p> <p>On 2/5/25 at 2:25 PM, V3, ADON, stated I was called Saturday (2/1/25) because we had a bunch of call-offs. I couldn't get anyone to come in, so I came in. There was only one Nurse and one CNA working the 100-South unit. When I got here (R3's) daughter was very upset and I had to talk to her. The CNA working (V9) did tell (R3) that she was by herself and could not get her up to use the toilet and to go ahead and go in the bed and she will clean her up afterwards. I had a talk with (V9) and told her that was not the way she should have handled it. (V9) could have gotten the nurse on duty to help her or ask me when I got here. I told (V9) that it was not acceptable, and she should never tell a resident something like that. I called the DON, and she didn't answer, and I don't blame her, it was her day off. I tried again later, and she answered, and I explained what was going on and the DON called (R3's) daughter to talk to her. I ended up working the entire shift because no one would come in. I know that (R3's) daughter did not help with other residents because I was here helping out.</p> <p>On 2/5/25 at 2:35 PM, V10, PTA, stated I was here visiting my grandmother who is staying on this floor (100-South). There was only one CNA working and she had no help to get people up. I did not help anyone but my grandmother that day. I did not see (R3's) daughter assisting other residents either.</p> <p>On 2/5/25 at 2:55 PM, V2, DON, stated Yes, that did happen Saturday, we only had one CNA, but (V3) did come in to assist. (V9) should not have told any resident to go in the bed and she'll clean her up afterwards. I only received one phone call, and I was in the shower and as soon as I got out, I called (V3) back to see what was going on.</p> <p>On 2/5/25 at 3:55 PM, R3 stated (V9) did tell me to just go in my pants in bed and she would clean me up later. She said she didn't have any help to get me up. It's embarrassing enough to go in my pants by accident, but for someone to tell you to do it, it hurt my pride and my dignity. I could not believe someone who works here told me to do that, that is her job.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>3. R5's Admission Record, dated 2/6/25, documents R5 was originally admitted to the facility on [DATE] with diagnosis of Cholecystitis, Deep Vein Thrombosis (DVT), Hemiplegia/Hemiparesis, Cerebral Infarction, PVD, Morbid Obesity, Cervicalgia, Type 2 Diabetes Mellitus (DM), Myocardial Infarction (MI), Hyperlipidemia, HTN, CHF, Osteoarthritis, Cardiomegaly, Benign Prostatic Hyperplasia (BPH), and Atherosclerosis.</p> <p>R5's Care Plan, dated 12/26/24, documents R5 has an ADL Self Care Performance Deficit. Interventions: can transfer from bed to chair with stand by assist-1 assist, uses quarter rails to help with repositioning in bed, Active Range of Motion, Transfer using one assist, Toilet Use: The resident is able to wash hands, hold grab bars, wipe self, adjust clothing.</p> <p>R5's MDS, dated [DATE], documents R5 is cognitively intact and requires substantial/maximal assistance from staff for toileting, and supervision/touching assistance with transfers. R5 is always continent of both bowel and bladder.</p> <p>On 2/6/25 at 11:00 AM, R5 stated I am the President of the Resident Council, and we have meetings every month. In just about every meeting, there are complaints of the facility not having enough staff to take care of the resident needs. I feel that one of the biggest problems I see at the facility is that we are being treated like children and don't know what is going on, or that the staff think we are ignorant. They should treat everyone the same, as adults. It makes me feel like a lesser person because of how I am treated. There are some staff who seem to bully me, for example, they will bring me something like juice and will just sit it down and say Here. I don't know why some staff are even working because they don't want to do their job.</p> <p>The Facility's Resident Rights Policy, dated 12/2024, documents Each resident residing in this community has the right and will be afforded the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the community without interference, coercion, discrimination or reprisal. No staff member or contracted provider of care will hamper, compel, treat differently or retaliate against a resident for exercising Resident Rights. It is the responsibility of all who work in this community, including employees of the community and any others who provide services to the residents of the community, to advocate and protect the rights of each resident. All staff members are trained on this Resident Right Policy at the time of employment, prior to providing care to residents, and at least annually to ensure full understanding related to ensuring each resident's Resident Rights.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44967</p> <p>Based on observation, record review and interview the facility failed to provide a safe transfer for 1 of 1 resident (R1) reviewed for resident safety in the sample of 4.</p> <p>The Findings Include:</p> <p>R1's Admission Record, dated 2/5/25, documents R1 was admitted to the facility on [DATE] with diagnoses of Chronic Obstructive Pulmonary Disease (COPD), Respiratory Failure, Malignant Neoplasm of bronchus or lung, Hypertension (HTN), Morbid Obesity, Diverticulosis, Sleep Apnea, Nicotine Dependence, Lymphedema, Pulmonary HTN, Congestive Heart Disease (CHF), and Peripheral Vascular Disease (PVD).</p> <p>R1's Care Plan, dated 1/24/25, documents R1 has COPD: Interventions: Give aerosol or bronchodilators as ordered, give oxygen therapy as ordered by the physician, monitor for difficulty breathing (Dyspnea) on exertion, remind resident not to push beyond endurance, monitor for signs/symptoms of acute respiratory insufficiency. It continues R1 has oxygen (O2) Therapy related to shortness of breath (SOB). Interventions: The resident has O2 via nasal prongs/mask continuously, humidified, monitor for signs/symptoms of respiratory distress and report to Medical Doctor as needed (PRN). It continues R1 has altered respiratory status/Difficulty Breathing related to acute respiratory failure. Interventions: Administer medication/puffers as ordered, elevate head of bed (HOB). It continues R1 has bladder incontinence. Interventions: the resident uses disposable briefs, change (freq) and PRN, check the resident (freq) and as required for incontinence, wash, rinse and dry perineum, change clothing PRN after incontinence episodes. R1 has bowel incontinence. Interventions: Provide bedpan/bedside commode, provide peri-care after each incontinent episode.</p> <p>R1's Minimum Data Set (MDS), dated [DATE], documents R1 is cognitively intact and is dependent on staff for Activities of Daily Living (ADLs). R1 is frequently incontinent of both bowel and bladder.</p> <p>On 2/5/25 at 10:15 AM, R1 stated The staff have to use a (full body mechanical lift device) to get me out of bed and to my wheelchair.</p> <p>On 2/5/25 at 2:25 PM, V3, Assistant Director of Nursing (ADON), stated I was called Saturday (2/1/25) because we had a bunch of call-offs. I couldn't get anyone to come in, so I came in. There was only one Nurse and one CNA working the 100-South unit.</p> <p>On 2/5/25 at 2:35 PM, V10, Physical Therapy Assistant (PTA), stated I was here visiting my grandmother who is staying on this floor (100-South). There was only one CNA working, and she had no help to get people up.</p> <p>On 2/5/25 at 3:50 PM, R1 stated This past Saturday (2/1/25), (V9, CNA) told me that she was the only one working the floor, and in the morning, she got me cleaned up and out of bed and to my wheelchair with the (full body mechanical lift device) by herself, so I was able to go to the dining room for breakfast.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/6/25 at 8:52 AM, V13, CNA, and V16, CNA/Staffing Coordinator, was seen assisting R1 from her bed to her wheelchair using the full body mechanical lift device. The lift device sling was placed under R1, then V16 brought the full body mechanical lift device in and attached the sling to the lift. R1 was lifted off her bed by V16 and pulled to the middle of the room, while free swinging in the air. V13 brought the unlocked wheelchair over to R1, and R1 was lowered to the unlocked wheelchair and disconnected from the sling. There was no one holding onto R1 while she was freely swinging in the air and moving toward the wheelchair. The wheelchair was not locked while R1 was being lowered into the wheelchair.</p> <p>The Facility's Safe Lifting and Movement of Residents Policy, dated 12/2024, documents Resident safety, dignity, comfort, and medical condition will be incorporated into goals and decisions regarding the safe lifting and moving of residents.</p> <p>The (Full Body Mechanical Lift Device User Manual, dated 5/2011, documents Page 36, 8.3: Transferring to a Wheelchair. When the sling is elevated a few inches off the surface of the bed and before moving the patient, check again to make sure that the sling is properly connected to the hoks of the swivel bar. Although (company) recommends that two assistants be used for all lifting preparation, transferring from and transferring to procedures, our equipment will permit proper operation by one assistant. The use of one assistant is based on the evaluation of the health care professional for each individual case. 1. Ensure the legs of the lift (with patient) are in the open position. 2. Move the wheelchair into position. 3. Engage the rear wheel locks of the wheelchair to prevent movement of the chair. Page 37: Use the straps or handles on the side and the back of the sling to guide the patient's hips as far back as possible into the seat for proper positioning.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44967</p> <p>Based on Interview, observation, and record review, the facility failed to provide timely and complete incontinent care for 2 of 4 residents (R1, R3) reviewed for incontinence care in the sample of 5.</p> <p>The Findings Include:</p> <p>1. R1's Admission Record, dated 2/5/25, documents R1 was admitted to the facility on [DATE] with diagnosis of Chronic Obstructive Pulmonary Disease (COPD), Respiratory Failure, Malignant Neoplasm of bronchus or lung, Hypertension (HTN), Morbid Obesity, Diverticulosis, Sleep Apnea, Nicotine Dependence, Lymphedema, Pulmonary HTN, Congestive Heart Disease (CHF), and Peripheral Vascular Disease (PVD).</p> <p>R1's Care Plan, dated 1/24/25, documents R1 has bladder incontinence. Interventions: the resident uses disposable briefs, change (freq) and as needed (PRN), check the resident (freq) and as required for incontinence, wash, rinse, and dry perineum, change clothing PRN after incontinence episodes. R1 has bowel incontinence. Interventions: Provide bedpan/bedside commode, provide peri-care after each incontinent episode.</p> <p>R1's Minimum Data Set (MDS), dated [DATE], documents R1 is cognitively intact and is dependent on staff for Activities of Daily Living (ADLs). R1 is frequently incontinent of both bowel and bladder.</p> <p>On 2/6/25 at 8:40 AM, R1 was seen lying on her side with a strong odor of feces in the room. R1 stated I am very upset because I let the Certified Nursing Assistant (CNA) know that I had a Bowel Movement (BM) and was saturated about 30-minutes ago and was told that she would be right back. I have been lying in my BM since then, and no one has come in to take care of me yet this morning. I am usually out of bed by now.</p> <p>On 2/6/25 at 8:43 AM, V13, CNA, brought in R1's breakfast tray and set it on her bedside table. R1 stated You're bringing me my breakfast without even cleaning me up first? V13 stated We already had this discussion. and walked out of the room. R1 stated her discussion was You missed breakfast and now have to eat in your room. R1 stated Now my breakfast will be cold by the time I get to eat it. I am very messy and stinky. This has me very frustrated and embarrassed and takes away my dignity and pride and I have no control over it.</p> <p>(continued on next page)</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/6/25 at 8:52 AM, V13, CNA, entered R1's room with a few washcloths, placed them in the sink with running water. There was no hand hygiene performed prior to V13 donning gloves to do peri-care on R1. V16, CNA/Staffing Coordinator, entered to assist. V13 used a wet washcloth, with no peri-cleaner, and wiped once to R1's right groin, once to R1's left groin, then folded the washcloth and wiped once down the middle of R1's vagina. V13 then told R1 to roll over to her right side. Very large bowel movement noticed going up and all over both buttocks. V13 then used wet washcloths, with no peri-cleaner, and wiped R1's anal area and buttocks. V13 kept the same gloves on, which had visible feces on them, and while adjusting the linen and holding R1 over to her side, smeared more feces onto R1's buttock and sheets. V16 then brought more wet washcloths in and V13 wiped the feces she had smeared on R1's buttocks, off R1's buttock again, then had R1 roll to her back while a clean incontinence brief was pulled through her legs. R1 then rolled to her left side and soiled linen/brief was pulled out and clean brief fastened to R1. There was no wiping of R1's right side once rolled to her left side. With the same soiled gloves on, V13 then got R1's clean clothes from her recliner and began putting R1's clothes on her. There was no cleaning solution used to clean R1, no rinsing, and no drying of R1 after incontinent care was provided. V13 used the same pair of gloves throughout the care even when visibly soiled with feces.</p> <p>On 2/6/25 at 9:20 AM, When asked if R1 notified her of being soiled this morning, V13, CNA, stated Yes, she did. She put her call light on, and I answered it and told her I would be right back. Then I was helping another resident and was going to go to her after that. When asked why she would bring her breakfast tray to her before cleaning her up, V13 stated I was given the cart of trays and told to deliver them to all the residents in the rooms and I didn't want all the food to get cold. What was I supposed to do?</p> <p>On 2/6/25 at 3:25 PM, V2, Director of Nursing (DON), stated I was told the same thing about the peri-care, the CNA was smearing feces all over and did not change her gloves, and giving her a breakfast tray before cleaning her up. That CNA was sent home and will not be back here again.</p> <p>2. R3's Admission Record, dated 1/5/25, documents R3 was admitted to the facility on [DATE] with diagnosis of Hypoglycemia, End Stage Renal Disease (ESRD), Dependence on Renal Dialysis, Cerebral Infarction, Aphasia, HTN, Spinal stenosis cervical, and Anemia.</p> <p>R3's Care Plan, dated 12/9/24, documents R3 has bladder incontinence. Interventions: the resident uses disposable briefs, change (freq) and prn, check the resident every two hours and as required for incontinence, wash, rinse, and dry perineum, change clothing PRN after incontinence episodes. It continues R3 has bowel incontinence. Interventions: Check resident every two hours and assist with toileting as needed, observe pattern of incontinence, and initiate toileting schedule if indicated, provide bedpan/bedside commode, provide peri-care after each incontinent episode, take resident to toilet at same time each day resident usually has bowel movement. It continues R3 has an ADL Self Care Performance Deficit. Interventions: The resident is totally dependent on staff for toilet use, requires two staff participation to use toilet.</p> <p>R3's MDS, dated [DATE], documents R3 has a moderate cognitive impairment and is dependent on staff for toileting and transfers, requires substantial/maximum assistance from staff for other ADLs. R3 is frequently incontinent of both bowel and bladder.</p> <p>On 2/5/25 at 9:45 AM, R3 stated there are times when she is incontinent and will let the staff know when she is incontinent, and sometimes will still have to wait a long time to get cleaned up.</p> <p>(continued on next page)</p>		

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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 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/5/25 at 1:56 PM, V11, R3's Daughter, stated My mom (R3) called me on Saturday morning (2/1/25) around 7:30 AM. She told me she had to use the restroom and had put her call light on, and no one was answering it. Mom said her call light had been on for an hour and a half already. While I was on the phone with her, a CNA (V9) came in and told her that she was the only one working the floor and that mom was a two-person assist and she could not get her to the restroom herself. The CNA told her to just go in her bed and to put her call light on, and she will clean her up when she is done. When the CNA left, my mom said [NAME], I don't sh** in my pants, what am I supposed to do. We waited about two-minutes later, and I had mom turn on the call light to see if the CNA would come back. We waited another 20-minutes, and she never came back. At that point, I decided to come on in myself. It took me a while to get there, but I would say within an hour, I was there, and mom's call light was still on, and no one had helped her. Mom did wet her pants but did not have a bowel movement.</p> <p>On 2/5/25 at 2:25 PM, V3, Assistant Director of Nursing (ADON), stated I was called Saturday (2/1/25) because we had a bunch of call-offs. I couldn't get anyone to come in, so I came in. There was only one Nurse and one CNA working the 100-South unit. When I got here (R3's) daughter (V11) was very upset and I had to talk to her. The CNA (V9) working did tell (R3) that she was working by herself and could not get her up to use the toilet and to go ahead and just go in the bed and she will clean her up afterwards. I had a talk with (V9) and told her that was not the way she should have handled it. (V9) could have gotten the nurse on duty to help her or ask me when I got here. I told (V9) that it was not acceptable, and she should never tell a resident something like that.</p> <p>On 2/5/26 at 2:55 PM, V2, DON, stated Yes, that did happen Saturday (2/1/25), we only had one CNA, but (V3) did come in to assist. (V9) should not have told any resident to just go in the bed and she'll clean her up afterwards.</p> <p>On 2/5/25 at 3:55 PM, R3 stated (V9) did tell me to just go in my pants in bed and she would clean me up later. She said she didn't have any help to get me up. It's embarrassing enough to go in my pants by accident, but for someone to tell you to do it, it hurt my dignity and my pride. I could not believe someone who works here told me to do that, that is her job.</p> <p>On 3/6/25 at 3:30 PM, V2, DON, stated I would expect the staff to perform timely and completed incontinent care, including changing their gloves when they are soiled and providing hand hygiene. I would expect the staff to ensure the residents dignity and pride are maintained and never to tell the resident to just void in their pants and they will clean them up afterwards. We don't have an Incontinence Care policy; we just follow standard of practice for peri-care. All I have is our Skills Checklist.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Facility's Peri-Care Skills Checklist, undated, documents Identify patient, explain procedure; Wash hands; Ensure privacy; Place basin of warm water and cleansing solution on over-bed table; Put on gloves; Position bed at comfortable working height; Offer resident bed pan or urinal; Help resident into Dorsal Recumbent position, not restrictions in mobility; Ask patient to bed knees and open legs; Drape with bath blanket; Position towel or disposable protector under buttocks; Wash and dry upper thighs covering thighs with bath blanket when finished; Raise bath blanket to expose perineal area; Apply soap to wet washcloth; Separate Labia and wash Urethral area first; Wash between and outside Labia in downward strokes alternating from side to side moving outward to thighs; Use different part of washcloth for each stroke; With fresh water and a clean washcloth, rinse area thoroughly with same strokes; Gently pat dry in same direction; Position patient on side exposing buttocks toward caregiver; Apply soap to wet washcloth; Clean rectal area wiping from base of Labia over Buttocks using a different part of washcloth for each stroke; Rinse and dry anal area thoroughly; Remove pad or towel from underneath patient; Assist patient to comfortable position; Lower bed, call light in reach; Remove gloves and wash hands; Document Procedure in clinical record.</p> <p>The Facility's Infection Prevention and Control Policy, dated 2019, documents Gloves: a. Wear gloves when it can be reasonably anticipated that contact with blood or other potentially infectious materials, mucous membranes, non-intact skin, or potentially contaminated intact skin (e.g., of a patient incontinent of stool or urine) could occur. e. Remove gloves after contact with a patient, bodily fluids/excretions, and the surrounding environment (including medical devices) using proper technique to prevent hand contamination. f. Change gloves during patient care if the hands will move from a contaminated body site (e.g., perineal area) to a clean body site (e.g., face, clothing, etc.).</p>		

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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>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44967</p> <p>Based on Interview, observation, and record review, the facility failed to provide oxygen (O2) to 1 of 3 residents (R2) that is Oxygen dependent, reviewed for residents on oxygen in the sample of 5.</p> <p>The Findings Include:</p> <p>1. R2's Admission Record, dated 2/5/25, documents R2 was admitted to the facility on [DATE] with diagnosis of Chronic Obstructive Pulmonary Disease (COPD), Respiratory failure, Malnutrition, Thrombocytopenia, Hypertension (HTN), Anxiety disorder, Depression, Hyperlipidemia, and Dysphagia.</p> <p>R2's Care Plan, dated 1/24/25, documents R2 has Oxygen Therapy related to acute Respiratory Failure. Interventions: Oxygen Settings: The resident has O2 via nasal prongs/mask at three Liters (L) continuously. Humidified, monitor for signs/symptoms of respiratory distress and report to Medical Doctor (MD) as needed (PRN): Respirations, pulse oximetry, increased heart rate (Tachycardia), restlessness, diaphoresis, headaches, lethargy, confusion, atelectasis, hemoptysis, cough, pleuritic pain, accessory muscle usage, skin color. It continues R2 as Shortness of Breath (SOB) while lying flat. Interventions: Assist with positioning over bedside table with pillows, elevate head of bed (HOB), encourage patient to use pursed lip breathing, prop with extra pillows, administer PRN medications as ordered. It continues R2 has COPD: Interventions: Give aerosol or bronchodilators as ordered, monitor/document any side effects and effectiveness, give oxygen therapy as ordered by the Physician, HOB to be elevated (semi-Fowlers to fowlers) or out of bed upright in a chair during episodes of difficulty breathing (Dyspnea), monitor for difficulty breathing (Dyspnea) on exertion, remind resident not to push beyond endurance, monitor for signs/symptoms of acute respiratory insufficiency: Anxiety, confusion, restlessness, SOB at rest, cyanosis, somnolence. It continues R2 has altered respiratory status/Difficulty Breathing related to anxiety and acute respiratory failure. Interventions: Administer medication/puffers as ordered, elevate HOB, encourage sustained deep breaths, maintain a clear airway by encouraging resident to clear own secretions with effective coughing, monitor/document changes in orientation, increased restlessness, anxiety, and air hunger, monitor for signs/symptoms of respiratory distress and report to MD PRN.</p> <p>R2's Minimum Data Set (MDS), dated [DATE], documents R2 is cognitively intact and requires partial to moderate assistance from staff for Activities of Daily Living (ADLs).</p> <p>On 2/5/25 at 10:00 AM, R2 was seen lying in bed. There was a loud beeping coming from her room which was audible from the nurse's desk down the hall. Upon entrance to R2's room, R2 had a nasal cannula (NC) on, and it was connected to a oxygen concentrator which was beeping and appeared to be off with no O2 running. V5, Certified Nursing Assistant (CNA), entered the room and turned the oxygen concentrator switch on and the O2 began infusing at 2 L/NC. V5 stated I'll tell the nurse about the machine beeping. After notification of R2's O2 not running, the nurse did not go check on the resident. The nurse was seen sitting at the desk.</p> <p>On 2/5/25 at 10:23 AM, V6, CNA, stated (R2) was on a facemask with a breathing treatment being given earlier, but there was nothing in the container, so I took it off and put her NC back in her nose. I assumed the O2 was on at that time.</p> <p>(continued on next page)</p>

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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 2/5/25 at 10:25 AM, V7, Registered Nurse (RN), stated (R2) has continuous Oxygen and should always be on 3 L/NC. I did not know about R2's O2 being off. It was on earlier because I did her vital signs, and her oxygen was working at that time. I did not give (R2) a breathing treatment today, so if she had one on earlier, it must have been from the night nurse. There were no vital signs documented as completed in R2's Electronic Medical Record except for 1:46 AM.</p> <p>On 2/5/25 at 12:13 PM, V3, Assistant Director of Nursing (ADON), stated I went in and checked (R2's) O2 concentrator in her room and it was still randomly beeping, and then it shut itself off. I immediately got her a new one and took that one to maintenance because there must be something wrong with it when it beeps like that. The new one is working fine and is not beeping.</p> <p>On 2/5/25 at 3:35 PM, V4, R2's Daughter, stated I visit my mother every day and twice last week, when I got to the facility, mom was sitting in the dining room without her oxygen on. I had to get staff to get her oxygen and put it on. During this interview, R2's Oxygen concentrator was noted to only be on 1 L/NC, V4 stated it's only on 1 L/NC and she is supposed to be on 3 L/NC. This was confirmed as only on 1 L/NC and V4 turned it up to 3 L/NC herself.</p> <p>On 2/6/25 at 12:55 PM, V18, Nurse Practitioner (NP), stated I follow (R2's) care and (R2) was just sent to the hospital last week for exacerbation of her COPD. She is to always be on continuous Oxygen and should not be off it. If her Oxygen is off, it could be detrimental to her health and life.</p> <p>R2's Physician Order, dated 2/1/25, documents Cont. (continuous) O2 at 3L.</p> <p>R2's Physician Order, dated 1/24/25, documents Continuous O2 at 3 liters via nasal cannula, every shift.</p> <p>On 2/6/25 at 3:30 PM, V2, Director of Nursing (DON), stated I would expect the staff to make sure any resident who requires oxygen will be provided oxygen as ordered by their Physician.</p> <p>The Facility's Oxygen Administration Policy, dated 12/2024, documents Verify that there is a Physician's order for this procedure for Oxygen administration. 6. Turn on the Oxygen. Start the flow of oxygen at the rate ordered. 8. Adjust the Oxygen delivery device so that it is comfortable for the resident and the proper flow of Oxygen is being administered. 10. Check the mask, tank, humidifying jar, etc., to be sure they are in good working order and are securely fastened. 11. Observe the resident upon setup and periodically thereafter to be sure Oxygen is being tolerated.</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44967</p> <p>Based on interview, observation, and record review, the facility failed to provide sufficient staff to care and tend to resident needs for 4 of 5 residents (R1, R2, R3, R5) reviewed for sufficient staffing in the sample of 5.</p> <p>The Findings Include:</p> <p>1. R1's Admission Record, dated 2/5/25, documents R1 was admitted to the facility on [DATE] with diagnoses of Chronic Obstructive Pulmonary Disease (COPD), Respiratory Failure, Malignant Neoplasm of bronchus or lung, Hypertension (HTN), Morbid Obesity, Diverticulosis, Sleep Apnea, Nicotine Dependence, Lymphedema, Pulmonary HTN, Congestive Heart Disease (CHF), and Peripheral Vascular Disease (PVD).</p> <p>R1's Care Plan, dated 1/24/25, documents R1 has an Activities of Daily Living (ADL) Self Care Performance Deficit. Interventions: Toilet Use: The resident requires (two) staff participation to use toilet, the resident requires assistance (specify: wash hands, adjust clothing, clean self, transfer onto toilet, transfer off toilet) to use toilet, Transfer: The resident requires (two) staff participation with transfers. Mobility: The resident requires staff (Specify: supervision, encouragement, assistance) with mobility (Specify: by placing equipment nearby, providing weight bearing support, providing non-weight bearing support, praising efforts), the resident uses wheelchair for locomotion, provide supportive care, assistance with mobility as needed. It continues R1 has bladder incontinence. Interventions: the resident uses disposable briefs, change (freq) and as needed (PRN), check the resident (freq) and as required for incontinence, wash, rinse and dry perineum, change clothing as needed (PRN) after incontinence episodes. R1 has bowel incontinence. Interventions: Provide bedpan/bedside commode, provide peri-care after each incontinent episode.</p> <p>R1's Minimum Data Set (MDS), dated [DATE], documents R1 is cognitively intact and is dependent on staff for ADLs. R1 is frequently incontinent of both bowel and bladder.</p> <p>On 2/5/25 at 10:15 AM, R1 stated The staff have to use a (full body mechanical lift device) to get me out of bed to my wheelchair. I use my call light for help, and it can get answered in around 15-30 minutes, depending on if they have staff working. I know when I have to use restroom, however I am incontinent at times, and will get cleaned up eventually, it all depends on if the staff show up or not.</p> <p>On 2/5/25 at 3:50 PM, R1 stated On Saturday (2/1/25), (V9, CNA) said she was the only one working the floor. She got me out of bed with the (full body mechanical lift device) by herself. She cleaned me up first, then got me up using the (full body mechanical device) to my wheelchair, then I went to the dining room for breakfast.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 2/6/25 at 8:40 AM, R1 was seen lying on her side with a strong odor of feces coming from the room. R1 appeared tearful and stated I am very upset because I let the CNA know that I had a BM (bowel movement) and was wet 30-minutes ago and was told that she would be right back. I have been lying in BM since then, and no one has come in to take care of me yet this morning. I am usually out of bed by now. I am very messy and stinky. This has me very frustrated and embarrassed and takes away my dignity and pride and I have no control over it.</p> <p>2. 1. R2's Admission Record, dated 2/5/25, documents R2 was admitted to the facility on [DATE] with diagnoses of Chronic Obstructive Pulmonary Disease (COPD), Respiratory failure, Malnutrition, Thrombocytopenia, Hypertension (HTN), Anxiety disorder, Depression, Hyperlipidemia, and Dysphagia.</p> <p>R2's Care Plan, dated 1/24/25, documents R2 has an ADL Self Care Performance Deficit. Interventions: Transfer: The resident requires (two) staff participation with transfers, provide supportive care, assistance with mobility as needed. Document assistance as needed.</p> <p>R2's MDS, dated [DATE], documents R2 is cognitively intact and requires partial to moderate assistance from staff for Activities of Daily Living (ADLs).</p> <p>On 2/5/25 at 10:00 AM, a loud beeping was heard coming from R2's room which was audible from nurse's desk. Upon entrance to her room, R2 had a nasal cannula on and connected to oxygen concentrator which was beeping and appeared to be off with no O2 running and no one going to check the loud beeping. V5, CNA, was working the hall and</p> <p>a room away from R1's room. V5 eventually entered R1's room and turned the oxygen concentrator switch on and O2 began infusing at 2 L/NC. V5 stated she would notify the nurse of the machine beeping, no nurse arrived to check out the concentrator. The nurse was seen sitting at the desk.</p> <p>On 2/5/25 at 10:05 AM, R2 stated I use my call light, but it takes a while for it to get answered. I usually let them know when I have to use the restroom, and eventually they will come and help me. The staffing is ok but could use more since it takes a while to get some assistance.</p> <p>On 2/5/25 at 3:35 PM, V4, R2's Daughter, stated I visit my mother every day and when we use the call light when my mother needs help, sometimes it takes a while to get someone to answer it, and one time, no one ever showed up at all. They definitely need more help here.</p> <p>3. R3's Admission Record, dated 1/5/25, documents R3 was admitted to the facility on [DATE] with diagnosis of Hypoglycemia, End Stage Renal Disease (ESRD), Dependence on Renal Dialysis, Cerebral Infarction, Aphasia, HTN, Spinal stenosis cervical, and Anemia.</p> <p>R3's Care Plan, dated 12/9/24, documents R3 has an ADL Self-Care Performance Deficit. Interventions: The resident is totally dependent on staff for toilet use, requires two staff participation to use toilet. It continues R3 has bladder incontinence. Interventions: The resident uses medium disposable briefs, change (freq) and PRN, check the resident Every Two Hours and as required for incontinence, wash, rinse, and dry perineum, change clothing PRN after incontinence episodes. It continues R3 has bowel incontinence. Interventions: Check resident every two hours and assist with toileting as needed, observe pattern of incontinence, and initiate toileting schedule if indicated, provide bedpan/bedside commode, provide peri-care after each incontinent episode, take resident to toilet at same time each day resident usually has bowel movement.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R3's MDS, dated [DATE], documents R3 has a moderate cognitive impairment and is dependent on staff for toileting and transfers, requires substantial/maximum assistance from staff for other ADLs. R3 is frequently incontinent of both bowel and bladder.</p> <p>On 2/5/26 at 1:56 PM, V11, R3's Daughter, stated My mom (R3) called me on Saturday morning (2/1/25) around 7:30 AM. She told me she had to use the restroom and put her call light on, and no one is answering it. Mom said her call light has been on for an hour and half already. While I was on the phone with her, a CNA (V9) came in and told mom that she was the only one working the floor and that mom was a two-person assist and she could not get her to the restroom herself. The CNA told her to just go in her bed and to put her call light on and she will clean her up when she is done. When the CNA left, my mom said (V11), I don't sh** in my pants, what am I supposed to do. We waited about two minutes later, and I had mom turn on the call light to see if the CNA would come back and we waited 20 more minutes, and she never came back. At that point, I decided to come on in myself. It takes me a while to get there but I would say within an hour I was there, and mom's call light was still on, and no one had helped her. Mom did wet her pants but did not have a bowel movement. (V3, Assistant Director of Nursing/ADON) was here by then and told me that everyone called in and she was the one on-call, so she had to come in to assist. (V3) told me she was very sorry and that it was just her and one CNA working. She said she called (staffing agency) and they didn't have anyone. (V3) told me she called (V2, Director of Nursing/DON) five times and that (V2) did not answer her phone. (V2) never showed up to help the staff out. There was mom's physical therapist (V10, Physical Therapist Assistant/PTA) who happened to be visiting her family member and both of us were helping other residents get up and to the dining room to eat. I'm a Licensed Practical Nurse (LPN) so knew what needed to be done, however, I did not work as a nurse, more as a CNA, and (V3) allowed us to help everyone out. I have been working with (V1, Administrator) and the Social Service person to get mom out of there and I believe we are moving her this coming Friday (2/7/25).</p> <p>On 2/5/25 at 3:55 PM, R3 stated (V9) did tell me to just go in my pants in bed because she was working by herself and she didn't have anyone to help her, so she would clean me up after I went. It's embarrassing enough to go in my pants by accident, but for someone to tell you to do it, it hurt my pride and my dignity. I could not believe someone who works here told me to do that, that is her job.</p> <p>4. R5's Admission Record, dated 2/6/25, documents R5 was originally admitted to the facility on [DATE] with diagnoses of Cholecystitis, Deep Vein Thrombosis (DVT), Hemiplegia/Hemiparesis, Cerebral Infarction, PVD, Morbid Obesity, Cervicalgia, Type 2 Diabetes Mellitus (DM), Myocardial Infarction (MI), Hyperlipidemia, HTN, CHF, Osteoarthritis, Cardiomegaly, Benign Prostatic Hyperplasia (BPH), and Atherosclerosis.</p> <p>R5's Care Plan, dated 12/26/24, documents R5 has an ADL Self Care Performance Deficit. Interventions: can transfer from bed to chair with stand by assist-one assist, uses quarter rails to help with repositioning in bed, active range of motion, transfer using one assist, Toilet Use: The resident is able to wash hands, hold grab bars, wipe self, adjust clothing.</p> <p>R5's MDS, dated [DATE], documents R5 is cognitively intact and requires substantial/maximal assistance from staff for toileting, and supervision/touching assistance with transfers.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146122	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/10/2025
NAME OF PROVIDER OR SUPPLIER St Paul's Senior Community		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 2/6/25 at 11:00 AM, R5 stated I am the President of the Resident Council, and we have meetings every month. In just about every meeting, there are complaints of the facility not having enough staff to take care of the resident needs. I have had conversations with (V1) and (V2), and both told me that they are trying to eliminate using agency staff and are trying to hire more of their own staff. There are not enough CNAs working to take care of all the residents, especially at night. At night there is only one CNA working the hall and that one CNA can't help everyone.</p> <p>On 2/5/25 at 2:25 PM, V3, ADON, stated I was called Saturday (2/1/25) because we had a bunch of call-offs. I couldn't get anyone to come in, so I came in. There was only one Nurse and one CNA working the 100-South unit. When I got here (R3's) daughter was very upset and I had to talk to her. The CNA working (V9) did tell (R3) that she was by herself and could not get her up to use the toilet and to go ahead and go in the bed and she will clean her up afterwards. (V9) could have gotten the nurse on duty to help her or ask me when I got here. I called the DON, and she didn't answer, and I don't blame her, it was her day off. I tried again later, and she answered, and I explained what was going on and the DON called (R3's) daughter to talk to her. I ended up working the entire shift because no one would come in.</p> <p>On 2/5/25 at 2:35 PM, V10, Physical Therapy Assistant (PTA), stated I was here visiting my grandmother who is staying on this floor (100-South). There was only one CNA working and she had no help to get people up.</p> <p>On 2/5/25 at 2:55 PM, V2, DON, stated Yes, that did happen Saturday, we only had one CNA, but (V3) did come in to assist. I only received one phone call, and I was in the shower and as soon as I got out, I called (V3) back to see what was going on.</p> <p>On 2/6/25 at 8:45 AM, V15, CNA, stated I am on this floor (100-South) and covering the first set of rooms on the first hall, and (V13) is covering the other hall rooms, there are just the two of us.</p> <p>On 2/5/25 at 11:35 AM, V3, Assistant Director of Nursing (ADON), stated We staff with one nurse per unit, then usually two Certified Nursing Assistants (CNAs) per unit. The 100-South floor usually has three CNAs. We have an internal agency that we use for staffing, and we also use (outside staffing agency). If there is a call-off, and once it is put into the system, both agencies get automatically notified that there is an open shift and it almost always gets filled by one of them, and if by chance it does not get filled, then the manager-on-call will come in and work. I have never heard of only having one CNA and one Nurse on the 100-South Unit, there would never be just one CNA working by herself.</p> <p>On 2/5/25 at 11:40 AM, V6, CNA, stated I heard (V3) mention that we staff with three CNAs on the 100-South Hall. They may schedule three of us, but they pull one of us to be a float, so we always only have the two working on the floor.</p> <p>The Facility's Daily Staffing Sheets, dated 2/1/25, documents only one CNA was working on the 1-South Unit.</p> <p>On 2/6/25 at 3:00 PM, V1 stated We don't have a Staffing Policy, we follow state guidelines.</p>		