

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 02/24/2025
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 0695</p> <p>Level of Harm - 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** 50908</p> <p>Based on observation, interview, and record review the facility failed to ensure respiratory care needs met current standards of practice for 5 of 6 (R1, R2, R4, R5, R6) reviewed for respiratory care. This failure resulted in R1 experiencing chest pain and tightness, shortness of breath and decreased oxygen saturations after R1 did not receive ordered nebulizer treatments.</p> <p>Findings include:</p> <p>1.R1 was admitted to the facility on [DATE] with diagnoses of, in part, acute on chronic congestive heart failure (CHF), lymphedema and chronic obstructive pulmonary disease (COPD).</p> <p>R1's Minimum Data Set (MDS) dated [DATE], documented R1 is cognitively intact, and is on oxygen therapy.</p> <p>R1's Care Plan dated 2/18/25 documented R1 has oxygen therapy related to shortness of breath (SOB); R1 has pneumonia, give medications as ordered, monitor/document for side effects and effectiveness; R1 has asthma related to COPD, give nebulizer treatments and oxygen therapy as ordered, monitor for signs and symptoms of impending asthma attack: coughing spells, decreased energy, rapid breathing, complaint of chest tightness or hurting, wheezing, shortness of breath, tightness of neck or chest muscles, malaise or fatigue; and R1 has COPD, give aerosol or bronchodilators as ordered, monitor/document any side effects and effectiveness, give oxygen therapy as ordered by the physician.</p> <p>R1's orders dated 2/17/2025 at 12:00, documented Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML (Ipratropium-Albuterol) 3 ml inhale orally every 6 hours for cough, shortness of breath for 5 Days.</p> <p>R1's Medication Administration Record (MAR), documented on 2/17/25 through 2/20/25, V14 LPN, V19, LPN, and V20 LPN gave R1 breathing treatments. R1's breathing treatments on 2/17/25 at 12:00 PM and 6:00 PM were documented as administered by V14. R1's breathing treatments on 2/18/25 at 12:00 AM and 6:00 AM were documented as administered by V19 LPN. R1's breathing treatment on 2/19/25 at 6:00 AM was documented as administered by V19. R1's breathing treatments on 2/20/25 at 12:00 AM and 6:00 AM were documented as administered by V20 LPN.</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 0695</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/18/25 at 12:40 PM, V4, Licensed Practical Nurse (LPN), went into R1's room to administer her breathing treatment. V4 stated she would need some time getting the supplies together because it is a new order and would be the first treatment she's received at the facility. R1 was receiving oxygen via nasal cannula and her tank was set to 3(liters)L. At this time, R1 stated she had not received a breathing treatment at the facility yet, she had gotten some while in the hospital though and feels like it would help her.</p> <p>On 2/18/25 at 1:16 PM, V4 went back to R1's room after getting all the supplies she needed for R1's breathing treatment. R1 stated she had feeling constricted in her chest for a few days now. R1 had her right hand over her chest stating her chest felt heavy. V4 stated the orders were for 3milliters(mL) of breathing treatment solution to be given over 10-15minutues for five days. V4 administered the breathing treatment to R1. V4 stated she was not aware the breathing treatments were to be started yesterday and was not told they hadn't been given. V4 stated she noticed the orders today and assumed she was the first to get them. At 1:35 PM, R1 stated she was not feeling worse after the breathing treatment was completed but not much better.</p> <p>On 2/19/25 at 10:30 AM, R1 stated last night she got her breathing treatment but did not get it this morning. R1 stated, The nurse might have charted giving me my breathing treatment, but I know it wasn't done. R1 stated she doesn't like to complain because the CNAs (certified nursing assistant) don't care. R1 stated she doesn't remember anyone checking her vital signs today yet either. R1 stated the less I say the better off I am but she was feeling lightheaded and tired now.</p> <p>On 2/19/25 at 10:40 AM, V6, LPN checked R1's oxygen level and reported it to be 93% while R1 was receiving 2L of oxygen via nasal cannula. R1 reported to V6 her chest felt tight and did not get her breathing treatment this morning. V6 told R1 she would look at her orders and get her something to help.</p> <p>On 2/19/25 at 10:47 AM, V4, LPN, stated she was not aware R1 missed her breathing treatment this morning, the nurse did not report that to her in hand off.</p> <p>On 2/20/25 at 10:03 AM, R1 stated she did not get her breathing treatment again at midnight or at 6:00 AM. R1 stated she was having chest pain and reported it to the CNA about 44 minutes ago and still hasn't been seen. R1's oxygen was set to 1.5L via nasal cannula at this time. R1 does not have orders for oxygen to be given or orders on the settings it should be at.</p> <p>On 2/20/25 at 10:06 AM, this surveyor reported R1's complaints of chest pain to nurses V6 LPN and V14 LPN. V14 stated V13 CNA had not reported anything to her about R1 having chest pain. V14 stood up and went to R1's room with vitals sign monitor. R1's vitals were 98.2 temperature, 131/66 blood pressure, 88% oxygen saturation, 125 heart rate with reports of shortness of breath, feeling uncomfortable and having audible wheezes while breathing. V14 told R1 to take some deep breaths and offered her a dose of her albuterol inhaler. R1 stated would rather get her breathing treatment instead since she missed her other doses earlier today. V14 left and came back with a different pulsometer and got readings of 100% oxygen saturation with heart rate of 72. V14 stated R1's lungs were crackled but did not listen to them with a stethoscope. V14 stated the nurse that gave hand off report to her did not mention R1 missed any breathing treatments. V14 told V6 to contact R1's provider about her findings.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/20/25 at 12:45 PM, R1 stated she feels like the staff should be giving her breathing treatments as ordered, if they had been I might be feeling better now but my chest still feels heavy. V14 came in and checked R1's oxygen levels and reported them to be 76%. R1's oxygen was set at 1.5L. V14 changed R1's oxygen to 3L after her readings. R1 had a saturation of 82% after being placed on 3L. V14 stated she was going to notify the doctor.</p> <p>On 2/19/25 at 2:39 PM, V2, DON, stated V19 charted giving R1 her breathing treatments but did not actually administer them. V2 stated she could not deny this because R1 is cognitively with it. V2 stated the nurse told her she had pulled R1's nebulizer treatment and had it ready to go, charted that it was given but forgot to give it. V2 stated she told V19 if she charts it given, then she needs to actually give it. V2 stated she expects staff to document accurately. V2 stated she was going to be completely honest, on 2/17/25 the breathing treatments hadn't been started if V4 had to go and find new supplies to administer it.</p> <p>On 2/24/25 at 8:48 AM, V18, R1's Nurse Practitioner, stated she would expect the facility to administer medications to R1 as ordered and if she was missing over half the amount of breathing treatments to be notified of that also. V18 stated the breathing treatments were ordered for R1 due to an acute breathing issue with shortness of breath. V18 stated R1 should be on 2L of oxygen but just noticed now R1 didn't have oxygen orders in her chart. V18 stated missing breathing treatments and having the wrong amount of oxygen administered could cause R1 to have worsening/exacerbation of her COPD and increased workload on her heart with all the excess fluid she has.</p> <p>2.R2 was admitted to the facility on [DATE] with diagnoses of, in part, congestive heart failure, iron deficiency anemia, and chronic obstructive pulmonary disease.</p> <p>R2's MDS dated [DATE] documented R2 is moderately cognitively impaired.</p> <p>R2's Care Plan dated 2/17/25 documented R2 has oxygen therapy related to CHF and to monitor for signs and 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; R2 has oxygen (O2) via nasal prongs/mask; R2 has asthma relate to CHF; R2 has COPD, give aerosol or bronchodilators as ordered, monitor/document any side effects and effectiveness; R2 has altered respiratory status/difficulty breathing related to chronic respiratory therapy.</p> <p>R2's orders dated 2/19/2025 at 2:30 PM documented R2 to be on 3L of oxygen nasal cannula continuously.</p> <p>On 2/20/25 at 9:42 AM, R2 was in his room directly across the hall from the nurse's station with his door wide open, no nasal cannula was attached to his face. This surveyor observed R5 looking out his window in his wheelchair and could hear an oxygen concentrator turned on from the hallway. Upon entering R2's room, this surveyor observed</p> <p>R2's nasal cannula hooked up to the concentrator set to 3L laying on the floor.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/20/25 At 10:20 AM, R2 was in the same position with his nasal cannula lying on the floor. At 10:22 AM, V10, Physical Therapy, came to take R2 for a session. V10 removed R2's nasal cannula from his concentrator and hooked it up to the empty tank on the back of R2's wheelchair. At 10:25 AM, R2 was noted to be pale and took fast shallow breaths. This surveyor requested V11, CNA, check R2's oxygen saturation level before leaving to physical therapy. V11 assessed his oxygen levels and were running at 48-50%. V11 asked R2 via a communications board if he was having trouble breathing and he responded yes. V11 hooked R2 back up to his concentrator and removed R2 from the oxygen saturation monitor before leaving him in his room. V11 left R2 in his room alone after having oxygen saturation levels at 50% and reports of trouble breathing without notifying his nurse. At 10:30 AM, V11 returned with one oxygen tank and told the other CNA that she is going on break then left the unit. V12, Registered Nurse, stated V11 did not report any vital signs to her on R2.</p> <p>On 2/20/25 at 10:37 AM, V10, came back to R2's room and hooked R2 up to the new oxygen tank. V10 stated he was not told of what R2's oxygen saturations levels were and did not check to see what they were or verify if it was safe with nursing staff to take him. V10 left the unit with R2 at 10:44 AM.</p> <p>On 2/20/25 at 8:50 AM, V5 CNA stated she did not know how to check how many liters a resident was on while receiving oxygen, she would rely on the nurses to set it and check to make sure it was right. V5 stated yesterday, 2/19/25, R2 had come back from physical therapy with an empty oxygen tank and his saturation levels were in the 50s, she reported it immediately to the nurse who told her to stay with R2 while she went to get more oxygen for him and set it up.</p> <p>On 2/20/25 at 10:45 AM, V15, CNA, stated that she would tell the nurse immediately if a resident had oxygen levels in the 50s.</p> <p>On 2/20/25 at 10:55 AM, V16, CNA, stated she would get the nurse and wait to do anything while staying with the resident if they had oxygen levels in the 50s or reported chest pain.</p> <p>On 2/20/25 at 10:58 AM, V17, CNA stated she would get the nurse for oxygen levels in the 50s or chest pain reports. V17 stated she checks on oxygen tanks before hooking them up and every two hours while using them to make sure they are not empty.</p> <p>3.R4 was admitted to the facility on [DATE] with diagnosis of, in part, type two diabetes mellitus and chronic kidney disease.</p> <p>R4's MDS dated [DATE] documented R4 is moderately cognitively impaired.</p> <p>R4's Care Plan dated 1/9/25, documented R4 has oxygen therapy with no documentation of what it was related to and R4 has shortness of breath.</p> <p>R4's current orders dated 4/10/2024 at 2:30 PM are for oxygen at 2L continuously.</p> <p>On 2/19/25 at 10:51 AM, R4 was lying in bed with oxygen on via nasal cannula at 3L (Liters).</p> <p>4. R5 was admitted to the facility on [DATE] with diagnoses of, in part, acute and chronic respiratory failure, acute on chronic congestive heart failure, emphysema, and chronic obstructive pulmonary disease.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>R5's MDS dated [DATE] documented R5 is cognitively intact.</p> <p>R5's Care Plan dated 2/17/25 documented R5 has respiratory infection; R5 has oxygen therapy related to chronic respiratory failure; and R5 has COPD Give oxygen therapy as ordered by the physician.</p> <p>On 2/20/25 at 9:33 AM, R5 was sitting in the dining room with an empty oxygen tank hooked to the back of his wheelchair set to 3L. R5 stated he could not feel any oxygen running through his nasal cannula. R5 stated his lungs felt a little tight usually and thinks he should get breathing treatments but doesn't. R5 pulled out an albuterol inhaler from his pocket and stated he will take puffs from that whenever he needs it. R5 reported to V8 that he needed more oxygen. V8 stated looks like you're out of oxygen too, then left to get R5's concentrator from his room. R5's oxygen saturation was 97%.</p> <p>On 2/17/2025 at 6:30 AM documented R5 is supposed to get 2L of oxygen nasal cannula.</p> <p>5.R6 was admitted to the facility on [DATE] with diagnosis of, in part, chronic obstructive pulmonary disease, acute respiratory failure with hypoxia, and malignant neoplasm of bronchus.</p> <p>R6's MDS dated [DATE] documented R6 is cognitively intact.</p> <p>R6's Care Plan dated 2/10/25 documented R6 has altered respiratory status/difficulty breathing related to acute respiratory failure and R6 has COPD, give oxygen therapy as ordered by the physician.</p> <p>On 2/20/25 at 9:30 AM, R6 was sitting in the dining room with an empty oxygen tank hooked to the back of her wheelchair set to 2L. R6 stated she did not feel any oxygen coming through the nasal cannula.</p> <p>At 9:35 AM, V8 stated the floor was completely out of oxygen tanks.</p> <p>On 2/20/25 at 1:45 PM, V2 stated her expectation from staff when running low on oxygen tanks is to be notified right away so I can make an urgent delivery on them. V2 stated if someone has oxygen saturations in the 50s after not having oxygen on or if oxygen is not being administered, I expect to be notified.</p> <p>The facility's Oxygen Administration Policy dated 12/24, documented under preparation to verify that there is a physician's order for this procedure for oxygen administration. The facility's Medication Administration Policy undated, documented all staff members are expected to follow these guidelines strictly and to report any issues or deviations from the policy; residents who self-administer must have a profile only MAR which lists their medications and indicates that they self-administer; medication administration should be accurately documented on the MAR immediately after each administration, any errors, omissions, or incidents related to medication administration must be documented in the clinical record and reported as per facility policy. The facility's Nebulized Medication Policy undated, documented under tasks to access lung sounds before and after treatments are given.</p>		