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	03/27/2026

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to provided timely turning/repositioning and incontinent care to prevent pressure ulcers/injuries from worsening or developing new pressure ulcers/injuries for 1 of 4 residents (R50) reviewed for pressure ulcers in a sample of 47. Findings Include: R50's Face Sheet, documents that she has diagnoses of but not limited to primary osteoarthritis of right and left hand, pressure ulcer of sacral region, stage 4, and peripheral vascular disease. R50's Minimum Data Set (MDS), documents that R50 is cognitively intact with a Brief Interview of Mental Status (BIMS) of 13 out of 15 and she is dependent on staff for all her activities of daily living (ADLs). R50 is always incontinent of bowel and bladder. R50s, Care Plan, documents that R50 has impairment to skin integrity related to (r/t) pressure injury to coccyx r/t pain, bladder incontinence, decreased mobility and poor circulation. R50 refuses repositing at times. Interventions include but are not limited to administer treatments as ordered and monitor for effectiveness, apply moisture barrier with each incontinent episode, evaluate wound for: size, depth, margins: peri-wound skin, sinuses, undermining, exudates, edema, granulation, infection, necrosis, eschar, gangrene. Document progress in wound healing on an ongoing basis. Notify physician as indicated, float heels while in bed as tolerated, heel protectors on while in bed, and the resident needs assistance to turn/reposition at least every 2 hours, more often as needed or requested. R50's Current Braden Scale- for Predicting Pressure Ulcer Risk Evaluation, dated 02/05/26, documents that R50 is a very high risk for developing pressure ulcers. R50's Physician's Orders, dated 12/05/25 at 2:18 PM, documents COCCYX: Cleanse wound with soap and water. Pat dry. Protect peri-wound area with skin protectant (Skin Prep). Do not put it in open area. Apply collagen particles to wound bed. Apply a thin layer of SSD to wound bed. Apply calcium alginate to wound base. Cut to fit INSIDE wound edges. Do not place on skin. Cover with bordered gauze. Change dressing daily and PRN (as needed) for soiling, saturation, or unscheduled removal. R50's Skin and Wound Note, dated 03/12/28, documents that R50's wound assessment location: coccyx, is pressure ulcer/injury, stage 4, currently stable, measures 5 centimeters (cm) x 4 cm x2 cm, and has subcutaneous and adipose tissue exposed. It also documents that the peri wound (the skin surrounding the wound) is macerated and the wound has a moderate amount of serosanguineous amount of drainage. She rates wound pain a four at rest. Assessment/Plan: Pressure Injury to coccyx assessed and debrided on today's skin assessment; please keep the patient's skin clean and dry, apply barrier cream as necessary to prevent skin breakdown, and avoid pressure on any bony prominence by adhering to turning protocols and floating heels as applicable. Given patients history, comorbidities, and current condition; the risk of complications and/or morbidity/mortality of the patient's management is high. During observations on 03/24/26 from 9:15 AM through 2:10 PM, with 15-minute intervals R50 was seen up in her wheelchair with no repositioning or checking for incontinence being done. On 03/23/2026 at 10:15 AM, R50 is sitting up in her wheelchair in her room. R50 asked this surveyor if I knew what a pressure ulcer was. She said she has got one since she has been here at the facility. She was asked if she had any pressure ulcers before she came to the facility and she said, Absolutely Not! R50 said they do not come and check, change or turn her every two hours. On 03/25/2026 at 10:27 AM, V27, Certified Nursing Assistant (CNA) said residents should be turned/repositioned/changed every two hours. V27 (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	said she feels like they don't have enough staff working and sometimes it's hard to get her rounds done every two hours. On 03/26/26 at 11:50 AM, V3, Assistant Director of Nursing (ADON) and V33, Infection Preventionist (IP) both stated they would expect the resident to be checked, changed, and repositioned at least every two hours. On 03/26/26 at 1:00 PM, V3, ADON said they don't have a turning and repositioning policy they just follow protocol for wounds and turn the residents every two hours. She said for someone who has wounds they want to relieve that pressure.