STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009120	A. BUILDING: _____ B. WING _____	C 12/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST PAUL'S SENIOR COMMUNITY	1021 WEST E STREET BELLEVILLE, IL 62220

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S 000	Initial Comments Complaint Investigation: 23410526/IL167922	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b) 300.1210d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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. 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 Regulations are not met as evidenced by: Based on interview, observation and record review, the facility failed to implement fall interventions to prevent falls for 3 of 3 residents (R1, R2, R3) reviewed for falls in the sample of 3. This failure resulted in R1 sustaining a laceration to her left eye and R2 sustaining a left hip	S9999		

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S9999	Continued From page 2 fracture. Findings include: 1. R1's Face Sheet, undated, documents R1 has a diagnosis of Dementia, Osteoporosis, Stage 3 Chronic Kidney Disease and Type 2 Diabetes. R1's MDS (Minimum Data Set), dated 10/23/23, documents R1 has severe cognitive impairment, is dependent with toileting, bed mobility and transfers and has a history of falls. R1's Care Plan, dated 7/1/22, documents R1 is at risk for falls with an intervention, dated 12/4/23, not to leave R1 in her room unattended. R1's Fall Risk Assessment, dated 9/24/23, documents R1 is at high risk for falls. R1's Progress Note, dated 12/3/23 at 8:16 PM, documents resident fell out of her reclining wheelchair around 6:55 PM. The aide stated that she stepped out of the room to go across the hall and when she went back to the resident's room, she was on the floor. The nurse assessed R1, and she was lying face down on the floor. The aides turned her over and there was a laceration to the left eyebrow, redness to the tip of her nose and chin, a skin tear to the left elbow and an abrasion to the left knee. Hospice called and notified, verbal orders received to monitor and treat. POA (Power of Attorney) and DON (Director of Nurses notified. Provider and management notified via texting application. Vital signs WNL (within normal limits). Resident is stable at this time. Bed is in the lowest position and call light is within reach. R1's Progress Note, dated 12/17/23 at 2:14 PM,	S9999		

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S9999	Continued From page 3 documents at 1:28 PM, resident was found in room by aide after falling out of her chair onto the floor. Resident able to respond to name. Breathing is even and non-labored. Injury noted to the left eye and left upper leg. Hospice, POA and DON notified. Resident sent to hospital for evaluation. R1's Progress Note, dated 12/17/23 at 9:57 PM, documents resident returned to the facility at 9:45 PM by ambulance. Resident went out for an unwitnessed fall and was seen for a left eyebrow laceration. CT/computed tomography scan of the head was clear, and no fractures were found. Steri-strips were applied to the laceration with instructions to change the dressing as needed, use antibiotic ointment on area 2-3 times per day and to wash with mild soap and water. Resident is alert and oriented to self. Resident is lying in bed with the bed in the lowest position and the call light within reach. R1's AVS (After Visit Summary), dated 12/17/23, documents R1's CT scan showed chronic bilateral nasal bone fractures, no new fractures, new left frontal scalp hematoma and periorbital hematoma and a contusion/hematoma tracking down the left cheek bones. R1 was diagnosed with a Fall and had laceration repair to the left eyebrow. On 12/20/23 at 9:20 AM, R1 was observed at the dining room table in her reclining wheelchair. R1 had a laceration to the left eyebrow with steri-strips in place and reddish bruising to the left upper eye, eye lid and lower eye area. There was a bandage in place below the left eye. On 12/20/23 at 2:00 PM, V11, LPN, stated that R1 fell on 12/17/23 after lunch between 12:00 PM	S9999		

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S9999	Continued From page 4 and 1:00 PM. V11 stated the CNA who was caring for R1, unsure of name, was not familiar with R1 and was taking R1 out of the dining room. V11 stated she asked the CNA where she was taking R1, and the CNA told her she was taking her to her room to lay her down. V11 stated she told the CNA they normally keep her at the nurse's station or in the dining room for a little while until they get her in bed and the CNA stated she was going to lay her down. V11 stated approximately 3-4 minutes later, the CNA told her R1 was on the floor. When V11 entered the room, R1 was on the floor face down in front of her reclining wheelchair. V11 stated the CNA told her she stepped away to get towels to clean R1 up and R1 fell while she was out of the room. 2. R2's Face Sheet, undated, documents R2 has a diagnosis of Sepsis, Dehydration, Stage 3 Chronic Kidney Disease, Vascular Dementia, Muscle Weakness, Left Femur Fracture (7/18/23), Heart Failure, Hypertension (HTN), History of Falling, Atrial Fibrillation, Muscle Wasting and Atrophy. R2's MDS, dated 10/9/23, documents R2 has severe cognitive impairment, is dependent with toileting and transfers and requires maximum assistance with bed mobility. R2's Care Plan, dated 7/10/23, documents R2 is at risk for falls. R2's Fall Risk Assessment, dated 12/1/23, documents R2 is at high risk for falls. R2's Progress Note, dated 11/29/23 at 10:17 PM, documents the CNA (Certified Nurse Assistant) went into the resident's room to do the last round and the CNA informed the nurse that the	S9999		

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S9999	Continued From page 5 resident's legs were hanging off of the side of the bed. CNA stated that one of R2's legs was against the bedside table and that she (CNA) put the resident's legs back on the bed. The nurse went to assess the resident. No bruising, bleeding, lacerations, swelling or complaints of pain were noted. Resident lying in bed resting with eyes closed. Bed is in lowest position and call light is within reach. There was no documentation in R2's care plan or progress note that an intervention was implemented to prevent R2 from falling after she was observed by staff with her legs hanging off of the bed. R2's Progress Note, dated 12/18/23 at 1:30 AM, documents while the CNA was doing her rounds, she found the patient down on the mat on her left side by the bed. The bed is in the lowest position with the call light on her side. Assessed with no physical injuries. Vital signs were taken and are stable. Patient is awake and not really good at verbal communication. Nurse called for help from the regular staff in charge to help assess the patient. They put her back to bed with a full mechanical lift. R2's Progress Note, dated 12/18/23 at 2:37 AM, documents the patient was re-evaluated at bedside and it was noted that R2 was guarding her left thigh and made a moan when changing her incontinence brief. When asked if she was in pain, she answered yes, and her hand was on that side of the leg. There was a bump and swelling noted to the left thigh. Hospice was called and was advocated for an x-ray. Informed POA/power of attorney (V15, R2's Daughter) and Physician (V16, R2's Physician/Medical Director) and V16 stated to send to the ER/emergency room for further evaluation and treatment. Family was informed that the patient was being sent out	S9999		

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S9999	Continued From page 6 to the ER for an x-ray. After some time, hospice called and said they just wanted a portable x-ray for the patient. V16 was called to inform of hospice's wish and V16 insisted that the patient be sent to the ER. R2's Progress Note, dated 12/20/23 at 12:40 PM, documents R2 returned to the facility with an indwelling urinary catheter, family requests not to remove. Continues with hospice services. Resident is not verbally responsive. Will open eyes for brief periods. R2's Progress Note, dated 12/20/23 at 12:43 PM, documents R2's left lower extremity (LLE) displays internal rotation. R2's Hospital Records, dated 12/20/23, documents R2 was admitted to the hospital from 12/18/23 - 12/20/23 with a diagnosis of a Closed Femur Fracture. On 12/20/23 at 1:00 PM, R2 was observed in her room with her bed with family at bedside. R2 appeared ill with open mouth breathing and was not responsive. On 12/20/23 at 1:00 PM, V14, R2's Granddaughter, stated R2 was sent to the hospital after a fall on 12/18/23 and was diagnosed with a left hip fracture and bladder infection. V14 stated they did not do any surgical repair of the left hip fracture due to R2 already being on hospice and the doctors said she most likely wouldn't make it through the surgery. V14 stated R2 moans in pain when turned or when being provided care, so they left the indwelling urinary catheter in place to help with the pain. V14 stated the facility staff had told her that R2 had been putting her legs out of the bed and she	S9999		

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S9999	Continued From page 7 isn't sure why they didn't put alarms on her or do more than just have the mats beside her bed, "you'd think they would put other precautions in place." V14 stated R2 had a fall in July 2023 at home, sustained a left hip fracture and they had to put pins in it and it healed, then she fell and broke it again. V14 stated R2 was somewhat awake before the fall on 12/18/23. On 12/20/23 at 1:00 PM, V15, R2's Daughter, stated on the day R2 fell (12/17/23), she was here until around 9:30 PM. V15 stated she received a call from the facility nurse, unsure of name, around 2:00 AM, stating R2 had fallen out of bed. V15 stated then a little later on, unsure of time, she received another phone call from the same nurse, stating that the nurse looked at R2's hip and it was swollen and R2 was in pain, so they were sending her to the hospital for an x-ray. V15 stated they did an x-ray at the hospital and her left hip was broken, she had a bladder and kidney infection. On 12/20/23 at 1:20 PM, V10, LPN, stated that R2 had been fidgety and would put her legs out of the bed. V10 stated that is how they knew she was ready to get out of bed, so they would get her up. V10 stated she doesn't work nights so she isn't sure how she is on nights, but she does that during the day at times. On 12/20/23 at 2:40 PM, V16, R2's Physician and Medical Director stated he was on call the night that R2 fell. V16 stated the nurse called him and stated that R2 had fallen and had a deformity of the upper leg, and she was thinking it was fractured, so he revoked hospice's order to complete the x-ray at the facility and told them to send her to the hospital for further evaluation and treatment. V16 stated he would expect the facility	S9999		

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S9999	Continued From page 8 to implement interventions to prevent falls. On 12/21/23 at 10:00 AM, V12, Agency RN, stated R2 was last checked on by her around 10:00 PM and she was awake. V12 stated R2 was stiff, doesn't really move but at times tries to get out of bed. 3. R3's Face Sheet, undated, documents R3 has a diagnosis of Acute Cystitis, Neurocognitive Disorder with Lewy Bodies, Need for Assistance with Personal Care, Dementia, Parkinson's Disease, Syncope, Unsteadiness of Feet, HTN and Stage 4 Kidney Disease. R3's MDS, dated 11/6/23, documents R3 has severe cognitive impairment, requires maximum assist with toileting, is independent with bed mobility, requires supervision/touching assist with transfers and has a history of falls. R3's Care Plan, dated 8/5/23, documents R3 is at risk for falls related to weakness with an intervention to be sure the call light is within reach. R3's Fall Risk Assessment, dated 11/6/23, documents R3 is at high risk for falls. On 12/20/23 at 9:05 AM, R3 was observed in his room in bed. R3's call light was on the floor to the left of the resident out of his reach. R3 stated he's had a couple of falls but didn't get hurt. R3 stated he uses his call light "sometimes." On 12/21/23 at 8:30, V2, DON, stated she would expect fall interventions be implemented and in place to prevent falls. The Fall Policy, dated 9/17/19, documents the	S9999		

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S9999	Continued From page 9 facility shall ensure that a fall management program be maintained to reduce the incidence of falls and risk of injury to the resident to promote independence and safety. Residents found to be at high risk for falls are placed on the fall program and interventions are implemented to meet their individual needs. (A)	S9999		