

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0056085		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/27/2026	
NAME OF PROVIDER OR SUPPLIER ST PAUL'S SENIOR COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 1021 WEST E STREET , BELLEVILLE, Illinois, 62220			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
S0000	Initial Comments Annual Licensure and Certification Complaint Investigation: 2642709/2960222		S0000			04/14/2026	
S9999	Final Observations Statement of Licensure Violations 1 of 2: SHELTERED CARE 330.1720c)2) Section 330.1720 Content of Medical Records c) In addition to the information that is specified above, each resident's medical record shall contain the following: 2) A physician's order sheet that includes orders for all treatments, diet, activities and special procedures or orders required for the safety and well-being of the resident. The physician's order sheet shall also include a record of the medications prescribed for the resident by the physician, and a statement that the resident is capable of self-administering these medications. These Regulations are not met as evidenced by: Based on interview and record review the facility failed to administer medication per physician order for 1 of 3 (R109) residents reviewed for medication administration in a sample of 47. Findings include: R109's Admission Record, not dated, documents that R109's original admission date was 10/19/2024. R109's Admission Summary, dated 9/29/2025 at 7:09 PM, documents that Note Text: resident admitted to ALF (assisted living facility) room 3014 60y/o (year old) blk (black) female alert and oriented x3 with confusion, mood pleasant not able to tell me how she takes pills states her daughter has to answer those questions, resident did ask who decision was it for her moving to this floor this		S9999			04/14/2026	

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 nurse made her aware her daughter felt like she needed more assistance resident verbalized understanding, DX (diagnosis): type 2 DM (diabetes mellitus), HTN, Wernickes Encephalopathy, chronic toxic neuropathy secondary to ETOH (alcohol) . skin intact no lesions or rashes noted, PERRL (pupils equal round reactive to light), lungs CTA (clear to auscultation) bilat (bilaterally), heart rate regular, abdomen soft, non-tender not distended , feet intact no areas of concern noted, resident has w/w (wheeled walker) she uses also a cane noted in room, some left side weakness is noted and verbalized, resident meds given to this nurse and all refills will be taken care of per daughter (V41) POA (power of attorney) , nurse staff to give medications as ordered, resident has no teeth she has a full set of dentures she say this nurse does not see them but she says she does have but does not wear, she has eyeglasses and daughter states she legally blind, no hearing problem noted. resident has states she does not want to be awaken early for breakfast or meds she will get up when ready and plans on eating meals on the independent side this nurse made her aware staff will check daily what her meal plan is for the day and can wait till, she gets up to give medications. call light instructions given resident states she wears depends on and usually can make to bathroom for urine but not for bowel movements. R109's Outside Clinic Report, dated 7/09/2026, documents Sertraline HCl Oral Tablet 100 MG 9milligram) tab. Take one-half tablet by mouth every morning for depression. R109's Medication Administration September 2025 to February 2025 documents that R109 received Sertraline HCl Oral Tablet 100 MG tab daily. On 3/23/2026 at 10:47 AM R109 stated that her daughter orders her medication. R109 Stated that the facility informed the resident that she was out of her medication. R109 Stated that when the daughter requested the refill it was order too soon. R109 Stated that is how they found out she was receiving twice the dose. R109 Stated at one-time when the nurse came in, she would tell them to leave it on the table and she would get it later. R109 Stated that the problem was that R109 would spill the medications and then didn't know what she took and didn't. R109 stated that someone must have said something because now they hand it to her now and stand there until she takes them. R109 Stated that she is ok with that. On 3/24/2026 at approximately 9:30 AM V14,	S9999		04/14/2026

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S9999	Continued from page 2 Licensed Practical Nurse, Ceola stated that when passing medications on the hall is individualized. V14 stated that residents can give their medications. V14 stated that she prepares them, and the resident self-administer, and she monitors the administration. V14 stated that R109 is legally blind but able to see shapes. V14 stated that R109 requested medications be placed in her reach. V14 stated that this worked for a while then R was spilling her medication. V14 stated that now they hand her the medication and watch her take them. V14 stated that R109 doesn't like that much but it works to make sure she gets her medicine. V14 stated that R109 is talkative and its not easy to just walk out of R109's room. On 3/24/2026 at 11:11 AM V41, R109's Family, stated that the facility had given R109 a double dose of medication. V41 stated that her R109 received Sertraline HCl Oral Tablet 100 MG and was only supposed to receive 50mg. V41 came to light when a refill to soon occurred. V41 stated that the was informed by the pharmacy that the medication should have 45 days left of medication. V41 stated that she was informed by the pharmacy to check to see if R109 was receiving a whole or half of pill. V41 stated that she notified V40 and V40 verified that R109 was receiving a whole tablet. V41 stated at that physician was notified and the medication was changed. V41 stated that the directions were on the bottle. On 3/24/2026 at 3:51 PM V2, Previous Director of Nursing, stated that there was a transcription error. V2 stated that R109 was to received Sertraline HCl Oral Tablet 100 MG a half tablet and received whole. V2 stated that this was transcribed upon admission to the unit. V2 stated that he does not believe that there was a negative outcome. V2 stated that when R109 initially transition she had a lot of behaviors, and this helped with those behaviors. V2 stated that the physician was notified, and new orders were put in place. On 3/26/2026 at approximately 2:20 PM V40, Licensed Practical Nurse stated that there was an issue with R109 receiving the wrong medication. V40 stated that R109 came from the Assisted Living. V40 stated that the order in the computer was for Sertraline HCl Oral Tablet 100 MG. V40 stated that this is the dose that was administered. V40 stated that she notified the daughter that the medication was low and R109 needed a refill on her medication. V40 stated that at that time she was informed that the medication was supposed to half a tab. V40 stated that the physician was notified, and the medication was given correctly. V40 stated that the			S9999			04/14/2026

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S9999	Continued from page 3 medication bottle had the directions on it. V40 stated that they don't go by the bottles because orders change before medications are refilled. V40 stated that they follow the order in the chart. The facilities Administration of Medications policy, dated 4/21, documents that D. Drugs brought to the facility by the patient, or patient's family, should be used only in accordance with written physician's orders. Such drugs must be properly labeled as set forth previously in the section entitled "Drug Labeling". It is encouraged that all orders undergo automatic drug allergy and interaction checks. Critical Care RX, LLC will not label any medications it did not dispense. E. The facility shall check the Physician's Order Sheet and MAR against the current Physician's Orders, to assure proper administration of medications to each resident. (B) Statement of Licensure Violations 2 of 2: SKILLED CARE 300.610a) 300.1210b) 300.1210c) 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	S9999				04/14/2026	

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S9999	Continued from page 4 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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 prevent a fall, implement fall interventions and safely transfer 4 out of 6 residents (R5, R50, R108, R89) reviewed for falls in a sample of 47. This failure resulted in R5 sustaining a closed displaced fracture of phalanx of right great toe. The Findings include: 1.R5's Facesheet documented he was admitted to the facility on 1/20/26 with diagnosis of, in part, cellulitis of right lower limb, congestive heart failure, end stage renal disease and hemiplegia and hemiparesis following cerebral infarction affecting right dominant side. On 2/26/26 R5's Facesheet documented diagnosis of contusion of scalp and displaced unspecified fracture of right great toe. R5's Minimum Data Set (MDS) dated 2/18/26 documented he was cognitively intact, required substantial/maximal assistance to go from sitting to standing, partial/moderate assistance transferring on the toilet, and supervision or touching assistance to walk 10 feet. R5's Fall Risk Data Collection dated 2/11/26 documented R5 requires hands-on assistance to move from place to place.			S9999			04/14/2026

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S9999	Continued from page 5 R5's Fall Investigation dated 2/26/26 documented V32 certified nursing assistant (CNA) stated, "Resident was last seen at 0555 (5:55AM). Resident rang his call light for assistance in cleansing his bottom in bathroom d/t (due to) having BM (bowel movement). Resident refused helped to bed. I continued rounds in another room and heard resident say help went into room and resident was on floor outside bathroom door. Resident had on grippy socks. The room was well lit. The floor waws dry. Resident encouraged to use call light and not refuse help." The facility's IDPH (Illinois Department of Public Health) Notification dated 2/27/26 documented the hospital report determined R5 had a closed displaced fracture of phalanx of right great toe post fall. On 3/24/26 at 11:22 AM, R5 stated he fell at the facility once and doesn't know how he fell but he hit his head. R5 stated he has not fallen since. On 3/25/26 at 3:39 PM, V32 (CNA) stated she was taking care of R5 the day he fell. V32 stated R5 put his call light on and needed assistance wiping after having a bowel movement on the toilet. V32 stated R5 had self-transferred to the toilet with no assistance. V5 stated she assisted R5 with wiping and asked if he needed help getting back to bed but he said he was fine. V32 stated she stood by watching R5 while he went to the sink to wash his hands and then he started to get agitated and told me he didn't need help. V32 stated she then left and went to the resident's room next door while he stood with his walker next to the sink. V32 stated shortly after getting to the next room, she heard him saying help. V32 stated R5 doesn't let them help him. V32 stated she went to find R5 on the floor and told him he should have let her help him. V32 stated she got the nurse right away and after assessing him he told them he hit his head but refused to go to the hospital and nothing hurt. V32 stated she wasn't sure of his transfer status, but he did make it to the bathroom himself, at that time she wasn't sure if he was a fall risk. On 3/26/26 at 8:41 AM, V31 licensed practical nurse (LPN) stated she was taking care of R5 at the time of his fall. V31 stated it was early morning when the CNA told her he had fallen, and she went to assess him. V31 stated R5 was on the floor outside the restroom, his walker and wheelchair were not next to him, she had to get his walker from next to his bed. V31 stated R5 was on blood thinners and said he hit his head. V31 stated she was concerned and wanted			S9999			04/14/2026

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S9999	Continued from page 6 to send him out to the hospital, but he refused and refused to let her take his vital signs also. V31 stated she notified the providers right away who were later able to convince him to go get seen. V31 stated R5 required assistance for transfers at the time, and they had to use the mechanical lift to get him back to bed. V31 stated R5 ended up breaking his toe after getting seen in the hospital. V31 stated the CNA told her R5 had gone to the restroom himself prior to his fall. V31 stated the CNA helped R5 wipe after his bowel movement but did not know details on what happened next. V31 stated she would never leave a resident requiring transfer assistance alone, even if they refused, she would call to get help. V31 stated she would expect the aides to make sure residents are safely transferred before leaving them. V31 stated R5 would try to transfer without help but she would always remind him to ask for assistance. V31 stated she could never leave a resident alone that needed assistance. On 3/26/26 at 9:44 AM, V3 assistant director of nursing (ADON) stated she would expect staff to stay with a resident who requires assistance transferring. On 3/26/26 at 9:46 AM, V33 (Infection Preventionist) stated she would expect staff to stay with a resident who requires assistance transferring. On 3/26/26 at 10:08 AM, V35 (Physician Assistant) stated R5 is difficult with getting assistance. V35 stated she would expect staff to make sure R5 was safe before leaving and to know his transfer status. 2. R108's Admission Record, dated 3/25/26, documents R108 was originally admitted to the facility on 6/28/23. R108's Care Plan, dated 3/14/26, documents R108 is at risk for falls related to osteoarthritis, failure of right hip replacement, and medication use. Interventions: Be sure R108's call light is within reach and encourage the resident to use it for assistance as needed, Dropped seat in wheelchair to facilitate appropriate positioning, (non-slip pad) on or under bedsheet, (non-slip pad) to recliner, Ensure that all personal items are within reach, Ensure that the resident is wearing appropriate footwear, frequent monitoring, High traffic area while awake, Low bed, Mat on floor beside bed when resident is in bed, and a scoop mattress. R108's MDS, dated 3/19/26, documents R108 has a severe cognitive impairment and is dependent on staff for all Activities of Daily Living (ADLs) and transfers.	S9999				04/14/2026	

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S9999	Continued from page 7 On 3/23/26 at 10:45 AM, R108 was observed lying in bed, mats on both sides of bed, with his call light on the floor on left side of bed and not in reach. There is a sign on the wall "Make sure call light is in reach before you leave the room." On 3/26/26 at 3:00 PM, V3, Assistant Director of Nursing (ADON), stated "I expect the staff to follow all fall precautions put in place for a resident who is a high fall risk." 3. R89's Care Plan, dated 12/24/2025, documents that (R89) is at risk for falls r/t (related to) medication use, recent hospitalization. It continues Assistive devices will be within reach of resident while they are in the recliner/lift chair, be sure (R89's) call light is within reach and encourage the resident to use it for assistance as needed. bed mats. Call don't fall sign. Dycem under wheelchair cushion. Educate family members to call for assistance. Ensure personal items are within reach. High traffic area while awake. low bed. PT/OT (physical therapy / occupational therapy) evaluate and treat as ordered or PRN. Res should not be left in the room unattended by staff or visitors when awake. Staff to reorientate resident to facility and facility surroundings. R89's Incident Reports, dated 12/29/2026 at 8:30 AM, documents that R89 was noted on the floor. Resident stated that she slid to the floor. Interventions Bed Mats. R89's Incident Reports, dated 12/29/2026 at 9:30 AM, documents that R89 resident sitting on floor. R89's Incident Reports, dated 12/30/2026 at 4:40 AM, documents that R89 was found on floor. Probable cause: rolling out of bed. No intervention put in place. R89's Incident Reports, dated 12/31/2026 12:45 AM, documents that R89 slid off bed to floor. Resident stated that she slid off the bed when trying to put on shoes. Intervention High traffic area while awake. R89's Incident Reports, dated 1/6/2026 at 1:45 AM, documents that R89 was sitting on the floor. Interventions: staff to reorient resident to facility and facility surroundings. R89's Incident Reports, dated 1/6/2026 at 8:24 PM, documents that R89 in hallway sitting on floor. Intervention Med (medication) review.			S9999			04/14/2026

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S9999	Continued from page 8 R89's Incident Reports, dated 1/18/2026 at 4:00 PM, documents that R89 was found on floor next to wheelchair by window. Intervention Resident not left in room unattended. R89's Incident Reports, dated 2/23/2026 at 9:05 PM, documents that R89 was found on her knees with upper body across bed. High traffic area while awake. On 3/25/2026 at approximately observed R89 sitting in wheelchair in room. No call light in reach. No bed mats in room, no Call Don't Fall signs in room. On 3/27/2026 at approximately 2:00 PM V24, Care Plan Nurse, stated that she over sees the care plans but the departments create their own interventions and apply to care plan. V24 stated that she would expect the interventions on the care plan to be in place and followed. On 3/27/2026 at 1:55 PM V3, assistant Director of Nursing, stated that the interventions should be appropriate, in place and followed. 5. 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. On 03/24/26 at 2:10 PM, V26, CNA and V27, CNA are putting R50 back in her bed at this time. Gloves and gowns were donned prior entering R50's room. R50 was lifted in the mechanical lift by V26. She was up in the air just freely swinging with no hands on her while V27 moved R50's wheelchair back out of the way. R50 was then guided into the bed by V27 while V26 lowered R50 on to the bed. On 03/27/26 at 2:40 PM, V33, Infection Preventionist said when someone is being transferred via mechanical lift she would expect two staff in the room, she would expect one person to have their hand on the resident, and would not to expect the resident to be swinging while up in the lift.			S9999			04/14/2026

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S9999	Continued from page 9 The facility's Fall Policy dated 5/2025 documented that each resident at this facility will be provided services and care that ensures that the resident's environment remains as free from accident hazards as is possible ad each resident receives adequate supervision and assistive devices to prevent accident. The policy continues to document that after each fall, an occurrence report will be completed, root cause will be determined, and interventions will be implemented. (B)			S9999			04/14/2026