Illinois Department of Public Health

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 04/18/2024

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: 2442970/IL171960	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 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 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.	S9999		

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c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

These Regulations are not met as evidenced by:

Based on interview and record review the facility failed to ensure proper transfer techniques to prevent falls and injuries for one of 7 residents (R2) reviewed for supervision to prevent falls in the sample of 7. V8, Certified Nurse's Aide (CNA) transferred R2 incorrectly. This failure resulted in R2 sustaining bilateral femur (thigh) fractures and expiring on 04/14/24. This past non-compliance occurred from 04/11/24 to 04/12/24.

Findings include:

R2's Electronic Medical Record, EMR, undated documents R2 was admitted to the facility on 11/19/2020.

R2's EMR, dated 05/29/19, documents R2 has a diagnosis of "Alzheimer's Disease, unspecified."

R2's EMR, dated 02/17/21, documents a diagnosis of "chronic pain syndrome."

R2's EMR, dated 10/01/22, documents a diagnosis of "Vascular Dementia, unspecified severity, with agitation."

R2's Care Plan dated 04/13/21 documents "ADL (Activities of Daily Living): (R2) has an ADL Self Care Performance Deficit r/t (related to) limited mobility from her past left hip fracture, weakness and confusion. Alert, oriented to self. Incontinent of B&B (bowel and bladder). Able to feed self. Utilizes wheelchair for mobility. Hesitant in new

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environments and does not do well with too many options. Requires extensive assist and encouragement to complete most tasks. Has a stuffed, interactive cat that she often has nearby as a companion." R2's Care Plan Intervention, dated 03/10/22 documents "TRANSFER: sit to stand using 2 assist."

R2's Minimum Data Set, MDS, dated 02/21/24 documents a BIMS (Brief Interview of Mental Status) score of 99, which means the resident had severe cognitive impairment. The MDS documents that the resident required substantial/maximal assistance for roll left and right, sit to lying, and lying to sitting on side of bed. The MDS documents that the resident was dependent for sit to stand, chair/bed to chair transfer, toilet transfer, and tub/shower transfer.

R2's Health Status Note dated 04/11/24 at 11:39 PM documents "The resident was being transferred into the room by aide and the resident's weight shifted toward the aide making the aide fall backward the resident came down forward and once this nurse immediately arrived at the room it was observed that the resident down on one knee and the aide holding her up best, she could. Resident was immediately assessed for injuries. there was no open area to the knees, this nurse attempted ROM (Range of Motion) and upon review the left femur seems to have a deformity. The right thigh had some swelling and at this time the aide and nurse was not clear if this was normal muscular tight swelling or from the fall. So, EMS (Emergency Medical Services), MD (Medical Director) and family notified once EMS arrived and was given report was informed of all concerns of bilateral knees and femurs. Pt (patient) vitals were stable. pt did not hit her head and was sent to (local

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hospital)."

R2's Health Status Note dated 04/12/24 at 12:24 PM documents "Resident admitted to (local hospital) due to BLE (bilateral lower extremities) fractures."

R2's Radiology Report dated 04/12/24 documents "Acute significantly displaced and comminuted fracture of the mid left femur. Acute significantly fracture of the mid right femur."

R2's Health Status Note dated 04/12/24 at 1:43 PM documents "Clarification note per Nurses note incident occurred at 21:00."

Facility's "Lift Transfer Past Non-Compliance" form, dated 04/12/24 documents under problem "On 4-11-24 patient (R2) was transferred with 1 person assist but care plan was for sit to stand using 2 assist."

On 04/16/24 at 2:09 PM, V8, CNA (Certified Nursing Aide) stated that she was putting R2 in her bed and R2 fell on her. She stated that she yelled for help because R2 was on top of her, and she could not move. She stated that she noticed R2's leg was deformed. She stated that she told the nurse that something was not right with R2's leg. She stated that R2 is normally a 2 assist, but she has been working with her for months. She (V8) stated she has been transferring R2 by herself for a while. She stated that R2's legs are contracted, and she always has her legs crossed. She (V8) stated that lifted her (R2) with a gait belt and put her (V8's) leg between R2's legs. She (V8) stated that she stumbled and R2 fell on top of her. She (V8) stated that the unit was not short staffed. She (V8) stated that R2 fell between 9:00 PM and 9:30 PM. She (V8) stated that it took a

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long time for the ambulance to get there. She (V8) stated that the ambulance arrived around 10:30 PM. She (V8) stated that the nurse ordered x-rays instead of calling an ambulance.

On 04/16/24 at 2:27 PM, V9, Licensed Practical Nurse, LPN, stated that she was sitting at the nurses' station. V9 stated that she heard yelling down the hall. She (V9) stated she ran to see R2 with one knee on the floor kneeling and V8 holding R2 up with R2's back against the dresser. She (V9) stated that she was able to assist R2 into her wheelchair. She (V9) stated that she assessed R2 and noticed a bulging area on her right thigh. She (V9) stated that she ordered a STAT x-ray. She stated that she had another aide come look at R2's legs and that aide stated that her legs did not look that way before. She (V9) stated that instead of waiting on (mobile x-ray company), she called the ambulance. She (V9) stated that the hospital could get an x-ray quicker and that R2 had already been given her norco (pain medication) at 8:00 PM, so the ER (Emergency Room) could give her more pain meds. She (V9) stated that she did not see a gait belt or a sit to stand. She stated that V8 never asked her or the other CNA on the unit for help to transfer R2.

On 04/17//24 at 12:47 PM, V21, ER Physician, stated that the resident (R2) had very severe osteopenia and never would have survived surgery. He (V21) stated that he is unsure if the fractures contributed to her death, but it did not help.

On 04/17/24 at 2:08 PM, V19, Medical Director stated that in his professional opinion the bilateral femur fractures contributed to R2's death.

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S9999	Continued From page 5 Facility's "Fall Prevention Policy (S.A.F.E.) dated 02/2021 documents "The S.A.F.E. program promotes Safety, Assessment, Fall prevention and Education of both staff and residents."	S9999		