STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008759	A. BUILDING: _____ B. WING _____	C 02/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHGATE HEALTH CARE CENTER	900 EAST NINTH STREET, PO BOX 843 METROPOLIS, IL 62960

(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) COMPLETE DATE
S 000	Initial Comments Complaints 1950661/IL109075 - F689 is cited.	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210b) 300.1210c) 300.1210d)6) 300.3240a) 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. Restorative measures shall include, at a minimum, the following procedures: 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These Regulations were not met as evidenced by: Based on record review and interview, the facility failed to implement a fall prevention measure identified on the care plan to ensure a safe resident transfer was provided for 1 resident (R5) reviewed for transfers. This improper transfer resulted in R5 being sent to the emergency room and diagnosed with a displaced fracture of the right clavicle adjacent to the sterno clavicular joint and a likely minimally displaced fracture of the sternum (per hospital emergency room report and computerized tomography scan (CT). Findings include: 1. R5 is an 88 year old resident with diagnoses that include Parkinson's Disease, Chronic Pain, Dystonia and Degenerative Disease of the Nervous System, as noted on R5's Admission Record. A 12/24/2018 Quarterly Minimum Data Set (MDS) assessment notes that R5 requires extensive assist of two for transfers. The current Care Plan has a problem area of Potential for Falls' and includes an approach with an initiation date of 11/1/14 for staff to use a gait belt for all	S9999		

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S9999	Continued From page 2	S9999		

transfers.

A Nurse Progress Note dated 1/24/19 for 16:30 (4:30 PM) documented by V7 (Nurse) notes an incident where V6, Certified Nurse Aide (CNA) yelled for a nurse and V7 entered R5's room and found R5 on the floor. V6 stated on 2/1/19 at 2:40 PM that she had been in R5's room, getting R5 dressed as R5 laid in bed. V6 stated that she was trying to sit R5 up as she waited for another CNA to come assist with the transfer into the wheelchair. V6 stated that R5 started to slide off the edge of the bed, at which time she "grabbed hold of her and slid her down my leg into the floor. " V6 stated that R5 did not cry out or act as if in pain at the time this occurred and that she yelled for help with V7 coming into the room. After V7 had assessed R5, they together lifted R5, under her arms, into her wheelchair. V6 stated that she had not brought her gait belt into the room and no gait belt was used to assist in lifting R5 off the floor. V6 stated that at that time R5 started to cry and V7 asked her if she was ok with R5 stating "yes". R5 was taken out to supper and during supper, R5 complained of her arm hurting. It was noted that R5 had 2 skin tears on her arm under her skin protector sleeves she was wearing. V7 documented in the 1/24/19, 4:30 PM note that V7 had helped V6 transfer R5 to her wheelchair and that after complaints of pain in her right arm, had given R5 Tylenol, ordered as needed for pain. V6 stated that R5 had continued to complain of pain and that the nurse (V7) had sent R5 to the hospital to be checked. V7 documented a note for 1/24/19 20:46 (8:46 PM) that after contacting the Doctor and family, R5 was transferred to the emergency room for evaluation, with R5 returning the same evening at 11:19 PM, with a diagnosis of fractured right clavicle and displaced fractured sternum. R5 returned with orders for

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S9999	Continued From page 3	S9999		

pain medication as needed.

The hospital emergency room report included results of a CT (computerized tomography) scan of head and C-Spine which stated "Chest with Displaced fracture of the right clavicle adjacent to the Sterno clavicular joint and likely minimally displaced fracture of sternum." Instructions were to take medications as prescribed with an order for Norco 5-325 and to follow up with primary care physician (PCP) in 2 days. No activity restrictions were documented. R5's PCP ordered a change in R5's pain medication after an allergy to codeine was identified, however there were no further instructions for R5's care.

V3 CNA, stated on 2/1/19 at 1:21 PM that prior to the new order to use a mechanical lift for transfers, R5 was transferred with 2 staff and a gait belt. V3 stated they would dress R5 with her laying down, put the gait belt on her, chair, place R5's wheelchair beside the bed prior to the transfer (if moving her from bed to wheel chair) then lift R5 using the gait belt and placing their arms under R5's arms. V3 stated that R5 has not been able to bear weight for many years, and is not able to be sat up on the side of the bed. V3 stated that R5 has contractures and usually keeps her arms pulled up across her chest and that R5 "is a total for feeding, basically for everything". V8 LPN (Licensed Practical Nurse) stated on 2-1-19 at 1:02 PM that R5 was a 2 person transfer prior to new order to use a mechanical lift. The 12/24/2018 Quarterly Minimum Data Set (MDS) assessment notes R5 needs total assist with eating.

V2, Director of Nursing, (DON) stated on 2-1-19 at 3:00 PM that V6 should have had her gait belt with her and used it when sitting R5 up and when

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S9999	Continued From page 4 V6 and V7 lifted R5 from the floor. (B)	S9999		