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	IL6008759	A. BUILDING: _____ B. WING _____	C 08/12/2020

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SOUTHGATE HEALTH CARE CENTER	900 EAST NINTH STREET, PO BOX 843 METROPOLIS, IL 62960

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S 000	Initial Comments Facility Reported Incidents of 7/17/2020/IL125773 & 7/18/2020/IL125791-F689 G	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b)5) 300.1210d)6) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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: 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. 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. 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 interview and record review the facility failed to implement interventions to safely transfer 2 (R1 and R2) residents reviewed for transfers. This failure resulted in a displaced fracture of	S9999		

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S9999	Continued From page 2 R1's left arm and a fracture of R2's left leg. Findings Include: 1) R1's face sheet documents an admission date of 8/12/2020 with diagnoses that include; Alzheimer's disease, dementia, abnormal posture, reduced mobility, and muscle weakness. R1's MDS (Minimum Data Set) dated 6/13/2020 documents R1 has a BIMS (Brief Interview for Mental Status) score of 0, which indicates a severe cognitive impairment. The MDS documents under section G, R1 requires extensive two person assist with transfers. R1's restorative needs assessment dated 7/13/2020 documents R1 is dependent on staff for transfers. R1's care plan documents a focus area of potential for injury related to gait balance problems with an intervention dated 1/18/18 to use a gait belt for all lifts and transfers. The intervention documents, "DO NOT lift R1 by arms or under her arms." R1's progress notes document; 7/19/2020 a bruise was reported to R1's upper left arm with some swelling noted in the deltoid area passive range of motion is performed and R1 does not indicate pain. Radial pulse is good with normal capillary refill. 7/20/2020 resident is assessed by the hospice nurse and R1 is noted to be holding her left arm with her right hand and has the left arm crossed over her body. Edema and bruising are noted to the inner aspect of the upper left arm. The physician is notified and ordered x-rays to be done of the left arm. This progress note	S9999		

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documents, "Pt's daughter is upset and wants answers....She stated she was going to speak to her brother to see what their legal options are for another agency to investigate and if she had to call State (sic) she would do so."
7/21/2020 1:02 AM "...no FX (fracture) of distal humerus or elbow but displaced FX of proximal humerus. MD (physician), hospice et dtr (and daughter) aware of FX."
7/21/2020 1:16 AM "...dtr told this writer that she didn't want mom to have a cast but was ok with sling."
7/21/2020 8:46 AM "...Spoke with (name of daughter) again. She's very upset with the dx (diagnosis) of fracture. States her mother didn't do this to herself. It does still have a clear line of demarcation as though it was a b/p cuff, though an investigation for other answers is ongoing."

R1's investigative narrative summary dated 7/23/2020 documents R1 requires extensive assist upon admission with most activities of daily living. The summary documents since 3/2020 R1 has experienced a deteriorating condition and was admitted to hospice on 7/8/2020." On 7/19/2020 CNA's (not named) went to get resident up for the day & (and) noted a large bruise to upper left arm & immediately came and reported bruise to the charge nurse at approximately 6:30 am." The summary documents staff was interviewed and V9 (Certified Nursing Assistant/CNA) stated she assisted V10 (CNA) in putting R1 to bed on the evening of 7/18/2020. V9 stated they transferred R1 by putting their arms under R1's arms and lifting her with the other arm by the pants. V9 stated they did not use a gait belt during transfer. The summary documents continues to document V9 stated she remembered being trained during orientation to use a gait belt when transferring

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residents. According to the summary, V10 was interviewed and stated she used a gait belt to transfer R1 on the evening of 7/18/2020. After being told it was reported they did not use a gait belt to transfer R1, V10 then stated they had not used the gait belt. The summary documents, "Safety committee is unsure of how fx (fracture) actually occurred but it could be related to improper transfer without use of gait belt in combination with osteopenia....A full staff re-education was initiated due to lack of gait belt usage, improper transfers, & further failure to follow this policy will result in termination."

On 8/11/2020 at 2:02 PM, V14 (Certified Nursing Assistant/CNA) stated she and V15 (CNA) went into R1's room to provide morning care. V14 stated, when they pulled back the covers V15 noticed the bruise to R1's upper arm. V14 stated they reported it to the nurse immediately.

On 8/11/2020 at 2:04 PM V15 (CNA) stated she went with V14 (CNA) to get R1 up, and when they pulled the covers back, they noticed the bruise to R1's left arm. V15 stated when she started to move R1's arm it did not feel right so they stopped what they were doing, and reported it to the nurse. V15 stated R1 did not appear to be in pain at first but then did appear to be in pain off and on.

On 8/11/2020 at 4:37 PM V4 (Licensed Practical Nurse/LPN) stated she came to work on Monday and R1's left arm was swollen and bruised. V4 stated she got an order for an x-ray but the results of a fracture did not get reported to the facility until around midnight. V4 stated R1 should have been transferred using a gait belt prior to the injury and is currently to be transferred using a mechanical lift.

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On 8/11/2020 at 11:50 PM V12 (Licensed Practical Nurse) stated R1 had a bruise from her shoulder to mid-way down her arm. V12 stated there had been a sign in R1's room that stated she was not to be transferred using her arms. V12 stated the staff should have used a gait belt to transfer R1.

On 8/11/2020 at 11:10 PM V9 (Certified Nursing Assistant/CNA) stated she was working the 2-10 PM shift on 7/18/2020, shadowing V10 (CNA). V9 stated they transferred R1 by putting their arms under her arm pits and lifting her into the bed. V9 stated R1 did not cry out or appear to be in pain during or after the transfer. V9 stated R1 was a two-person with gait belt transfer and they did not use a gait belt. When asked why, V9 stated she didn't think V10 used a gait belt.

On 8/11/2020 at 12:26 PM V2 (Director of Nurses) stated it was reported to her in the morning on 7/19/2020 R1 had bruising on her arm. She assessed R1 and it looked like a blood pressure cuff may have bruised it. V2 stated R1 winced with range of motion so she reported it to the physician and got an order for a mobile x-ray. V2 stated after they got the results of a fracture they reported them to the physician and family. V2 stated after the investigation it was determined R2 had been transferred without a gait belt, but they could not say definitively that is how R1's arm was fractured.

At 12:57 PM on 8/12/2020, V11 (family member) stated she was not pleased at all with the care R1 had received. V11 stated R1 was not to be lifted by her arms due to a previously torn rotator cuff in her right arm. V11 stated they lifted R1 by her arms anyway and broke her left arm. V11 stated

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the only way to repair the arm was with surgery and they can't do that, so now R1 can't even scratch her nose. V11 stated she was allowed to see her because R1 was on hospice. V11 stated when she saw her on the day the injury was reported she did not think she would live a week. V11 stated R1's left arm was swollen three times its normal size and bruised from her shoulder to her elbow. V11 stated R1 was in a lot of pain and she felt it was detrimental to her physically as well as mentally.

2. R2's face sheet dated 8/12/2020 documents diagnoses that include; altered mental status and unspecified lack of coordination,

R2's order summary report dated 7/17/2020 documents an order to use mechanical lift for all transfers with an order date of 5/1/2020.

R2's MDS (Minimum Data Set) dated 7/25/2020 documents R2 has a BIMS (Brief Interview for Mental Status) score of 9, which indicates a moderate cognitive impairment.

R2's restorative needs assessment dated 7/23/2020 documents R2 is dependent on staff for all transfers.

Care plan documents a focus area, dated 11/28/2017, of potential for falls/injuries. Interventions listed include (mechanical) lift with assist of 2 for all transfers with an initiation date of 11/28/2017.

R2's progress notes document; 7/17/2020 10:51 AM "...Res (resident) calling out in pain. Upon assessing, this nurse noticed left foot was swollen and red. Res yelled out when foot was barely touched. When asked, CNA's

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said that resident's foot got caught when moving from bed to chair. DON (director of nurses) came down and looked and (sic) foot and established pedal pulse...MD (physician) notified and gave orders to send res to ER (emergency room)..."
7/17/2020 12:47 PM "... (name of local hospital) called facility and reported res had a fracture of left tib (tibia) and fib (fibula) and that she was sent out to (name of regional hospital). This nurse called her POA (power of attorney) to notify him of her updated condition and new room number. POA was extremely unsatisfied and threatened to have this facility "talk to his lawyers." All of this information was relayed to DON and administrator"
7/18/2020 4:43 PM , "...Returned to facility at 3:40 PM via ambulance. Placed in bed. No distress. Is alert with confusion per usual for her... Has cast to lle (left lower extremity) and ace wrap. Elevated on pillow at this time..."
8/2/2020 "...Resident is resting in bed at this time... Requires total care with all ADLS (activities of daily living). Transfers via (name of mechanical lift) with assist X2 (times 2). Is currently receiving skilled care r/t (related to) tib/fib (tibia/fibula) fracture. Has a splint cast on LLE...Turned q2hr (every two hours) No s/s (signs/symptoms) of pain or discomfort."

R2's investigative narrative summary dated 7/17/2020 documents, "On 7/17/20 at approximately 8:30 AM, it was noted that resident (R2) began to call out as if she were in pain. Nurse noted at that time that resident's left foot appeared slightly red and swollen. This nurse asked CNA's if they knew if anything had happened that may have caused this change in condition. They replied her foot had got caught during transfer from the bed to her chair. The DON (Director of Nurses) was notified and came

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down to look at foot immediately. Pedal pulse was found and VS (vital signs) were determined to be WNL (within normal limits). MD (physician) gave orders to send pt (patient) to local ER (emergency room)...X-rays from (name of local hospital) were brought up and reviewed....and reveal a displaced fracture of the distal tibia and fibula...Osteopenia is also noted in the x-rays as well." Under investigation this summary documents, "All staff were questioned regarding the transfer. Resident has a care plan and order for a (mechanical lift) transfer. One of the CNA's (not named) was unfamiliar with the resident and did not follow facility protocol for transfer. The other 2 CNA's (not named) present were more familiar with the resident but did not correct the 3rd CNA in time to stop the process. All staff stated that resident did not immediately complain of any pain and no immediate changes were noted at the time of the transfer. At that time, they had no reason to assume there had been any injury until resident began to complain of pain approximately 1 hour later."

R2's local hospital records dated 7/17/2020 documents "NH (nursing home) patient presents with c/o (complaints of) injury/trauma of uncertain mechanism during transfer at NH with c/o pain and deformity to LLE (left lower extremity)."The local hospital x-ray results document a comminuted displaced distal tibial and fibular fractures.

R2's regional hospital record dated 7/18/2020 documents R2 was transferred from the local hospital after a fall with a left distal tibial fracture. The hospital record documents staff at nursing home were trying to stand her and her leg got stuck. Patient had splint casting to her left lower extremity and was seen by orthopedic consultant

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who recommended nonoperative treatment due to the fact R2 is nonweight bearing and has a weakness in her left lower extremity. The regional hospital recommendations were to continue with a splint to R2's left lower extremity and follow up with orthopedics.

On 8/11/2020 at 5:50 PM, V6 (Certified Nursing Assistant/CNA) stated she took care of R2 on the day of the incident (7/17/20). V6 stated she and V7 (CNA) were in R2's room getting ready to transfer her using the mechanical lift when V5 (CNA) came into the room to get R2's vital signs. V6 stated V5 picked R2 up with his arms under R2's arm pits and put her in her chair. V6 stated as V5 was sitting R2 down in her chair R2's legs got caught on the the chair. V6 stated she was telling V5 R2's legs were caught and R2 was yelling out during the transfer and saying no to V5. V6 stated V5 picked R2 up out of the chair and adjusted her leg so it was no longer caught on the chair and R2 stopped yelling. V6 stated R2 was crying and wanted her husband but they were not aware R2 was injured until approximately thirty minutes later when she cried out and said her foot was hurting. When asked how R2 should have been transferred V6 stated she should have been transferred using a mechanical lift.

On 8/11/2020 at 1:25 PM, V7 (Certified Nursing Assistant) stated she and V6 were getting R2 up when V5 came into her room picked the resident up and transferred her to the chair. V7 stated V5 did the transfer so fast she didn't have the opportunity to stop him. V7 stated she knew R2's foot had gotten caught in the transfer but was unable to see how it happened. V7 stated she was unable to speak with the nurse until R2 was in the dining room. R2 began to complain of her

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toes hurting. V7 stated R2 has always been transferred with a mechanical lift. V7 states V5 no longer works at the facility.

On 8/11/2020 at 3:17 PM, V16 (Licensed Practical Nurse) stated she heard R2 holler out early in the morning (approximately 7:00 AM). V16 stated she asked the CNA's to check on her at this time and they said R2 was wanting her husband. V16 stated approximately an hour and a half later she heard R2 yell again and was able to check her and R2 stated her leg was hurting. V16 stated she assessed R2's lower extremity and when she touched R2's sock she "let out a howl" and R2's foot was red and swollen. V16 stated she went to get the director of nurses and on her way V6 and V7 pulled her aside and told her they didn't use a mechanical lift to transfer and her foot got caught and they hadn't reported it because they were afraid they would be in trouble. V16 stated R2 should not have been transferred without a mechanical lift.

On 8/11/2020 at 12:26.PM, V2 (Director of Nurses) stated V16 reported to her R2's foot got caught during transfer and she was yelling out. R2's foot had an external rotation and she yelled with range of motion. V2 stated R2 was transferred to the local emergency room for evaluation where it was determined she had a fracture and was sent to the regional hospital. V2 stated she later learned V5 had transferred R2 without using a mechanical lift.

On 8/11/2020 at 2:07 PM, V3 (Assistant Director of Nurses) stated R2 is a total lift with a mechanical lift because of her condition. V3 stated V5 decided to lift R2 into her chair instead of using the mechanical lift and R2's foot got entangled. R2 started to complain of pain. R2

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S9999	Continued From page 11 was sent to the local emergency room and found a fracture of her left leg. R2's husband opted for no treatment, so it was casted and wrapped and she returned here. The facility safe patient lifting policy dated 2/1/2013 documents under process and procedures, "...Gait belt usage is mandatory for all resident handling with the exception of bed mobility & medial contraindication. The gait belt will be considered part of the certified nursing assistant's uniform..." (A)	S9999		