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 12/22/2021

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

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S 000	Initial Comments Complaint 2159228/IL141253	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 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 each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: 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 fall interventions and supervision to prevent falls for 2 residents (R1 and R2) reviewed for falls. This failure resulted in R1 falling out of bed and sustaining a fracture of the left hip. Findings include: 1. R1's Electronic Medical Record denotes R1 is a 90-year-old female with diagnoses including: Chronic pain syndrome, repeated falls, scoliosis, delirium, lack of coordination, Dementia with	S9999		

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S9999	Continued From page 2 behavioral disturbances, displaced fracture of base of neck of right femur and subsequent encounter for closed fracture with routine healing. R1's Minimum Data Set (MDS) dated 11/16/21, documents a Brief Interview for Mental Status (BIMS) score of 3, indicating R1's cognition is Severely Impaired. Section G-Functional Status for: Bed Mobility is documented as self-performance as extensive assistance with the assistance of two plus persons physical assist. Transfers are documented as self-performance as extensive assistance with assistance of two plus persons physical assist, Walk in Room is documented as, self-performance as limited assistance with assistance of two plus staff physical assist. R1's Morse Fall Scale dated 10/09/21 has a documented score of 65 which notes R1 is a High Risk for falling. R1's Morse Fall Scale dated 10/13/21 has a documented score of 55 and that R1 is a High Risk for falling. R1's Morse Fall Scale dated 10/31/21 has a documented score of 55 which denotes R1 is a High Risk for falling. R1's Morse Fall Scale dated 11/02/21 has a documented score of 65 which notes R1 is a High Risk for falling. R1's Morse Fall Scale dated 11/03/21 has a documented score of 55 which notes R1 is a High Risk for falling. R1's Morse Fall Scale dated 11/09/21 has a documented score of 55 which notes R1 is a High Risk for falling. R1's undated Care plan documents, R1 has potential for falls and injury, history of recurrent falls at home, recent fall with left sacral iliac fracture, use of pain medications daily, use of psychotropic medications daily, requires assist of 1 with all ADL's (Activities of Daily Living) and	S9999		

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documenting falls on 10/09/21, 10/31/21 and 11/03/21. Under "goals" states R1 will be free of injury related to falls through next review, documenting a date initiated as 02/20/2020, with a revision date of 02/24/2021 and a target date of 02/05/2022. Under Interventions, an intervention of; Bed against wall in low position with mat on floor is listed, with an initiated date of 11/01/2021 and a revision date of 11/04/2021.

R1's Incident Report dated 11/03/2021 at 8:38 PM, documents an unwitnessed fall, with the Incident Location: Resident's room. The report documents under the section titled, "Incident Description" Note Text: R1 was yelling out at 8:08 PM, R1 had an unwitnessed fall to the floor, with the floor mat not being in place. R1 complained of left hip pain and left hip looks shorter than right on assessment. R1 cried out in pain when touched anywhere on left hip. The section titled, "Level of Pain" documents PAIN as 8; with breathing scored as 0, detailing, normal, Negative Vocalization scored at 2, detailing, repeated troubled calling out, loud moaning or groaning, crying. Facial Expression was scored at 2, detailing, facial grimacing. Body Language was scored at 2, detailing, rigid, fists clenched, knees pulled up, pulling, or pushing away or striking out. Consolability was scored at 2, detailing, unable to console, distract or reassure.

R1's electronic medical record documents on 11/4/2021 12:50 AM Health Status Note: Note Text: "Talked to ER charge nurse, (R1) resident is being admitted with a fractured hip."

R1's hospital discharge report documents section Hospital Course: R1 is a 90-year-old female who presents to the emergency department after falling, R1 was found on the floor at nursing home

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after falling. R1 had pain and deformity of left hip so EMS called. This is the second fall she has had this month. Prior fall resulted in right hip fracture status post-surgery 3 weeks ago. Xray revealed left hip fracture. Ortho repaired and she has had no acute problems. Result Date: 11/04/2021, Exam: Xray of femur left (2 views), left intertrochanteric hip fracture. The CT scan of the left hip is performed without intravenous contrast enhancement. There is a moderately comminuted (breakage of the bone in two or more pieces) intertrochanteric fracture of the left proximal femur with moderate impaction. The hip articulations intact. There is moderate diffuse osteopenia (weakening & thinning of the bones). Atheromatous (accumulation of plaque) changes of the external iliac and common femoral artery are noted.

R1's Incident Reports document falls on 10/09/2021, 10/31/2021, and 11/03/21 with the 10/09/2021 fall resulting in a right hip fracture and 11/03/21 resulting in a left hip fracture.

The final Incident Report submitted to IDPH dated 11/10/21 states, "During our in-house investigation it was discovered that fall mat had not been put in place during residents fall, but bed was in low position."

On 12/20/21 at 12:15 PM, V2 (Director of Nursing/Care Plan Coordinator) stated, R1's mat by her bed was not in place at the time of the fall. On the fall on 11/03/21, R1 did fracture her left hip, she was in the hospital until 11/08/21. Staff have been re-educated on the importance of making sure safety measures are in place.

On 12/20/21 at 10:55 AM, V5 (Certified Nurse Aide) stated, she was not here for R1's falls, she

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S9999	Continued From page 5 knows her bed is supposed to be in a low position with the mat next to it for fall prevention. On 12/20/21 at 11:30 AM, V6 (Licensed Practical Nurse) stated she was not here for R1 or R2's falls. She is aware that R1 is to have her bed in the low position and the mat by the bed, she also has pad alarms for her bed and wheelchair. On 12/16/21 at 2:30 PM, V4 (Certified Nurse Aide) stated she does not believe she was working when R1 fell. R1 did recently fracture her hip in her recent fall. She knows her bed is supposed to be in the low position with the mat at the bedside, and she also has a bed alarm and a chair alarm for her wheelchair. On 12/21/21 at 8:58 AM, V14 (Director of Rehabilitation) stated, R1 has never been independent with ambulation. Due to cognition and unsteady balance, she has always required complete assistance to minimal assistance with a wheeled walker with staff for ambulation. After R1's first hip fracture and at evaluation on 10/14/21, R1 required strengthening, bed mobility, transfers and to begin ambulation again with therapy with a rolling walker. Prior to this first hip fracture she was able to perform bed mobility modified independent. She was making gains in all areas. After R1 sustained her second hip fracture on 11/3/21 she had regressed requiring additional assistance in all aspects again. Her pain has been being managed and therapy works with nursing and pain management during her therapies. She is able to self-reposition in her wheelchair. She has been able to improve in her wheelchair mobility to which is at a supervision level with use of her lower extremities. Her weakness in lower extremities and discomfort that comes with a fracture in a lower extremity is	S9999		

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S9999	Continued From page 6 what therapy is working with currently. R1's Electronic Health Record documents, 11/8/2021 1:03 Health Status Note: Note Text: Resident is resting in bed at this time with eyes closed. No signs or symptoms of distress. R1 is readmitted for skilled nursing services and physical therapy and occupational therapy evaluation and participation this shift following hospital stay at (local hospital) related to a fall resulting in left hip fracture. R1 arrived at facility at approximately 6:35 PM this shift via ambulance. R1 has one suture line present on upper outer left hip measuring 60 cm (centimeters) in length, 0 width, and 0 depth. There is no signs or symptoms of infection present. The area is glued with no visible sutures or staples present. R1 is now incontinent of bowel and bladder due to recent injury to left hip. R1 will use wheelchair for mobility, and to discontinue order due to R1 is weight bearing as tolerated. R1 has not been able to tolerate being out of bed since readmitted this shift. 2. R2's Electronic Medical Record documents R2 is a 74-year-old male with diagnoses including: Dementia without behavioral disturbances, Alzheimer's Disease, Major Depressive Disorder, Mononeuropathy, and Acquired absence of right leg below the knee. R2's MDS with a signed date of 11/03/21, documents a BIMS score of 6, indicating R2's cognition is Severely Impaired. R2's care plan documents: 10/26/18, R2 has been assessed with the operation of his new power chair, he is able to control the joystick of wheel chair with supervision, and occasional cues. May be up in power chair with supervision. Date initiated: 11/06/2018. Revision on: 05/06/2019.	S9999		

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S9999	Continued From page 7 R2's Electronic Medical Record documents R2's Health status note on 12/08/21 at 5:40 PM stating, R2 had oral surgery on 12/08/21 removing eight teeth. R2 has gauze packing in place and ice pack rotated off and on. R2 has no complaints of pain at this time. R2 has no active bleeding noted. R2's face is slightly swollen bilaterally. R2's Electronic Medical Record documents Administration Note on 12/09/2021 at 7:45 AM Hydrocodone-Acetaminophen tablet 7.5-325 MG was given, order states, give one tablet by mouth every four hours as needed for pain with a maximum dose of 4g/24hr for recent teeth extractions. R2's incident report dated 12/9/2021 at 8:58 PM, documents an un-witnessed fall on 12/09/2021, Incident location: Resident's room. This report documents under section titled, Incident Description: Nursing Description: V3 (Licensed Practical Nurse/LPN) was assisting another resident off the floor when V4 (Certified Nursing Assistant/CNA) reported that R2 was on the floor. V4 (CNA) had recently put R2 in his room in R2's chair and noted seatbelt in place, when V4 (CNA) was called by V3 (LPN) to help assist with another resident. V3 (LPN) ran to R2's room and saw R2 laying on his left side by his motorized wheelchair. R2 was assessed with complaints of right and left shoulder pain, left wrist pain and edema noted to left posterior side of head. Neuro check is within normal limits. Immediate Action Taken section documents: EMS (Emergency Medical Service) called and R2 was sent to Emergency Room for further evaluation. On 12/20/21 at 12:15 PM, V2 (Director of	S9999		

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S9999	Continued From page 8 Nursing/Care Plan Coordinator) stated R2 was left unsupervised in his wheelchair in his room. V4 went to assist another resident that had fallen and when V3 (LPN) and V4 (CNA) returned to his room, R2 was found on the floor next to his motorized wheelchair. V2 stated, he must be kept in visual range when in his wheelchair. On 12/16/21 at 2:30 PM, V4 (Certified Nurse Aide) stated, the fall that involved R2 happened in his room. She was taking R2 to his room to transfer R2 back to bed when she heard a yell that another resident (R4) needed urgent assistance, he had fallen and V3 (LPN) needed assistance. V4 (CNA) made sure his seat belt was secured and quickly went to help assist the other resident. When they returned, they found R2 on the floor next to his motorized wheelchair. R2 stated to staff, he was reaching for something and he fell. He was sent out for evaluation. V4 (CNA) stated, R2 was left unsupervised when staff had to leave to assist R4. V4 (CNA) stated, she does not believe he was found to have any injuries. R2's electronic medical record's progress notes documents: on 12/9/2021 at 9:49 PM Incident Note Late Entry: Note Text: V4 was present and assisting V3 (LPN) while she was assessing this resident. Note states, "Floor staff all agree seat belt was in place and in proper position. Seat belt of chair noted to be dangling on each side of the chair. It appears as if seatbelt snapped open or resident undid seat belt before fall happened." R2's incident report dated 12/9/2021 documents under the section titled, "Notes" dated 12/13/2021 states, after review of incident, review of statements, review of medical records, and knowledge of resident's overall condition, the	S9999		

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S9999	Continued From page 9 safety committee has reminded staff members that when this resident is up in his chair he needs to be in a public area and not unsupervised in his room. The policy titled "Incident & Falls Tracking, Interventions, & Prevention policy and procedure" dated 04/03/15 states, "It is the policy of Southgate Nursing and Rehabilitation Center to develop and maintain a system that ensures the safest possible environment for each resident using the least restrictive appliance or safety device with a personalized plan of care for each individual resident's needs. This tracking system was devised to monitor all incidents and falls to ensure appropriate interventions to each occurrence. " 3. A Restraint/Safety Devices/ Positioning/ Mobility Device Assessment will be completed on each resident who uses a safety device or restraint that consists of personal data of each resident that will review possible causative factors that may include resident's history, diagnosis, current appliance or safety device and any changes in safety device or appliance that might be implemented. 9. Labels (for Bed) will be updated with any changes in safety device/appliance. (A)	S9999		