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 11/29/2022

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

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S 000	Initial Comments Complaint 2259077/IL153304	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) 300.3210t) 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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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 300.3210 General

t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property.

These Regulations were not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure resident's fall interventions were in place to prevent falls for 3 residents (R3, R5, and R8) reviewed for falls and fall interventions. This failure resulted in R3 sustaining a traumatic closed minimally displaced fracture to the right distal ulna (long bone between wrist and elbow), R3 sustaining a scalp laceration requiring staples, and R5 sustaining a scalp laceration requiring staples.

Findings include:

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S9999	Continued From page 2 1. R3's face sheet documented an admission date of 12/25/19 with diagnoses including: anxiety disorder, difficulty in walking, abnormal posture, muscle weakness, reduced mobility, age- related osteoporosis. R3's 8/29/22 Minimum Data Set documented a Brief Interview for Mental Status (BIMS) score of 7, indicating severe cognitive impairment. R3's 11/19/21 through 10/9/22 Morse fall scale documented R3 was a high risk for falling. R3's current care plan documented in part " ... has potential for falls and injury, has hx (history) of falls prior to admission, recent hospitalization r/t (related to) falls ... Interventions:..6/6/19 [R3] requires pad alarms in bed at bedtime, alarm box on tamper resistant mode at all times, & monitor for placement, r/t [R3]will remove and hide them ..." and " ... has had an actual fall with continue to have falls, unaware of safety ... removes and shuts off alarms, often closes door to room so can't hear alarms to see [R3's] movement. Currently will unfasten seatbelt alarm and set listen to it ring, waiting for staff, and as soon as they fasten it she removes it again and again when [R3] is in one of [R3's] moods. 1/2/22 U/Fall (unwitnessed fall) room (major injury), 2/1/22 U/Fall room (no injury), 2/26/22 U/Fall room (major injury), 6/3/22 U/Fall room (no injury), 8/10/22 U/Fall room (no injury), 8/24/22 U/Fall (no injury), 10/9/22 U/Fall room (minor injury), 10/28/22 U/Fall room (major injury) 11/10/22 U/Fall room (no injury) ..." On 11/17/22 at 9:40 AM, V13 (R3's Power of Attorney (POA)) stated R3 "has been in the facility for several years and is progressively getting worse. Back in February of 2022 [R3] had a wrist fracture from a fall and recently has had a	S9999		

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laceration to [R3's] head that required staples. I think the only thing they are doing is putting alarms on her and not actually checking on [R3]. I'm afraid [R3] is going to get seriously injured from one of these falls."

R3's 12/30/21 unwitnessed fall investigation documented in part " ... CNA (Certified Nurse's Assistant) came to this nurse ... stated this nurse was needed in resident's room as [R3] was in the floor. CNA stated alarms were not sounding ... After review of incident ... the safety committee has ensured that pad alarms have new batteries in them and sound to alert staff when resident is attempting to ambulate or transfer without assist ..."

R3's 2/26/22 unwitnessed fall investigation documented in part " ... This nurse was alerted to resident's room. Resident on floor by [R3's] couch in [R3's] room ... resident c/o (complained of) R (right) hand/ wrist pain upon palpation .... Slight bruising noted. ROM (Range of Motion) limited d/t (do to) pain ... [R3's] alarms were located in [R3's] closet, where [R3] had placed them ..." R3's 2/27/22 right forearm X-ray report documented in part " ...Oblique fracture distal ulna is noted ..."

R3's 10/29/22 unwitnessed fall investigation documented in part " ... Found resident sitting in the floor, bleeding from top right of head area ... complains of headache ... physician notified for orders to send to ED (Emergency Department) ..." R3's 10/29/22 progress note documented in part " ... [hospital nurse] stated ... resident had to get staples on right side of head due to laceration from fall ..." and " ... Resident has four staples on right side of head ..." The facility's 10/31/22 Interdisciplinary Fall Committee Meeting Minutes documented in part " ... [R3] 10/29/22 0400 u/fall

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(unwitnessed fall) ... Major injury ... Res (resident) stated fell out of bed ... alarm not sounding ... will look for tamper proof alarms ..."

On 11/15/22 at 10:05 AM, V4 Licensed Practical Nurse (LPN) said the Certified Nurse's Assistants (CNA) were responsible for ensuring resident's alarms were intact and functioning appropriately. V4 said R3 will take her alarm off frequently and hide it around the facility. V4 said R3 was not alert and oriented.

On 11/15/22 at 10:35 AM, V5 (CNA) said staff can find if a resident has an order for an alarm on the resident's Kardex in the resident's Electronic Medical Record (EMR). V5 said any resident with an alarm ordered should have the alarm on and functioning.

On 11/17/22 at 1:09 PM, V16 (CNA) said CNAs were responsible for ensuring resident's alarms are intact and functioning. V16 said R3 would pull the alarm pad out of R3's bed while up in the wheelchair and hide it around the facility. V16 said when assisting R3 to bed staff should check R3's bed to be sure the alarm pad is present because it does go missing sometimes.

On 11/18/22 at 10:20 AM, V1 Director of Nursing (DON) said R3 had behaviors of shutting off her alarms, hiding the alarms in her room, and hiding her alarms around the facility. V1 said R3 did not have alarms functioning at the time of the 2/26/22 and 10/29/22 falls with major injuries. V1 said she expected staff to follow all safety interventions on a resident's care plan including making sure alarms were functioning and present.

On 11/17/22 at 11:37 AM, V2 (R3's Medical Provider/ Family Nurse Practitioner) said he

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expected the facility to have interventions in place to keep R3 from falling. V2 said if R3 had a fall intervention of having alarms in place he expected the alarms to be in place and functioning. V2 said he expected staff to have all safety interventions in place if listed in the care plan.

2. R5's face sheet documented an admission date of 4/29/13 and diagnoses including: Alzheimer's disease, osteoporosis, repeated falls, and hypertensive heart disease. R5's 10/9/22 MDS section C documented a BIMS score of 2, indicating severe cognitive impairment. R5's care plan documented in part " ... potential for injury: Resident is at risk for falls ... 3/15/22 u/fall (unwitnessed fall) room (major injury) ... Interventions: ... 12/21/20 [R5] requires chair and bed pad alarms at all times ... ensure the device is in place as needed ..."

R5's 3/15/22 unwitnessed fall investigation documented in part " ... found lying on back on floor with head against wall ... has laceration to back of head approximately 1 inch in length ... EMS (Emergency Medical Services) called ... After review of incident ... agency aide had put resident to bed, alarm pad was on bed, she did not make sure was functioning prior to leaving room. CNA educated on use of alarms and being sure that they are functioning prior to leaving resident unattended. Box was not synced to pad on bed ..."

R5's 3/15/22 progress note documented in part " ... returned to facility per transport from ER (Emergency Room) has 6 visible staples to back of head ..."

3. R8's face sheet documented an admission

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S9999	Continued From page 6 date of 7/28/16 and diagnoses including: major depressive disorder, syncope, heart failure, history of falling, unspecified dementia, dysphasia, unsteadiness on feet, cognitive communication deficit, osteoarthritis, muscle weakness, difficulty in walking. R8's 9/2/22 MDS section C documented a BIMS score of 5, indicating severe cognitive impairment. R8's Physician Order Sheet (POS) documented a 8/14/20 order for "pad alarm at all times while in chair or wheelchair." On 11/17/22 at 2:24 PM, R8 was observed to be sitting in a recliner in R8's room. R8's pad alarm box was hanging on the handrail outside of R8's room and the light "not in use" was on. V10 (CNA) said R8's pad alarm was in R8's wheelchair and not under R8 in the recliner. V10 said R8 was supposed to have a pad alarm on when R8 was out of bed. V10 said she was not sure why R8 did not have a pad alarm on because V10 had just arrived at the facility. The facility's 12/20/21 Falls- Prevention and Risk Reduction policy documented in part " ...1. The MDS Coordinator will: A. Complete a comprehensive care plan for all residents who are identified at risk for falls. B. Communicate the falls care plan to the health care team ... D. Update interventions on the falls care plan with any new occurrences of falls ..." The facility's 12/20/21 Falls, Post- Fall Protocol policy documented in part " ... 7. The health care team will discuss the resident's fall ... and agree on at least one new intervention for the resident's fall risk care plan ..." (B)	S9999		