STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145386	A. BUILDING _____ B. WING _____	C 10/11/2011

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) COMPLETION DATE
F 000	INITIAL COMMENTS Incident of 9-25-11/ IL54656 - F309 and F323 Complaint 1153036/ IL54720- F309 and F323	F 000		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to assess and manage pain for 1 of 3 residents (R1) reviewed for pain management in the sample of 3. On 10/4/2011 at 12:10 pm R1 was observed in the dining in a reclining chair trying to feed herself lunch yelling "my leg hurts." At 12:45 pm on 10/4/2011 R1 was observed still in the reclining chair in the dining room looking at the television yelling "help me my leg is hurting." At 3:00 pm on 10/4/2011 R1 was observed lying in bed, eyes closed when staff entered the room. When R1's bed was accidently bumped R1 yelled "don't do that my leg hurts." On 10/5/2011 at 9:15 am R1 was observed lying in bed, quiet, eyes closed. When staff approached the bed R1 yelled "don't touch my leg, it hurts, I've had surgery on my leg." R1's right leg was noted with a cast on it and it	F 309		11/18/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145386	A. BUILDING _____ B. WING _____	C 10/11/2011

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) COMPLETION DATE
F 309	Continued From page 1 was elevated on a pillow. Further observation noted R1's left leg had a yellow bruise extending from above the ankle to below the knee. A review on 10/5/2011 of R1's clinical record notes the Physician Order Sheet of 9/26/2011 lists Lortab 5/325mg one tablet by mouth every four hours as needed for pain, also Acetaminophen tab 500 mg one tablet by mouth every 6 hours as needed. The Medication Administration Record dated 10/1/2011 to 10/5/2011 notes R1 only received pain medication on 10/1/2011 at 1:00 pm, 10/2/2011 at 10 am, and 10/5/2011 at 8:15 am. During an interview on 10/5/2011 at 12:00 pm with E2 (Director of Nurses), when discussing R1's verbal complaints of pain and not receiving pain medication, E2 stated "I agree R1's pain should have been assessed and pain medication should have been offered routinely, the nurses should not have waited for R1 to ask for pain meds." E2 also stated she would notify the physician and get an order to give R1 pain medication every four hours and as needed.	F 309		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 323		11/18/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145386	A. BUILDING _____ B. WING _____	C 10/11/2011

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) COMPLETION DATE
F 323	Continued From page 2	F 323		

by:
Based on observation, interview and record review the facility failed to prevent an accident for 1 of 3 residents (R1) reviewed for accidents in the sample of 3. These failures resulted in R1 sustaining fractures to the distal tibia and fibula of the right and left legs.

Findings include:

R1 is an 83 year old resident with diagnoses of Dementia, Panic Disorder, Cerebral Vascular Accident with Left Sided Weakness and Hard of Hearing according to the October Physician Orders dated 10/1/2011 to 10/31/2011. According to R1's Minimum Data Set Assessment dated 6/27/2011 in the clinical record R1 has severely impaired cognitive skills, long term memory loss, R1 is total staff care for transfers, has impaired range of motion in upper and lower extremities and R1 does not ambulate.

On 10/4/2011 at 12:10 pm and 12:45 pm R1 was observed in a reclining chair in the dining room. R1 was noted with a cast to her right leg and the right leg was elevated on a pillow. At 3:00 pm on 10/4/2011 R1 was observed lying quietly in bed with the cast on her right leg and the right leg elevated on a pillow. On 10/5/2011 R1 was observed at 9:15 am and 12:45 pm lying in bed the cast remained on her right leg and the right leg was elevated on a pillow. Further observation at this time noted R1 to have yellow bruising to her left leg. E1 (Administrator) and E2 (Director of Nurses) were present when this observation was made. E1 (Administrator) and E2 (Director of Nurses) notified the physician of the bruising to the left leg and orders were received to transport

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145386	A. BUILDING _____ B. WING _____	C 10/11/2011

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) COMPLETION DATE
F 323	Continued From page 3 R1 via ambulance to Massac Memorial Hospital for x-rays to the right leg. A review on 10/4/2011 of R1's clinical record notes the care plan dated 3/5/2008 and updated 9/27/2011 shows R1 has a potential for falls and is in a reclining chair for positioning and comfort. This care plan instructs staff to use Hoyer Lift or Sit to Stand Lift with two staff for transfers. The CNA Flow Sheet Signature Form certified with signature that staff has read and followed the plan of care for this resident. Nurses notes dated 9/25/2011 at 10:35 pm notes R1's right ankle and foot bruising with slight swelling. R1 complains of pain to the ankle and is unable to move the ankle but did raise the knee slightly without assist. Nurses notes dated 9/26/2011 at 4:15 am notes R1 yelling about pain in her foot and ankle stating "its back, ouch, it hurts bad." The facility's Occurrence Report conclusion dated 10/4/2011 notes that R1 sustained injuries during a transfer on 9/25/2011 when staff failed to follow R1's care plan to use the Hoyer Lift or Sit to Stand Lift when transferring R1. The x-ray report dated 9/29/2011 from Massac Memorial Hospital notes distal tibia and fibula fracture of the right leg. On 10/5/2011 a diagnostic report was received from the emergency room at Massac Memorial Hospital indicating distal fracture to the left tibia and fibula. An interview was conducted with E3 (Certified Nurse Assistant/CNA) on 10/4/2011 at 12:15P.M. in the conference room at the facility. E3 stated she did not know how R1 was injured and she reported the skin tear R1 received to E6 (Licensed Practical Nurse) as soon as she noticed it. E3 denied causing injury to R1 but E3 stated "no we did not use the Hoyer Lift or Sit to	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145386	A. BUILDING _____ B. WING _____	C 10/11/2011

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) COMPLETION DATE
F 323	Continued From page 4 Stand Lift when we transferred her we each took her under the arm and moved her." When asked if she knew what was in R1's care plan for transferring E3 (CNA) stated "yes." An interview was conducted with E5 (Certified Nurse Assistant/CNA) on 10/5/2011 at 2:30 pm in the conference room at the facility. During this interview E5 (CNA) stated "no we did not use the Hoyer Lift or Sit to Stand Lift when we transferred her and most of the time we don't use it, but nothing like this happened before." E5 (CNA) added "we transferred her under her arm with the chair close to the bed, we lifted her over the arm of the chair on to the bed." When E5 (CNA) was asked what happened to R1's legs during the transfer E5 (CNA) stated "they are left just hanging there until we get her on the bed then one person picks up her legs and puts them on the bed." E5 (CNA) replied "yes" when asked if she knew the method to be used to transfer R1 as noted in the care plan. E4 (Licensed Practical Nurse/LPN) was interviewed on 10/4/2011 at 1:20 pm in the conference room of the facility. During this interview E4 described her role in conducting the investigation. E4 (LPN) stated after reviewing the information and after interviewing E3 (CNA) and E5 (CNA) the conclusion is that R1 "was injured when she was improperly transferred by E3 (CNA) and E5 (CNA)."	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS: 300.610a) 300.1010h) 300.1010i)	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145386	A. BUILDING _____ B. WING _____	C 10/11/2011

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) COMPLETION DATE
F9999	Continued From page 5 300.1210a)5)6) 300.1210c) 300.1210d)3) 300.3240a) 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. 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. i) At the time of an accident or injury, immediate treatment shall be provided by personnel trained	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145386	A. BUILDING _____ B. WING _____	C 10/11/2011

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) COMPLETION DATE
F9999	Continued From page 6 in first aid procedures. 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. 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. 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145386	A. BUILDING _____ B. WING _____	C 10/11/2011

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) COMPLETION DATE
F9999	Continued From page 7 d3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These regulations was not met as evidenced by: Based on observation, interview and record review the facility failed to prevent an accident for 1 of 3 residents (R1) reviewed for accidents in the sample of 3. These failures resulted in R1 sustaining fractures to the distal tibia and fibula of the right and left legs. Findings include: R1 is an 83 year old resident with diagnoses of Dementia, Panic Disorder, Cerebral Vascular Accident with Left Sided Weakness and Hard of Hearing according to the October Physician Orders dated 10/1/2011 to 10/31/2011. According to R1's Minimum Data Set Assessment dated 6/27/2011 in the clinical record R1 has severely impaired cognitive skills, long term memory loss, R1 is total staff care for transfers, has impaired range of motion in upper and lower extremities and R1 does not ambulate. On 10/4/2011 at 12:10 pm and 12:45 pm R1 was	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145386	A. BUILDING _____ B. WING _____	C 10/11/2011

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) COMPLETION DATE
F9999	Continued From page 8	F9999		

observed in a reclining chair in the dining room. R1 was noted with a cast to her right leg and the right leg was elevated on a pillow. At 3:00 pm on 10/4/2011 R1 was observed lying quietly in bed with the cast on her right leg and the right leg elevated on a pillow. On 10/5/2011 R1 was observed at 9:15 am and 12:45 pm lying in bed the cast remained on her right leg and the right leg was elevated on a pillow. Further observation at this time noted R1 to have yellow bruising to her left leg. E1 (Administrator) and E2 (Director of Nurses) were present when this observation was made. E1 (Administrator) and E2 (Director of Nurses) notified the physician of the bruising to the left leg and orders were received to transport R1 via ambulance to the hospital for x-rays to the right leg.

A review on 10/4/2011 of R1's clinical record notes the care plan dated 3/5/2008 and updated 9/27/2011 shows R1 has a potential for falls and is in a reclining chair for positioning and comfort. This care plan instructs staff to use mechanical lift or Sit to Stand Lift with two staff for transfers. The CNA Flow Sheet Signature Form certified with signature that staff has read and followed the plan of care for this resident. Nurses notes dated 9/25/2011 at 10:35 pm note R1's right ankle and foot bruising with slight swelling. R1 complained of pain to the ankle and was unable to move the ankle but did raise the knee slightly without assist. Nurses notes dated 9/26/2011 at 4:15 am notes R1 yelling about pain in her foot and ankle stating "it's back, ouch, it hurts bad." The facility's Occurrence Report conclusion dated 10/4/2011 notes that R1 sustained injuries during a transfer on 9/25/2011 when staff failed to follow R1's care plan to use the mechanical lift or Sit to Stand Lift

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145386	A. BUILDING _____ B. WING _____	C 10/11/2011

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) COMPLETION DATE
F9999	Continued From page 9	F9999		

when transferring R1. The x-ray report dated 9/29/2011 from the hospital notes distal tibia and fibula fracture of the right leg. On 10/5/2011 a diagnostic report was received from the emergency room at the hospital indicating distal fracture to the left tibia and fibula.

An interview was conducted with E3 (Certified Nurse Assistant/CNA) on 10/4/2011 at 12:15P.M. in the conference room at the facility. E3 stated she did not know how R1 was injured and she reported the skin tear R1 received to E6 (Licensed Practical Nurse) as soon as she noticed it. E3 denied causing injury to R1 but E3 stated "no we did not use the mechanical lift or Sit to Stand Lift when we transferred her, we each took her under the arm and moved her." When asked if she knew what was in R1's care plan for transferring E3 (CNA) stated "yes."

An interview was conducted with E5 (Certified Nurse Assistant/CNA) on 10/5/2011 at 2:30 pm in the conference room at the facility. During this interview E5 (CNA) stated "no we did not use the mechanical lift or the Sit to Stand Lift when we transferred her and most of the time we don't use it, but nothing like this happened before." E5 (CNA) added "we transferred her under her arm with the chair close to the bed, we lifted her over the arm of the chair on to the bed." When E5 (CNA) was asked what happened to R1's legs during the transfer E5 (CNA) stated "they are left just hanging there until we get her on the bed then one person picks up her legs and puts them on the bed." E5 (CNA) replied "yes" when asked if she knew the method to be used to transfer R1 as noted in the care plan.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145386	A. BUILDING _____ B. WING _____	C 10/11/2011

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) COMPLETION DATE
F9999	Continued From page 10 E4 (Licensed Practical Nurse/LPN) was interviewed on 10/4/2011 at 1:20 pm in the conference room of the facility. During this interview E4 described her role in conducting the investigation. E4 (LPN) stated after reviewing the information and after interviewing E3 (CNA) and E5 (CNA) the conclusion is that R1 "was injured when she was improperly transferred by E3 (CNA) and E5 (CNA)." (B)	F9999		