

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6008759	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/18/2014
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NAME OF PROVIDER OR SUPPLIER SOUTHGATE HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 900 EAST NINTH STREET, PO BOX 843 METROPOLIS, IL 62960
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S9999	<p>Final Observations</p> <p>STATEMENT OF LICENSURE VIOLATIONS:</p> <p>300.610a) 300.1210b) 300.1210d)6) 300.3240a)</p> <p>Section 300.610 Resident Care Policies</p> <p>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.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>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.</p>	S9999		

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

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S9999	<p>Continued From page 1</p> <p>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:</p> <p>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.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>THESE REGULATIONS WERE NOT MET AS EVIDENCED BY:</p> <p>Based on observation, record review, and interview, the facility failed to implement strategies to prevent falls in 5 residents reviewed for falls (R4, R7, R8, R14, R13). These failures resulted in a fractures of the left metatarsal and left fibula accompanied by decline in mobility for R14.</p> <p>Findings include:</p> <p>1. On 03/13/14 at 9:45 am, R14 was observed unattended, sitting on the bedside commode. Her call light was within reach, but had not been activated. She did not have a pull tab alarm on.</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>She had a cast on her left foot/lower leg. E8 and E9, both Certified Nursing Assistants, came in and, after cleaning R14, they both transferred R14 to the bed using a gait belt.</p> <p>An Incident Report dated 02/23/14 showed that on that date R14 fell while attempting to self transfer from the bedside commode to the bed. This report further stated, "Resident also has an order for a pull tab alarm while on the commode which was not in place at the time of the fall. It has been determined that the residents fall may have been avoided if all ordered safety interventions were in place. Additional information: On the 02/26/14 nurse's note, it was noted that the resident had been voicing inconsistent complaints of pain in her left foot and was sent to the emergency room for evaluation, the resident returned to the facility with a diagnosis of left metatarsal fracture and left fibula fracture." A Care Plan with a review date of 02/23/14 showed a problem area of "risk of falls". Interventions for this problem area included "pull tab alarm while up on bedside commode".</p> <p>On 03/13/14 at 9:30 am, E3, Assistant Director of Nurses, during interview, confirmed that R14 is to have on a pull tab alarm when on the bedside commode. On 03/13/14 at 9:50 am, E9, Certified Nurse Aide (CNA), stated that before R14 broke her foot and leg, she could be transferred by one staff member but now requires the assistance of two. During this same interview E8, CNA, acknowledged that R14 did not have a pull tab alarm in place on 3/13/14</p> <p>2. An Occurrence Report dated 8/21/13, at 4:45 a.m. R7 was found lying on her side in front of her bedside commode with a 3 centimeter (cm) laceration to her forehead surrounded by purple</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>bruising, complaining of pain in her right 4th and 5th toes. According to a Follow up Report dated 8/23/13, "(R7) is at high risk of falls," and "(R7's) plan of care states that (R7) is not to be left unattended on bedside commode for safety," and that in addition to the forehead laceration, R7 sustained fractures to the right 4th and 5th metatarsals.</p> <p>On R7's most recent Care Plan with a revision date of 8/2/1/13 the facility initiated the following intervention on 6/25/13 to prevent R7 from falling: Staff to keep a hand on resident at all times when she is on the bedside commode. According to the Follow up Report dated 8/23/13, on 8/21/13 at 4:45 a.m., E16 (Certified Nurses Aid [CNA])stated that she had assisted R7 to the commode, and walked to the other side of the room while R7 was on the commode. The Follow up Report also states that E16, was "disciplined for not following the resident plan of care, resulting in a fall with injury."</p> <p>On 3/14/14 at 10:00 a.m., E15, CNA, stated that she recalled the accident and R7 did not suffer a decline, since R7 had been non-weight bearing prior to the fall.</p> <p>3. On 3/11/14 at 2:30 p.m., R13 was propelling self down the hallway in a wheelchair with a pad alarm in place.</p> <p>R13's Minimum Data Sets (MDS) dated 12/25/13 indicates a score of 2 (severe cognitive impairment) on the Brief Interview for Mental Status; normally uses a wheelchair for mobility and requires extensive assist with transfers. A Fall Risk Assessment dated 1/9/2014 states that R13 "Overestimates or forgets limits," and identifies R13 as high risk for falls.</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>R13's Care Plan dated 9/30/14 with a revision date of 2/14/14 includes a Focus of Potential for Injury: Resident is at risk for falls due to unaware of safety needs, psychoactive drug use, gait/balance problems, and requires assistance with transfers. R13's Care Plan includes the following interventions for falls: 1. Anticipate and meet the residents needs; 2. Attempt to keep visible when out of bed; 3. Be sure the resident's call light is within reach and encourage to use it for assistance as needed; 4. Supervise resident and assist with transfers; 4. Respond promptly to request for assistance to toilet; and 5. The resident uses a pad alarm, ensure the device is in place as needed.</p> <p>An Incident Report of 1/9/2014 at 7:00 p.m. states resident was found sitting on the floor in another resident's room with urine noted in the floor surrounding her. No injuries were noted. Intervention: Staff counseled to remove resident from the dining room after meals and place her in highly visible area. No new interventions were added to R13's Care Plan.</p> <p>An Incident Report dated 2/06/14 at 3:20 p.m. states that R13 was found in the dining room sitting on the floor next to her wheelchair, and "Alarm was turned off." A note on the Incident Report dated 2/7/14 states, "It has been determined that the resident reached forward to pick up something off the floor and lost her balance. Alarm in place but turned to off position. Intervention: Staff counseled to ensure that residents alarms are on at all times for safety." No new interventions were added to R13's Care Plan.</p> <p>On 3/14/10 at 10:00 a.m., E12, CNA (Certified</p>	S9999		

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S9999	<p>Continued From page 5</p> <p>Nurses Aide), during interview stated that R13 is to always have the pad alarm on when R13 is in the wheelchair or in bed; that the alarm is turned off only when R13 is being assisted to the bathroom or transferring to bed at night, showering, etc. and then turned back on; and that R13 should not be left alone with pad alarm in off position.</p> <p>An Incident Report dated 2/12/14 at 7:00 p.m. states that " Resident was found on floor in room at foot of bed". She stated, she was trying to get into bed. Wheelchair alarm sounding when found by CNA. A note on this report dated 2/14/14 states, "Encourage staff to keep resident visible when up in wheelchair". No new intervention was added to R13's Care Plan after this date.</p> <p>4. On 3/13/14 at 9:00 a.m., R4 was sitting in a wheelchair in the hallway outside of his room with head down and eyes closed. This writer called R4's name several times in close proximity to his ear before he lifted his head.</p> <p>R4's Physician's Order Sheet for 3/2014 includes a diagnoses of Chronic pain related to back fracture, Degenerative Joint Disease, Dementia, Fracture of Pelvic Ramus. Medications for R4 listed on this document include Roxanol 10 milligrams every four hours for pain at 6 am, 10 am, 2 pm, 6 pm, and 10 pm. OxyContin 115 milligrams at 8 a.m. and 4 p.m. A Hospice Agreement for R4 was signed on 7/7/2013. A Fall Risk Evaluation for R4 dated 7/9/13 identifies R4 at high risk for falls with a score of 18 (score of 10 or above represents high risk). R4's Minimum Data Set of 7/19/13 identifies R4 as using a wheelchair for mobility, requiring assistance of 2 persons for bed mobility and transfers. R4's Care Plan with initiation date of</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>7/7/2013 includes: Potential for Injury: Resident is at risk for falls due to balance problems. Interventions for fall reduction on R4's Care Plan include: 1. Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. 2. Pad alarm at all times. 3. Supervise resident and assist appropriately with transfers (2 assist). 4. High-sided mattress. 5. Follow Facility Fall Protocol</p> <p>An Incident Report dated 7/7/2013 at 9:45 p.m. states that R4 was found lying in floor with head on pillow under the bed when nurse heard resident moaning. Report states alarm was not sounding due to resident laying on alarm and that R4 experienced no pain with range of motion. This report further states that R4 was admitted to the hospital on 7/8/2013 at 5 pm p.m. following complaints of pain to lower extremities and was admitted with a diagnosis of a pelvic fracture. A note of 7/9/2013 of this report concludes that R4 sustained a fall while trying to get out of bed without assistance. All safety measures were in place at time of fall. Recommendation added to R4's Care Plan was "High-sided mattress due to safety awareness."</p> <p>An incident report dated 10/08/2013 states that at 10:45 a.m. R4 was sitting in the wheelchair in the hallway sleeping when he leaned forward and fell out of the wheelchair. R4 hit his head on the floor and was noted to have a large hematoma to the forehead. Pad alarm was sounding at the time of the fall. An intervention was added to R4's Care Plan on this date for "Staff to offer to lay resident down if he looks tired while up in wheelchair"</p> <p>An Incident Report dated 10/27/13 states that at 2:01 p.m.. that in response to an alarm sounding.</p>	S9999		

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S9999	<p>Continued From page 7</p> <p>R4 was found sitting on the floor in the room with back against the wall and legs extended straight out. Resident states " I fell out of wheelchair after I fell asleep." Reddened area with dark bruising and small abrasion noted to the right of R4's forehead. Intervention of " Encourage resident to sit in recliner after every meal for safety" was added to the Care Plan on 10/27/13.</p> <p>An incident report dated 12/5/2013 states that at 10:00 am, R4 was found sitting in the floor with his wheelchair behind him. Alarm was sounding. The breaks were not engaged. Small bruise noted to left hand. Recommendation : Anti roll-back device to wheelchair for safety. This recommendation does not appear on R4's Care Plan.</p> <p>An Incident Description dated 1/19/2014 states that on this date at 7:25 am R4 sustained a fall from the wheelchair in the hallway. Alarm sounded. Raised bruised area noted to top of head. Resident stated, " I must have fell asleep" A note of 1/21/14 included on the report states that after review of the incident by the safety committee an intervention was recommended for Maintenance Department to" drop residents wheelchair seat in the back to create a slight decline for safety." This intervention does not appear on R4's Care Plan.</p> <p>On 3/14/14 at 9:05 a.m., when asked if R4's wheelchair was equipped with an anti-rollback device E13 Certified Nurses Aid stated she was not sure and but would check and located R4 in the hallway accompanied by this writer. E13 stated that there were no devices added to R4's wheelchair.</p> <p>On 3/14/14 at 1:50 pm E3 Assistant Director of</p>	S9999		

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S9999	<p>Continued From page 8</p> <p>Nurses accompanied this writer to R4's room to check for anti-rollback device and lowered wheelchair seat. R4 was in bed sleeping with the wheelchair next to the bed. E3 confirmed that anti-rollback devices were not present on the wheelchair and that the seat had not been lowered in the back.</p> <p>5. On 03/13/14 at 9:35 am, R8 was observed in her wheelchair self propelling down the hallway. R8 had a personal safety alarm in place. When asked, R8 was unable to give her name, the date, or the name of the facility.</p> <p>An Incident Report dated 12/04/13 showed that on that date, R8 fell from a shower chair when she was left unattended in the shower room. The Incident Report further stated, " The Safety Committee has concluded that (E6, CNA) went to central supply and (E7, CNA) didn't hear (E6) tell her she was going to central supply" thus leaving the resident unattended. When E6 came back in the room the resident was unattended and lying on the floor in front of the shower chair. An undated Shower Policy/Procedure stated "Residents should never be left alone in the shower room." A Minimum Data Set dated 01/28/14 showed that R8 is totally dependent on at least two staff for assistance with bathing.</p> <p>On 03/13/14 at 9:25 am, E3, Assistant Director of Nurses, confirmed that it is against facility policy to leave residents unattended in the shower room.</p> <p>(B)</p>	S9999		