DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 07/07/2016

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 Complaint 1653726/IL86739	F 000		
F 223 SS=D	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that residents are free from abuse for 1 of 4 (R3) residents reviewed for abuse in the sample of 4. The findings are: R3 is a 68 year old resident with diagnoses that include Right Above the Knee and Left Below the Knee Amputation, Diabetes Mellitus Type II, Peripheral Vascular Disease and Non-Pressure Chronic Ulcer as noted on R3's Order Summary Report dated 7-7-2016. R3 has orders for treatment and dressings as well as stump shrinking wraps on both lower extremity amputation sites. R3 was observed up in R3's wheel chair on 7-7-2016 at 1:50 pm. R3 was noted to have ordered stump shrinking wraps in place. R3 was identified as alert and interviewable by the facility and was noted to have a cognitive assessment score based on a Brief Interview for Mental Status of 11 out of 15	F 223		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 223	Continued From page 1 (moderately impaired), as noted on the Minimum Data Set dated 4-11-2016. A Behavior Note entry was made in the Progress Notes for 10:59 am on 6-19-2016. The note indicated that R3 was verbally aggressive with staff that AM, cursing and yelling at staff while staff attempted care. The note further documents that R3's visitor (not identified) was video recording a nurse who was bent over providing R3 care and that the visitor was asked to stop, at which time R3's visitor and R3 "became verbally aggressive". The documentation indicates that the nurse who was being recorded left the room and other staff present completed care. E2, Administrator, stated on 7-7-2016 at 9:10 AM that the facility was investigating an allegation of verbal abuse of R3 by a nurse. E2 presented a preliminary investigation dated 7-5-2016 which involved R3, E4 -Licensed Practical Nurse (LPN) and an allegation of verbal abuse. The report indicated that the allegation was made on 7-5-2016 at 6:30 PM by two visitors to the facility who presented E2 with a video located on one of the visitor's phones. E2 stated that she watched the video and was immediately concerned. E2 stated that it is believed that the video recording was taken on 6-19-2016. E2 stated that an investigation was initiated at that time. E2 stated that E2 called E4 after review of the video and notified E4 of the allegation, and that E4 was being suspended, pending outcome of an investigation. E2 stated that the investigation has included staff and resident interviews, further review of the video and discussion among E1-President, E2, E3-Social Services, E5-Director of Nursing and E6-Assistant Director of Nursing, with a determination being made that	F 223		

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F 223	Continued From page 2	F 223		

verbal abuse had occurred. E2 stated that E4 was terminated from E4's position.

E1 stated on 7-7-2016 at 11:20 AM that he viewed the video on 7-6-2016 which E1 believed to have been taken on 6-19-2016 and after viewing, felt that E4 had "crossed a line" in reference to E4's remarks made to and in the presence of R3. E1 stated that it was felt that the facility had no choice but to terminate E4.

The mentioned video was reviewed and it was noted that E4 was speaking in a very loud, some what agitated tone, saying "Oh my God (and stating resident's name)" and then was observed to shake something white, (believed to be a treatment dressing) at R3 while standing at the bed side and leaning over towards R3. At the same time, E4 was yelling "What is this" repeating it 3 times. R3 answered "it fell off" and E4 stated, again in a loud, agitated tone "It did not fall off, you are lying" and then repeated "you are lying, how is this ever going to heal if you don't leave it alone" and continued with "Oh my gosh, somebody's going to beat him." The video ends with E4 walking off camera briefly then approaching R3's bed again, and using a less agitated, lower tone, E4 states R3's name and tells R3 "I'm going to put it back on, okay?"

Included in the facility's investigation was a hand written note by E4 dated 7-6-2016. E4 wrote that as R3's treatment nurse, E4 had found that "you have to be stern with R3 for R3 to leave his wounds alone and if E4 caught R3 taking off his bandages, E4 would be very stern with him about leaving them alone." E4 indicated that E4 did not feel that E4 had been verbally abusive to R3 because their relationship is different than E4's is

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with any other resident, with E4 documenting that R3 is family. During an interview on 7-7-2016 at 11:20 AM, it was verified by E1 that there was a family relationship due to E4 being married to R3's nephew. R3's current Care Plan with an initiation date of 3-1-2016 lists behaviors as a problem area. Approaches do not include being very stern with R3.

The undated facility Abuse Policy/Procedures states under Policy Statement "Each resident has the right to be free from mistreatment, neglect and misappropriation of property... All employees are expected to follow this policy. Failure to do so will result in disciplinary action."

A form signed by E 1 and dated 7-6-2016 was provided by E1. It includes E4's name and a statement that E4's reason for leaving is "unvoluntarily" and that termination is due to E4 speaking to R3 in an inappropriate manner, with documentation on a video taken by Z1.