Illinois Department of Public Health

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 11/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHGATE HEALTH CARE CENTER	900 EAST NINTH STREET 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) COMPLETE DATE
S 000	Initial Comments Facility Reported incident of 10/22/20/ IL128503-F689G cited.	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210b) 300.1210d)6) 300.3240a) 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 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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

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S9999	Continued From page 1	S9999		

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 observation, interview and record review, the facility failed to ensure staff properly used a mechanical lift for transfer for 1 resident (R1) reviewed for safe transfers. This failure resulted in R1's emergency transfer and hospitalization after falling from a mechanical lift during a transfer. R1 sustained a Subarachnoid Hemorrhage and Closed Fractures of 1st and 2nd Lumbar Vertebra and required a 2 day hospitalization.

Findings include:

R1 is an 82 year old resident with diagnoses that include Vascular Dementia, Cortical Blindness, and Anxiety, as noted on R1's medical diagnosis list. An Incident Note documented in R1's progress notes indicates that on 10-22-2020 at 5:00 AM, after giving R1 a shower, V7, Certified Nurse Aide, was attempting to transfer R1 from a shower chair back into her bed using a mechanical lift when the lift sling broke and R1 fell to the floor, landing on the legs of the mechanical lift. R1 was assessed by V12,

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S9999	Continued From page 2	S9999		

Licensed Practical Nurse, and transferred to the hospital by ambulance. V12 documented that when she entered the room, R1 had eyes open with a blank stare and did not respond verbally, noting that she was unable to assess for pain as resident was not responding to her normal baseline.

On 11-19-2020, at 3:05 PM, V12 stated she was called to R1's room where she observed R1 laying on her back with her neck on one of the lift's stabilizer legs and her lower extremities on the other stabilizer leg. She noted that the sling was still attached to 3 of the 4 hooks of the lift. V12 stated R1 had a 'flat look' on her face and wasn't responding initially. R1 did finally verbalize some pain and after the ambulance personnel arrived, R1 moaned some when they started moving her to the gurney. V12 stated that after R1 left the facility she inspected the sling that was used and noted that 1 of the 4 loops was torn which had then caused it to come off the hook. She noted that it was not the standard sling used with the mechanical lifts but a cloth sheet used for moving a resident in bed that has a looped like area at each corner which can be used to hold onto the sheet during assisted bed mobility.

Hospital imaging reports dated 10-22-2020 document fractures of vertebrae L1 and L2, a right frontal lobe Subarachnoid hemorrhage and a probable small intraparenchymal hemorrhage. A hospital discharge summary dated 10-24-2020 documents R1 presented with back pain after a fall from a mechanical lift on 10-22-2020, it notes a principal problem of Subarachnoid bleed, and active problems which included Closed Fractures of the first and second Lumbar Vertebra.

R1's nurse progress notes document R1 returned

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S9999	Continued From page 3 to the facility on 10-24-2020. R1 returned with orders for therapy evaluation and to treat as indicated. A 10-28-2020 nurses note documents an order was received for R1 to receive acetaminophen 500 mg, two tablets twice daily, after therapy reported R1 was showing some signs of pain during therapy. R1 was observed on 11-20-2020 at 12:15 PM eating in room, up in a chair, mechanical lift sling under resident. The facility investigation's Narrative Summary documents that an examination of the 'sling' used during the attempted transfer was a looped 'slide sheet' and not a traditional 'hoyer sling' and that V7 reported that the sling broke as she started transferring R1 from the shower chair to her bed. The summary indicates V7 had received past re-education training regarding use of the mechanical lifts and had been observed during return demonstration. V7 was terminated for not following facility policy to have a second person to assist with the mechanical lift transfers and for improper use of equipment. On 11-17-2020 at 11:35 AM, V1 verified the accuracy of the narrative summary. (A)	S9999		