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

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**X1 PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:**

445220

**X2 MULTIPLE CONSTRUCTION**

A. BUILDING
B. WING

**X2 DATE SURVEY COMPLETED**

C 02/19/2013

---

**NAME OF PROVIDER OR SUPPLIER**

SPRING GATE REHAB & HEALTHCARE CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**

3999 COVINGTON PIKE, MEMPHIS, TN 38135

---

**SUMMARY STATEMENT OF DEFICIENCIES**

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 323</td>
<td>SS=D</td>
<td>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</td>
<td>3/3/13</td>
</tr>
</tbody>
</table>

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 by:

Intakes: TN00031174

Based on policy review, review of a facility's investigation, medical record review, and interview, it was determined the facility failed to implement interventions to prevent falls for 1 of 5 (Resident #1) sampled residents at risk for falls.

The findings included:

Review of the facility's "Lifting Machine, Using a Portable" policy documented, "...The portable lift can be used by one nursing assistant if the resident can participate in the lifting procedures. If not, two (2) nursing assistants will be required to perform the procedure...."

Review of the facility's investigation dated 1/25/13 documented, "...On 1/25/13, a CNA [Certified Nursing Assistant #1] was transferring a resident from chair to bed using the mechanical lift. The pad of the lift machine had slipped up the resident's [Resident #1] back causing the resident to fall from slings..."

---

**LABORATORY DIRECTORS OR PROVIDER/SUPPLIER/REPRESENTATIVE'S SIGNATURE**

---

**RECEIVED**

FEB 28 2013
Continued From page 1

Medical record review for Resident #1 documented an admission date of 2/1/07 with diagnoses of Severe Mental Retardation, Seizure Disorder, Presenile Dementia, and Congestive Heart Failure. Review of the Minimum Data Set (MDS) with an Assessment Reference Date of 11/27/12 revealed Section G G0110 Activities of Daily Living (ADL) Assistance documented, "...Transfer - how resident moves between surfaces including to or from bed, chair, wheelchair... 4 [Total Dependence]... Support 3 [Two plus persons physical assist]." Review of the care plan dated 12/7/12 documented, "...Potential for falling related to seizure disorder, related to total dependence on staff for mobility... Transfer with 2 person assist & [and] hoyer lift..." A Nurse’s Notes dated 1/25/13 at 10:30 AM documented, "...res [resident] fell from hoyer sling to the floor. Res was noted on L [left] side on floor next to her bed in a semi-fetal position with L arm under body... Medium size bump noted @ [at] back of head..."

During an interview in the conference room on 2/11/13 at 3:00 PM, the Director of Nursing stated, "She [CNA #1] was transferring her [Resident #1] by herself... No, she [Resident #1] could not assist..."