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	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southgate Health Care Center	900 East Ninth Street Metropolis, IL 62960

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32765 Based on interview and record review the facility failed to ensure allegations of abuse were reported timely to the Administrator and to the State Survey Agency for 2 of 3 (R1 and R13) residents reviewed for abuse in the sample of 14. Findings Include. 1. R1's Admission Record with a print date of 3/6/25 documents R1 was admitted to the facility on [DATE] with diagnoses that include multiple fractures, osteoarthritis, and hypertension. R1's MDS (Minimum Data Set) dated 3/5/25 documents R1 has a BIMS (Brief Interview for Mental Status) score of 13, which indicates R1 is cognitively intact. On 3/5/25 at 11:45 AM, R1 stated V13 (LPN/Licensed Practical Nurse) came in his room talking louder than normal and handed him about 16 pills in one cup. R1 stated he sat the pills down and asked for a list of his medications and V13 stated she didn't have time to get him the list and walked around to the other side of his bed. R1 stated V13 picked up his left hand and started to do an accu check. R1 stated he gave V13 his right hand and told her he wanted it done on the right hand not the left. R1 stated V13 called him hateful and left the room immediately. R1 stated he called the police and reported elder abuse after V13 left his room. R1 stated she came back to his room and grabbed a hold of the door and stated she wasn't able to come in his room by herself, they had to have two staff members provide care to him now. R1 stated he asked the police to come to the facility and write a report, but they didn't, and they alerted the staff about his call. R1 stated he later saw V13 and V3 (Quality Assurance Nurse/QA) come into his room. R1 stated V3 was a little easier to talk with. R1 stated V13 has worked since the incident occurred and he believed it occurred on Saturday, March 1. R1 stated V13 has been in his room one time since the incident to give him the list of medications he requested. When asked if he felt safe at the facility, R1 stated he contacted Veteran's Affairs regarding the incident, and they asked him if he wanted to move to a different facility. R1 stated he told them he did. R1 did not directly answer the question about feeling safe at the facility. On 3/5/25 at 12:53 PM, V5 (Police Dispatch) stated she took a call from the facility on 3/1/25 at 10:41 AM. V5 stated R1 called and stated he resided at the facility and advised he was being abused by a nurse (V13). V5 stated R1 reported the nurse (V13) grabbed his arm and told him she didn't have time for him. V5 stated R1 reported after the nurse (V13) grabbed his arm she grabbed his hand to do a blood sugar and he told her they use the other hand. V5 stated R1 reported the nurse threw his hand down on the bed and told him she didn't have time for him. (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Progress Notes document the following. 3/1/25 10:51 AM, Note Text: (V13), floor nurse called this nurse manager (V3) and stated that the police department had called her stating this resident called 911 stating he had been assaulted. (V13) explained she went to give his meds (medications) and he wanted a list of all medications, and she told him she would get him a list when she was finished passing (sic) her medications. He (R1) then became very agitated and would not let her do his accu check. This nurse (V3) notified (V1), Administrator. Orders for 2 people at all times when providing care or administering medications. On 3/5/25 at 1:25 PM, V1 (Administrator) stated she was notified on Sunday night R1 had called the police. V1 stated V3 (QA Nurse) called her and reported it. V1 stated when she came in on Monday she thought since the police had been called, they probably should have reported the allegation but because of who the resident was she didn't think she needed to. V1 stated she didn't start an investigation and didn't interview any other staff or residents. V1 stated no one had a conversation with R1 about what had occurred other than V3 (QA Nurse) and V13 (LPN) was present when V3 spoke with R1. The facility Initial Report sent to the Illinois Department of Public Health dated 3/5/25 documents, On 3/1/25 at approx (approximately) 10:51 am on call nurse (V3) was notified by floor nurse that resident had called police and stated that he had been assaulted, when nurse had attempted to check his blood sugar. (V3) notified (V1) administrator received (sic) instructions to ensure 2 staff were in room at all times when providing care including nursing. Investigation initiated, final to follow. 2. R13's Admission Record with a print date of 3/6/25 documents R13 was admitted to the facility on [DATE] with diagnoses that include diabetes, major depressive disorder, repeated falls, and hypertension. R13's MDS dated [DATE] documents a BIMS score of 02, which indicates R13 has a severe cognitive deficit. On 3/5/25 at 3:56 PM, R13 was sitting in a wheelchair in the facility common area. R13 denied any concerns with care and didn't exhibit signs or symptoms of distress. On 3/5/25 at 2:57 PM, when asked about abuse, V14 (Resident Assistant) stated she had witnessed staff to resident mental abuse. V14 stated V17 (CAN/Certified Nursing Assistant) and V16 (CNA) were the staff members and she reported it to V26 (Business Office Manager) because V1 (Administrator) and V2 (Director of Nurses) were not in the facility. V14 stated she witnessed V17 being rude to R13. V14 stated V17 told R13 to shut up and no one was going to get him out of bed. V14 stated it happened on 3/2/25 between 6 am and 2 pm. V14 stated she didn't have a specific incident that occurred with V16 (CNA) but she was just rude at times. On 3/6/25 9:41 AM, V26 (Business Office Manager/BOM) stated she was the manager on duty, and she spoke with V14 (Resident Assistant) and she reported V17 (CNA) was standing in the hallway at R13's door yelling at R13 and being rude and hateful or having an attitude. V26 stated she assured V14 they would discuss it on Monday in morning meeting and she would let V1 (Administrator) know about the allegation. V26 stated she wrote it on a piece of paper and gave it to V1 on Monday morning. V26 stated she didn't know if R13 was interviewable. V26 stated she did not check on R13 after V14 reported the incident to her. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/5/25 at 3:17 PM, V1 (Administrator) stated on Monday 3/3/25 she was told, V17 (CNA) had an attitude. V1 stated it was reported V17 was in the hallway outside R13's room, raised her voice to R13 and was rude. V1 stated she hadn't talked to V14 (RA) who reported the allegation and she wished they would report these things to her before the survey agency enters the facility. V1 stated V14 had worked the past two days and hadn't approached V1 about the incident. V1 stated she hadn't attempted to speak with V14 regarding the incident and didn't begin an investigation. The facility Initial Report sent to the Illinois Department of Public Health dated 3/5/25 documents, On 3/5/25 at approximately 305 pm was notified by surveyor that an employee had reported a complaint of alleged verbal abuse on 3/2/25 to manager on call. Investigation initiated, Final to follow. The facility Abuse Policy dated 3/5/25 documents, Purpose: Each resident has the right to be free from mistreatment, neglect, and misappropriation of property 4. Identification a. If any employee suspects that a resident has been a victim of abuse, they should report this information to their immediate supervisor and directly to the facility administrator as soon as possible .d. When suspected abuse is reported, the administrator and DON (Director of Nurses) should be notified immediately, and the administrator or DON should make a report to (State Survey Agency) within 24 hours

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32765 Based on interview and record review the facility failed to ensure allegations of abuse were thoroughly investigated and residents were protected from possible further abuse for 2 of 3 (R1 and R13) residents reviewed for abuse in the sample of 14. Findings Include. 1. R1's Admission Record with a print date of 3/6/25 documents R1 was admitted to the facility on [DATE] with diagnoses that include multiple fractures, osteoarthritis, and hypertension. R1's MDS (Minimum Data Set) dated 3/5/25 documents R1 has a BIMS (Brief Interview for Mental Status) score of 13, which indicates R1 is cognitively intact. R1's current Care Plan documents a Focus area of (R1) has potential for a behavior problem R/T (related to) making false allegations toward staff of assault during routine cares, or bullying, yelling, being belligerent, not cooperative with care at times. Date Initiated: 03/05/2025. The interventions included for this Focus area include, Administer medications as ordered. Monitor/document for side effects and effectiveness. Date Initiated: 03/05/2025, Caregivers to provide opportunity for positive interaction, attention. Stop and talk with him/her as passing by. Date Initiated: 03/05/20205, If reasonable discuss the resident's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to the resident. Date Initiated: 03/05/2025, Staff to enter resident's room with 2 staff members at all times including nurses' aides, therapy to do anything at all. Document any behaviors. Date Initiated: 03/05/2025. On 3/5/25 at 11:45 AM, R1 stated V13 (LPN/Licensed Practical Nurse) came in his room talking louder than normal and handed him about 16 pills in one cup. R1 stated he sat the pills down and asked for a list of his medications and V13 stated she didn't have time to get him the list and walked around to the other side of his bed. R1 stated V13 picked up his left hand and started to do an accucheck. R1 stated he gave V13 his right hand and told her he wanted it done on the right hand not the left. R1 stated she called him hateful and left the room immediately. R1 stated he called the police and reported elder abuse after V13 left his room. R1 stated she came back to his room and grabbed a hold of the door and stated she wasn't able to come in his room by herself, they had to have two staff members provide care to him now. R1 stated he asked the police to come to the facility and write a report, but they didn't, and they alerted the staff about his call. R1 stated he later saw V13 and V3 (Quality Assurance Nurse/QA) V3 was a little easier to talk with. R1 stated V13 has worked since the incident occurred and he believed it occurred on Saturday, March 1. R1 stated V13 has been in his room one time since the incident to give him the list of medications he requested. When asked if he felt safe at the facility, R1 stated he contacted Veteran's Affairs regarding the incident, and they asked him if he wanted to move to a different facility. R1 stated he told them he did. R1 did not directly answer the question about feeling safe at the facility. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/5/25 at 12:53 PM, V5 (Police Dispatch) stated she took the call from the facility on 3/1/25 at 10:41 AM. V5 stated R1 called and stated he resided at the facility and advised he was being abused by a nurse (V13). V5 stated R1 reported the nurse (V13) grabbed his arm and told him she didn't have time for him. V5 stated R1 reported after the nurse (V13) grabbed his arm she grabbed his hand to do a blood sugar and he told her they use the other hand. V5 stated R1 reported the nurse threw his hand down on the bed and told him she didn't have time for him. On 3/5/25 at 2:45 PM, V13 (LPN/Licensed Practical Nurse) stated she went into R1's room on Saturday 3/1/25 in the morning with medications and to do his accu check. V13 stated R1 asked what was in the medication cup and she told him the same thing he had been taking. V13 stated R1 asked for a copy of his medications, and she told him she would get it for him when she was done with the medication pass. V13 stated she picked up R1's left hand to do an accu check and R1 jerked it back and screamed at the top of his lungs and it scared her. V13 stated she left and finished the medication pass and was at the nurse's station when the police called. V13 stated she called V3 (QA Nurse) and told her what happened and then took an unknown CNA/Certified Nursing Assistant with her when she went in his room. V13 stated R1 seemed fine after that. V13 stated the next morning, R1 put his call light on, and she went to his room. V13 stated he needed his urinal emptied. V13 stated she told him she would have a CNA come with her since she couldn't be in his room alone. V13 stated R1 was angry and wanted to know why they had to have two staff. V13 stated she got V3 (QA Nurse) and they went in and talked to R1. V13 stated R1 was better in the afternoon. V13 stated he didn't seem aggressive. V13 denied any other physical contact with R1. V13 stated she didn't throw down his hand or jerk his arm or call him hateful. V13 stated she did tell R1 she wouldn't be spoken to that way. V13 stated she charted the incident in R1's progress notes. V13 stated no one in administration asked her any questions related to the incident after she told V3 what happened. V13 stated V3 was working at the time of the incident. V13 stated V3 told her she would notify V1 (Administrator). On 3/5/25 at 1:12 PM, V3 (QA Nurse) stated she was working when V13 (LPN) told her the police had called. V3 stated R1 had called the police with an abuse allegation. V3 stated the police told them they weren't coming to the facility, and she called V1 (Administrator) and reported it. V3 stated they decided two people needed to go in R1's room for care since he had made the allegation. V3 stated V13 told her she had in no way abused R1. V3 stated V13 reported, R1 wanted a list of medications, she started to do his accu check and told R1 she would get a list of his medications for him. V3 stated V13 reported R1 became hostile and started yelling and screaming. V3 stated V13 reported she started to do R1's accu check and he jerked his hand back and wouldn't let her do the accu check. V3 stated V13 reported she walked out and shortly after she left R1's room the local police called her. V3 stated V13 explained to the police what had happened, and they didn't believe abuse occurred. V3 stated after the incident and the local police called the facility, R1 put his call light on to have his urinal emptied. V3 stated she went with V13 and told R1 two people had to be in his room. V3 stated R1 wanted to know why, and she explained to him due to the allegation there would be two people in his room. V3 stated R1 told her V13 yelled at him from the door and told him he was hateful. V3 stated she explained to R1 administration would be at the facility on Monday and he could ask them questions. V3 stated she documented the incident in the progress notes. V3 stated she didn't ask any other residents and/or staff if they witnessed anything. V3 stated R1's roommate was not in his room and wouldn't be able to answer questions if he had been. R1's Progress Notes document the following. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/1/25 10:51 AM, Note Text: (V13), floor nurse called this nurse manager (V3) and stated that the police department had called her stating this resident called 911 stating he had been assaulted. (V13) explained she went to give his meds (medications) and he wanted a list of all medications, and she told him she would get him a list when she was finished passing (sic) her medications. He (R1) then became very agitated and would not let her do his accu check. This nurse (V3) notified (V1), Administrator. Orders for 2 people at all times when providing care or administering medications. On 3/1/25 1327, Note Text: This writer (V13) entered resident's (R1) room at 0915 to administer morning medications. Resident requested a list of medications he was taking. Resident was told he would get a copy once the morning medications were passed. This writer picked up resident's right (hand) for his accu check, resident immediately and aggressively jerked his hand away, and started screaming angerly and incoherently at this writer. Resident was instructed his accu check would be completed a different time when he was compliant. This writer received a call from (name of local police department) regarding to resident calling the police. On call nurse (V3) was notified of resident's action. Anyone entering resident's room from this point forward is to enter room [ROOM NUMBER] at a time, this includes all staff. On 3/2/25 4:18 PM, Note Text: Resident's call light was on, this writer went down to this room, and from the doorway resident stated he needed his urine emptied, resident was informed that when a CNA (Certified Nursing Assistant) was available we would enter the room together to take care of his bedside urinal. Resident became verbally aggressive. CNA (V15) entered room with this writer, resident requested to know why we was not allowed to enter his room alone. I told this resident I would get my nursing supervisor to speak with him. Resident again became verbally aggressive. (V3 LPN) was notified of resident's actions and enter room with this nurse. Resident continued to be verbally aggressive while LPN (V3) was explaining to him why needed to enter his room two at time. On 3/5/25 at 1:02 PM, V2 (Director of Nurses) stated she hadn't had any abuse investigations since January 2025. V2 stated R1 yelled assault, to the local police. V2 stated V3 (QA Nurse) was in the facility at the time and her and V13 (LPN) talked to R1. V2 stated R1 called the police but she didn't consider it an allegation. V2 stated then on Monday she got a call from Veterans Affairs that R1 had called them and wanted moved out of the facility. V2 stated on Monday she got R1 the medication list he had requested and when she took it to him the only thing, he was concerned about was his cardiac medications and his cardiac appointment. V2 stated she discussed those concerns with him and his trip to his home that was scheduled for Friday. V2 stated she didn't discuss the allegation with R1. On 3/5/25 at 1:25 PM, V1 (Administrator) stated she was notified on Sunday night R1 had called the police. V1 stated V3 (QA Nurse) called her and reported it. V1 stated when she came in on Monday she thought since the police had been called, they probably should have reported the allegation but because of who the resident was she didn't think she needed to. V1 stated she didn't start an investigation and didn't interview any other staff or residents. V1 stated no one had a conversation with R1 about what had occurred other than V3 (QA Nurse) and V13 (LPN) was present when V3 spoke with R1. The facility Initial Report dated 3/5/25 documents, On 3/1/25 at approx (approximately) 10:51 am on call nurse (V3) was notified by floor nurse that resident had called police and stated that he had been assaulted, when nurse had attempted to check his blood sugar. (V3) notified (V1) administrator received (sic) instructions to ensure 2 staff were in room at all times when providing care including nursing. Investigation initiated, final to follow. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. R13's Admission Record with a print date of 3/6/25 documents R13 was admitted to the facility on [DATE] with diagnoses that include diabetes, major depressive disorder, repeated falls, and hypertension. R13's MDS dated [DATE] documents a BIMS score of 02, which indicates R13 has a severe cognitive deficit. On 3/5/25 at 3:56 PM, R13 was observed sitting in a wheelchair in the facility common area. R13 denied any concerns with care and didn't exhibit signs or symptoms of distress. On 3/5/25 at 2:57 PM, when asked about abuse, V14 (Resident Assistant) stated she had witnessed staff to resident mental abuse. V14 stated V17 (CNA) and V16 (CNA) were the staff members and she reported it to V26 (Business Office Manager) because V1 (Administrator) and V2 (Director of Nurses) were not in the facility. V14 stated she witnessed V17 being rude to R13. V14 stated V17 told R13 to shut up and no one was going to get him out of bed. V14 stated it happened on 3/2/25 between 6 am and 2 pm. V14 stated she didn't have a specific incident that occurred with V16 (CNA) but she was just rude at times. On 3/6/25 9:41 AM, V26 (Business Office Manager/BOM) stated she was the manager on duty, and she spoke with V14 (Resident Assistant) and she reported V17 (CNA) was standing in the hallway at R13's door yelling at R13 and being rude and hateful or having an attitude. V26 stated she assured V14 they would discuss it on Monday in morning meeting and she would let V1 (Administrator) know about the allegation. V26 stated she wrote it on a piece of paper and gave it to V1 on Monday morning. V26 stated she didn't know if R13 was interviewable. V26 stated she did not check on R13 after V14 reported the incident to her. On 3/6/24 at 12:42 PM, V17 (CNA) stated she had never witnessed and/or she herself had never told R13 to shut up and/or they weren't going to provide care. On 3/5/25 at 3:17 PM, V1 (Administrator) stated on Monday 3/3/25 she was told, V17 (CNA) had an attitude. V1 stated it was reported V17 was in the hallway outside R13's room, raised her voice to R13 and was rude. V1 stated she hadn't talked to V14 (RA) who reported the allegation and she wished they would report these things to her before the survey agency enters the facility. V1 stated V14 had worked the past two days and hadn't approached V1 about the incident. V1 stated she hadn't attempted to speak with V14 regarding the incident and didn't begin an investigation. The facility Initial Report dated 3/5/25 documents, On 3/5/25 at approximately 3:05 pm was notified by surveyor that an employee had reported a complaint of alleged verbal abuse on 3/2/25 to manager on call. Investigation initiated, Final to follow. The facility Abuse Policy dated 3/5/25 documents, 5. Investigation .b. When an incident or suspected incident of resident abuse, neglect, misappropriation of resident's property, or injury of unknown origin is reported, the administrator will appoint a staff member to investigate the incident Protection: a. Any employee suspected of abuse or that has been alleged in a potentially abusive situation will be put on leave without pay until the investigation has been completed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32765 Based on interview and record review the facility failed to ensure showers were provided and residents received timely toileting assistance 4 of 6 residents (R2, R3, R12, and R14) reviewed for showers in the sample of 14. Findings Include: 1. R2's Admission Record with a print date of 3/6/25 documents R2 was admitted to the facility on [DATE] with diagnoses that include diabetes, heart disease, and muscle weakness. R2's MDS (Minimum Data Set) dated 2/22/25 documents a BIMS (Brief Interview for Mental Status) score of 14, which indicates R2 is cognitively intact. This same MDS documents R2 requires partial to moderate assistance of staff for toilet transfers. R2's current Care Plan with a Focus area of, (R2) has an ADL (Activities of Daily Living) self-care performance deficit r/t (related to) Activity Intolerance, Impaired balance, Limited ROM (Range of Motion) Date Initiated: 10/28/2024. This Focus area include interventions of, Bathing/Showering: (R2) requires extensive assistance by x1 (times 1) staff with bathing/showering twice a week and as necessary. CNA's (Certified Nursing Assistants) to ensure that (R2) receives at least one shower per week, if the two are unable to be given. R2's Shower Skin Assessment forms document R2 did not receive a shower/bath on 2/28/25 and went from 2/25/25 to 3/4/25 (six days) without a shower. On 3/5/25 at 11:31 AM, R2 stated they don't have enough staff to meet her needs timely. R2 stated she sometimes doesn't get her showers because they are short staffed. R2 stated she didn't get one Friday 2/28/25 because they didn't have enough staff to do it. R2 stated last night (3/4/25) her and her roommate (R3) had to wait two hours to get assistance to the bathroom. R2 stated she woke up to R3 calling out for help to go to the bathroom. R2 stated R3 had her call light on. R2 stated R3 started hitting her call light on the bedside table to get the attention of staff. R2 stated she called the facility and spoke with V19 (RN/Registered Nurse) who transferred her call to her nurse's station, and no one answered. R2 stated no one answered the phone so she called again and V19 transferred her call again. R2 stated she started calling around 12:00 AM and it was 1:30 AM before they got assistance. R2 stated they only had one CNA working on her hall. 2. R3's Admission Record with a print date of 3/6/25 documents R3 was admitted to the facility on [DATE] with diagnoses that include heart failure, cognitive communication defect, diabetes, and adult failure to thrive. R3's MDS dated [DATE] documents a BIMS score of 15, which indicates she is cognitively intact. This same MDS documents R3 requires partial to moderate assist for toilet hygiene, toilet transfer, showers, and is occasionally incontinent of bowel and bladder. R3's current Care Plan documents a Focus area of (R3) has an ADL self-care performance deficit r/t (related to) Impaired balance, Limited Mobility. Date Intimated: 10/17/2024. This Focus area includes an intervention of, Bathing/Showering: (R1) requires extensive assistance by x (times) 1 staff with showering twice a week and as necessary. CNAs to ensure that (R1) receives at least one shower per week, if two are unable to be given. (continued on next page)

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Southgate Health Care Center	900 East Ninth Street Metropolis, IL 62960

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R3's Shower Skin Assessment forms document R3 did not receive a shower on 2/28/25 and went from 2/25/25 to 3/4/25 (six days) without a shower. On 3/6/25 at 1:00 PM R3 stated she doesn't always get showers when she is supposed to. When asked if she had issues getting her call light answered on 3/4/25, R3 stated she did. R3 stated she put her call light on, and no one answered for a long time. R3 stated she yelled out and still no one answered, and her roommate (R2) was trying to get help also. R3 stated she had to go to the bathroom but did not have an incontinence episode due to the delay. On 3/5/25 at 3:44 PM, V19 (RN) stated she got a phone call from R2 on the night shift that began on 3/4/25 who asked her to get a hold of her nurse. V19 stated R2 called her twice. On 3/5/25 at 11:08 PM, V22 (CNA) stated he worked on R2 and R3's hall on the night of 3/4/25. V22 stated he answered their call light, but he was working by himself on the unit with no nurse. V22 stated his nurse was responsible for two units that night and was on the other unit from 12 AM to 2 AM. V22 stated he was trying to answer R2 and R3's call light but in the process, he had other alarms going off and knew those residents were at risk of falling and had to prioritize fall risks over toileting/incontinence care. V22 stated it may have taken 45 minutes to answer R2 and R3's call. V22 stated he felt bad for the resident. V22 stated they don't get a discount if they have to wait. On 3/6/25 at 9:58 AM, V2 (Director of Nurses) stated V1 watched the camera to determine how long it took for a staff member to answer R2 and R3's call light. V2 stated V22 was in the room from 1:33 AM to 1:56 AM. When asked if any staff entered R2 and R3's room from 12:00 AM to 1:24 AM when V2 stated V13 (LPN) entered the room, V2 stated, No. 3. R12's Admission Record with a print date of 3/6/25 documents R12 was admitted to the facility on [DATE] with diagnoses that include atrial fibrillation, dementia, and hypertension. R12's MDS dated [DATE] documents R12 has a severe cognitive impairment. This same MDS documents R12 is dependent on staff for bathing. R12's current Care Plan does not document a Focus area and/or interventions for bathing. R12's Shower Skin Assessment forms document R12 did not receive assistance with bathing from 1/25/25 to 2/5/25 (10 days) and from 2/12/22 to 2/22/25 (9 days) or from 2/26/25 to 3/6/25 (7 days). On 3/5/25 at 9:23 AM, R12 was sitting in a wheelchair in the hallway. R12 did not respond verbally when asked questions. On 3/5/25 at 2:39 PM, V12 (CNA/Certified Nursing Assistant) stated lately they have been short staffed. V12 stated they were not able to get R12's shower done on 3/5/25. On 3/5/25 at 3:04 PM, V15 (CNA) stated they were able to get one shower done today 3/5/25 but weren't able to get R12's done. 4. R14's Admission Record with a print date of 3/6/25 documents R14 was admitted to the facility on [DATE] with diagnoses that include diabetes, legal blindness, diabetes, and hypertension. R14's MDS dated [DATE] documents a BIMS score of 15, which indicates R14 is cognitively intact. This same MDS documents R14 requires supervision/touching assistance for bathing. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R14's Shower Skin Assessment forms document R14 did not receive assistance with bathing from 1/28/25 to 2/13/25 (16 days) and from 2/23/25 to 3/6/25 (11 days). On 3/5/25 at 1:30 PM, V4 (CNA) stated it depended on the day if they had enough staff to meet the needs of the residents timely. V4 stated they weren't able to get the showers done on 3/5/25. V4 stated they didn't do R14's shower. When asked why they didn't get the showers done V4 stated it was too busy with only two CNA's. On 3/5/25 at 1:39 PM, V6 (CNA) stated they didn't have enough staff to meet the needs of the residents timely. V6 stated they weren't able to the four showers done today including R14's because of staffing. On 3/5/25 at 9:15 AM, R14 was lying in bed and stated he gets showers on Wednesday and Saturdays and he got one yesterday. On 3/5/25 at 1:49 PM, V7 (Resident Assistant) stated she didn't think they had enough staff to meet the needs of the residents timely. V7 stated she didn't think showers were done as they should be. On 3/5/25 at 2:02 PM, V8 (CNA) stated sometimes they had enough staff to meet the needs of the residents timely. V8 stated when they don't have enough staff showers don't always get done. On 3/5/25 at 2:05 PM, V9 (LPN/Licensed Practical Nurse) stated they didn't have enough staff to meet the needs of the residents timely. V9 stated showers didn't always get done as they should. V9 stated they didn't have enough staff to do the showers on her unit on 3/5/25. On 3/5/25 at 3:13 PM, V18 (CNA) stated they didn't have enough staff to assist residents with bathing as they should. On 3/6/25 at 9:58 AM, V2 (Director of Nurses) stated they did have some staffing issues and she had recently hired new staff, but they hadn't started yet. V2 stated when they are short, staffed administration will work the floor. V2 stated staff can always get the basic needs met but sometimes things like showers were delayed. On 3/6/24 at 1:33 PM, V1 (Administrator) stated she hadn't had any complaints/concerns related to showers. V1 stated they had plenty of staff working on 3/5/25 to meet the needs of the residents timely and to assist with showers. V1 stated residents should be assisted with bathing twice a week but they always absolutely get showers weekly. V1 stated they have seen where someone missed a shower or where the CNAs didn't have time to give a shower because someone called in. Reviewed with V1 the R2, R3, R12, and R14's Shower Skin Assessment forms that document R2 and R3 didn't get showers from 2/7 to 2/18 and on 2/28/25, R12 didn't get a shower from 1/25 to 2/5/25, 2/12 to 2/22/25, 2/26/to 3/6/25, and R14 didn't get a shower from 1/28/25 to 2/13/25 and from 2/23/25 to 3/6/25. V1 stated she would check to see if there were any more forms. After searching for more Shower Skin Assessment forms V1 stated she was not able to locate any other reproducible evidence of more showers for R2, R3, R12, and R14. The facility Bath and Shower policy dated 1/3/24 documents, Purpose: Staff at (name of facility) will ensure all staff (sic) are offered baths/showers twice a week or as often as requested to cleanse and refresh the resident, skin assessments, and promote increased circulation

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32765 Based on interview and record review the facility failed to ensure there were sufficient staff to provide timely care and assistance to its residents. This has the potential to affect all 91 residents who currently reside at the facility. Findings Include: The facility Daily Census Report dated 3/6/25 documents 91 residents reside at the facility. 1. R2's Admission Record with a print date of 3/6/25 documents R2 was admitted to the facility on [DATE] with diagnoses that include diabetes, heart disease, and muscle weakness. R2's MDS (Minimum Data Set) dated 2/22/25 documents a BIMS (Brief Interview for Mental Status) score of 14, which indicates R2 is cognitively intact. R2's current Care Plan with a Focus area of, (R2) has an ADL (Activities of Daily Living) self-care performance deficit r/t (related to) Activity Intolerance, Impaired balance, Limited ROM (Range of Motion) Date Initiated: 10/28/2024. This Focus area include interventions of, Bathing/Showering: (R2) requires extensive assistance by x1 (times 1) staff with bathing/showering twice a week and as necessary. CNA's (Certified Nursing Assistants) to ensure that (R2) receives at least one shower per week, if the two are unable to be given. R2's Shower Skin Assessment forms document R2 did not receive a shower/bath on 2/28/25 and went from 2/25/25 to 3/4/25 (six days) without a shower. On 3/5/25 at 11:31 AM, R2 stated they don't have enough staff to meet her needs timely. R2 stated she sometimes doesn't get her showers because they are short staffed. R2 stated she didn't get on Friday 2/28/25 because they didn't have enough staff to do it. R2 stated last night (3/4/25) her and her roommate (R3) had to wait two hours to get assistance to the bathroom. R2 stated she woke up to R3 calling out for help to go to the bathroom. R2 stated R3 had her call light on. R2 stated R3 started hitting her call light on the bedside table to get the attention of staff. R2 stated she called the facility and spoke with V19 (RN/Registered Nurse) who transferred her call to her nurse's station, and no one answered. R2 stated no one answered the phone so she called again and V19 transferred her call again. R2 stated she started calling around 12:00 AM and it was 1:30 AM before they got assistance. R2 stated they only had one CNA working on her hall. 2. R3's Admission Record with a print date of 3/6/25 documents R3 was admitted to the facility on [DATE] with diagnoses that include heart failure, cognitive communication defect, diabetes, and adult failure to thrive. R3's MDS dated [DATE] documents a BIMS score of 15, which indicates she is cognitively intact. This same MDS documents R3 requires partial to moderate assist for toilet hygiene, toilet transfer, showers, and is occasionally incontinent of bowel and bladder. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R3's current Care Plan documents a Focus area of (R3) has an ADL self-care performance deficit r/t (related to) Impaired balance, Limited Mobility. Date Intimated: 10/17/2024. This Focus area includes an intervention of, Bathing/Showering: (R1) requires extensive assistance by x (times) 1 staff with showering twice a week and as necessary. CNAs to ensure that (R1) receives at least one shower per week, if two are unable to be given. R3's Shower Skin Assessment forms document R3 did not receive a shower on 2/28/25 and went from 2/25/25 to 3/4/25 (six days) without a shower. On 3/6/25 at 1:00 PM R3 stated she doesn't always get showers when she is supposed to. When asked if she had issues getting her call light answered on 3/4/25, R3 stated she did. R3 stated she put her call light on, and no one answered for a long time. R3 stated she yelled out and still no one answered, and her roommate (R2) was trying to get help also. R3 stated she had to go to the bathroom but did not have an incontinence episode due to the delay. On 3/5/25 at 3:44 PM, V19 (RN) stated she got a phone call from R2 on the night shift that began on 3/4/25 who asked her to get a hold of her nurse. V19 stated R2 called her twice. On 3/5/25 at 11:08 PM, V22 (CNA) stated he worked on R2 and R3's hall on the night of 3/4/25. V22 stated he answered their call light, but he was working by himself on the unit with no nurse. V22 stated his nurse was responsible for two units that night and was on the other unit from 12 AM to 2 AM. V22 stated he was trying to answer R2 and R3's call light but in the process, he had other alarms going off and knew those residents were at risk of falling and had to prioritize fall risks over toileting/incontinence care. V22 stated it may have taken 45 minutes to answer R2 and R3's call. V22 stated he felt bad for the resident. V22 stated they don't get a discount if they have to wait. On 3/6/25 at 9:58 AM, V2 (Director of Nurses) stated V1 watched the camera to determine how long it took for a staff member to answer R2 and R3's call light. V2 stated V22 was in the room from 1:33 AM to 1:56 AM. When asked if any staff entered R2 and R3's room from 12:00 AM to 1:24 AM when V2 stated V13 (LPN) entered the room, V2 stated, No. 3. R12's Admission Record with a print date of 3/6/25 documents R12 was admitted to the facility on [DATE] with diagnoses that include atrial fibrillation, dementia, and hypertension. R12's MDS dated [DATE] documents R12 has a severe cognitive impairment. This same MDS documents R12 is dependent on staff for bathing. R12's current Care Plan does not document a Focus area and/or interventions for bathing. R12's Shower Skin Assessment forms document R12 did not receive assistance with bathing from 1/25/25 to 2/5/25 (10 days) and from 2/12/22 to 2/22/25 (9 days) or from 2/26/25 to 3/6/25 (7 days). On 3/5/25 at 9:23 AM, R12 was sitting in a wheelchair in the hallway. R12 did not respond verbally when asked questions. On 3/5/25 at 2:39 PM, V12 (CNA/Certified Nursing Assistant) stated lately they have been short staffed. V12 stated they were not able to get R12's shower done on 3/5/25. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/6/24 at 1:33 PM, V1 (Administrator) stated she hadn't had any complaints/concerns related to showers. V1 stated they had plenty of staff working on 3/5/25 to meet the needs of the residents timely and to assist with showers. V1 stated residents should be assisted with bathing twice a week but they always absolutely get showers weekly. V1 stated they have seen where someone missed a shower or where the CNAs didn't have time to give a shower because someone called in. Reviewed with V1 the R2, R3, R12, and R14's Shower Skin Assessment forms that document R2 and R3 didn't get showers from 2/7 to 2/18 and on 2/28/25, R12 didn't get a shower from 1/25 to 2/5/25, 2/12 to 2/22/25, 2/26/to 3/6/25, and R14 didn't get a shower from 1/28/25 to 2/13/25 and from 2/23/25 to 3/6/25. V1 stated she would check to see if there were any more forms. After searching for more Shower Skin Assessment forms V1 stated she was not able to locate any other reproducible evidence of more showers for R2, R3, R12, and R14. The undated Facility Assessment documents, .A staffing plan will be developed for each nurse's station to provide adequate staffing based on the number and acuity level of the resident's served by each nurse's station .The specific needs of the residents will determine how to calculate and staff by each nurse's station