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	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43088 Based on observation, interview, and record review the facility failed to assess a resident's skin on admission for 1 of 5 residents (R4) reviewed for pressure ulcers out of a sample of 39 residents. Findings include: 1. R4's face sheet documented an admission of 4/1/24 with diagnoses including: osteomyelitis, pressure ulcer of sacral region, obesity, heart failure, multiple sclerosis, urinary incontinence. R4's 4/1/24 Nursing Admission Screening/History documented no pressure ulcers on R4's right lower extremity. R4's 4/1/24 Wound - Weekly Observation Tool documented no pressure ulcers on R4's right lower extremity. R4's 4/3/24 Treatment Nurse Weekly Note documented no pressure ulcers on R4's right lower extremity. R4's 4/2/24 Braden Scale for Predicting Pressure Sore Risk documented a score of 9, indicating R4 was at very high risk of developing pressure ulcers. R4's Medication Review Report on or After Date: 4/2/24 documented a 4/2/24 order .Walking boot to Left ankle (at) all times for stabilization/ protection. (Nondisplaced impacted commuted left distal (tibia fibula) fracture prior to admission) . On 5/30/24 at 1:40 PM, V24 (Registered Nurse/ RN) stated she was working on the evening of 4/1/24 when R4 was admitted to the facility. V24 stated she assisted V19 (RN) with R4's admission. V24 stated R4 was admitted with a sacral pressure ulcer but V24 was not aware of R4 having any other wounds. V24 stated when R4 was admitted to the facility R4 had a walking boot on to the Left Lower Extremity (LLE) due to R4 having an LLE fracture. V24 stated she thought staff were not allowed to remove R4's walking boot and when doing the skin assessment R4's walking boot was not removed. (continued on next page)

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.

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/30/24 at 3:41 PM, V19 (RN) stated she completed R4's 4/1/24 admission. V19 stated on 4/1/24 R4 came to the facility status post left tibia and left fibula fracture. V19 stated R4's documentation from the previous hospital had an orthopedic recommendation for a walking boot. V19 stated she obtained an order from the facility medical director for R4 to wear the walking boot until R4's follow up with the orthopedic center. V19 stated she did not remove R4's walking boot at the time of R4's admission to the facility. V19 stated she was unaware of any staff removing R4's walking boot until R4 was transferred to the hospital on 4/4/24. On 5/31/24 at 11:41 AM, V3 (Licensed Practical Nurse/ LPN) stated she had completed R4's weekly treatment note on 4/3/24. V3 stated she did not remove R4's walking boot during her assessment. V3 stated they were not supposed to remove R4's walking boot prior to R4's 4/4/24 hospital transfer. On 5/31/24 at 11:58 AM, V2 (Director of Nursing/DON) stated she expected a full head to toe skin assessment would be completed for every resident upon admission. R4's R4's hospital record documented an admitted [DATE] through 4/9/24. During this hospitalization pressure wounds were found on R4's LLE under the CAM (Controlled Ankle Movement) walking boot. The facility's revised 4/13/23 Skin Care Management Policy/ Procedure documented in part . It shall be the policy . to provide good skin care that will prevent or improve existing pressure ulcers and skin problems . Procedure for General Skin Care . 1. All residents will be assessed for presence of and potential for pressure ulcer using the Braden Skin Assessment Scale . Procedures for Pressure Ulcers/ Wounds . 1. If a resident is admitted with or develops a pressure ulcer/ concern, an assessment shall be done by a nurse as to the stage, depth, size by measurement, drainage, odor, presence of necrotic tissue, and location. This shall be documented along with the date discovered and where the pressure ulcer developed on the pressure ulcer treatment record and a brief note entered in the nurse's notes documenting the pressure ulcer .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40666 Based on interview, observation, and record review the facility failed to assess residents for smoking safety to ensure each resident receives adequate supervision to prevent accidents for 2 of 3 residents (R44, R27) reviewed for smoking in the sample of 39. The findings include: 1. R44's Admission Record notes that R44 was admitted to the facility on [DATE]. R44's admission record documents R44's diagnoses in part as Parkinson's disease without dyskinesia, epilepsy, bipolar disorder, and encounter for palliative care. R44's MDS (Minimum Data Set) dated 4/15/24 document that R44 has a BIMS (Brief Interview of mental status) of 14 which indicates R44 is cognitively intact. R44's current care plan notes R44 is a smoker. R44's interventions listed: resident can smoke unsupervised, initiated on 10/11/21. Resident is able to smoke unsupervised and hold onto own smoking materials, initiated 10/11/21. Observe clothing and skin for signs of cigarette burns. There were no smoking assessments located in R44's Clinical Record. On 5/29/24 at 1:30am, R44 stated he does not wear an apron when he smokes and does not have supervision. 2. R27's admission record documents that R27 was admitted to the facility on [DATE]. The same admission record documents diagnoses to include chronic obstructive pulmonary disease, chronic viral hepatitis C, Fibromyalgia, polyneuropathy. R27'2 MDS dated [DATE] note that R27 has a BIMS of 15 which indicates R27 is cognitively intact. R27's current care plan notes a problem area that R27 is a smoker. R27's interventions listed are notify charge nurse if it is suspected resident has violated facility smoking policy, initiated 12/14/22. Observe clothing and skin for signs of cigarette burns, initiated 12/14/22. Resident can smoke unsupervised initiated 12/14/22. Resident smoking supplies are stored at nurses desk in medication cart initiated 12/14/22. There were no smoking assessments located in R27's Clinical Record. On 5/29/24 at 11:30am, R27 stated she has to get her cigarettes from the nurse and does not wear any kind of apron when she smokes and smokes without supervision. On 5/31/24 at 10:39am, V7 (Social Services) stated she does the smoking assessments on residents on admission and if there is a significant change, but she has not been doing them. V7 stated she is also going to start doing them quarterly. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/29/24 at 2:00pm, V3 (DON/Director of Nurses) state she cannot find any smoking assessments on either R27 or R44 upon admission or quarterly. Facility document labeled Smoking Policy/Procedure document under smoking assessments that staff will complete an initial smoking assessment on any resident who chooses to smoke, and these will be reviewed quarterly and as needed. Based upon this assessment, the facility reserves the right to determine whether a resident is safe to smoke independently or requires supervision.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43088 Based on observation, interview, and record review the facility failed to provide urinary catheter care per current standards of practice for 1 of 4 residents (R18) reviewed for urinary catheters in a sample of 39. Findings include: 1. R18's face sheet documented an admitted [DATE] with diagnoses including: hypothyroidism, aphasia, dementia, retention of urine, need for assistance with personal care, dysphagia. R18's Order Summary Report documented a 5/10/24 order for catheter care every shift and as needed. On 5/30/24 at 9:29 AM, V33 (Certified Nursing Assistant/ CNA) preformed urinary catheter care for R18. V33 removed R18's incontinence brief which was soiled with feces. V33 cleaned feces from R18's scrotum and groin folds from front to back with wipes. V33 assisted R18 to turn in the bed and cleaned the feces from R18's gluteal cleft from front to back with wipes and removed R18's soiled incontinence brief. Without changing gloves or performing hand hygiene, V33 used a wipe to clean R18's penis with strokes away from R18's body. V33 pinched R18's urinary catheter tubing at R18's urinary meatus and used a wipe to clean the catheter tubing away from R18's body. V33 changed gloves but did not perform hand hygiene and assisted R18 to position in bed. V33 then picked up R18's package of wipes and placed them in R18's bedside table. V33 doffed her gloves and exited the room without performing hand hygiene. On 5/31/24 at 11:58 AM, V2 (Director of Nursing/ DON) stated she expected staff to perform catheter care with aseptic techniques and practice good hand hygiene per the facility policy to prevent infections. The facility's revised 1/3/24 Catheter Care policy documented in part . Staff . will follow proper procedures for urinary catheter care once per shift to reduce or prevent urinary tract infections related to indwelling urinary catheters . Procedures: Note: Handwashing remains the single most important step in preventing the spread of infection . 2. Position resident . 3. Put on gloves. 4. Wash perineum will with soap and warm water or wipes, making sure to was (sic) from front to back. a. Note: Do not contaminate area with feces. If a resident has had an involuntary bowel movement, clean this area first. Wash your hands and obtain clean equipment for catheter care. 5. Cleanse area well at catheter insertion . 6. All debris must be removed from the catheter at the insertion site . 7. If using soap and water, rinse the area will with warm water and pat dry gently with clean towel .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43088 Based on observation, interview, and record review the facility failed to administer medication in the form recommended by the pharmacy for 1 of 12 residents (R20) reviewed for medication administration in a sample of 39. Findings include: 1. R20's face sheet documented an admitted [DATE] with diagnoses including: unspecified dementia, hypothyroidism, major depressive disorder, essential (primary) hypertension. R20's 5/31/24 Order Summary Report documented a 6/12/23 order for nifedipine ER (Extended Release) oral tablet extended release 24-hour 30 mg (milligram) give 1 tablet by mouth one time a day related to essential (primary) hypertension. On 5/28/24 at 12:11 PM, V21 (Licensed Practical Nurse/ LPN) was administering R20's medications. V21 placed R20's nifedipine ER tablet in a medication crushing bag and crushed R20 nifedipine ER tablet. V21 placed R20's crushed nifedipine ER in applesauce and administered R20's nifedipine. On 5/31/24 at 3:12 PM, V2 (Director of Nursing/ DON) stated she expected staff would not crush an extended release medication per the pharmacy's recommendations. The facility's revised 3/19/24 General Medication Administration policy documented in part . 10. Only crush medications as ordered . Consult a pharmacist before crushing medications if unsure. Some medications that are never to be crushed include: b. Sustained or extended-release tablets . https://www.mayoclinic.org/drugs-supplements/nifedipine-oral-route/proper-use/drg-20071680 documented in part .Nifedipine (Oral Route) .Swallow the extended-release tablet whole. Do not break, crush, or chew it .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43088 Based on observation, interview, and record review the facility failed to accurately label resident's insulin and eye drops with date of opening and failed to maintain security of controlled medications for 4 of 12 residents (R16, R24, R62, and R64) reviewed for medication labeling and storage in a sample of 39. Findings including: 1. R16's face sheet documented an admitted [DATE] with diagnoses including: aphasia, muscle weakness, other symbolic dysfunctions, history of falling. R16's Order Summary Report documented a [DATE] order for basaglar kwikpen subcutaneous solution inject 7 units subcutaneously one time a day. On [DATE] at 12:22 PM, R16's basaglar kwikpen was in the medication cart with the seal broken and was not dated with an open date. V21 (Licensed Practical Nurse/ LPN) verified R16's basaglar kwikpen did not have an open date was not sure when it was opened. V21 stated R16's undated basaglar kwikpen would be disposed of and a new one would be obtained per the facility policy. 2. R24's face sheet documented an admitted [DATE] with diagnoses including: osteomyelitis, intestinal malabsorption, difficulty in walking, hypertension. R24's Order Summary Report documented an [DATE] order for olopatadine hydrochloride (HCL) ophthalmic solution 0.1% install one drop to both eyes two times a day. On [DATE] at 12:22 PM, R24's patanol (olopatadine) 5 ml (milliliter) 0.1 % solution eye drops were in the medication cart with the seal broken and did not have an open date. V21 (LPN) verified R24's patanol eye drops were open and did not have an open date. V21 stated she would dispose of R24's patanol eye drops and a new bottle would be obtained per the facility policy. 3. R62's face sheet documented an admitted [DATE] with diagnoses including: cerebral infarction, peripheral vascular disease, hyperlipidemia, hypertension. R62's Order Summary Sheet documented a [DATE] order for basaglar kiwikpen subcutaneous solution inject 30 unit subcutaneously at bedtime. On [DATE] at 12:22 PM, R62's basaglar kwikpen was in the medication cart with the seal broken and was not dated with an open date. V21 (LPN) verified R62's basaglar kwikpen did not have an open date was not sure when it was opened. V21 stated R62's undated basaglar kwikpen would be disposed of and a new one would be obtained per the facility policy. 4. R64's face sheet documented an admitted [DATE] with diagnoses including: type 2 diabetes, atherosclerotic heart disease, anxiety disorder, aphasia, hypertension. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R64's Order Summary Report documented a [DATE] order for Humulin R injectable solution inject per sliding scale subcutaneously before meals. On [DATE] at 12:22 PM, R64's Humulin R insulin was in the medication cart with an open date of [DATE]. V21 (LPN) verified R64's Humulin R insulin vial had an open date of [DATE]. V21 stated R64's Humulin R insulin vial should have been disposed of 30 days after opening. V21 verified R64 did not have another open vial of Humulin R in the medication cart. V21 stated she would dispose of R64's outdated Humulin R insulin vial and a new one would be obtained per the facility policy. On [DATE] at 12:41 PM, V2 (Director of Nursing/ DON) verified R64's Humulin R insulin vial was dated [DATE]. On [DATE] at 11:58 AM, V2 stated she expected staff to date any medication when it is opened due to the time frames of expiration after opening. V2 stated insulin pens expire in 28 days after opening, Humulin R expires 30 days after opening, and any eye drop should be dated but was unsure when they would expire. V2 stated she expected staff to dispose of any open medication without an open date and obtain new medications from the pharmacy. V2 stated all of the doses of Humulin R R64 received after [DATE] would have been given from the expired Humulin R vial because no other Humulin R vial was in the medication cart. R64's [DATE] - [DATE] Medication Administration Record documented R64 received Humulin R insulin subcutaneously on [DATE], 11, 12, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, and 27 of 2024. 5. On [DATE] at 1:05 PM, a medication storage room was toured, and an unlocked refrigerator was found to have an unlocked emergency medication box containing 2 vials of injectable Ativan and 2 bottles of Ativan oral suspension. V4 (LPN) stated she was not aware there was any Ativan stored in the refrigerator. V4 took the emergency medication box containing the injectable Ativan and Ativan oral suspension to V2 (Director of Nursing/ DON) for direction on what to do. On [DATE] at 1:13 PM, V2 (DON) stated she was not aware there was Ativan in the medication storage room refrigerator. V2 stated she was not sure why the pharmacy had sent the facility Ativan oral suspension because the facility was not able to measure it and the facility did not accept it. V2 stated all narcotic medications were to be kept in the narcotic emergency medication kit in a specific medication cart behind two locks. The facility's revised [DATE] General Medication Administration policy documented in part . 22. Record date a bottle of container is opened on the label . 25. 2 nurses must sign the accounting for all narcotics at each change of shift . The facility's [DATE] Medication Storage policy documented in part . 2. Controlled medications must be stored in a manner to limit access and to facilitate reconciliation in accordance with the facility policies. a. Narcotics must always be stored under a double locking system; They must be kept in the locked box in the unit's locked medication room or in the locked drawer in the locked medication cart. b. Only the Unit Nurse, Charge Nurse, and the Shift Supervisor may have keys to the narcotic drawers . ii. Medications will be monitored by the Unit Nurse, Charge Nurse, and consultant pharmacist to assure that they are not expired, contaminated, or unusable .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43088 Based on observation, interview, and record review the facility failed to provide wound care per current standards of practice for 3 of 5 residents (R4, R6, and R55) reviewed for pressure ulcers out of a sample of 39 residents. Findings include: 1. R4's face sheet documented an admission of 4/1/24 with diagnoses including: osteomyelitis, pressure ulcer of sacral region, obesity, heart failure, multiple sclerosis, urinary incontinence. R4's Order Summary Report documented the following orders: 5/22/24 Pressure area to Left Medial Ankle with n/s, apply Santyl Ointment to wound bed cover with Adaptic and cover with dry gauze and cover loosely with roll gauze drsg (dressing). Change daily and as needed. 5/22/24 Pressure to Left Medial Calcaneus (Heel), cleanse with n/s, apply Santyl Ointment to wound bed, apply Adaptic and then apply dry gauze and cover loosely with roll gauze drsg. Change daily and as needed. 5/22/24 Pressure to Left Medial Foot, cleanse with n/s apply Santyl to wound bed, apply Adaptic and cover dry gauze and cover loosely with roll gauze. Change daily and as needed. 5/30/24 Pressure wound to Left Lateral, Inferior Ankle, cleanse with n/s, apply Betadine to wound, cover with dry gauze/Roll gauze drsg. Change daily and as needed. 5/30/24 Pressure area to Left Lateral Ankle, cleanse with n/s (normal saline), apply Santyl Ointment to wound bed apply Adaptic then cover with dry gauze and cover loosely with roll gauze. Change twice a day and as needed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/30/24 at 1:40 PM, V3 (Licensed Practical Nurse/ LPN) preformed wound care for R4. V3 donned gloves and removed R4's pressure relieving boot and used a pair of bandage scissors to cut off R4's left foot bandage. V3 removed R4's gauze and adaptic from R4's left foot and ankle wounds. V3 changed gloves without performing hand hygiene. V3 cleaned R4's left medial foot wound with normal saline and gauze, then cleaned R4's left medial inferior ankle wound with normal saline and gauze, then cleaned R4's left lateral ankle wound with normal saline and gauze, then cleaned R4's left medial calcaneus with normal saline and gauze. V3 changed her gloves but failed to perform hand hygiene. V3 applied betadine to R4's left lateral inferior ankle wound. V3 used an applicator to apply santyl ointment for R4's left lateral ankle wound, then used a new applicator to apply santyl ointment to R4's left medial ankle wound, then used a new applicator to apply santyl to R4's left medial calcaneus wound, then used a new applicator to apply santyl ointment to R4's left medial foot wound. V3 changed her gloves without performing hand hygiene. V3 used the bandage scissors (previously used to cut off R4's left foot bandage) without sanitizing them to cut adaptic into smaller pieces to fit over R4's wounds. V3 placed adaptic and gauze over all of R4's left foot and ankle wounds. V3 changed her gloves without performing hand hygiene. V3 wrapped R4's left ankle and foot with kerlix gauze and used the bandage scissors again without sanitizing them to cut the extra kerlix and secured the dressing with tape. V3 changed her gloves without performing hand hygiene. V3 assisted R4 with positioning in bed and then placed the bandage scissors without sanitizing them into her pocket. V3 doffed for gloves without performing hand hygiene and exited R4's room. On 5/31/24 at 11:58 AM, V2 (Director of Nursing/ DON) stated she expected staff to perform wound care with clean aseptic techniques and practice good hand hygiene per the facility policy to prevent infections. 49664 2. R55's Admission Record documents an admitted [DATE]. The document contains diagnoses list which include Age related osteoporosis, pathological fractures of the right clavicle (shoulder), right radius, and thoracic vertebra, complete rotator cuff tear, vascular dementia, dysphagia, hypothyroidism, major depressive disorder, hyperlipidemia, emphysema. R55's MDS (Minimum Data Set) dated 5/26/2024 section GG documents R55 is dependent on staff for total care for all Activities of Daily Living and R55 is incontinent of bowel and bladder. Document titled Non-Pressure Wound Data Tracking Log dated 5/27/2024 documents R55 site #1 right hip, Status: New 5/27/2024, Acquired: NF (In Facility), Measurements: 1.0cm Length, 1.0cm Width, 0.2cm Depth, Drainage: scant amount of blood, Wound Type: [NAME] Ulcer. Site #2 Coccyx, Status: New 5/27/2024, Acquired: NF (In Facility) Measurements: 3.0cm Length, 2.0cm Width, 0 Depth, no drainage noted, Wound Type: [NAME] Ulcer. POS (Physician Order Sheet) contains orders for wound care for sites #1 and #2 as: Cleanse with Normal Saline, pat dry and apply Polymem dressing, check daily and change every 7 days and PRN (as needed). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/30/2024 at 2:20pm observation of dressing change for R55 was performed by V3 (LPN). Dressing supplies were set up on bedside table with appropriate barrier placed, hand hygiene was completed before set up of supplies, gloves were applied and used to remove dressing from right hip, dirty dressing and gloves were disposed , no hand hygiene was done before applying a new pair of gloves, area to right hip was cleaned with normal saline, patted dry, and applied Polymem dressing and secured with medical tape. Gloves were disposed and new gloves applied without hand hygiene before starting the removal of Site #2 dressing. R55 was noted to be incontinent of bowel, pericare was performed. V3 washed hands with soap and water and began dressing change to Site #2. Gloves were applied and removal of old dressing was done, dressing and gloves were disposed. New gloves were applied without hand hygiene. Site #2 was cleaned with Normal Saline, patted dry and applied Polymem dressing securing with medical tape. 40666 3. R6's Admission record documents that R6 was admitted to the facility on [DATE]. The same admission record notes some of R6's diagnoses as Multiple Sclerosis, Essential (primary) hypertension, Type 2 diabetes mellitus, major depressive disorder. R6's facility document labeled order summary report active orders as of 5/31/24 note the following orders for wound care: Contact isolation r/t (related to) MRSA (Methicillin-resistant Staphylococcus aureus)/Proteus Mirabillis on buttock wounds, cleanse stage 4 left gluteal fold wound with normal saline, apply medi-honey to wound bed and cover with dry gauze dressing and change daily and prn(as needed), cleanse stage 4 ulcer to right gluteal fold with normal saline, apply medi-honey to wound bed and cover with dry gauze dressing change daily and prn, cleanse US(unstageable)/Kennedy ulcer area to right heel with normal saline, apply medi-honey to wound bed and cover with gauze dressing and change daily and prn, cleanse DTI (Deep tissue injury)/Kennedy ulcer to left calf with normal saline, apply medi-honey to wound bed and cover with dry gauze dressing, change daily and prn, DTI/Kennedy ulcer to right heel apply skin prep every shift for wound healing/protection. On 5/30/24 at 11:15am, Observations were made of V3 (LPN/Licensed Practical Nurse) performing R6's wound care. V3 had R6's dressing supplies in a paper tray when brought to the bedside. V3 did not have a barrier to put under the supplies. V3 donned her gloves and proceeded to cleanse the wounds on R6's buttocks. V3 cleansed the area on R6's right buttock and applied the medihoney to the wound using a cotton swab. V3 then threw cotton swab in the trash and applied adhesive dressing without changing her gloves. After applying the occlusive dressing, V3 did not change her gloves, pushed trash in the bag down, then proceeded to the dressing on R6's left lower extremity. V3 did not change her gloves, proceeded to use the same scissors to cut the gauze dressing off. V3 did not change her gloves to perform the dressing change and then using the same scissors, cut the gauze dressing off of the left lower extremity. V3 then performed the dressing change to the left lower extremity. V3 put the scissors on top of the box of supplies in R6's room. V3 did not use hand sanitizer between any of the glove changes. On 5/30/24 at 11:50am, V3 stated she was so nervous, she knew she didn't change her gloves like she should have. On 5/31/24 at 12:30pm, V2 (DON/Director of Nurses) stated that V3 knew better than that and that V3 was very nervous with surveyor watching. (continued on next page)

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	145386	A. Building B. Wing	05/31/2024

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Document titled Skin Care Management Policy/Procedure dated reviewed/revised 4/13/2022 reviewed. Policy statement states It shall be the policy of (Facility Name) to provide good skin care that will prevent or improve existing pressure ulcers and skin problems. Section titled Procedures For Pressure Ulcer/Wounds , #7 documents Clean technique using good hand washing, or hand sanitizer (when appropriate), and wearing clean exam gloves shall be utilized when giving pressure ulcer/wound care unless physician specifically orders sterile technique. Staff should use barrier/trays for all dressing supplies when taking them into resident rooms.

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41610 Based on interview and record review, the facility failed to: 1.) offer pneumococcal vaccinations for 2 of 5 residents (R18 and R12) reviewed for immunization in a sample of 39; and 2.) update the facility's Pneumonia Vaccine policy and to include Vaccination Timing for Adults following the most recent recommendations from the Centers for Disease Control and Prevention (CDC). This has the potential to affect any residents eligible to receive the Pneumococcal vaccines. Findings include: 1. R18's Face Sheet documents a birthdate indicating that R18 is [AGE] years of age and documents an admitted [DATE]. R18's Face Sheet documents diagnoses including major depressive disorder, hypothyroidism, essential hypertension, dementia, pancytopenia, and alcoholic cirrhosis of liver without ascites. R18's Immunization Report with a date range of 05/01/15 - 05/31/24 documents that R18 received Prevnar 13 vaccination (Pneumococcal 13-Valent Conjugate/PCV13) on 08/08/17. R18's Immunization Report does not document any other pneumococcal vaccinations being administered or refused including Prevnar 20 (Pneumococcal 20-Valent Conjugate/ PCV20). 2. R12's Face sheet documents a birthdate indicating that R12 is [AGE] years of age with an admitted [DATE]. R12's Face Sheet documents diagnoses including hypothyroidism, major depressive disorder, hemiplegia, and hemiparesis, Meniere's disease, essential hypertension, and chronic embolism and thrombosis. R12's Immunization Report with a date range of 05/01/2020 - 05/31/24 documents, Not eligible for Pneumovax dose 1 and Prevnar. R12's Immunization Report does not document any administration or refusal for Prevnar 20. R12's untitled previous health record documents a Prevnar 13 (PCV 13) vaccination was administered on 9/24/18. R12's Immunization Report does not document any pneumococcal vaccinations being administered or refused. The Centers for Disease Control website (https://www.cdc.gov/vaccines/vpd/pneumo/hcp/who-when-to-vaccinate.html) documents that adults age [AGE] years or older and do not have an immunocompromising condition, cochlear implant, or cerebrospinal fluid leak, and have only received PCV13 to give 1 dose of PCV20 or PPSV23 (Pneumococcal Polysaccharide Vaccine) at least 1 year after PCV13. Regardless of vaccine used, their vaccines are then complete. On 05/30/24 at 11:17 AM, V20 (Infection Preventionist/Licensed Practical Nurse) stated, they have not offered the Prevnar 15 or the Prevnar 20 for pneumococcal vaccines to her knowledge. On 05/31/24 at 2:45 PM, V2 (Director of Nursing) stated, the facility has not offered the Prevnar 15 or 20 to the residents yet. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy dated, 10/01/21 titled, Pneumonia Vaccine - Pneumococcal Immunization - PPV (Pneumococcal Polysaccharide Vaccine) documents in part: 1. PPV should be administered to all residents in the facility unless it is contraindicated or refused. Step 10b. documents The Infection Control Nurse will: Stay current with information from the CDC on immunizations. The Pneumonia Vaccination policy did not include the most recent CDC recommendations for administering the series of Pneumococcal vaccines. On 5/30/24. According to https://www.cdc.gov/vaccines/vpd/pneumo/index.html, the following recommendations are documented for adults is recommended: CDC recommends PCV15 or PCV20 for adults who never received a PCV and are: Ages [AGE] years or older Ages 19 through [AGE] years old with certain risk conditions If PCV15 is used, it should be followed by a dose of PPSV23. Adults who received an earlier PCV (PCV7 or PCV13) should talk with a vaccine provider. The provider can explain available options to complete the pneumococcal vaccine series. Adults [AGE] years or older have the option to get PCV20 if they have already received: PCV13 (but not PCV15 or PCV20) at any age AND PPSV23 at or after the age of [AGE] years old These adults can talk with a vaccine provider and decide, together, whether to get PCV20. PPSV23 at or after the age of [AGE] years old These adults can talk with a vaccine provider and decide, together, whether to get PCV20.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41610 Based on interview and record review, the facility failed to administer the updated (2023-2024 Formula) COVID-19 vaccine to 3 of 5 residents (R18, R67 and R36) reviewed for immunizations in a sample of 39. Findings include: 1. R18's Face Sheet documents a birthdate indicating that R18 is [AGE] years of age and documents an admitted [DATE]. R18's Face Sheet documents diagnoses including: Major Depressive Disorder, Hypothyroidism, Essential Hypertension, Dementia, Pancytopenia, and Alcoholic Cirrhosis of Liver without Ascites. R18's Immunization Report with a date range of 05/01/15 - 05/31/24 documents: R18 was administered the COVID-19 vaccine on the following dates: 01/12/21, 02/02/21, 11/02/21 and 06/08/22. There is no order in R18's medical record for the updated (2023-2024 Formula) COVID-19 vaccine or documentation that it was administered. 2. R36's Face Sheet documents and admitted [DATE] and a date of birth indicating R36 is [AGE] years of age. R36's Face Sheet documents diagnoses including: emphysema, atherosclerotic heart disease, chronic obstructive pulmonary disease, and essential hypertension. R36's Immunization Report has no documentation for Covid-19 vaccinations. There is no order in R36's medical record for the updated (2023-2024 Formula) COVID-19 vaccine or documentation that it was administered. 3. R67's Face Sheet documents an admitted [DATE] and a date of birth indicating that R67 is [AGE] years of age. R67's Face Sheet documents diagnoses including: major depressive disorder, atrial fibrillation, benign prostatic hyperplasia, atherosclerotic heart disease, hyperlipidemia, and dementia. R67's Immunization Report has no documentation for Covid-19 vaccinations. There is no order in R67's medical record for the updated (2023-2024 Formula) COVID-19 vaccine or documentation that it was administered. On 05/29/24 at 2:45 PM, V20 (Infection Preventionist/Licensed Practical Nurse) stated, she does not have any consent or refusal documentation for the updated 2023-2024 Formula of the Covid-19 vaccination for R18, R67 or R36. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/30/24 at 1:15 PM, V2 (Director of Nursing) said they had a delay with getting the COVID-19 vaccines scheduled for administration because they had been waiting on the Health Department to get the vaccinations. V2 stated, they have not given any Covid-19 vaccinations since the initiation of the use of Covid-19 vaccines. V2 stated, they do not have a policy for Covid-19 vaccinations, they utilize the CDC recommendations. The (CDC) Immunization Schedule (https://www.cdc.gov/vaccines/schedules/hcp/imz/adult.html#note-covid-19) documents adults age [AGE] years or older: Previously vaccinated with 1 or more doses of any COVID-19 vaccine: 1 dose of any updated (2023-2024 Formula) COVID-19 vaccine administered at least 8 weeks after the most recent COVID-19 vaccine dose. The CDC Use of Updated COVID-19 Vaccines 2023-2024 Formula for Persons Aged (Greater than or equal to) 6 Months (https://www.cdc.gov/mmwr/volumes/72/wr/mm7242e1.htm#suggestedcitation) documents On September 11, 2023, the Food and Drug Administration (FDA) authorized the updated (2023-2024 Formula) COVID-19 mRNA vaccines by Moderna and Pfizer-BioNTech for use in persons aged 6 months-[AGE] years under Emergency Use Authorization (EUA) and approved the updated Moderna and Pfizer-BioNTech COVID-19 vaccines for persons aged (Greater than or equal to) [AGE] years.