STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265771	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southgate Living Center	500 Truman Boulevard Caruthersville, MO 63830

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 0570 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure the security of all personal funds of residents deposited with the facility. 46555 Based on interview and record review, the facility failed to maintain the surety bond (a purchased bond for security of residents' personal funds) for at least one and one-half times the average monthly balance of the residents' personal funds for the last 12 consecutive months from February 2024 through January 2025. The facility's census was 58. Review of the facility's policy titled, Surety Bond, revised March 2021, showed: - A surety bond is an agreement between the facility, the insurance company, and the resident or the state acting on behalf of the resident, wherein the facility and the insurance company agree to compensate the resident for any loss of residents' funds that the facility holds, accounts for, safeguards, and manages; - This facility holds a surety bond to guarantee the protection of residents' funds managed by the facility on behalf of its residents; - All funds (including refundable deposits) entrusted to the facility for a resident are covered by the surety bond; - The purpose of the surety bond is to guarantee the facility will pay the residents for losses occurring from any failure by the facility to hold, account for, safeguards, and manage the residents' funds (i.e., losses occurring as a result of acts or errors of negligence, incompetence or dishonesty); - Inquiries concerning the financial security of personal funds managed by the facility should be referred to the Administrator. Review of the Residents' Personal Funds Account for the last 12 consecutive months from February 2024 through January 2025, showed: - The facility's approved bond amount equaled $99,000.00; - The average monthly balance of the residents' personal funds equaled $66,606.98; - An average monthly balance of $66,606.98 rounded to the nearest thousand equaled $67,000.00, at one and one-half times would equal the required bond amount of at least $100,500.00. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0570 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/05/25 at 11:22 A.M., the Business Office Manager said he/she had not been checking to ensure the bond was correct because he/she had never been told to do that. They had a corporate person that he/she assumed was supposed to do that. During an interview on 03/06/25 at 3:45 P.M., the Administrator and the Director of Nursing (DON) said they would expect the bond to be sufficient to cover the residents' funds.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47447 Based on observation, interview, and record review, the facility failed to develop and implement an individualized comprehensive care plan with specific interventions to meet the highest practicable physical, mental, and psychosocial well-being for two residents (Residents #15 and #30) out of 15 sampled residents. The facility's census was 58. Review of the facility's policy titled, Comprehensive Person - Centered Care Plans, revised March 2022, showed: - The care plan is person-centered and includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs; - Describes services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well being. 1. Review of Resident #15's medical record showed: - An admitted [DATE]; - Diagnosis of chronic obstructive pulmonary disease (COPD - a chronic inflammatory lung disease that causes obstructed airflow from the lungs); - An order for oxygen at three liters per minute (lpm) by nasal cannula (a device to deliver oxygen through to the nose) as needed to titrate oxygen saturation greater than 89%, dated 07/01/24; - An order for bipap (a device to assist with breathing) at bedtime for hypoxia (low oxygen), sleep apnea (compromised airway making it difficult to breathe) may place on when the oxygen saturation is low when sleeping during the day, dated 01/13/25; - An order to check the oxygen saturation every shift two times a day related to acute respiratory failure with hypoxia. If oxygen saturation is less than 93%, apply oxygen by nasal cannula, dated 04/08/24; - An order to elevate the head of bed 30-45 degrees at bedtime when sleeping for shortness of breath when lying flat related to COPD, dated 09/29/24; - An order for ipratropium-albuterol (medication used to treat COPD) nebulizer (a medical device that converts liquid medication into a fine mist) solution 3 milligram (mg)/3 milliliters (ml) to inhale orally every six hours as needed for shortness of breath and hypoxia, dated 10/22/24. The resident's care plan, undated, did not address COPD, the resident's respiratory status, or the resident's oxygen needs. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 03/03/25 at 11:30 A.M., showed the resident in his/her room with 5 lpm of oxygen per nasal cannula and a bipap at the bedside. Observations on 03/04/25 at 12:45 P.M., 03/05/25 at 9:10 A.M., and on 03/06/25 at 11:38 A.M., showed the resident in his/her room with 4 lpm of oxygen per nasal cannula and a bipap at the bedside. 2. Review of Resident #30's medical record showed: - An admitted [DATE]; - Diagnoses of hemiplegia (muscle weakness) and hemiparesis (partial paralysis) following an intracranial hemorrhage (trauma to the brain that may cause brain damage), pneumonia (an infection involving the lungs), acute respiratory failure (not breathing normal or impaired gas exchange causing issues) with hypoxia, and acute pulmonary edema (fluid in or around the lung space making it more difficult to breathe; - An order for oxygen at 2 lpm per nasal cannula as needed for shortness of breath, wheezing, congestion to keep oxygen saturation greater than 90%, dated 02/07/25. The resident's care plan, undated, did not address the resident's respiratory status and oxygen use. Observations on 03/03/25 at 10:01 A.M., 03/04/25 at 12:15 P.M., 03/05/25 at 2:55 P.M., and on 03/06/25 at 11:37 A.M., showed the resident in his/her room with oxygen on at 2 lpm per nasal cannula. During an interview on 03/06/25 at 3:45 P.M., the Minimum Data Set (MDS - a federally mandated assessment instrument completed by the facility) Coordinator and Administrator said they would expect the care plans to reflect the residents' current conditions. 49152

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. 46555 Based on interview and closed record review, the facility failed to complete a comprehensive discharge summary for one resident (Resident #59) out of two sampled closed discharge records. The facility's census was 58. Review of the facility's policy titled, Discharge Summary and Plan, revised October 2002, showed: - The discharge summary includes a recapitulation of the resident's stay at the facility and a final summary of the resident's status at the time of the discharge in accordance with established regulations governing the release of resident information and as permitted by the resident. The discharge summary shall include a description of the resident's: current diagnosis; medical history (including any history of mental disorders and intellectual disabilities); course of illness, treatment and/or therapy since entering the facility; current laboratory, radiology, consultation, and diagnostic test results; physical and mental functional status; ability to perform activities of daily living including such as bathing, dressing, grooming, transferring, ambulating, toilet use, eating, using speech, language, and other communication systems; the need for staff assistance and assistive devices or equipment to maintain or improve functional abilities; the ability to form relationships, make decisions including health care decisions, and participate (to the extent physically able) in the day-to-day activities of the facility; sensory and physical impairments (neurological, or muscular deficits; for example, a decrease in vision and hearing, paralysis, and bladder incontinence); nutritional status and requirements including weight and height; nutritional intake; eating habits, preferences and dietary restrictions; special treatments or procedures (treatments and procedures that are not part of basic services provided); mental and psychosocial status (ability to deal with life, interpersonal relationships and goals, make health care decisions, and indicators of resident behavior and mood); discharge potential (the expectation of discharging the resident from the facility within the next three months); dental condition (the condition of the teeth, gums, and other structures of the oral cavity that may affect a resident's nutritional status, communications abilities, quality of life, and the need for and use of dentures or other dental appliances); activities potential (the ability and desire to take part in activity pursuits which maintain or improve physical, mental, and psychosocial well-being); rehabilitation potential (the ability to improve independence in functional status through restorative care programs); cognitive status (the ability to problem solve, decide, remember, and be aware of and respond to safety hazards); and medication therapy (all prescription and over-the-counter medications taken by the resident including dosage, frequency of administration, and recognition of significant side effects that would be most likely to occur in the resident); - As part of the discharge summary, the nurse reconciles all pre-discharge medication with the resident's post-discharge medications. The medication reconciliation is documented; - Every resident is evaluated for his or her discharge needs and has an individualized post-discharge plan; (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The post-discharge plan is developed by the care planning/interdisciplinary team with the assistance of the resident and his/her family and includes: where the individual plans to reside; arrangements that have been made for follow-up care and services; a description of the resident's stated discharge goals; the degree of caregiver/support person availability, capacity and capability to perform required care; how the interdisciplinary team will support the resident or representative in the transition to post-discharge care; what factors may make the resident vulnerable to preventable readmission; and how those factors will be addressed; - The discharge plan is re-evaluated based on changes in the resident's condition or needs prior to discharge; - The resident/representative is involved in the post-discharge planning process and informed of the final post-discharge plan; - Residents are asked about their interest in returning to the community. If the resident indicates an interest in returning to the community, he/she will be referred to local agencies and support services that can assist in accommodating the resident's post-discharge preferences; - If it is determined that returning to the community is not feasible, it will be documented why this is the case and who made the determination; - Residents transferring to another skilled nursing facility or who are discharged to a home health agency, long-term care hospital or inpatient rehabilitation facility are assisted in selecting a post-acute care provider that is relevant and applicable to the resident's goals of care and treatment preferences. 1. Review of Resident #59's medical record showed: - Resident discharged to the community on 01/23/25; - No documentation of the recapitulation/discharge summary of the resident's stay. During an interview on 03/05/25 at 3:40 P.M., the Social Services Director (SSD) said a recapitulation of the resident's stay was not completed. During an interview on 03/06/25 at 3:45 P.M., the Administrator and Director of Nursing (DON) said they would expect a recapitulation of a resident's stay to be completed when a resident was discharged from the facility.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 49152 Based on observation, interview, and record review, facility staff failed to provide activities of daily living (ADL's) when staff failed to provide assistance with eating for one resident (Resident #15) of three sampled residents, who was assisted with meals by another resident (Resident #21). The facility census was 58. Review of the facility policy titled, Activities of Daily Living, Supporting, dated March 2018, showed: - Residents will be provided with care, treatment and services to ensure their ADL's do not diminish unless the circumstances of their clinical condition(s) demonstrate that diminishing ADL's are unavoidable; - Residents who are unable to carry out ADL's independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene; - Appropriate care and services will be provided for residents who are unable to carry out ADL's independently, with the consent of the resident and in accordance with the plan of care; - A resident's ability to perform ADL's will be measured using clinical tools, including the Minimum Data Set (Minimum Data Set (MDS - a federally mandated assessment instrument completed by the facility). Functional decline or improvement will be evaluated in reference to the assessment reference date (ARD). 1. Review of Resident #15's medical record showed: - An admitted [DATE]; - Diagnoses of Chronic Obstructive Pulmonary Disease (COPD - a chronic inflammatory lung disease that causes obstructed airflow from the lungs), diabetes mellitus (DM - abnormal blood sugar) , genetic torsion dystonia (causes shaking or tremors), unspecified dementia (a disorder marked by memory loss, personality changes, and impaired reasoning that interferes with daily functioning), major depressive disorder (long-term loss of pleasure or interest in life), and morbid obesity (excess body fat); - An order for controlled carb diet with regular texture and regular/thin consistency, order start date 06/03/24. Review of the resident's Care Plan, undated, showed: - The resident experienced tremors of hands and made it difficult at times to complete ADL's or participate in activities; - Interventions of assisting as needed and administering Parkinson's (disorder of the nervous system affecting movements and causing tremors) medications as ordered. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's annual MDS, a federally mandated assessment instrument completed by the facility staff, dated 01/17/25, showed: -Section GG showed no impairment of upper or lower extremities, supervision or touching assistance with eating; -Section V showed care area triggered for ADL functional/rehabilitation potential and nutrition status. Observation of on 03/04/25 at 12:35 P.M., showed the resident sat up in bed with a tray table over his/her lap attempting to eat meatloaf with a regular spoon in his/her right hand. The resident's plate had a small amount of meatloaf left. The spinach and mashed potatoes were not touched. The resident's shirt had a large amount of the meatloaf on the front of it. The resident said his/her roommate was not available today to help feed him/her. The resident had a Sip-A-Mug (a specialty cup with a lid) on the tray table next to his/her tray. Resident #15 asked for assistance with his/her meal multiple times during the observation. Observation on 03/05/25 at 12:45 P.M., showed Resident #21 stood beside Resident #15 as he/she sat up in bed. Resident #21 cut up and fed Resident #15 a chili dog. During an interview on 03/03/25 at 11:50 A.M., Resident #21 said he/she helped feed Resident #15 all the time. Resident #15 needed help eating meals because of his/her shaking. Resident #21 said he/she was aware he/she was not supposed to feed Resident #15, but none of the staff would help him/her, and Resident #15 needed to eat. Resident #21 said he/she has had to assist Resident #15 since they had become roommates, which had been months now. During an interview on 03/03/25 at 11:52 A.M., Resident #15 said he/she needed help eating because he/she can't do it himself/herself. He/She can't cut up his/her food and was difficult to eat most things due to his/her shaking. Staff hardly assisted him/her with feeding and he/she did not have any special utensils for eating. Most meals were brought to his/her room to eat. During an interview on 03/05/25 at 12:51 P.M., the Dietary Manager said he/she was not aware Resident #15 needed assistance or had difficulty eating. The resident did shake sometimes but did not have any difficulty eating as far as he/she knew. During an interview on 03/06/25 at 8:19 A.M., Certified Nurse Assistant (CNA) L said Resident #15 received assistance with eating each meal due to his/her shaking. The resident had a normal spoon but a special cup to drink from that the resident had requested. The resident would probably do better if he/she had a built-up spoon to use. CNA L said Resident #21 tries to feed Resident #15 sometimes and take care of Resident #15 and had informed Resident #21 that it is not ok to feed Resident #15. During an interview on 03/06/25 at 9:02 A.M., Occupational Therapist (OT) M said the resident was screened in the past and did not need any assistive devices or have difficulty eating even though the resident shook some. When the resident became upset, then his/her shaking worsened. He/She monitored the weight loss list and watched eating in the dining room at least once a month to see what residents might need to be evaluated. Resident #15 had not really lost weight and mostly ate in his/her room. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/06/25 at 1:48 P.M., Licensed Practical Nurse (LPN) K said therapy had assessed the resident before and he/she did not need assistive devices. The specialty cup the resident had was something the resident wanted on his/her own because another resident had one. If the resident did need help eating, then staff could provide the assistance. Other residents were not supposed to feed other residents and was aware Resident #21 had tried to feed and fed Resident #15. When that happens, staff try to redirect the residents and explain why that was not acceptable. During an interview on 03/06/25 at 3:45 P.M., the Director of Nursing (DON) and the Administrator said they would expect residents who need assistance to eat or perform ADL's to be given that assistance by staff. They assess the residents need for assistance at least quarterly, with significant change, or as needed in order to meet or maintain the residents' needs. Residents were not allowed to feed other residents, were aware Resident #21 feeds Resident #15, and had told the residents not to feed each other and if they need help to just ask and staff will assist.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47447 Based on interview and record review, the facility failed to follow physician's orders for one resident (Resident #4) out of two sampled residents with wounds. The facility census was 58. The facility did not provide a policy regarding following physician orders. 1. Review of Resident #4's medical record showed: - admitted on [DATE]; - Diagnoses of post-traumatic stress syndrome (PTSD - psychological distress following a traumatic event), generalized anxiety disorder (persistent worry and fear about everyday situations), major depressive disorder (long-term loss of pleasure or interest in life), chronic obstructive pulmonary disorder (COPD - a chronic inflammatory lung disease that causes obstructed airflow from the lungs), right above the knee amputation, and hypertension (high blood pressure). Review of the resident's wound care showed: - An order for the right stump to cleanse with wound cleanser, pat dry, cover with a band aid. Change daily and as needed, dated 10/11/24, and discontinued on 12/04/24; - An order for the right stump to cleanse with wound cleanser, pat dry, apply calcium alginate (a type of wound treatment), and cover with a band aid. Change daily and as needed, every day shift, dated 12/05/24, and discontinued on 12/18/24; - An order for the right stump to cleanse with wound cleanser, pat dry, pack the open area daily with Iodoform (a type of wound treatment), apply a 4x4 bandage, apply ABD (a type of dressing), and wrap with Kerlix (a type of dressing) every day shift, dated 12/19/24, and discontinued on 01/22/25; - An order for the right stump to cleanse the with wound cleanser, pat dry, apply adapact (a type of treatment) and a foam dressing daily and as needed, every day shift, dated 01/22/25, and discontinued on 02/13/25; - An order to cleanse the right stump with wound cleanser/normal saline, pat dry, 1/2 inch Iodoform gauze, 4x4, and ABD daily, one time a day for the wound, dated 02/14/25; - November 2024 Treatment Administration Record (TAR) with no treatments completed on 11/02/24, 11/03/24, 11/04/24, 11/16/24 and 11/24/24, with five missed opportunities out of 30 opportunities; - December 2024 TAR with no treatments completed on 12/02/24, 12/03/24, 12/04/24, 12/18/24, 12/22/24, and 12/25/24, with six missed opportunities out of 31 opportunities; - January 2025 TAR with no treatments completed on 01/04/25, 01/16/25, 01/18/25, 01/28/25 and 01/31/25, with five missed opportunities out of 31 opportunities; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- February 2025 TAR with no treatments completed on 02/03/25, 02/04/25, 02/14/25, 02/19/25, 02/21/25, 02/23/25, and 02/26/25, with seven missed opportunities out of 28 opportunities. During an interview on 03/03/25 at 12:15 P.M., Resident #4 said his/her wound care wasn't done at times. During an interview on 03/06/25 at 1:56 P.M., Licensed Practical Nurse (LPN) K said Resident #4's wound dressing was supposed to be changed every day and didn't know it had not been done. During an interview on 03/06/25 at 3:47 P.M., the Administrator and Director of Nursing (DON) said they expected wound care and dressing changes to be completed as ordered.

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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 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. 47447 Based on interview and record review, the facility failed to ensure three nurse aides (NAs) (NA B, NA C, and NA D) completed a nurse aide training program within four months of his/her employment at the facility. The facility's census was 58. Review of the facility's policy titled, Nurse Aide Qualification and Training Requirements, revised August 2022, showed: -The facility will not employ any individual as a nurse aide for more than four months full-time, temporary, per diem, or otherwise unless: that individual is competent to provide designated nursing care and nursing related services; and that individual has completed a training program and competency evaluation program, or a competency evaluation program approved by the state; or that individual has been deemed competent as provided in 483.150 9 (a) and (b) of the requirements of participation; - Nursing Assistants failing to successfully complete the required training program within the first four months of their date of employment may be terminated from employment or may be reassigned to non-nursing related services. 1. Review of NA B's personnel file showed: - A hire date of 07/24/24; - NA B completed the nurse aide program, but did not test; - The facility failed to ensure the completion of the program within four months of the hire date. 2. Review of NA C's personnel file showed: - A hire date of 05/29/24; - NA C completed the nurse aide program, but did not test; - The facility failed to ensure the completion of the program within four months of the hire date. 3. Review of NA D's personnel file showed: - A hire date of 05/01/24; - NA D completed the nurse aide program, but did not test; - The facility failed to ensure the completion of the program within four months of the hire date. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265771	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southgate Living Center	500 Truman Boulevard Caruthersville, MO 63830

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 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/06/25 at 10:00 A.M., the Director of Nursing (DON) said NA B, NA C, and NA D had completed the nurse aide training, but had not tested yet. All three were working in the nurse aide positions. The DON did not know why the NAs had not tested in a timely manner. During an interview on 03/06/25 at 3:45 P.M., the Administrator said she expected NA's to be certified within four months of hire.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265771	A. Building B. Wing	03/06/2025

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 49152 Based on observation, interview, and record review, the facility failed to ensure drugs and biologicals were labeled and stored in accordance with currently accepted practices. This had the potential to affect all residents. The facility census was 58. Review of the facility policy titled, Medication Labeling and Storage, revised February 2023, showed: - If the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items; - The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner; - Medications are stored separately from food and are labeled accordingly; - Labeling of medications and biologicals dispensed by the pharmacy is consistent with applicable federal and state requirements and currently accepted pharmaceutical practices. The medication label includes, at a minimum the medication name, prescribed dose, strength, expiration date, when applicable, resident's name, route of administration, and appropriate instructions and precautions; - For over the counter (OTC) medications in bulk containers (if permitted by state law) the label contains the medication name, strength, quantity, accessory instructions, lot number, and expiration date (if applicable); - Multi-dose vials that have been opened or accessed (e.g., needle punctured) are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial. Review of the Insulin Aspart Manufacturer's Instructions showed: - Keep at room temperature or refrigerated for up to 28 days; - Dispose after 28 days, even if there is insulin left in the vial. 1. Observation on 03/05/25 at 3:20 P.M., of the medication cart on 400 Hall showed: - One opened, unlabeled, and undated glargine (long-acting insulin) insulin pen; - Two opened and undated Fiasp (rapid-acting insulin) insulin pens; - One opened and undated Tresiba (long-acting insulin) insulin pen; - One opened and undated basaglar (long-acting insulin) insulin pen; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265771	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southgate Living Center	500 Truman Boulevard Caruthersville, MO 63830

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- One glucagon (medication used to treat low blood sugar) 1 milligram container with an expiration date of 10/24/24, and one glucagon 1 milligram container with an expiration date of 01/10/25. Observation on 03/05/25 at 3:30 P.M., of 100/200 Hall storage rooms showed: - One opened insulin aspart multidose vial, dated 01/14/25; - Two Vitamin B Complex bottles an expiration date of 11/26/24. During an interview on 03/05/25 at 4:01 P.M., Licensed Practical Nurse (LPN) K said insulin should be discarded 30 days after being opened and should be labeled with the resident's name and the date when it was opened. During an interview on 03/06/25 at 3:45 P.M., the Administrator and the Director of Nursing (DON) said they would expect insulin should be labeled and dated appropriately and multi-dose vials discarded 28 days after opened.