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	06/05/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to follow infection control precautions by failing to implement Enhanced Barrier Precautions (EBP - precautions for use during high-contact resident care activities for residents infected with a multidrug-resistant organism (MDRO - microorganisms resistant to one or more classes of antimicrobial agents) or residents with a chronic wound and/or indwelling medical device) for two residents (Residents #2 and #8) out of three sampled residents. The facility census was 58.Review of the facility's policy titled, Enhanced Barrier Precautions, dated 2024, showed: - EBP refers to an infection control intervention designed to reduce transmission of MDROs that employs targeted gown, and gloves use during high contact resident care activities; - High contact resident care activities include dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, wound care, and care of central lines, urinary catheters, feeding tubes, and tracheostomy/ventilator tubes. 1. Review of Resident #2's clinical record showed the resident had a gastrostomy tube (G-tube - a tube surgically inserted into the stomach to provide hydration, nutrition, and medications), which qualified the resident for EBP. Observation on 06/04/26 at 9:46 A.M., of medication administration and a water flush through Resident #2's G-tube showed:- EBP signage was posted on the resident's door;- Licensed Practical Nurse (LPN) F entered the resident's room;- LPN F performed hand hygiene and wore gloves but did not wear a gown;- LPN F administered medications and performed a water flush through the resident's G-tube;- LPN F removed gloves, performed hand hygiene, and exited the room. 2. Review of Resident #8's clinical record showed the resident had a unstageable pressure wound – Slough (dead tissue) is present, the actual base and condition of the ulcer cannot be determined. Observation on 06/04/26 at 2:28 P.M., of Resident #8's transfer using a gait belt (device used to transfer residents from one position to another) showed:- EBP signage was posted on the resident's door;- Certified Nurse Aide (CNA) A and Nurse Aide (NA) B entered the resident's room;- CNA A and NA B performed hand hygiene and wore gloves but did not wear gowns;- CNA A leaned against the resident's bed while assisting the resident to sit on the side of the bed;- CNA A and NA B placed a gait belt around the resident's waist and transferred the resident from the bed to a wheelchair;- CNA A and NA B removed gloves, performed hand hygiene, and exited the room. During an interview on 06/04/26 at 11:00 A.M., LPN F said he/she should have worn a gown while providing G-tube care because Resident #2 required EBP due to the G-tube.During an interview on (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
	265771	A. Building B. Wing	06/05/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	06/04/26 at 2:45 P.M., CNA A and NA B said they knew Resident #8 required EBP based on the sign posted on the resident's door. CNA A and NA B stated they did not believe EBP required gown use during resident transfers. During an interview on 06/04/26 at 2:56 P.M., LPN C said staff should wear gowns and gloves while providing G-tube care, catheter care, and wound care, but stated gowns were not required during resident transfers or linen changes. During an interview on 06/04/26 at 3:05 P.M., the Director of Nursing (DON) said staff should wear gowns and gloves while performing transfers for residents who required EBP. During an interview on 06/05/26 at 12:00 P.M., the Administrator and DON said they expected staff to wear gowns and gloves while administering medications and performing water flushes through a G-tube for residents requiring EBP.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to maintain an error rate of less than five percent (%) during medication administration. There were 25 opportunities with two errors made, for an error rate of 8.00%, which affected two residents (Residents #2 and #35) out of eight sampled residents. The facility census was 58.Review of the facility policy titled, Administering Medications, dated April 2019, showed:- Medications are administered in accordance with prescriber orders;- The individual administering the medication checks the label three times to verify the right resident, right medication, right dosage, right time, and right method of administration before giving the medication. Review of the facility policy titled, Medication and Treatment Orders, dated July 2016, showed:- Drugs and biologicals that are required to be refilled must be reordered from the issuing pharmacy not less than three days prior to the last dosage being administered to ensure that refills are readily available. 1. Observation on 06/04/26 at 8:33 A.M., of Resident #35's medication administration showed:- Certified Medication Technician (CMT) E could not find the resident's sodium bicarbonate medication (a fast-acting antacid used to relieve occasional heartburn, acid indigestion, and sour stomach) card;- The facility failed to administer the resident's sodium bicarbonate. Review of the resident's physician order sheet (POS), dated 06/05/26, showed:- An order for sodium bicarbonate 650 milligram (mg) two times a day per gastrostomy (G-tube - a tube surgically inserted into the stomach to provide hydration, nutrition, and medications), dated 05/20/26. During an interview on 06/04/26 at 8:45 A.M., CMT E said the sodium bicarbonate for Resident #35 had to be reordered. He/She said it was the CMTs' and the nurses' responsibility to make sure medications were reordered. Medications should be ordered when they run out. 2. Observation on 06/04/26 at 9:46 A.M., of Resident #2's medication administration showed:- Licensed Practical Nurse (LPN) F administered five tablets of vitamin D 400 units for a total of 2,000 units through the resident's G-tube;- The facility failed to administer the Vitamin D 5,000 units as ordered. Review of the resident's POS, dated 06/04/26, showed:- An order for Vitamin D 5,000 units via gastrostomy one time a day for vitamin D deficiency, dated 02/05/26. During an interview on 06/04/26 at 2:48 P.M., LPN F said he/she did not do the math correctly when figuring out the number of tabs of vitamin D that Resident #2 should have been administered. During an interview on 06/04/26 at 2:23 P.M., CMT D said nurses were responsible for reordering narcotic medications. CMTs were responsible for ordering all other medications from the pharmacy. Medications should be ordered when the number of tablets left fell into the reorder area marked off on the medication cards. During an interview on 06/04/26 at 2:48 P.M., LPN F said the pharmacy made daily deliveries during the week and as needed on the weekends. During an interview on 06/05/26 at 12:00 P.M. the Administrator and the Director of Nursing (DON) said they would expect the medication error rate to be under five percent.