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 _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHGATE LIVING CENTER	500 TRUMAN BOULEVARD CARUTHERSVILLE, MO 63830

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 570 SS=D	Surety Bond-Security of Personal Funds CFR(s): 483.10(f)(10)(vi) §483.10(f)(10)(vi) Assurance of financial security. The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by: 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	F 570		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	3/24/25

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.

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 _____	C 03/06/2025

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SOUTHGATE LIVING CENTER	500 TRUMAN BOULEVARD CARUTHERSVILLE, MO 63830

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F 570	Continued From page 1 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. 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.	F 570		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable	F 656		

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	265771	A. BUILDING _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHGATE LIVING CENTER	500 TRUMAN BOULEVARD CARUTHERSVILLE, MO 63830

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 2	F 656		

objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.

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 _____	C 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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F 656	Continued From page 3	F 656		

This REQUIREMENT is not met as evidenced by:
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 admission date of 04/07/24;
- 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

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 _____	C 03/06/2025

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SOUTHGATE LIVING CENTER	500 TRUMAN BOULEVARD CARUTHERSVILLE, MO 63830

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F 656	Continued From page 4	F 656		

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.

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 admission date of 01/30/25;
- Diagnoses of hemiplegia (muscle weakness) and hemiparesis (partial paralysis) following an intracranial hemorrhage (trauma to the brain that may cause brain damage), pneumonia (an

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	265771	A. BUILDING _____ B. WING _____	C 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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F 656	Continued From page 5 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.	F 656		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to	F 661		

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 _____	C 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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F 661	Continued From page 6	F 661		

include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative.
(iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).
(iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.
This REQUIREMENT is not met as evidenced by:
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

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	265771	A. BUILDING _____ B. WING _____	C 03/06/2025

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SOUTHGATE LIVING CENTER	500 TRUMAN BOULEVARD CARUTHERSVILLE, MO 63830

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F 661	Continued From page 7	F 661		

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

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	265771	A. BUILDING _____ B. WING _____	C 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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F 661	Continued From page 8	F 661		

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;
- 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

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	265771	A. BUILDING _____ B. WING _____	C 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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F 661	Continued From page 9 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.	F 661		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	F 677		

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 _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHGATE LIVING CENTER	500 TRUMAN BOULEVARD CARUTHERSVILLE, MO 63830

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 10 §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: 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	F 677		

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 _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHGATE LIVING CENTER	500 TRUMAN BOULEVARD CARUTHERSVILLE, MO 63830

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 11	F 677		

showed:
- An admission date of 04/07/24;
- 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.

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

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 _____	C 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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F 677	Continued From page 12	F 677		

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.,

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 _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHGATE LIVING CENTER	500 TRUMAN BOULEVARD CARUTHERSVILLE, MO 63830

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 13	F 677		

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.

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

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 _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHGATE LIVING CENTER	500 TRUMAN BOULEVARD CARUTHERSVILLE, MO 63830

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 14 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.	F 677		
F 684 SS=D	. Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 684		

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 _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHGATE LIVING CENTER	500 TRUMAN BOULEVARD CARUTHERSVILLE, MO 63830

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 15	F 684		

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 07/09/21;
- 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

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 _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHGATE LIVING CENTER	500 TRUMAN BOULEVARD CARUTHERSVILLE, MO 63830

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 16	F 684		

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, ½ 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;
- 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.

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 _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHGATE LIVING CENTER	500 TRUMAN BOULEVARD CARUTHERSVILLE, MO 63830

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 17 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.	F 684		
F 728 SS=D	Facility Hiring and Use of Nurse Aide CFR(s): 483.35(d)(1)-(3) §483.35(d) Requirement for facility hiring and use of nurse aides- §483.35(d)(1) General rule. A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless- (i) That individual is competent to provide nursing and nursing related services; and (ii)(A) That individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §483.151 through §483.154; or (B) That individual has been deemed or determined competent as provided in §483.150(a) and (b). §483.35(d)(2) Non-permanent employees. A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (d)(1)(i) and (ii) of this section. §483.35(d)(3) Minimum Competency A facility must not use any individual who has worked less than 4 months as a nurse aide in that facility unless the individual- (i) Is a full-time employee in a State-approved training and competency evaluation program;	F 728		

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 _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHGATE LIVING CENTER	500 TRUMAN BOULEVARD CARUTHERSVILLE, MO 63830

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 728	Continued From page 18	F 728		

(ii) Has demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation program or competency evaluation program; or
(iii) Has been deemed or determined competent as provided in §483.150(a) and (b).
This REQUIREMENT is not met as evidenced by:
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;

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 _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHGATE LIVING CENTER	500 TRUMAN BOULEVARD CARUTHERSVILLE, MO 63830

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 728	Continued From page 19 - 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. 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.	F 728		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 761		

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 _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHGATE LIVING CENTER	500 TRUMAN BOULEVARD CARUTHERSVILLE, MO 63830

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 20 §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: 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	F 761		

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 _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHGATE LIVING CENTER	500 TRUMAN BOULEVARD CARUTHERSVILLE, MO 63830

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 21	F 761		

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;
- One glucagon (medication used to treat low blood sugar) 1 milligram container with an expiration date of 10/24/24, and one glucagon 1

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 _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHGATE LIVING CENTER	500 TRUMAN BOULEVARD CARUTHERSVILLE, MO 63830

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 22 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.	F 761		

Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	01081A	A. BUILDING: _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHGATE LIVING CENTER	500 TRUMAN BOULEVARD CARUTHERSVILLE, MO 63830

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4031	19 CSR 30-85.042(27) Communicable Disease-Employees The facility must develop and implement policies and procedures which ensure employees are screened to identify communicable diseases and ensure that employees diagnosed with communicable diseases do not expose residents to such diseases. The facility's policies and procedures must comply with the Missouri Department of Health's regulations pertaining to communicable diseases, specifically 19 CSR 20-20.010 through 19 CSR 20-20.100, as amended. II This regulation is not met as evidenced by: Class II Based on interview and record review, the facility failed to follow appropriate infection prevention practices for six out of ten employee tuberculosis (TB - a contagious lung disease) screenings when the facility failed to ensure administration of a two-step tuberculosis skin test (TST) prior to employment. The facility's census was 92. Review of 19 CSR 20-20.100 Tuberculosis Testing for Residents and Workers in Long-Term Care Facilities (LTC) showed: LTC Employees and Volunteers. All new long-term care facility employees and volunteers who work 10 or more hours per week are required to obtain a Mantoux Purified Protein Derivative (PPD) two-step tuberculin test within one month prior to starting employment in the facility. If the initial test is zero to nine millimeters (mm), the second test should be given as soon as possible within three weeks after employment begins, unless documentation is provided indicating a Mantoux PPD test in the past and at least one subsequent annual test	A4031		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	01081A	A. BUILDING: _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHGATE LIVING CENTER	500 TRUMAN BOULEVARD CARUTHERSVILLE, MO 63830

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4031	Continued From page 1 within the past two years. It is the responsibility of each facility to maintain documentation of each employee's and volunteer's tuberculin status. Employees and volunteers with an initial zero - nine mm Mantoux PPD two-step test shall be one-step tuberculin tested annually and the results recorded in a permanent record. Review of the facility's policy titled, "Employee Screening for Tuberculosis," revised March 2021, showed: - All employees are screened for latent tuberculosis infection and active tuberculosis disease using tuberculin skin test (TST) or interferon gamma release assay (IGRA) and symptom screening prior to beginning employment; - Screening includes a baseline test for latent tuberculosis infection using either a TST or IGRA, individual risk assessment and symptom evaluation. 1. Review of Employee A's employee file showed: - Hire date of 03/01/24; - No documentation of a step one TB screening with results prior to hire. 2. Review of Employee E's employee file showed: - Hire date of 06/05/24; - A first-step TST administered on 06/05/24, and read with a result of 0 mm on 06/08/24; - The facility failed to administer a second-step TST. 3. Review of Employee F's employee file showed: - Hire date of 04/18/24; - A first-step TST administered on 04/18/24, and no documentation the TST was read with results; - The facility failed to administer a second-step TST.	A4031		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	01081A	A. BUILDING: _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHGATE LIVING CENTER	500 TRUMAN BOULEVARD CARUTHERSVILLE, MO 63830

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4031	Continued From page 2 4. Review of Employee G's employee file showed: - Hire date of 05/01/24; - A first-step TST administered on 05/01/24, and read with a result of 0 mm on 05/03/24; - The facility failed to administer a second-step TST. 5. Review of Employee H's employee file showed: - Hire date of 11/27/24; - A first-step TST administered on 11/27/24, and read with a result of 0 mm on 11/29/24; - The facility failed to administer a second-step TST. 6. Review of Employee I's employee file showed: - Hire date of 12/19/24; - A first-step TST administered on 12/18/24, and read with a result of 0 mm on 12/21/24; - The facility failed to administer a second-step TST. 7. Review of Employee J's employee file showed: - Hire date of 02/01/25; - A first-step TST administered on 02/28/25, and read with a result of 0 mm on 03/02/25; - The facility failed to administer the first-step TST prior to the employee's duty assignment; - The facility failed to administer a second-step TST. During an interview on 03/05/25 at 10:10 A.M., the Infection Preventionist said the two-step TST should be done at the time of hire for all employees. During an interview on 03/06/25 at 3:55 P.M., the Administrator and the Director of Nursing (DON) said they expected the two-step TST to be done	A4031		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	01081A	A. BUILDING: _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHGATE LIVING CENTER	500 TRUMAN BOULEVARD CARUTHERSVILLE, MO 63830

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4031	Continued From page 3 for all employees upon hire.	A4031		
A4065	19 CSR 30-85.042(56) Schedule II Meds-Storage Facilities shall store Schedule II medications, including those in the emergency drug supply, under double lock separately from noncontrolled medication. Schedule II medications may be stored and handled with other noncontrolled medication if the facility has a single unit dose drug distribution system in which the quantity stored is minimal and a missing dose can be readily detected. II This regulation is not met as evidenced by: Class II. Refer to F761.	A4065		
A4075	19 CSR 30-85.042(66) Nursing Care per Res Condition Each resident shall receive personal attention and nursing care in accordance with his/her condition and consistent with current acceptable nursing practice. I/II This regulation is not met as evidenced by: Class II. Refer to F684.	A4075		
A4077	19 CSR 30-85.042(68) Res Groomed/Dressed Appropriately Taking into consideration the resident's preferences, residents shall be well-groomed and dressed appropriately for the time of day, the environment and any identified medical	A4077		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	01081A	A. BUILDING: _____ B. WING _____	C 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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A4077	Continued From page 4 conditions. II/III This regulation is not met as evidenced by: Class III. Refer to F677.	A4077		
A4108	19 CSR 30-85.042(98)(B) Clinical Records - assessment/interventions Facilities shall ensure that the clinical record contains sufficient information to- (B) Reflect the initial and ongoing assessments and interventions by each discipline involved in the care and treatment of the resident; and II/III This regulation is not met as evidenced by: Class III Refer to F661	A4108		
A9023	19 CSR 30-88.020(14) Resident Fund Bond Requirements The bond required by section 198.096, RSMo, for operators holding personal funds of residents shall be in a form approved by the department and shall provide that residents who allege that they have been wrongfully deprived of moneys held in trust may bring an action for recovery directly against the surety. The bond shall be in an amount equal to at least one and one-half (1 1/2) times the average monthly balance of the residents ' personal funds, including residents ' petty cash, or the average total of the monthly balances for the preceding twelve (12) months. The average monthly balance(s) or the average	A9023		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A9023	Continued From page 5 total of the monthly balance(s) shall be rounded to the nearest one thousand dollars ($1,000). One (1) bond may be used to cover the residents ' funds in more than one (1) facility operated by the same operator, if the facility is a multilicensed facility on the same premises. If not on the same premises, then one (1) bond may be used if the bond specifies the amount of coverage provided for each individual facility and the coverage for each facility is a minimum of one thousand dollars ($1,000). II/III This regulation is not met as evidenced by: Class III. Refer to F570.	A9023		

PLAN OF CORRECTION

Provider/Supplier Name:	Southgate Living Center
Street Address, City, Zip:	500 Truman Blvd Caruthersville, MO 63830
Date of Survey:	March 6, 2025

265771

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
F 570 SS=D	Surety Bond-Security of Personal Funds CFR(s): 483.10(f)(10)(vi)	04/18/2025
	The facility will ensure the surety bond is one and one-half times the average monthly balance of the resident's personal funds to assure the security of all personal funds of resident's deposited with the facility.	04/18/2025
	The balance of the resident's personal funds and the surety bond will be checked monthly to ensure the current bond is one and one-half times the balance of the resident's personal funds.	04/18/2025
	The administrator will provide education to the business office personnel regarding the policy of Surety Bond.	04/18/2025
	The administrator or designee will monitor the balance of the resident's personal funds to ensure the surety bond is at least one and one-half times the balance of resident's personal funds weekly for 4 weeks, then monthly thereafter per facility policy.	04/18/2025
	Issues of non-compliance will be addressed upon discovery and during monthly Quality Assurance Performance Improvement meetings.	04/18/2025

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Crystal Lane LPN/LNHA Administrator 3/24/25

PLAN OF CORRECTION

Provider/Supplier Name:	Southgate Living Center
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Date of Survey:	March 6, 2025

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F656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3)	04/18/2025
	The facility will ensure the comprehensive care plan is evaluated and updated with specific interventions to meet the individual needs of the residents.	04/18/2025
	Resident #15 The comprehensive care plan will be updated to reflect the resident's diagnosis of COPD, the resident's respiratory status and the resident's oxygen needs.	04/18/2025
	Resident #30 The comprehensive care plan will be updated to reflect the resident's respiratory status and the resident's oxygen needs.	04/18/2025
	The MDS Coordinator and nursing staff will be educated via in-service provided by the Director of Nursing or designee regarding updating the individualized comprehensive care plan and documentation.	04/18/2025
	The Director of Nursing or designee will monitor comprehensive care plans weekly in the weekly care plan meetings.	04/18/2025
	Any issues of non-compliance will be addressed upon discovery and in the monthly Quality Assurance Performance Improvement meeting.	04/18/2025

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Crystal Cline LPN/LNHA Administrator 3/24/25

PLAN OF CORRECTION

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F 661 SS=D	Discharge Summary CFR(s): 483.21 (c)(2)(i)-(iv)	04/18/2025
	The facility will ensure that a discharge summary and recapitulation of stay is completed on all resident's prior to/upon discharge from the facility.	04/18/2025
	Resident #59: A discharge summary/recapitulation of resident's stay will be completed.	04/18/2025
	The SS Coordinator and Interdisciplinary Team will be educated via in-service provided by the Director of Nursing or designee regarding completion of a discharge summary and recapitulation of stay on all resident's prior to/upon discharging from the facility.	04/18/2025
	The Director of Nursing or designee will monitor discharge summary and recapitulation of stay assessments weekly for 4 weeks and then monthly for 3 months.	04/18/2025
	Any issues on non-compliance will be addressed upon discovery and in the monthly Quality Assurance Performance Improvement meeting.	04/18/2025

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Crystal Tune LPN/LVN/RA Administrator 3/24/25

PLAN OF CORRECTION

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F677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	04/18/2025
	The facility will ensure all residents who are unable to carry out activities of daily living receive the necessary services to maintain good nutrition, grooming, personal hygiene and oral hygiene.	04/18/2025
	Resident 15: -Therapy will conduct a new evaluation with resident to observe for the need of any additional adaptive equipment needed to assist resident in consuming meals and/or performing any other ADL's. -Nursing staff will assist with ADL's and all meals as needed and upon resident request. -The MDS will be completed to reflect the resident's need for assistance with consuming meals.	04/18/2025
	The therapy staff, nursing staff and MDS Coordinator will be educated via in-service provided by the Director of Nursing or designee regarding our policy on providing ADL care for dependent residents and ensuring those needs are properly documented.	04/18/2025
	All staff will be educated via in-service provided by the Director of Nursing or designee regarding the need for observation and reporting of any noticeable and/or suspected decline to charge nurse, ADON or DON immediately.	04/18/2025
	The Director of Nursing or designee will monitor for decline in resident's ability to perform ADL's and/or documentation reflecting any decline daily in clinical meeting and weekly in PAR meetings.	04/18/2025
	Any issues of non-compliance will be addressed upon discovery and in monthly Quality Assurance Performance Improvement meeting.	04/18/2025

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Crystal Anne Lankford Administrator 3/24/25

PLAN OF CORRECTION

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PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	

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F684 SS=D	Quality of Care CFR(s): 483.25	04/18/2025
	The facility will ensure that all residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan and the residents' choices, based on the comprehensive assessment of the resident.	04/18/2025
	Resident #4: Wound care will be provided by a nurse according to the physician's order and the treatment provided will be documented on the Treatment Administration Record.	04/18/2025
	The nursing staff will be educated via in-service provided by the Director of Nursing or designee regarding policy on following physician's orders.	04/18/2025
	The nursing staff will be educated via in-service provided by the Director of Nursing or designee regarding policy on documenting provided/attempted care on MAR/TAR.	04/18/2025
	The Director of Nursing or designee will monitor MAR/TAR(s) for missing documentation weekly for 4 weeks and then monthly for 3 months.	04/18/2025
	The Director of Nursing or designee will monitor all wound care dressings 2 days per week for 4 weeks, weekly for 4 weeks and then monthly for 2 months	04/18/2025
	The Director of Nursing or designee will monitor for new physician's orders and ensure compliance daily in clinical meetings and weekly in PAR meeting.	04/18/2025
	Any issues of non-compliance will be addressed upon discovery and in the monthly Quality Assurance Performance Improvement meeting.	04/18/2025

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Crystal Cline LPN/LVN Administrator 3/24/25

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F728 SS=D	Facility Hiring and Use of Nurse Aide CFR(s): 483.35(d)(1)-(3)	04/18/2025
	The facility will ensure that all nurse aides will complete the nurse aide training program and obtain certification within 4 months of their hire date.	04/18/2025
	NA B: Will be required to enroll in the nurse training program again as a new student and will be required to complete the program and obtain certification within 4 months of re-hire date.	04/18/2025
	NA C: Will be required to enroll in the nurse aide training program again as a new student and will be required to complete the program and obtain certification within 4 months of re-hire date.	04/18/2025
	NA D: Will be required to enroll in the nurse aide training program again as a new student and will be required to complete the program and obtain certification within 4 months of re-hire date.	04/18/2025
	The Nurse Aide Instructor and all nurse aide enrollees will be educated via in-service provided by the Director of Nursing or designee regarding our policy on the nurse aide training program.	04/18/2025
	The Director of Nursing or designee will monitor the Nurse Aide Training Program weekly for 4 weeks then monthly for 3 months.	04/18/2025
	Any issues of non-compliance will be addressed upon discovery and in the monthly Quality Assurance Performance Improvement meeting.	04/18/2025

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Crystal Lane LPN/LNHA Administrator 3/24/25

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F761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	04/18/2025
	The facility will ensure all drugs and biologicals used in the facility are labeled with cautionary instructions and the expiration date when applicable.	04/18/2025
	The facility will store all drugs and biologicals in locked compartments under proper temperature controls and ensure only authorized personnel have access to the keys.	04/18/2025
	The facility will store all controlled drugs in a separate, permanently fixed, locked compartment and ensure only authorized personnel have access to the keys.	04/18/2025
	-The expired insulin, glucagon and Vitamin B Complex found on the 400 Hall med cart have all been destroyed per policy and replaced.	04/18/2025
	The med techs and nurses will be educated via in-service provided by the Director of Nursing or designee on policy regarding Medication Labeling and Storage.	04/18/2025
	The Director of Nursing or designee will monitor med carts and med storage rooms for proper labeling and storage including removal of all expired medications weekly for 4 weeks and then monthly for 3 months.	04/18/2025
	Any issues of non-compliance will be addressed upon discovery and in monthly Quality Assurance Performance Improvement meeting.	04/18/2025

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Crystal Hill LPN/LVN Administrator 3/24/25

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A4031	Communicable Disease-Employees	04/18/2025
	19 CSR 30-85.042(27)	
	The facility will follow appropriate infection prevention practices regarding tuberculosis screenings by ensuring administration of a two-step tuberculosis skin test prior to employment.	04/18/2025
	Infection Preventionist, Director of Nursing or designee will administer Step 1 TST upon hire and Step 2 TST ten days later unless contraindicated wherein a chest x-ray will be ordered.	04/18/2025
	Infection Preventionist, Director of Nursing or designee will administer Step 1 TST to all employees annually unless contraindicated wherein a chest x-ray will be ordered.	04/18/2025
	Infection Preventionist, Director of Nursing or designee will audit all employee files, and any employee found to be without a documented Step 1 TST and/or Step 2 TST will be administered the appropriate TST promptly.	04/18/2025
	Infection Preventionist, Director of Nursing or designee will monitor Tuberculin Skin Test log weekly to ensure compliance.	04/18/2025
	Any issues of non-compliance will be addressed upon discovery and in the monthly Quality Assurance Performance Improvement meeting.	04/18/2025
A4065	19 CSR 30-85.042(56) Schedule II Meds-Storage	04/18/2025
	Please refer to F761	
A4075	19 CSR 30-85.042(66) Nursing Care per Resident Condition	04/18/2025
	Please refer to F684	
A4077	19 CSR 30-85.042(68) Resident Groomed/Dressed Appropriately	04/18/2025
	Please refer to F677	
A4108	19 CSR 30-85.042(98)(B) Clinical Records-Assessment/Interventions	04/18/2025
	Please refer to F661	
A9023	19CSR 30-88.020(14) Resident Fund Bond Requirements	04/18/2025

	Please refer to F570	

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Crystal Grine LPN/LVN/HA Administrator 03/04/25