STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145386	A. Building B. Wing	03/17/2022

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. 41610 Based on interview and observation, the facility failed to provide a working call light in the community bathroom for 10 of 10 residents (R1, R5, R8, R11, R15, R23, R32, R40, R42, and R50) reviewed for accommodations of needs for residents in the sample of 59. Findings Include: On 03/14/22 at 8:45 AM, in the only bathroom on the northwest hall, the toilet in the second stall does not have a usable call light. The extension string is attached to the call light that is on the wall above the first stall's toilet and is draped over the wall between the toilets. This causes the extension string to pull the toggle switch from the side instead of pulling the toggle switch down, therefore does not activate the call light. On 03/15/22 at 11:55 AM, V2 (Director of Nursing) stated, all call lights should be able to be activated in case they are needed. On 03/15/22 at 1:50 PM, V28 (Housekeeping Supervisor) stated, the residents on the northwest hall (R1, R5, R8, R11, R15, R23, R32, R40, R42, and R50) use that bathroom, it is the only bathroom on that hall.

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 41610 Based on Observation and Interview the facility failed to provide comfortable/warm water temperatures in a shower for 39 (R1, R5, R7, R8, R9, R11, R12, R14, R15, R17, R19, R21, R23, R26, R28, R32, R34, R38, R40, R42, R43, R50, R51, R53, R54, R55, R60, R63 R69, R77, R79, R80, R81, R83, R84, R85, R239, R240, and R290) reviewed for a homelike environment in a sample of 59. Findings Include: On 03/14/22 at 11:40 AM, V32 (Maintenance) stated, he checks the water temperatures weekly, usually on Friday, because he does not come in on the weekends unless he is called. On 03/14/22 at 11:40 AM the hand sink in the shower room across from dining room on 200 hall water temperature was 71 degrees Fahrenheit after 10 minutes of the water running when measured with a calibrated metal stemmed thermometer. On 03/15/22 at 8:40 AM the water temperature at the hand sink in the shower room on the 200 hall was 77 degrees Fahrenheit after running the water for several minutes when measured with a calibrated metal stemmed thermometer. On 03/16/22 at 11:20 AM, V32 (Maintenance) stated, the water temperature in the shower rooms should definitely be warmer than 77 degrees Fahrenheit. Usually if the water starts getting cool the nurses will let him know and he will adjust the water temperature. On 03/14/22 at 11:30 AM, V27 (CNA) stated, the residents on the north west hall (R1, R5, R8, R11, R15, R23, R32, R40, R42, and R50) and the 200 hall (R1, R5, R7, R9, R12, R14, R17, R19, R21, R26, R28, R34, R38, R43, R51, R53, R54, R55, R60, R63 R69, R77, R79, R80, R81, R83, R84, R85, R239, R240, and R290) are the closest to the 200 hall shower room, so they would probably use that shower, unless they really stated they wanted to use the shower room on the 300 hall, if it was available. On 03/16/22 at 2:00 PM, during a Resident Council meeting R1, R25, R28, R48, R52, and R72 stated, the water in the 200 hall bathroom/shower room can get fairly cool at times.

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41610 Based on interview and record review, the facility failed to implement their Abuse Policy and Procedure by failing to notify the Illinois Department of Public Health (IDPH) of injuries of unknown origin, thoroughly investigate injuries of unknown origin and failed to maintain documentation of injury of unknown origin investigations for 1 of 3 residents (R60) reviewed for abuse in the sample of 59. Findings include: R60's Face Sheet Documents R60 is a [AGE] year old female with diagnosis including: Alzheimer's disease with late onset, Dysphagia following Cerebral Infarction, Major Depressive Disorder, single episode, Anxiety Disorder, other Sequelae of Cerebral Infarction, Unspecified Severe Protein-Calorie Malnutrition, Vascular Dementia with Behavioral Disturbance, Dysphagia, Essential Hypertension, History of Falling. R60's 1/24/22 Minimum Data Set (MDS) documents R60 has a BIMS (Brief Interview of Mental Status) of a 6 concluding R60 is severely impaired. 1. An untitled facility document dated 01/18/2022, by V2 (Director of Nursing) documents in part, Was reported to this writer that R60 had bruising to bilateral arms, and is saying staff got rough with her. I notified social services (V12) and asked her to go speak with R60 about allegation. V12 returns and informed this nurse that while staff was changing her bed they got a little rough with her, and bruised her arm. Asked if she was in bed, she said yes. R60's skin is very frail and fragle (sic), bruises very easy. R60 stated it happened about a week ago, did not know name of individual, but they had dark hair. A follow up report regarding the incident of bruising to R60's bilateral arms written by V12 (SSD), dated 01/28/2022 documents R60 said everyone is very sweet to me. V60 said she likes some staff better than others. V60 said she is not afraid of anyone. R60 denied any concerns. R60 was encouraged to report any concerns with care of staff and she expressed understanding. R60's Progress Note dated 01/18/22 at 4:16 PM by V37 (Licensed Practical Nurse/LPN) documents bruising to left forearm. R60's Progress Note dated 01/19/22 at 1:30 AM documents an Incident Note stating, no problem noted to left arm, was moving it without any problem of pain noted. R60's Progress Note dated 01/19/22 at 5:39 AM documents an Incident Note by V38 (LPN) stating, giving care this AM, R60 has same bruising on right forearm and upper brachial on the left arm. R60 denies any pain but says ouch when touched. R60's Progress Note dated 01/21/22 at 3:36 PM documents a Hospice Note by V39 (Hospice Social Worker) documenting: V41 (Family) voiced concern regarding the bruises on R60's arms and the fact that R60 states, that someone was rough with her. R60 states, she is okay and did not want to get anyone in trouble. V41 (Family) states, this has already been reported to facility earlier in the week but feels he cannot find anything out. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R60's Progress note dated 01/23/22 at 10:12 AM documents Health Status Note by V40 (LPN) documenting: resident is alert and oriented times four with confusion at times. R60 is able to make needs known. R60 has pool noodle cushions to arm rest and bed rails. On 03/15/2022, at 12:22 PM, V2 said I talked to night shift. I did not write down our conversation. R60 said they did not mean to hurt her. We did not investigate. We did pad the wheelchair arms and had an in service with staff and told them to be gentle since R60's skin that bruises easily. On 03/15/2022 at 2:28 PM, V2 verified that report documents that were provided was all the information she had into R60's injury of unknown origin. V2 stated she spoke to staff, but did not write down their interviews. There is no documentation of staff or residents interviews. The incident was not reported to Illinois Department of Public Health. 2. R60's Progress note dated 2/25/22 at 2:45pm by V40 (LPN) documents in part, CNA (Certified Nursing Assistant) approached this nurse stating that resident had what seemed to be new bruising to left arm. This nurse assessed resident left arm and noted bruising to left upper arm. This nurse measured bruise at 70 cm x 70 cm. Bruise in non-opened and with arm sleeves in place. This nurse asked resident if she knew what had happened. Resident stated she did not now what happened or that she even had a bruise .RN made aware. A Skin Report dated 02/25/2022, documents R60 has a bruise of unknown origin on the left arm. On 03/15/2022 at 2:28 PM, V2 verified there was no investigation initiated into the bruise found on R60 on 2/25/22 to determine the cause nor was IDPH notified. The undated facility policy titled Abuse Policy/Procedures documents in part, Identification B. Residents who have suspicious bruising, particularly of the face, arms, abdomen and shins, will have such bruising assessed by nursing and an Accident/Incident Form completed with investigation procedure followed D. When suspected abuse is reported, the administrator or acting administrator should make a report to IDPH within 24 hours. Section titled Investigation states: B. When an incident or suspected incident of resident's abuse, injury of unknown origin is reported, the administrator will appoint a staff member to investigate the incident. D. The investigation shall consist of: 1. Interview with the person(s) reporting the incident; 2. Interviews with any witnesses to the incident; 3. Interview the resident; 4. Review of the resident's medical record; 5. Interviews with staff members having contact with the resident during the period of the alleged incident; 6. Interviews with other appropriate persons; 7. Interviews with other residents as necessary to determine patterns or occurrences; and 8. Review of all circumstances surrounding the incident F. Upon receiving reports of physical or sexual abuse the licensed nurse shall be assigned to immediately examine the resident. Findings of the examination will be recorded on a body assessment form with a written explanation and placed in the resident's permanent medical record. A copy should also be attached to the Investigation report. G. the person in charge of the investigation must obtain a written, signed and dated statement from the person reporting the incident. H. Regardless of when the incident occurred, it must be reported to the supervisor in charge or administrator regardless of the time lapse. J. The Administrator will inform the resident and his/her representative of the results of the investigation, documenting this notification. The Section titled Reporting/Response states: A. The results of all investigations with a complete report shall be reported to the state survey and certification agency within five (5) working days of the reported incident.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 41610 Based on interview and record review the facility failed to report bruises of unknown origin to the Department as potential abuse allegations for 1 of 3 residents (R60) reviewed for abuse in the sample of 59. Findings include: 1. An untitled facility document dated 01/18/2022, by V2 (Director of Nursing) documents in part, Was reported to this writer that R60 had bruising to bilateral arms, and is saying staff got rough with her. I notified social services (V12) and ask her to go speak with R60 about allegation. V12 returns and informed this nurse that while staff was changing her bed they got a little rough with her, and bruised her arm. Ask is she was in bed, she said yes. R60's skin is very frail and fragle (sic), bruises very easy. R60 stated it happened about a week ago, did not know name individual, but they had dark hair. A follow up report regarding the incident of bruising to R60's bilateral arms written by V12 (SSD), dated 01/28/2022 documents R60 said everyone is very sweet to me. V60 said she likes some staff better than others. V60 said she is not afraid of anyone. R60 denied any concerns. R60 was encouraged to report any concerns with care of staff, and she expressed understanding. R60's Progress Note dated 01/18/22 at 4:16 PM by V37 (Licensed Practical Nurse/LPN) documents bruising to left forearm. On 03/15/2022 at 2:28 PM, V2 verified that report documents that were provided was all the information that she had into R60's injury of unknown origin. V2 stated she spoke to the staff, but did not write down their interviews. There is no documentation of staff or resident's interviews. The incident of the bruises were not reported to Illinois Department of Public Health. 2. R60's Progress note dated 2/25/22 at 2:45pm by V40 (LPN) documents in part, CNA (Certified Nursing Assistant) approached this nurse stating that resident had what seemed to be new bruising to left arm. This nurse assessed resident left arm and noted bruising to left upper arm. This nurse measured bruise at 70 cm x 70 cm. Bruise in non-opened and with arm sleeves in place. This nurse asked resident if she knew what had happened. Resident stated she did not now what happened or that she even had a bruise .RN made aware. A Skin Report dated 02/25/2022, documents R60 has a bruise of unknown origin on the left arm. On 03/15/2022 at 2:28 PM V2 verified there was no investigation initiated into the bruise found on R60 on 2/25/22 to determine the cause nor was IDPH identified. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The undated facility policy titled Abuse Policy/Procedures documents in part, Identification B. Residents who have suspicious bruising, particularly of the face, arms, abdomen and shins, will have such bruising assessed by nursing and an Accident/Incident Form completed with investigation procedure followed D. When suspected abuse is reported, the administrator or acting administrator should make a report to IDPH within 24 hours.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41610 Based on interview and record review the facility failed to thoroughly investigate and maintain documentation of a investigation into injuries of unknown origin for 1 of 3 residents reviewed for abuse in the sample of 59. Findings Include: R60's Face Sheet Documents R60 is a [AGE] year old female with diagnosis including: Alzheimer's disease with late onset, Dysphagia following Cerebral Infarction, Major Depressive Disorder, single episode, Anxiety Disorder, other Sequelae of Cerebral Infarction, Unspecified Severe Protein-Calorie Malnutrition, Vascular Dementia with Behavioral Disturbance, Dysphagia, Essential Hypertension, History of Falling. R60's 1/24/22 Minimum Data Set (MDS) documents R60 has a BIMS (Brief Interview of Mental Status) of a 6 concluding R60 is severely impaired. 1. An untitled facility document dated 01/18/2022, by V2 (Director of Nursing) documents in part, Was reported to this writer that R60 had bruising to bilateral arms, and is saying staff got rough with her. I notified social services (V12) and asked her to go speak with R60 about allegation. V12 returns and informed this nurse that while staff was changing her bed they got a little rough with her, and bruised her arm. Asked if she was in bed, she said yes. R60's skin is very frail and fragle (sic), bruises very easy. R60 stated it happened about a week ago, did not know name individual, but they had dark hair. A follow up report regarding the incident of bruising to R60's bilateral arms written by V12 (SSD), dated 01/28/2022 documents R60 said everyone is very sweet to me. V60 said she likes some staff better than others. V60 said she is not afraid of anyone. R60 denied any concerns. R60 was encouraged to report any concerns with care of staff, and she expressed understanding. R60's Progress Note dated 01/18/22 at 4:16 PM by V37 (Licensed Practical Nurse/LPN) documents bruising to left forearm. R60's Progress Note dated 01/19/22 at 1:30 AM documents an Incident Note stating, no problem noted to left arm, was moving it without any problem of pain noted. R60's Progress Note dated 01/19/22 at 5:39 AM documents an Incident Note by V38 (LPN) stating, giving care this AM, R60 has same bruising on right forearm and upper brachial on the left arm. R60 denies any pain but says ouch when touched. R60's Progress Note dated 01/21/22 at 3:36 PM documents a Hospice Note by V39 (Hospice Social Worker) documenting: V41 (Family) voiced concern regarding the bruises on R60's arms and the fact that R60 states, that someone was rough with her. R60 states, she is okay and did not want to get anyone in trouble. V41 (Family) states, this has already been reported to facility earlier in the week but feels he cannot find anything out. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R60's Progress note dated 01/23/22 at 10:12 AM documents Health Status Note by V40 (Licensed Practical Nurse) documenting: resident is alert and oriented times four with confusion at times. R60 is able to make needs known. R60 has pool noodle cushions to arm rest and bed rails. On 03/15/2022, at 12:22 PM, V2 said I talked to night shift. I did not write down our conversation. R60 said they did not mean to hurt her. We did not investigate. We did pad the wheelchair arms and had an in-service with staff and told them to be gentle since R60's skin bruises easily. On 03/15/2022 at 2:28 PM, V2 verified that report documents that were provided were all that she had into R60's injury of unknown origin. V2 stated the staff that she spoke with did not write down their interviews. There is no documentation of staff or residents interviews. The incident of the bruises were not reported to Illinois Department of Public Health. 2. R60's Progress note dated 2/25/22 at 2:45pm by V40 (LPN) documents in part, CNA (Certified Nursing Assistant) approached this nurse stating that resident had what seemed to be new bruising to left arm. This nurse assessed resident left arm and noted bruising to left upper arm. This nurse measured bruise at 70 cm x 70 cm. Bruise in non-opened and with arm sleeves in place. This nurse asked resident if she knew what had happened. Resident stated she did not now what happened or that she even had a bruise .RN made aware. A Skin Report dated 02/25/2022, documents R60 has a bruise of unknown origin on the left arm. On 03/15/2022 at 2:28 PM, V2 verified there was no investigation initiated into the bruise found on R60 on 2/25/22 to determine the cause nor was IDPH notified. The undated facility policy titled Abuse Policy/Procedures documents in part, Identification B. Residents who have suspicious bruising, particularly of the face, arms, abdomen and shins, will have such bruising assessed by nursing and an Accident/Incident Form completed with investigation procedure followed D. When suspected abuse is reported, the administrator or acting administrator should make a report to IDPH within 24 hours. Section titled Investigation states: B. When an incident or suspected incident of resident's abuse, injury of unknown origin is reported, the administrator will appoint a staff member to investigate the incident. D. The investigation shall consist of: 1. Interview with the person(s) reporting the incident; 2. Interviews with any witnesses to the incident; 3. Interview the resident; 4. Review of the resident's medical record; 5. Interviews with staff members having contact with the resident during the period of the alleged incident; 6. Interviews with other appropriate persons; 7. Interviews with other residents as necessary to determine patterns or occurrences; and 8. Review of all circumstances surrounding the incident F. Upon receiving reports of physical or sexual abuse the licensed nurse shall be assigned to immediately examine the resident. Findings of the examination will be recorded on a body assessment form with a written explanation and placed in the resident's permanent medical record. A copy should also be attached to the Investigation report. G. the person in charge of the investigation must obtain a written, signed and dated statement from the person reporting the incident. H. Regardless of when the incident occurred, it must be reported to the supervisor in charge or administrator regardless of the time lapse. J. The Administrator will inform the resident and his/her representative of the results of the investigation, documenting this notification. 44492

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 12820 41610 Based on observation and record review, the facility failed to provide Activities of Daily Living (ADL) assistance with eating to 4 of 7 residents (R51, R19, R46, R53) reviewed for ADL's in a sample of 59. Findings include: 1. The Resident Dashboard section of R51's Electronic Health record (EHR) documents that R51 was admitted on [DATE] with diagnoses of Parkinson's Disease, lack of coordination, muscle weakness, need for assistance with personal care, and abnormal posture. R51's Minimum Data Set (MDS) assessment dated [DATE] in Section G: Functional Status documents that R51 requires extensive assistant with eating requiring one person physical assist. R51's Medication Review Report dated 3/17/22 documents an order to for R51 to wear and elastic cervical support at meals to help with self-feeding dated 8/30/21. R51's Care Plan (last revision date 1/13/22) documents that R51 was admitted to the facility with less than R51's Ideal Body Weight (IBW) and includes an intervention of wearing the elastic cervical support at meals to assist with self-feeding. On 3/14/22 at 1:20 PM, R51 is observed sitting at a table with a tray of food in front on R51. R51 is noted to have her head leaning forward and R51 is attempting to feed herself. R51 was not wearing an elastic cervical support. On 3/15/22 at 12:15 PM, R51 is observed in the dining room being assisted by staff with feeding. R51 is not observed wearing an elastic cervical support. On 03/17/22 10:46 AM, R51 who was alert to person, place and time stated that she is supposed to wear the cervical support device at all meals. R51 said that she can feed herself when wearing the support but would rather have the staff assist her because she ends up with food all over. R51 states that there are some meals that she doesn't receive any assistance from staff and is able to eat some without assistance. R51 states that she often has to remind the staff to put her cervical support device on so she can eat. R51 states they say they will come back and put it on and they don't come back for a while and her food is cold. R51 also states that they will give her a tray and her food is cold when the staff get a chance to feed her. On 3/17/22 at 12:40 PM, V11 (Licensed Practical Nurse) said that R51 doesn't wear the elastic cervical support device every time R51 eats and that sometimes R51 will feed herself but requires the staffs assistance. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. R19's Minimum Data Set (MDS) assessment dated [DATE] in Section G: Functional Status documents that R19 requires supervision, including oversight, encouraging, and cueing, with eating requiring one person physical assist. On 03/15/2022, during continuous observations between, 11:40 AM and 12:35 PM, in the dining room where residents living on the 200 and 300 halls eat. R19 sat at a table from 11:45AM until 12:05 PM, with her meal in front of her. R19 could not reach her utensils. At 12:05PM, V36 (Certified Nursing Assistant/CNA), came to check on R19, searched for her utensils, found them and opened them and placed them on R19's plate. 3. R46's Minimum Data Set (MDS) assessment dated [DATE] in Section G: Functional Status documents that R46 requires extensive assistance with eating and one person physical assist. On 3/14/22 R46 was seated at a table with two other gentlemen from 11:55 AM until 12:30 PM. The two gentlemen at R46's table were served their meal at 11:55 AM. R46 did not receive his meal until 12:20 PM. V16 (CNA) placed R46's plate in front of him and walked away. R46 said, I am waiting for two girls. V16 did not remove the cover from the plate or provide R46 with utensils. At 12:30 pm, V9 (CNA) came over to R46's table and asked R46 if he was going to eat. R46 said, no I am waiting on two girls. V9 picked up a spoon from R46's table mate and began encouraging him. At 12:35 PM, V5 (Activities/ Certified Nurse's Aide) approached R46 and said are you going to eat and R46 said, no I am waiting on two girls. V5 assisted R46 out of the dining room. Staff did not remove the cover from R46's food or offer him a drink. 4. The Resident Dashboard section of R53's Electronic Health record (EHR) documents that R53 was admitted on [DATE] with diagnoses of unspecified dementia without behavioral disturbance, cognitive communication deficit, muscle weakness, lack of coordination, and need for assistance for personal care. R53's Minimum Data Set (MDS) assessment dated [DATE] in Section G: Functional Status documents that R53 requires supervision, including oversight, encouraging, and cueing, with eating requiring one person physical assist. On 03/14/22 at 12:29 PM, R53's food was delivered to her room and uncovered. At 12:47 PM no food had been eaten and no staff had entered the room or had assisted or encouraged. At 1:10 PM not one bite of food had yet been consumed and no staff had entered the room and had assisted or encouraged resident to eat. On 3/15/22 at 12:05 PM no staff noted in room with resident encouraging R53 to eat. 42547

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. 12820 42547 Based on observation, interview, and record review, the facility failed to provide activities of residents' preferences for 9 of 15 residents (R9, R12, R42, R1, R25, R28, R48, R52, and R72) reviewed for activities in a sample of 59. Findings include: 1. On 3/15/22 at 1:45 PM, R9 said that V5 (Activities) never talks to R9 or asks if R9 would like a book. R9 said there is nothing to do at the facility. R9 states that she likes to read and one of the nurses used to bring her books and crossword puzzles to do but that nurse quit. R9 said that everyone is too busy here and doesn't have time to talk to her. R9 states that they used to have bingo, but they had to stop that but (R9) doesn't like bingo anyway. R9 said that she has never gotten an activity schedule. On 3/15/22 at 1:30 PM, V5 came into R9's room and asked R9's roommate if she would like a book or something to read. At 1:42 PM, V5 returned and gave R9's roommate a book. V5 never spoke to R9 or asked if R9 would like anything. R9's Care Plan (revision date 6/29/21) documents that R9 has little or no scheduled activity involvement related to disinterest and wishes not to participate and prefers to be in her room with independent activities. Interventions documented on R9's Care Plan include preferred activities of reading, word search puzzles, and television, offer new magazines, and word search books as needed, and provide activity calendar monthly to encourage R9 to choose activities she may be interested in attending. 2. On 3/14/22 12:59 PM, R12 said that the staff do not ask if she would like to attend different activities or give her anything to do. R12 is sitting in her room watching TV. On 3/15/22 at 12:55 PM, R12 is observed in her room watching TV. On 3/16/22 at 12:15 PM, R12 is observed sitting in her room watching TV. R12's Care Plan (revision date 9/27/21) documents goals of R12 will attend/ participate in activities of choice 3 to 5 times weekly and R12 will maintain involvement in cognitive stimulation and social activities as desired. Interventions include inviting R12 to scheduled activities, assist and escort R12 to activity functions, and R12 prefers to be in the hall talking to others and watching television. 3. R42's care plan dated 04/21/21, documents R42 has head phones and likes to listen to his music with his head phones on. V2 (Director of Nursing), and V5 (Activities), said R42 did use head phones but they were not sure where the head phones were. V2 said staff play music for R42 on their personal phones sometimes. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. On 03/16/22 at 2:00 PM during Resident Council Meeting, R1, R25, R28, R48, R52, and R72 stated the facility no longer has any group activities, no church service, and no bingo for weeks. They have suggested having board games for them to play, they stated it would be a good idea, but never did it. On 03/16/22 at 2:55 PM V29 (Nurse Assistant) stated, he has not seen an Activity Schedule. He never hears about an activity until after the fact. The last activity he remembers is BINGO a few weeks ago. On 03/16/22 at 3:05 PM V15 (Activity Director) stated, she is the Activity Director however, she has been training for Medical Records because she is transferring to that position. V15 clarified there are no group activities on the schedule. On 03/16/22 at 2:58 PM V30 (Dietary) stated, Dietary passes coffee and snacks at 3:00 PM. She will take the drink cart around to the resident's rooms and see if they care for water or coffee or a snack. Dietary will also pass a snack at 8:00 PM to those who want one. On 03/16/22 at 3:00 PM, V6 (Licensed Practical Nurse) stated he has not seen an Activity Schedule lately. He does not remember seeing any activities lately. During an interview with V2 (Director of Nursing) on 03/16/2022, at 9:50 AM, she said V5 (Activities) has been working the floor a lot the last few months as a Certified Nurse's Aide (CNA). The March 2022 Activity Calendar documents activities daily Monday through Friday are 8:00 AM-morning news, 9:00 AM-1:1 visits, 1:00 PM-mail and phone calls, and 3:30 PM- Coffee/ Kitchen. Saturday and Sunday activities scheduled on the March 2022 Activity Calendar documents that activity packets are available outside of the activity office and coffee will be provided by the kitchen at 3:30 PM. There is no documentation of group activities. There were no observations of group activities during the survey.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41610 Based on interview and record review, the facility failed to develop and/or implement necessary interventions to effectively supervise a wandering resident for 1 of 1 resident (R39) reviewed for supervision in the sample of 59. This failure resulted in R39 entering R67's room, and R67 pushing R39, which caused R39 to fall. The fall resulted in a closed fracture to the left femur and subsequent hospitalization . Findings include: R39's Electronic Health Record (EHR), under the section titled, Resident Dashboard, documents R39 was admitted to this facility on 10/13/2021, with a diagnosis of Alzheimer's Disease, Altered Mental Status, Dementia with Behavioral Disturbance, among others. R39's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status (BIMS) score of 03, indicating R39 has severe cognitive impairment. R39's Care Plan with initiation date of 10/13/2021 documents that she is an elopement risk/wanderer related to disoriented to place, impaired safety awareness, enters other residents' rooms and takes their belongings. Interventions include: 1) Apply wanderguard, assess for fall risk, change wanderguard bracelet every 90 days and as needed, check wanderguard bracelet daily, and monitor for fatigue and weight loss (Initiation date: 10/13/2021). 2) Attempt to redirect resident from entering other residents' rooms; offer snacks, beverages, puzzles, and magazines to distract (Initiation date: 2/28/2022). R39's Care Plan had no interventions listed for wandering in other residents' rooms prior to 2/28/2022. A progress note in R39's EHR written by V11 (Licensed Practical Nurse/LPN) and dated 2/01/2022 at 9:07 a.m. describes R39 entering residents' rooms and was redirected multiple times. R39 attempted to enter R67's room and was redirected away from R67's door. R67 came to the doorway and yelled at R39, stating to R39, You belong in a damn mental institution! and slammed his door. A subsequent progress note, in R39's EHR written by V19 (LPN) and dated 2/27/2022 at 1:05 p.m. documents that R39 entered R67's room and R67 pushed R39, resulting in R39 falling to the floor. R39 began screaming that she hurt. Head to toe assessment was completed with external rotation of left hip. R39 was sent out to the hospital and admitted with a closed fracture of left femur. A hospital document dated 2/27/2022, at 2:47 p.m., documents that R39 has a comminuted 7 trochanteric fracture of the left femur. A progress note, in R39's EHR, dated, 1/03/2022, at 1:45 p.m., written by V12 (Social Services Director/SSD), describes R39 ambulating down A Hall and attempted to enter another resident's (R67) room, was told by (R67) that R39 was in the wrong room and R39 continued to enter the room until (R67) became angry and slammed his door. R39 was redirected toward the dining room. A progress note in R39's EHR, dated, 12/18/2021, at 5:59 p.m., written by V15 (Activities), describes R39 wandering into residents' rooms and going through the residents' belongings, bullied and took things from other residents, stuck her hands in family's food that was visiting and tried to take another resident's food, dumped her meal tray onto another's resident's meal tray while they were eating, flashed others her breasts, cursed at visitors, and tried to take items off the med cart. R39 was not easily directed and refused anything offered to her. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A progress note in R39's EHR, dated, 11/26/2021, at 5:24 p.m., written by V17 (LPN), describes R39 attempting to get into med cart, take applesauce, and carry water pitcher away. V17 and V12 (SSD) have tried to redirect R39 numerous times. R39 has wandered in and out of residents' rooms needing 1 on 1 attention most of the night. R39 is easy to redirect but redirection does not last long. A progress note in R39's EHR, dated, 11/16/2021, at 5:04 a.m., written by V18 (LPN), describes R39 got up between rounds and crawled into another's resident bed while that resident was occupied in it. When staff noticed that R39 was in another's resident's bed, they took R39 back to her room, but she would not stay there. R39 followed staff around until she got interested into some paperwork. R67's EHR, under the section titled, Resident Dashboard, documents R67 was admitted to this facility on 2/25/2000, with diagnoses of Schizophrenia, Major Depressive Order, Alcohol Dependence with Alcohol-Induced Dementia, among others. R67's MDS dated [DATE] documents R67 has a BIMS score of 12, R67 has moderate cognitive impairment. R67's EHR has a Progress Note dated 2/1/2022, at 9:07 a.m., written by V11, (LPN) that describes R67 resting in his room when R39 entered his room and R67 yelled at R39 and slammed the door after R39 was redirected out of the room. A subsequent progress note dated 2/27/2022 at 2:30 p.m. and written by V19, (LPN) documents R67 becoming angry when R39 entered his room and R67 pushed R39 resulting in R39 falling to the floor. R67's Care Plan with an initiation date of 6/11/2013 documents that he has a history of behavioral problems related to verbal altercations with residents or staff. He can become verbally aggressive towards other residents. He also isolates himself to his room, is paranoid and has fixed delusions at times, and thinks that others including staff are out to get him. Interventions include: 1) Intervene as necessary to protect the rights and safety of others. Approach/Speak to R67 in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. (Revision date: 11/16/2017). 2) Caregivers will provide me with opportunities for positive interaction, and attention. Stop and talk with me as passing by (Revision date: 2/20/2018). 3) If reasonable, discuss my behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to him (Revision date: 2/20/2018). 4) Nursing staff and Social Services will monitor my behavioral episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behaviors and potential causes (Initiation date: 6/11/2013). There are no new interventions implemented to R67's Care Plan after his verbal altercation with R39 that occurred on 2/01/2022. On 3/15/2022, at 10:00 a.m., V19 (LPN) stated that on 2/27/2022, at 12:56 p.m., R39 entered R67's room and R67 had pushed R39 resulting in R39 falling to the floor. V19 stated that this incident was witnessed by V20, (Housekeeping). V19 stated she assessed R39 and external rotation of the left hip was noted. V19 stated that R39 was screaming out that she hurt. V19 stated the physician was notified and R39 was sent out to the hospital and was admitted with a diagnosis of closed fracture of left femur. V19 stated that R39 wanders frequently in and out of residents' rooms. V19 stated that she usually redirects R39 by offering her a soda and she sits in the dining room to be monitored. V19 stated that R67 gets very irritated if anyone enters his room without permission. V19 stated that she has never witnessed R67 being physically aggressive with anyone. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 3/16/2022, at 1:10 p.m., V21 (MDS/ Care Plan Coordinator) stated that she has only worked at the facility for approximately 3 weeks or so. V21 stated that she has seen R39 wander in and out of residents' rooms. V21 stated that she has never seen R67 be physically aggressive with anyone since she has worked here. On 3/17/2022, at 9:15 a.m., V22 (Certified Nurse Assistant/CNA) stated that on 2/27/2022, at 12:56 p.m., she heard someone yell and went down the hall and saw R39 lying in the floor. V22 stated that R67 is cognitively intact and knows that hitting or pushing someone is not the right thing to do. V22 stated that R67 can get very irritated if someone enters his room without permission. V22 stated that she has never seen R67 be physically aggressive with anyone. V22 stated that R39 wanders frequently in and out of residents' rooms and usually is easily redirected but it only lasts for a short while. On 3/17/2022, at 9:45 a.m., V5 (Activity Assistant) stated that R39 wanders frequently in and out of residents' rooms. V5 stated that she has never seen R67 by physically aggressive with anyone. On 3/17/2022 at 12:00 p.m., V20 (Housekeeping) stated that on 2/27/2022, at 1:00 p.m., she heard R67 yell at R39 to get out of his room and then witnessed R67 push R39 up against the wall and R39 fell to the floor. V20 stated that R39 wanders frequently into other residents' rooms. On 3/17/2022 at 12:30 p.m., V2 (Director of Nursing) stated that she was notified on 2/27/2022 that R67 pushed R39 causing R39 to fall onto the floor and that R39 was sent out to the hospital related to her having an external rotation of her left hip and increased pain and was admitted to the hospital with a closed fracture of left femur. V2 stated that on 2/28/2022, a Velcro STOP sign was placed on R67's doorway to help keep other residents from entering his room. V2 stated that an IDT (Interdisciplinary Team) meeting was held on 3/9/2022, and it was discussed to have R67 moved to different hall. V2 stated that R67 was moved to the men's hall on 3/14/2022. V2 stated that she has never seen R67 be physically aggressive with anyone and that R39 wanders frequently in and out of residents' rooms. V2 stated that R39 is redirected out of residents' rooms and placed elsewhere and given something else to do like coloring, a drink or snack, etc. On 3/17/2022 at 3:00 p.m., V1 (Administrator) stated that he was notified by the staff nurse on 2/27/2022 of the incident of R67 pushing R39 which resulted in R39 falling to the floor. V1 stated that R39 was sent out to the hospital and was admitted with a fracture of the left hip. V1 stated that on 2/28/2022, a Velcro STOP sign was placed on R67's doorway to deter any residents from entering his room. V1 stated that on 3/9/2022, an IDT meeting was held, and it was further discussed to have R67 moved to a different hall. V1 stated that R67 was moved to the men's hall on 3/14/2022. V1 stated that R67 has been at the facility for a long time, and he has never seen him be physically aggressive to anyone. V1 stated it is R67's normal behavior to be verbally aggressive especially when someone enters his room unannounced.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 12820 Based on interview, observation and record review, the facility failed to anchor and secure indwelling urinary catheter tubing for 2 of 2 residents (R16 and R42) reviewed for catheter care in the sample of 59. Findings include: 1. On 03/15/2022 at 1:50 PM, V16 (Certified Nurse Aide/CNA) and V9 (CNA) washed R16's indwelling urinary catheter tubing. The catheter tubing did not have a device to hold it in place and the drainage tubing was not secured. V16 said sometimes they use a strap to hold the catheter tubing in place, sometimes they don't. 2. On 03/15/2022 at 2:10 PM, V22 (CNA) washed R42's indwelling urinary catheter tubing. The catheter tubing did not have a device to hold it in place and the drainage tubing was not secured. The facility Catheter Care Policy/Procedure dated 05/10/12, does not document that a device to secure the indwelling urinary catheter tubing should be used. On 03/15/2022 at 1:15 PM, V2 (DON) said staff should be using a cloth strap to hold catheter tubing in place. V2 said the Catheter Care Policy should include documentation indicating that a device should be used secure the catheter tubing. According to https://pubmed.ncbi.nlm.nih.gov/, in an article titled The importance of fixation and securing devices in supporting indwelling catheters the following is noted: Health-care professionals follow recognized national guidelines to assess clinical reasons for the insertion of urinary catheters. However, the use of fixation and securing devices is an area that is often neglected. Health-care professionals sometimes employ a 'do-it-yourself' approach, using adhesive tape or Velcro strapping devices, neither of which are appropriate. If urinary catheters are not secured appropriately, they can lead to severe trauma of a patient's urethra, potential damage to bladder neck, infection and inflammation, pain and irritation, possible bypassing, accidental dislodging of a catheter and a cleaving (condition whereby the catheter splits the penile or labial tissues).

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42547 Based on interview and record review, the facility failed to administer prescribed pain medication as ordered to effectively manage the pain for 1 of 3 residents (R9) reviewed for pain in a sample of 59. The failure resulted in R59 experiencing a severe level of pain for over 24 hours. Findings include: R9's Electronic Health Record (EHR) in the section titled Resident Dashboard documents that R9 was admitted to the facility on [DATE] with diagnoses including Chronic Pain Syndrome and Low Back Pain. R9's Medication Review Report dated 3/17/22 documents that R9 has an active order for Oxycodone/Acetaminophen 7.5-325 milligram (mg) tablet every 4 hours as needed (PRN) for pain with an order date of 7/15/21. On 3/15/22 at 1:00 PM, R9 who was alert to person, place and time said that she went over 24 hours without pain medication because the facility ran out of it. R9 said that she received a dose of the pain medication on Sunday evening, 3/13/22, and did not receive another dose until Tuesday morning, 3/15/22. R9 said that she was hurting so bad on Monday night, 3/14/22, that R9 was unable to get out of bed to change her clothes and put pajamas on. R9 said that this isn't the first time that the facility has ran out of R9's pain medication. R9 said that they wait until she runs out of medication to order it from the pharmacy and has to wait for it to come in. R9 also stated that sometimes it takes 2 to 3 hours to get her pain pill when R9 asks for it because the nurses get busy and forget. R9's Medication Administration Record (MAR) for March 2022 documents that R9 had a dose of Oxycodone/Acetaminophen on 3/13/22 at 7:26 PM. The next documented dose on the March MAR for Oxycodone/ Acetaminophen is 3/15/22 at 2:29 AM. R9's pain level is documented at a 7 on a 1-10 pain scale at the time the medication was administered on 3/15/22. On 3/16/22 at 12:45 PM, V11 (Licensed Practical Nurse) said that R9 ran out of her pain medication on Sunday (3/13/22) and they didn't get any in until Tuesday morning, 3/15/22. V11 states that R9's Oxycodone/Acetaminophen requires R9's physician's authorization to refill and R9's physician is often hard to get ahold of. V11 said that the facility does keep that medication in stock in their emergency supply and that it requires a pharmacist's approval to use the facilities emergency supply. V11 said that she attempted to contact the pharmacy on Monday, 3/14/22, to receive authorization and the pharmacy's receptionist said that all pharmacists were on the phone and unable to take calls at that time. V11 said that she told the pharmacy's receptionist that she would just call back later. V11 said that she forgot to call back but did pass the information along to the nurse on the next shift. R9's Care Pan (last updated 9/13/21) documents goals for R9 to exhibit no signs and symptoms of pain and will not have an interruption in normal activities related to pain with interventions of administration of pain medications as ordered and monitor for effectiveness. R9's Minimum Data Set (MDS) assessment completed on 12/8/21 in Section J: Health Conditions documents that R9 has pain frequently and documents yes for being on a scheduled pain medication regimen and receiving PRN pain medications. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	The facility policy titled Pain Management Policy/ Procedure (undated) in the section titled Policy Statement documents that Each resident has the right to obtain optimal pain relief to attain the highest practical physical, mental, and psychosocial well-being. Nurses caring for the residents have the ethical obligation to ensure exploration of all possible alternatives including pharmacological and non-pharmacological interventions.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 41610 Based on interview, observation and record review, the facility failed to provide palatable food with a preferred temperature for 6 of 33 residents (R34, R38, R51, R69, R83 and R84) reviewed for dining in the sample of 59. Findings Include: On 03/14/22 at 11:45 AM the food boxes/carts labeled 2 and another food box/cart with no labeled were already on the 200 hall. On 03/14/22 at 11:49 AM the food box/cart labeled 4 was delivered to the 200 hall. At that time V27 (Certified Nursing Assistant/CNA) and V7 (CNA) were passing trays to the resident's rooms. At 12:05 PM the unlabeled box/cart was taken to the 300 hall. At 12:05 PM both boxes/carts, 2 and 4 were on the hall with several trays left in them with both doors of the food boxes/carts open. At 12:22 PM 7 trays were left in box 2. At 12:25 PM 11 trays were left in box 4. At 12:38 PM 4 trays were still in box 2. At 12:43 PM 5 trays left in box 4. At 12:49 PM R38, R69 and R84 trays were retrieved and taken to the table on the hall for residents that required assistance. R69 and R84's lunches were sitting in front of them while V27 (CNA) was assisting R38. At 12:50 PM R7, R34, and R83's tray were still in the food box/cart. At 1:00 PM, V7 (CNA) came to get R83's tray after this tray had been in the food box/cart for 1.25 hours on the hall. R34's tray, a puree diet was still in the food box/cart. At 1:00 PM, R34's tray's food items temperature by this surveyor with a metal stemmed calibrated thermometer: the temperature of the ground beef with gravy was 108 degrees Fahrenheit, the mashed potatoes were 99.0 degrees Fahrenheit, the corn was 102 degrees Fahrenheit and apple crisp was 93 degrees Fahrenheit. During a tasting of these food times the ground beef with gravy and cold and filmy to taste. The potatoes were cold and stiff. Both were unappetizing. At that time a new tray was requested for R34 and was received at 1:03PM. On 03/17/22 10:46 AM, R51 states that she is supposed to wear the cervical support device at all meals. R51 states that she often has to remind the staff to put her cervical support device on so she can eat. R51 states they say they will come back and put it on and they don't come back for a while and her food is cold. R51 also states that they will give her a tray and her food is cold when the staff get a chance to feed her.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145386	A. Building B. Wing	03/17/2022

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 12820 41610 Based on observation, interview and record review the facility failed to ensure their infection control protocol was effectively eradicating parasites and failed to use a proper receptacle to dispose soiled linens for 2 of 2 residents (R16 and R85) reviewed for infection control practices in the sample of 59. Findings Include: 1. On 03/17/22 12:00 PM, V2 (Director of Nursing) said that R85 was treated several different times for lice with the first treatment about 3 months ago. V2 stated that she was not the Director of Nursing (DON) at that time. V2 that they would treat her and wash everything and clean R85's room really well and bag up all the laundry. V2 said that they obviously were missing something because the lice kept coming back. V2 said that R85 used to have really long hair. V2 said that this last time that R85 was treated on 3/3/22, the staff asked if they could cut R85's hair and so far R85 hasn't had lice again. V2 said that they had been soaking the brushes in a disinfectant cleaning solution but the last time R85 was treated V2 had the staff throw all of R85's hair brushes and hair ties away. V2 said that she doesn't think the staff were getting all of the lice each time it was retreated. V2 said that they are unsure where R85 got the head lice and that R85 has not been out of the facility prior to getting lice the first time, V2 said no other residents have had lice. On 3/17/22 at 10:05 AM, V43 (Licensed Practical Nurse) said that R85 was treated a couple of weeks ago when they noticed lice when washing R85's hair. V42 states that the staff cut R85's hair at that time. V42 states that R85 was treated a few times previously and was not working on the unit at the time R85 received the lice treatments. V42 said that she was not working when R85 was last treated so she is not sure if they cleaned R85's room or linens. A Progress Note dated 12/4/21 documents that R85's physician was notified of the findings of lice in R85's hair and an order was received for a lice treatment and to repeat the lice treatment in 7 days. R85's December 2021 Medication Administration Record (MAR) documents that R85 was treated with a lice treatment shampoo (Pyrethins-Piperonyl Btoxide 0.33-4%) on 12/4/21 and 12/11/21. A Progress Note dated 1/13/22 documents that R85's physician was notified of 2 nits found in R85's hair and an order for lice treatment shampoo now and to retreat in 7 days. R85's January 2022 MAR documents that R85 was again treated with the lice treatment shampoo (Pyrethins-Piperonyl Btoxide 0.33-4%) on 1/13/22 and 1/20/22. A Progress Note dated 2/1/2022 documents that Certified Nurse's Aide (CNA) notified the nurse that R85 had head lice noted and new orders for lice treatment to be applied to R85's head and repeat the treatment in 1 week. The Progress Note documents that housekeeping was notified to deep clean R85's bed and room and that R85 was in the shower with treatment being applied. (continued on next page)

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	145386	A. Building B. Wing	03/17/2022

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R85's February 2022 MAR documents that R85 received a lice treatment liquid (Premethrin) treatment on 2/1/22, 2/6/22, and 2/12/22. A Progress Note dated 3/2/22 documents that R85 had a rash all over and lice noted to R85's pubic area and head with numerous lice in the hair. The Progress Note further documents that R85's hair was so matted that there was no way to get R85's hair undone and R85's Power of Attorney (POA) was notified and consent was received to cut R85's hair to treat R85 properly. A Progress Note dated 3/3/22 documents that it took 2 and a half hours to give R85 the lice treatment, R85 had many lice over her entire body, underarms, perineal area, and bend of legs, and R85's hair was cut and styled per the family's request. The facility policy titled Lice: And Treatment (undated) documents that Bedding is to be stripped and bed cleaned with disinfectant prior to resident returning to room after treatment. Bag up all bedding, to include any throws, pillows, spreads and clothes that the resident has worn over the last 2 days and take to laundry. The policy also documents Housekeeping: Deep clean room. There is no documentation in the Progress Notes that R85's room was deep cleaned or bedding and clothes were bagged up an taken to laundry on 12/4/21, 12/11/21, 1/13/22, 1/20/22, 2/6/22, 2/12/22, or 3/3/22 when R85 received a lice treatment. The Centers for Disease Control (CDC) Treatment Guidelines for Head Lice (last reviewed October 15, 2019) (https://www.cdc.gov/parasites/lice/head/treatment.html) in the section titled When Treating Head Lice, step 3, documents Do not treat an infested person more than 2-3 times with the same medication if it does not seem to be working. This may be caused by using the medicine incorrectly or by resistance to the medicine. 2. During an observation on 03/15/2022 at 1:55 PM, V16 (Certified Nurse Aide/CNA), was assisting R16, with care. V16 used a disposable wash cloth to wipe a moderate amount of soft formed stool from R16 on to a cloth pad that was laying under R16. When V16 finished cleaning the stool from R16, V16 folded the soiled pad containing feces and tossed it across R16's bed. The soiled pad traveled over R16's hip and abdomen, passed over V9's shoulder and landed on the lid of a 33-gallon trash can next to the wall, behind V9. The soiled pad was resting against the wall and on top of the trash can lid. The soiled pad did unfold one tuck however the feces did not spill out onto R16, V9, or the wall. V16 did not use a trash bag at the foot of the bed to contain the soiled linen or disposable wash cloths. A Policy titled Alternative Incontinent Care Utilizing Disposable Wash Cloths, dated 03/05/09, documents under Equipment Needed, number 7, Trash Bag at the foot of the bed. Under Procedure, number 15, the policy documents to take the soiled linens to the laundry hamper. 42547