

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3001061		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/11/2026	
NAME OF PROVIDER OR SUPPLIER Southgate Health Care Center				STREET ADDRESS, CITY, STATE, ZIP CODE 900 EAST NINTH STREET PO BOX 843, METROPOLIS, Illinois, 62960			
(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	
S0000	Initial Comments First Probationary Licensure Survey. Annual Licensure and Certification	S0000				04/03/2026	
S9999	Final Observations Statement of Licensure Violations 1 of 9: 300.661 Section 300.661 Health Care Worker Background Check A facility shall comply with the Health Care Worker Background Check Act and the Health Care Worker Background Check Code. These Regulations are not met as evidenced by: Based on interview and record review the facility failed to complete employee background checks as required. This failure has the potential to affect all 99 residents residing in the facility. Findings include: According to V11's (Licensed Practical Nurse/ LPN) personnel file, V11's date of hire was 1/23/26. The facility checked the Illinois Department of Financial and Profession Regulation (IDFPR) website for V11's licensure status on 2/26/26. According to V30's (LPN) personnel file, V30's date of hire was 1/29/26. The facility checked the IDFPR website for V30's licensure status on 2/26/26. According to V29's (LPN) personnel file, V29's date of hire was 2/24/26. The facility checked the IDFPR website for V29's Licensure status on 3/5/26. On 2/25/26 at 10:37 AM, V32 (Business Office	S9999				04/03/2026	

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 Manager) said she had asked the newly hire nurses to bring in a copy of their nursing license to the facility prior to them starting. V32 said she was not aware licensed nurses should have the IDFPR website checked prior to starting. On 3/4/26 at 11:50 AM, V15 (Administrator) said V32 was new and might not have been aware of the facility hiring practices. V15 said she expected all licensed nurses to have their license status checked on the IDFPR website prior to hire. The facility's revised 12/28/25 Background Screening Investigations policy documented in part "... The director of personnel, or designee, conducts background screening check, reference checks and criminal conviction checks... on potential direct access employees. Background and criminal checks are initiated and completed prior to scheduled start date. These checks may include but are not limited to the IDPH (Illinois Department of Public Health) Healthcare worker Registry check, IDFPR, Nursys, and criminal background checks in accordance with regulatory guidelines..." The facility's 2/24/26 Daily Census documented 99 residents residing in the facility. (C) Statement of Licensure Violations 2 of 9: 300.1060c) Section 300.1060 Vaccinations c) A facility shall administer or arrange for administration of a pneumococcal vaccination to each resident in accordance with the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, who has not received this immunization prior to or upon admission to the facility unless the resident refuses the offer for vaccination or the vaccination is medically contraindicated. (Section 2-213(b) of the Act) These regulations were not met as evidence by:	S9999				04/03/2026	

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S9999	Continued from page 2 Based on interview and record review the facility failed to assess residents for eligibility and ensure residents were offered pneumococcal vaccines for 4 (R1, R2, R4, and R27) of 5 residents reviewed for vaccinations out of a sample of 45. Findings include: 1. R4's Admission record documented an admission date of 1/14/25 with diagnoses including acute and chronic respiratory failure with hypoxia, pneumonitis due to inhalation of other solids and liquids, and dysphagia. R4's Order Summary Report printed 3/5/26 documented a 12/15/25 order documenting in part "... may receive pneumovax as ordered unless contraindicated..." R4's Pneumococcal Vaccine Consent/ Declination Form signed by R4's POA on 6/30/25 documented a box marked with an "X" documented in part "... have already received the pneumococcal conjugate and/ or pneumococcal polysaccharide vaccine..." "2-3 yrs ago" (sic) was handwritten beneath it. No documentation could be found of the specific date or type on pneumococcal vaccination that had been administered. 2. R1's Admission Record documented an admission date of 7/23/25 with diagnoses including chronic obstructive pulmonary disease, adult failure to thrive, and anxiety disorder. R1's Order Summary Report printed 3/5/26 documented a 12/7/25 ordered documenting in part "... may receive pneumovax as ordered unless contraindicated..." R1's Pneumococcal Vaccine Consent/ Declination Form signed on 8/14/24 documented a box marked with an "X" documenting in part "... I have other reasons for declining and do not wish to specify my reasoning..." 3. R27's Admission Record documented an admission date of 8/6/17 with diagnoses including chronic obstructive pulmonary disease, sleep apnea, and personal history of covid-19.	S9999				04/03/2026	

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S9999	Continued from page 3 R27's Order Summary Report printed 3/5/26 documented a 12/7/25 ordered documenting in part "... may receive pneumovax as ordered unless contraindicated..." R27's Pneumococcal Vaccine Consent/ Declination Form was unsigned and not dated but did document an "X" on the line proceeding "... I have other reasons for declining and do not wish to specify my reasoning..." 4. R2's Admission Record documented an admission date of 6/3/21 with diagnoses including dementia mild without behavioral disturbance, osteomyelitis, and methicillin resistant staphylococcus aureus infection. R2's Order Summary Report printed 3/4/26 documented a 8/22/25 order documenting in part "... may receive pneumovax as ordered unless contraindicated..." R2's Pneumococcal Vaccine Consent/ Declination Form signed by R2 dated 6/25/24 documented a box marked with a "check mark" documented in part "... I choose to decline for philosophical, religious, or scientific beliefs that prohibit vaccination... I have other reasons for declining and do not wish to specify my reasoning..." On 3/4/26 at 1:22 PM, V3 (Assistant Director of Nursing/ ADON) presented R1, R2, R4, and R27's Pneumococcal Vaccine Consent/ Declination Forms. V3 said she was not sure of the date R27's form was completed but knew it was scanned into the Electronic Medical Record (EMR) on 9/19/17. V3 said she was not sure if R1, R2, or R27 had ever received a pneumococcal vaccine. V3 said she was not sure when or what variation of pneumococcal vaccine R4 had received. V3 said these were the most recent pneumococcal forms she could find and guessed no one had held a facility wide pneumococcal vaccine clinic since 2024. The facility's revised October 2023 Pneumococcal Vaccine policy documented in part "... All residents are offered pneumococcal vaccines to aid in preventing pneumonia/ pneumococcal infections... 2. Assessments of pneumococcal vaccination status are conducted within five (5) working days of the	S9999				04/03/2026	

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S9999	Continued from page 4 resident's admission if not conducted prior to admission. 3. Before receiving a pneumococcal vaccine, the resident or legal representative receives information and education regarding the benefits and potential side effects of the pneumococcal vaccine... Provisions of such education is documented in the resident's medical record..." (C) Statement of Licensure Violations 3 of 9: 300.1210d)6) Section 300.1210 General Requirements for Nursing and Personal Care d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These regulations were not met as evidence by: Based on interview and record review, the facility failed to add new fall interventions following falls and to reassess the fall risk for 1 of 4 residents (R8) reviewed for falls in the sample of 45. Findings include: R8's Admission Record documented an Admission Date of 6/30/25 and listed Diagnoses including Diabetes Type 2 and Cerebral Atherosclerosis. R8's Minimum Data Set dated 12/20/25 documented R8 is severely cognitively impaired and requires the use of a wheelchair or walker for locomotion. R8's 10/7/25 Fall Risk Assessment documented that R8 is at high risk for falls. There were no Fall Risk Assessments in the record newer than 10/7/25.	S9999				04/03/2026	

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S9999	Continued from page 5 R8's Care Plan dated 2/14/26 documented a problem area, "(R8) has potential for falls/injury, ambulates independently with no assistive device, uses trazodone at bedtime. History of falls: 5/25/25, 6/30/25, 8/27/25, 9/14/25, 10/6/25, 12/14/25, 12/30/25, 1/28/26, 2/14/26. "There were no corresponding fall interventions for the 6/30/25 and 8/27/25 falls. R8's 6/30/25 Fall Investigation documented that on that date, R8, "Had fallen in her room and hit her head on the wall," with no injuries. Predisposing factors: Ambulating without assist." There were no new fall interventions on the Fall Investigation. R8's 8/27/25 Fall Investigation documented that on that date, R8 was found in the hall lying in a supine position with feces on her legs, back and buttocks, uninjured, without undergarments on. Predisposing factors: Ambulating without assist." There were no new fall interventions listed on the Fall Investigation. On 03/04/2026 at 12:18 PM, V17, Minimum Data Set/Care Plan Coordinator, stated she was not yet employed at the facility when the 6/30/25 and 8/27/25 falls occurred and does not know why new interventions were not added. On 03/05/2026 at 12:28 PM, V15, Administrator, stated nursing staff are to be completing Fall Risk Assessments quarterly. V15 stated staff had not reassessed R8's fall risk status since 10/7/25. An Assessing Falls and Their Causes Policy dated March 2018 documented, "Purpose: The purpose of this procedure are to provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall. Documentation: When a resident falls the following information should be recorded in the residents medical record: 6. Appropriate interventions taken to prevent future falls." (B) Statement of Licensure Violations 4 of 9: 300.1640d) Section 300.1640 Labeling and Storage of			S9999			04/03/2026

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S9999	Continued from page 6 Medications d) Biologicals or medications requiring refrigeration shall be kept in a separate, securely fastened locked box within a refrigerator or a locked refrigerator, at or near the nurses' station or in a refrigerator within a locked medication room. These regulations were not met as evidence by: Based on observation, interview, and record review, the facility failed to ensure medications requiring refrigeration were kept at safe temperatures. This has the potential to affect 57 residents living on the intermediate and skilled units in the facility. Findings include: On 02/26/2026 at 2:35 PM, The Medication Room on Intermediate Hall was checked with V5 (Licensed Practical Nure /LPN) present. The medication refrigerator was noted to have a thermometer showing 80 degrees with all medications warm to touch. The actual medication room felt warm and it was noted that the boiler room was next to the medication room. V5 stated the refrigerator was working this morning, but she knows V12 (Maintenance Director) was in the room working on a fan. V5 stated she was going to put the medications in the other refrigerator but then stated, "I better call the pharmacy first." V7 (Licensed Practical Nurse/LPN) called the pharmacy and V7 started removing stickers off all of the refrigerated medications and placed them on a pharmacy order sheet. V5 stated we are ordering all of the medications because they cannot be used by the residents. V5 confirmed the medications in the refrigerator were stock medications for the residents. V5 and V7 stated the refrigerators are checked every day and documented on the temperature logs. On 2/26/26 At 2:45 PM, The Medication room on Skilled Back was checked and the thermometer was found in the back of the refrigerator under a box and was broken. The medications were extremely cold to touch. V8 (LPN) stated she would get a new thermometer because this one was broken. V8 was asked how she knew what the actual temperature was in the medication refrigerator and V8 stated, "I do not know the actual temp, but it is very cold."			S9999			04/03/2026

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S9999	Continued from page 7 Thermostat on refrigerator was turned to "MAX." Refrigerator checked and temperature was 33 degrees. V8 then pulled out all of the medications including the emergency kit box and started pulling stickers and stated all of the medications had to be replaced. V8 stated the refrigerators are to be checked every day and documented on the log but V8 stated she honestly can't remember if she checked the refrigerator that morning. V8 stated this was not the hall where she normally works. On 2/26/2026 at 3:15 PM, spoke with V1 (Chief Executive Officer) and informed him of the findings of refrigerated medications were outside the safe temperatures for use. V1 stated he would definitely take care of the issue immediately. On 2/27/2026 at 9:10 AM, V12 (Maintenance Director) came to the medication room on the intermediate hall to check on the refrigerator and stated the refrigerator had shorted out the day before, so he was able to get it fixed pretty quickly once he was notified. On 2/27/2026 at 9:35 AM, the medication room on Skilled Back Hall was checked with V10 (LPN) and medications were all dated 2/26/2026 and included the Emergency Kit in the refrigerator. Temperature of the refrigerator was 44 degrees. V10 stated he always checks the refrigerator temperature and logs the temperature. V10 stated if temperatures are off a little, they adjust the thermostat. According to the "Consolidated Delivery Sheet" from the pharmacy with date of 2/26/2026. The total number of items replaced were 12 Insulin Pens, 1-Emergency Kit, 1-Latanoprost eye drops (1 vial), 1-Calcitonin, Bisacodyl suppositories (20), and Acetaminophen suppositories (32). Documents titled "Med Room Refrigerator Temp Log" dated January 2026 and February 2026. Note at the top of this document shows *Temp should be kept between 38 and 42 degrees adjust accordingly. Log sheet for Intermediate medication room refrigerator documents temps for every day. Log documents on 1/2/2026, 1/12/2026, 1/13/2026, 1/19/2026, 1/15/2026, 1/19/2026, 1/21/2026, 1/24/2026, 1/28/2026, 1/31/2026, 2/5/2026, 2/7/2026, 2/8/2026, 2/9/2026, 2/13/2026, 2/16/2026, 2/19/2026, temp of 36. On 2/18/2026, 2/20/2026, and 2/21/2026 temp of 34 degrees. On 1/30/2026 temp of 37. Log sheet for Skilled Back documents			S9999			04/03/2026

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S9999	Continued from page 8 temps of 36 degrees on 2/1/2026, 2/4/2026, 2/5/2026, 2/6/2026, 2/7/2026, 2/9/2026, 2/10/2026, 2/14/2026, 2/15/2026, 2/20/2026, 2/23/2026, and 2/24/2026. Policy titled "Medication Labeling and Storage" dated February 2023 documents, The facility stores all medications and biologicals in locked compartments under proper temperature, humidity, and light controls. #6. Medications requiring refrigeration are stored in a refrigerator located in the medication room at the nurse's station or other secured location. Medications are stored separately from food and are labeled accordingly. According to the United States Food and Drug Administration: The product labels from all three U.S. insulin manufacturers, it is recommended that insulin be stored in a refrigerator at approximately 36°F to 46°F. Unopened and stored in this manner, these products maintain potency until the expiration date on the package. https://www.fda.gov/drugs/emergency-preparedness-drugs/information-regarding-insulin-storage-and-switching-between-products-emergency The facility's 2/24/26 Daily Census documented there are 99 residents living in the facility, 33 residents residing on the intermediate unit and 24 residents residing on the skilled back unit. (C) Statement of Licensure Violations 5 of 9: 300.2420h) Section 300.2420 Equipment and Supplies h) Each resident shall have a satisfactory nurse call device. (See Sections 300.2940(g) and 300.3140(e).) These regulations were not met as evidence by: R2's Admission Record documented an admission date of 6/3/21 with diagnoses including dementia mild without behavioral disturbance, osteomyelitis, and methicillin resistant staphylococcus aureus infection. R2's 11/29/25 Minimum Data Set (MDS)			S9999			04/03/2026

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S9999	Continued from page 9 documented a Brief Interview for Mental Status (BIMS) score of 14, indicating R2 was cognitively intact. On 2/25/26 at 1:26 PM, R2's call light was turned on with no light being observed to come on in the hallway or at the nurse's station and no call light noise was being made. The call light box in the hallway by R2's door was hanging out of the wall with uncapped exposed wires. On 2/25/26 at 1:31 PM, V12 (Maintenance Director) said R2's call light had not been working for about a week and the facility was working on getting it fixed. V12 said R2 had a door bell chime to be used as a call light. V12 picked up the door bell call box and pressed it no noise was heard at the nurses station. V12 went to the nurse's station and unplugged the door bell sound box and plugged it back in. V12 pressed the door bell call box again and a chime was heard. On 2/25/26 at 1:35 PM, R2 said the facility had given R2 the door bell to be used as a call light when she was moved into the room in December 2025. R2 said there had been a time R2 had pressed the door bell call box several times and no staff had come to R2's until the night nurse came into R2's room and told R2 the door bell sound box had been unplugged. The facility's September 2022 Call System, Residents documented in part "... Residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized work station... 3. The resident call system remains functional at all times..." (B) Statement of Licensure Violations 6 of 9: 300.4020b) Sections 300.4020 Reassessments for Residents with Serious Mental Illness Residing in Facilities Subject to Subpart S b) All persons admitted to a nursing home facility with a diagnosis of serious mental illness who remain in the facility for a period of 90 days shall be re-screened by the Department of Human Services or its designee at the end of the 90-day period, at 6 months, and annually thereafter to assess their	S9999				04/03/2026	

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S9999	Continued from page 10 continued need for nursing facility care and shall be advised of all other available care options. These regulations were not met as evidenced by: Based on interview and record review the facility failed to ensure an individual with a new mental illness diagnosis was referred to the appropriate state-designated authority for a Level II PASARR (Preadmission Screening and Resident Review) evaluation and determination of need for any specialized services for 1 (R10) of 3 residents reviewed for PASARR requirements in the sample of 45. Findings include: R10's Admission Record documented an admission date of 7/20/23 with an added 11/19/24 diagnosis of delusional disorders. R10's 7/21/23 Notice of PASARR level I Screen Outcome documented no level II required and no mental health diagnoses is known or suspected. On 3/5/26 at 11:50 AM, V25 (Social Services Director) said she was not aware of the new delusion disorders diagnosis being added. V25 said she had submitted R10 for a new PASARR and a level II PASARR was going to be completed with an onsite review. R10's 3/4/26 Notice of PASARR Level I Screen Outcome documented to refer for level II onsite due to mental health disability. On 3/10/26 at 10:21 AM, V25 was asked for a PASARR policy and V25 said the only policy pertaining to PASARR was the January 2026 Admission Criteria policy that did not refer to admitted residents with new diagnoses. (C) Statement of Licensure Violations 7 of 9: 300.610a) 300.1210b)	S9999				04/03/2026	

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S9999	Continued from page 11 Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. These Regulations are not met as evidenced by: Based on observation, interview and record review, the facility failed to provide prompt care in a manner by which to maintain a resident's dignity for 2 of 3 residents (R20, R50) reviewed for dignity in the sample of 45. This failure resulted in R20 and R50 lying in their own body waste for several hours and experiencing feelings of degradation and humiliation. Findings include: 1. R50's Admission Record documented an Admission Date of 9/27/25 and listed Diagnoses including Paraplegia, Diabetes Type 2, and Colostomy Status. R50's Minimum Data Set dated 12/4/25 documented that R50 has no deficits in cognition and is totally dependent on staff for transfers and toileting. R50's Care Plan dated 12/11/25 documented a problem area, "(R50) has a colostomy in place," with a corresponding intervention, "Nursing to change	S9999				04/03/2026	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3001061		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/11/2026	
NAME OF PROVIDER OR SUPPLIER Southgate Health Care Center				STREET ADDRESS, CITY, STATE, ZIP CODE 900 EAST NINTH STREET PO BOX 843, METROPOLIS, Illinois, 62960			
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S9999	Continued from page 12 wafer and bag as indicated, cleaning stoma, apply (trade name liquid film forming protective skin barrier), new wafer and bag with each change. Report to Nurse if any skin irritation noted." A Resident/Family Concern/Grievance Form dated 2/23/26 documented, "Nature of Concern: (V16, Family Member) said (R50's) ostomy bag leaking and she had been covered in fecal matter for 6 hours." Follow up must be made with the individual who voiced/wrote the concern: "Resident got bag changed that evening around 7:30pm and then she got a bed bath by the CNA (Certified Nursing Assistant). Resident stated, "I think there was a lot of miscommunications." On 02/24/2026 at 11:12 AM, R50 was alert and oriented to person, place, and time. R50 stated on 2/23/26, her colostomy bag started leaking at the bottom at 9:30am, so she alerted staff and was told one of the nurses would come and check it. R50 stated she rarely has any problems with her colostomy, and normally staff do a good job of taking care of it. R50 stated she reminded staff about it several times during the day, and feces was leaking onto her skin and clothing and bed linens. R50 stated she tried to mop up the mess with tissues. R50 stated finally at 7:30pm the night shift nurse came and changed the bag and got her cleaned up. R50 stated she told her family member, V16, and he called the facility and complained. R50 stated, "I know the staff do the best they can, but leaving somebody covered in feces all day is not their best. And I was extremely embarrassed and upset that I was covered in my own feces and other people could smell me, and I stunk. Imagine how that feels." On 02/27/2026 at 1:06 PM, V16 confirmed R50 told him the colostomy bag had been leaking and nobody came in to change it. V16 stated he called the facility and filed a grievance. V16 stated he is not happy and is considering moving R50 to a different facility. On 02/27/2026 at 1:29 PM, V19 (CNA) stated she worked with R50 on 2/23/26. V19 stated she was passing trays at noon when R50 showed her the bag was leaking. V19 stated she informed V4, former Wound Care Nurse, who stated she was busy but would come and change it when she was free. V19 stated V4 did not come and she called V4 again and she was still busy. V19 stated she cleaned and changed R50 before her shift ended at 6pm and when she left the bag had still not been changed. On 03/04/2026 at 2:36 PM, V4 stated she had been			S9999			04/03/2026

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S9999	Continued from page 13 made aware of R50's colostomy bag leaking as stated by V19. V4 stated only doing wound care was in her job description, not doing any treatments such as colostomy care. V4 stated it was the floor nurse's responsibility to change R50's colostomy bag. V4 stated the next day, she was made aware that staff members had told R50 that it was V4's fault that it took so long to change her colostomy bag. V4 stated she talked to R50, who was very upset and rightly so, and told R50 it had not been her responsibility to see that the bag was changed. 2. R20's Admission Record documented an Admission Date of 11/4/25 and listed Diagnoses including Epilepsy, Atrial Fibrillation, and Chronic Obstructive Pulmonary Disorder. R20's Minimum Data Set dated 2/6/26 documented that R20 has no deficits in cognition and R20 is dependent on staff for transfers and toileting. R20's Care Plan dated 2/3/26 did not document any problem areas or interventions related to incontinence care or ADLs (Activities of Daily Living). On 02/24/2026 at 10:24 AM, R20 was alert and oriented to person, place, and time. R20 stated in the past 90 days, date unknown, she waited from 5am to 10am to have her call light answered while sitting in her own urine. R20 stated, "Its humiliating and degrading, but after a while you get used to it, I guess. You lose all sense of having any dignity." On 02/26/2026 at 10:07 AM, V3, Assistant Director of Nurses, stated she does not think the facility ever audits call lights. V3 stated she was not aware of R20's complaint of waiting hours on her call light while lying in urine. A Resident Rights Policy dated February 2021 documented, "Policy statement: Employees shall treat all residents with kindness, respect, and dignity. 1. Federal and state laws guarantee certain basic rights to all residents of the facility. These rights include the resident's right to: a. dignified existence; b. be treated with respect, kindness and dignity..." (B) Statement of Licensure Violations 8 of 9: 300.610a) 300.1010h) 300.1210b)			S9999			04/03/2026

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S9999	Continued from page 14 300.1210d)2)3)5) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 2) All treatments and procedures shall be administered as ordered by the physician. 3) Objective observations of changes in a resident's condition, including mental and emotional changes,	S9999				04/03/2026	

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S9999	Continued from page 15 as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. These Regulations are not met as evidenced by: Based on observation, interview, and record review the facility failed to identify wounds, implement interventions and treatments for wounds, and notify a physician of new wounds for 2 (R33 and R2) of 3 residents reviewed for general skin conditions in a sample of 45. This failure resulted in R33 developing painful open wounds to the left and right buttocks. Findings include: 1. R33's "Admission Record" documents an admission date of 11/9/2023 with diagnoses of Chronic Diastolic Heart Failure, Type 2 Diabetes Mellitus, Morbid Obesity, Chronic Kidney Disease, Paraplegia, Spinal Stenosis, Major Depressive Disorder, Paroxysmal Atrial Fibrillation, and Benign Prostatic Hyperplasia without Lower Urinary tract Symptoms. R33's Minimum Data Set (MDS) dated 12/29/2025 documents a Brief Interview for Mental Status (BIMS) score of 11, indicating R33 has moderately impaired cognition. Section GG documents R33 is dependent on staff for oral hygiene, toileting hygiene, sit to lying, lying to sitting on side of bed, sit to stand, chair to bed to chair, and toilet transfer. Section H-Bladder and Bowel documents R33 is not on a toileting program for urinary or bowel toileting. Section M-Skin Conditions documents R33 does not have an unhealed pressure ulcer and no Venous Arterial Ulcers and documents R33 has a pressure reducing device for chair and bed, application of nonsurgical dressings, applications for ointments/medication and application of dressing for feet. R33's Care Plan documents a Focus area of "(R33)			S9999			04/03/2026

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S9999	Continued from page 16 has the potential for impairment to skin integrity related to decreased mobility, paraplegia requires assist with Activities of Daily Living, and Depression. Open areas to right and left lower leg, venous (on admission) right neck abscess, finished antibiotics MASD (Moisture Associated Skin Disease) to penis" dated 8/23/2024 with revision date of 2/26/2026. Interventions in place include: keeping skin clean and dry; Use lotion on dry skin; Low Air Loss Mattress (2/27/2026); monitor/document location, size, and treatment of skin injury; Report abnormality, failure to heal, signs and symptoms of infection, maceration etc. initiated on 9/18/2024 with a revision date of 12/11/2025); Roho Cushion (air-filled neoprene cushion) at all times when up in chair to promote wound healing/protection with an initiation date of 8/29/2024 and revision date of 12/11/2025; and Una boots (zinc-paste impregnated gauze compression bandage) to bilateral lower extremities at all times for edema with an initiation date of 12/4/2025 and revision date of 12/11/2025. On 2/24/2026 at 10:41AM, R33 was observed sitting in his room in his wheelchair. A low air loss mattress was observed on R33's bed. R33 had Una Boots to Bilateral Lower Extremities. R33 was alert and oriented to person place and time. R33 was asked if he had a sore on his bottom and R33 stated yes, I do and they hurt. R33 was asked if he gets treatments to his bottom, and R33 stated no they don't take care of my bottom at all. R33 was asked if he had a cushion in his chair and R33 stated "I do but it is flat, and it makes my butt hurt. I have asked for a long time for a new cushion that is not flat, but they will not get me one." R33 was asked if he is up in his wheelchair most of the day and R33 stated "I stay up in my wheelchair all day long." R33 stated they used a lift to get him out of bed and into his wheelchair. R33 was asked if the staff help him reposition himself in the wheelchair and R33 stated "well, I can't really reposition myself and the only time I get repositioned is when I must go to the bathroom and have a bowel movement a couple of times a day and I have a catheter for my urine." R33's "Progress Note" dated 2/22/2026 at 11:38 PM documents "Skin Check: No new skin issues identified. Skin Issue #001: skin issue has not been evaluated. Location: Font left lateral lower leg (crus). Issue type: Venous. Wound was present on admission. It is unknow how long the wound has been present. #002: Skin issue has not been evaluated. Located: Left anterior neck. Issue type: Abscess. Wound acquired in-house. It is unknown how long the wound has been present. #003: Skin issue has not been evaluated. Penis. Issue type:		S9999			04/03/2026	

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S9999	Continued from page 17 other skin issues. Other skin issue description: Excoriation wound was present on admission. It is unknown how long the wound has been present. #004: Skin issue has not been evaluated. Location: Front right lateral lower leg (crus) Issue type: Venous. Wound was present on admission. It is unknown how long the wound has been present.” Completed Clinical Suggestions is left blank. R33's Order Summary Report dated 2/27/2026 documents an order dated 10/31/25 for a Pressure Reducing Mattress to bed very night shift for reduce risk for skin breakdown; an order dated 10/31/25 for Roho Cushion at all times when up in chair for protection every shift; an order dated 10/31/25 for a low air loss mattress to promote wound healing/protection every shift to promote wound healing/protection; an order dated 2/17/26 to Change Bilateral Unna Boot compression wraps 2 times weekly on Tuesdays and Fridays as needed for soiled/dislodged Unna Boots; and an order dated 2/17/26 to Change Bilateral Unna Boot compression wraps 2 times weekly on Tuesday and Fridays every evening shift on Tuesdays and Fridays for edema. There is no documentation for treatment orders to R33's buttocks. On 2/27/2026 at 1:20 PM, R33 was observed being assisted to the bathroom by V13 (Certified Nurse Assistant /CNA) to assess R33's buttocks. V13 assisted R33 to a standing position. R33's incontinence brief was removed and was observed to have blood on the inside of the incontinence brief. V13 stated “(R33) has been having bleeding in his (incontinence brief) for quite a while now.” R33 was observed to have 2 open areas to right lower buttocks with bleeding noted and the left lower buttocks have 3 open areas noted that were also bleeding. R33 stated “those areas really hurt and they have been there awhile.” The cushion observed in R33's wheelchair was noted to be small for the wheelchair and was flat. R33 stated he had been asking for a new wheelchair cushion for a long time because the one he has was flat and “it hurt my butt where those sores are.” V13 stated she would get R33 a Roho Cushion and notify the nurse in charge of R33's wounds. R33's “Progress Note” dated 3/1/26 at 11:46 PM by V26 (Licensed Practical Nurse /LPN) documented a skin assessment with wounds to the front lower leg, left anterior neck, Penis, and right later lower leg. There was no documentation of wounds to R33's bilateral buttocks or sacral area. On 3/4/2026 at 9:03 AM, R33 was observed in the	S9999				04/03/2026	

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S9999	Continued from page 18 bathroom being assisted by V14 (Certified Nurse Assistant/ CNA). Upon removal of R33's incontinence brief, blood was noted in spots on the inside of the brief. V14 stated R33 has had the bleeding for a while. V14 was asked why R33 requires an incontinence brief since R33 had a foley catheter and R33 is continent of bowels, V14 stated "I believe it is for the bleeding of the wounds on his butt, but I am not real sure." The cushion in R33's chair was the same flat cushion which was observed on 2/27/2026. V14 was asked if she was aware that R33 had orders for a Roho cushion and V14 stated "I thought he used to have one, but I can't be absolutely sure." When R33 stood up from the toilet, blood was noted to be present on the toilet seat. R33 was asked if the wounds on his bottom still hurt and R33 stated "yes, they really hurt." R33 was assisted in cleaning himself up and a new incontinence brief was placed on R33. The wounds to R33's buttocks had worsened since observing them on 2/27/2026. R33's wounds to left buttock were 1 linear open area and the wounds to the right buttock were 1 linear wound, connecting the small open areas into one larger open area. On 3/4/2026 at 12:00 PM, R33 stated he does have sores on both of his legs. R33 was asked if he got dressings placed on his legs and R33 said only when I get my boot things changed and that was twice a week. R33 remained sitting in wheelchair with the same cushion noted previously. On 3/4/2026 at 12:30 PM, V9 (Licensed Practical Nurse/ LPN) stated R33 does have areas on his legs but no special treatment. V9 stated we just do treatments to those legs at the same time we change the Una boots which is twice a week. V9 was asked about R33's wounds to his bilateral lower buttocks, V9 stated he wasn't aware of any areas to R33's buttocks but R33 has had wounds there before. V9 stated he would assess and measure the open areas to R33's buttocks a little later. V9 stated that the Una boots were ordered to treat the edema in R33's leg only and that a kit was used for the Unna boots. On 3/4/2026 at 12:45 PM, V3 (Assistant Director of Nursing/ ADON) was asked to validate that there were no orders for treatments for the venous wounds (per skin assessment) for R33. V3 reviewed all the orders and validated there were no treatment orders for the areas to R33's bilateral legs or to bilateral buttocks open areas. On 3/4/2026 at 3:45 PM, R33 was assisted to the bathroom for assessment of new wounds to the right and left buttocks with V21 (Physician) and V20			S9999			04/03/2026

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S9999	Continued from page 19 (Licensed Practical Nurse/V21's Nurse) present. R33's Una Boot to the right and left legs were removed. R33's right leg was noted to have small black areas scattered and the left leg had several black round areas as well. V21 stated the black areas were venous wounds and are from the Una Boot but without the Una Boot the legs would swell severely. V21 stated if he were to debride the areas then the legs would split open from the edema. V21 stated he was not notified of the black areas to bilateral legs and those areas needed to have a treatment to keep them from worsening. V21 stated he thought he would use Silvadene for bilateral leg wounds. V21 stated R33 has had issues with venous wounds to his legs in the past but was not notified that the wounds were starting to be an issue again. R33 was then assisted to the bathroom for assessment of new wounds to the right and left buttocks. V21 stated he was not notified of R33's wounds to his buttocks until today, 3/4/2026. V20 and V21 assisted R33 to a standing position and removed R33's incontinence brief. There was blood observed inside the incontinence brief. V21 assessed the wounds to the bilateral lower buttocks and stated the wounds were caused by pressure from the edema. V21 stated the edema put so much pressure on the buttocks while he sits in the wheelchair that the wounds actually tore open. V21 stated R33 needed a better cushion in his wheelchair to help with pressure issues. V21 stated R33 definitely needs a Roho cushion in his chair. V21 explained that he had ordered a Roho cushion for R33 on 10/31/2025 according to R33's Order summary. V21 also stated R33 has a stage 1 Pressure Area to his sacral area. R33's "Physician Visit" form dated 3/4/2026 documents nursing concerns of wounds to bilateral lower extremities and buttocks. The Chief Complaint is marked as "new." The note has documentation under "History and Physical" of "Patient has lower extremity chronically requiring Unna boots, previously he failed trial of leaving Una boots off and wounds worsened, now has wounds to buttocks." The Physical Exam documents R33 is alert and oriented x4. Skin wounds: right and left buttocks open and lower extremities wounds with eschar, and maceration. Diagnosis: 1.) Sacral stage 1 pressure, New. 2.) Open skin tears, new. 3.) Lower extremity venous ulcers, stable. 4.) Congestive Heart Failure Diastolic stable. New Orders: 1.) Legs, Santyl with polyfoam; change Una Boot every 72 hours. 2.) Buttocks- adaptive and polyfoam to open areas every 8 hours with repositioning and document refusals. 3.) Pressure Ulcer Sacrum: on skin with Polymem.			S9999			04/03/2026

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S9999	Continued from page 20 The facility policy titled "Pressure Injury Risk Assessment" (revision date March 2020) under "Documentation" states "The following information should be recorded in the resident's medical record utilizing facility forms:... 4. Any change in the resident's condition, if identified. 5. The condition of the resident's skin (i.e., the size and location of any red or tender areas), if identified... 11. Initiation of a (pressure or non-pressure) form related to the type of alteration in skin if new skin alteration noted.12. Documentation in medical record addressing MD notification if new skin alteration noted with change of plan of care, if indicated..." Under "Reporting" states "...2. Report other information in accordance with facility policy and professional standards of practice. 3. Notify attending MD if new skin alteration noted..." The facility policy titled "Change in a Residents Condition or Status" (revision date February 2021) documents "our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.). Under "Policy Interpretation and Implementation" states "The nurse will notify the resident's attending physician or physician on call when there has been a (an):... d. significant change in the resident's physical/emotional/mental condition; e. need to alter the resident's medical treatment significantly." significant change in the resident's physical/emotional/mental condition. 2. R2's Admission Record documented an admission date of 6/3/21 with diagnoses including dementia mild without behavioral disturbance, osteomyelitis, and methicillin resistant staphylococcus aureus infection. R2's MDS dated 11/29/25 documents a BIMS score of 14, indicating R2 was cognitively intact. R2's Care Plan documented a focus area initiated on 6/19/21 and last revised on 2/24/25 documenting in part "... has potential for altered skin integrity, decreased mobility, ulcers to lower extremities, treated at wound care. Requires assist with ADL's (Activities of Daily Living)... is noncompliant with dressing changes, continues to use personal scissors to cut bandages off..." with an initiation date of 6/19/21 and revision date of 12/11/25 with an intervention of "...keep skin clean and dry..."			S9999			04/03/2026

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NAME OF PROVIDER OR SUPPLIER Southgate Health Care Center				STREET ADDRESS, CITY, STATE, ZIP CODE 900 EAST NINTH STREET PO BOX 843, METROPOLIS, Illinois, 62960			
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S9999	Continued from page 21 R2's 2/1/26-2/28/26 Treatment Administration Record (TAR) documented a 1/12/26- 2/24/26 order documenting in part "... Vascular wound to bilateral lower extremities; cleanse with N/S (normal saline), apply Santly oint (ointment) to wounds beds (nickel thick) cover with adaptic and then cover with ABD (abdominal) pad; wrap with kerlix; secure with medipore tape change daily and PRN (as needed) ever day shift for BIL (bilateral) lower Ext (extremity) vascular wounds..." and a 2/25/26 through current order documenting in part "... Vascular wound to bilateral lower extremities; wash with antibacterial soap, apply medi honey to wounds beds cover with adaptic and then cover with an ABD pad; wrap with kerlix; secure with medipore tape change daily and PRN..." There was no documentation indicating that this treatment was administered on an as needed basis. R2's 3/1/26-3/31/26 TAR there was no documentation indicating that this treatment was administered on an as needed basis the same 2/25/26 order. On 2/25/26 at 1:06 PM, R2 was observed to have ace warps on her bilateral lower extremities. R2 said she had wounds to her lower extremities for years and had been told they were vascular. R2 said she got daily dressing changes on dayshift. On 2/26/26 at 2:40 PM, V3 (Assistant Director of Nursing/ ADON) was observed providing wound care for R2's bilateral lower extremity (BLE) wounds. Upon entry to R2's room, R2's BLE were wrapped with ace bandages from the toes to the knee with shoe covers on both feet. R2's left foot was placed on a blue disposable absorbent pad on the bed and the disposable absorbent pad started to become saturated with wound drainage while V3 provided wound care to R2's right lower extremity. V3 removed R2's left lower extremity ace wrap to reveal the kerlix beneath was saturated with yellow drainage. V3 removed the kerlix to reveal ABD pads saturated in yellow drainage. Once R2's dressing was fully removed R2's left foot/ ankle/ lower leg was macerated with the intact tissue having a white pallor and a vascular wound stretching from the medial malleolus to the lateral malleolus across the top of the foot and ankle and another vascular wound to the top of the foot from approximately where the interdigital spaces begin to mid-foot. The wounds were malodourous with a small amount of slough noted to the inner aspect of the ankle wound. On 3/4/26 at 12:40 PM, V27 (Licensed Practical Nurse/ LPN) said R2's BLE wounds had a lot of			S9999			04/03/2026

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S9999	Continued from page 22 drainage. V27 said R2 gets daily dressing even if the dressings are saturated with drainage due to wound are not wanting the dressings to be changed any more frequently. On 3/4/26 at 3:21 PM, V27 provided wound care for R2. When R2's left foot wrapped with ace wraps with a shoe cover over the foot was placed on a blue disposable absorbent pad, again the disposable absorbent pad started to become saturated with drainage. V27 removed the ace wraps and the kerlix and ABD pads were saturated with yellow drainage. When R2's dressing was fully removed the foot/ ankle/ lower leg was macerated. The wound from the medial malleolus to the lateral malleolus was noted with more slough to the inner and outer aspects of the wound and the wound to the top of the foot appeared dark red in color. The wounds were highly malodorous. On 3/5/26 at 12:45 PM, V28 (Infectious Disease Medical Assistant) was contacted and said R2's Infectious Disease Physician was not in the office and would not be back in the office for the rest of the week. V28 said the last 2 times they had seen R2, R2's wounds had deteriorated. V28 said on R2's last visit to their office R2's BLE wound dressings had been saturated with drainage "like no one had changed them." V28 said they would never have recommended to only change R2's dressing daily. V28 said if R2's dressings are saturated with drainage the facility staff should be changing them. V28 said R2's Infectious Disease Physician had documented he had spoken to the facility and recommended more frequent washing of the BLE. On 3/4/26 at 2:16 PM and 3/5/26 at 1:45 PM, a message was left with R2's wound care office requesting R2's Wound Care Physician to call back for an interview with no return phone call. On 3/6/26 at 2:44 PM, V21 (Medical Physician) said he was familiar with R2. V21 said he thought R2's BLE dressing change orders were daily and as needed. V21 said he expected the facility to change R2's BLE dressings if they became saturated with drainage. V21 said if R2's wounds were covered with drainage saturated dressings causing the tissue to be macerated it could lead to deterioration of R2's wounds. R2's Infectious Disease Progress Note dated 11/24/25 documented in part "... (R2) is here for follow-up of bilateral lower extremity ulcers/wounds. Last time she was here there had been marked improvement. I really think the improvement she had	S9999				04/03/2026	

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S9999	Continued from page 23 last time was due to better cleaning of the wounds on a consistent basis and daily dressing changes. She indicates today they had not changed her dressing over the past 48 hours. She indicates she was not sure if they did not have the supplies or that there was not enough nursing support to get it changed. When we take her dressings off today she feels the wounds are a little bit worse. There are some patchy areas that are new and a little bit worse bur there are other areas on the wounds that are stable or even improved from when I last saw her. There is a lot of dry flaking skin..." R2's Infectious Disease Progress Note dated 2/23/26 documented in part "...She has bilateral lower extremity venous ulcers. 2 visits ago the wounds were doing great. They had shown significant improvement after years of marginal change. Last visit this wound did not... I really think it was the consistent cleaning and washing of her legs to remove any crust or dry flaky skin offered her tremendous benefit... spoke with (V4 LPN) at (R2's facility). (V4) will be helping with her wound care... (V4) was in agreement that (R2) needed more frequent washing of the legs and dressing changes..." R2's facility weekly wound measurements documented the following: 11/8/25: left anterior leg 7.0 cm x 2.5 cm x 0.2 cm, left medial malleolus 4.2 cm x 1.2 cm x 0.2 cm, left dorsal foot 4.0 cm x 2.5 cm x 0.2 cm, left lateral ankle 3.6 cm x 2.5 cm x 0.2 cm, left lateral foot 1.5 cm x 1.8 cm x 0.2 cm 12/3/25: left anterior leg 6.0 cm x 2 cm x 0.2 cm, left medial malleolus 4 cm x 2 cm x 0.2 cm, left dorsal foot 3.5 cm x 2.2 cm x 0.2 cm, left anterior ankle 2.5 cm x 2.2 cm x 0.2 cm, left lateral foot 1 cm x 1.5 cm x 0.2 cm 1/24/26: left anterior leg 0.8 cm x 0.5 cm x 0.2 cm, left medial malleolus 6.5 cm x 4.2 cm x 0.2 cm, left dorsal foot 9.8 cm x 3.0 cm x 0.3 cm, left lateral ankle 6.2 cm x 4.0 cm x 0.2 cm 2/7/26: left anterior leg 0.8 cm x 0.3 cm x 0.2 cm, left medial malleolus 5.0 cm x 3.8 cm x 0.2 cm, left dorsal foot 6.0 cm x 3.0 cm x 0.2 cm, left lateral ankle 5.8 cm x 4.0 cm x 0.2 cm. (B) Statement of Licensure Violations 9 of 9:			S9999			04/03/2026

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S9999	Continued from page 24 300.610a) 300.1210b) 300.1210d)5) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. Based on observation, interview, and record review the facility failed to identify, treat, and prevent the	S9999				04/03/2026	

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S9999	Continued from page 25 development of pressure ulcers for 2 (R44 and R33) of 3 residents reviewed for pressure ulcers in a sample of 45. This failure resulted in R44 developing an infected and painful stage 2 pressure ulcer to the left great toe. Findings include: 1.R44's "Admission Record" has an admission date of 5/31/2024 and includes diagnoses of Unspecified Psychosis, Major Depressive Disorder, Anxiety, Hyperlipidemia, Gastroesophageal Reflux Disease, Hammer Toe to Right Foot, and Deformities of Toe. R44's Minimum Data Set (MDS) dated 11/30/2025 documents a Brief Interview for Mental Status (BIMS) score of 14 indicating R44's cognition is intact. Section GG documents R44 require supervision or touching assistance with toileting, shower/bath, lower body dressing, lying sitting, sitting to stand, chair/bed-to-chair transfer, toilet transfer, tub/shower transfers, and walks 10 feet. R44 propels self throughout facility via a manual wheelchair. Section M- Skin Conditions, documents R44 has pressure reducing device for bed, nutritional or hydration interventions, and application of non-surgical dressing. R44's Care Plan documents potential for impairment of skin integrity related to vitamin deficiencies and muscle spasm with revision date of 9/9/2025. Documented interventions include: Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, s/sx (signs and symptoms) of infection, maceration etc. to MD (medical Doctor) with an initiation date of 6/3/24. R44's Progress Note dated 9/2/25 at 1:49 PM documents "Braden Scale for Predicting Pressure Ulcer Risk Evaluation" with a Braden score of 16 with no clinical suggestions documented. R44's Skin Assessments dated 2/2/26, 2/16/26, and 2/22/2026 all document "no skin issues." On 3/5/2025 at 11:00AM, R44 was sitting in the dining room working on a puzzle. R44 was observed to only have the right shoe on and a sock on the left foot. R44 was asked what happened to his left foot and R44 stated my new shoes that I have was	S9999				04/03/2026	

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S9999	Continued from page 26 putting pressure on my big toe and caused a bad sore. R44 was asked when the issue with his toe started and R44 stated "well it's been a few weeks since it started." R44 stated I noticed it one night as I was taking my shoe off, I knew it was hurting. R44 stated I rolled up to the nurse's station and told one of the nurses and she looked at it and said that it looked yucky and she just put a band aid on it, (Nurse unknown). R44 stated, "about a week later it was getting worse, and the open spot was getting bigger, and my toe was really swollen, red, painful, and hot so I went back up to the nurse's station and the nurse was V3 (Assistant Director of Nursing/ ADON). R44 said she looked at it and said she had to call the doctor immediately. R44 stated that is when they put the pink dressing on it and started me on antibiotics. R44 stated it is starting to feel better, but it is still really bad. R44 stated the doctor came yesterday and was concerned with my toe. R44 stated it is still pretty painful, and the doctor ordered me some pain medications. R44 stated he has bad toes on the right foot and is missing some toes from an accident in a plane crash. R44 stated he doesn't want to lose anymore toes and he is worried because this really got infected pretty fast. R44 was asked if the nurses ever do a full body skin assessment including his feet and R44 stated "no they don't ever check my skin at all." R44's Progress Note dated 2/28/26 at 11:03PM by V3 (Assistant Director of Nursing/ ADON) documents "This nurse reached out to MD regarding resident left great toe. Resident has c/o (complaints of) pain and discomfort. Upon assessment resident has redness and swelling with an open area to the tope [sic]. Per MD change dressing to polymem and start Keflex 500mg TID x 10 days. This nurse notified resident of new orders." R44's Treatment Administration Sheet dated March 2026 documents an order dated 3/1/2026 for Polymem dressing (polymeric membrane dressing) to left great toe, change daily with a discontinuation date of 3/4/2026; an order dated 3/5/2025 for Polymem to open area to left great toe, change every 3 days with a discontinuation date of 3/5/2026; and an active order dated 3/5/2026 to Cleanse Stage 2 pressure area with normal saline and apply Polymem and change every 3 days and as needed. R44's Physician Order Sheet documents order dated 2/28/2026 for Keflex 500mg (milligrams) by mouth			S9999			04/03/2026

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S9999	Continued from page 27 three times a day for left great toe for 10 days. R44's "Physician Visit" form dated 3/4/2026 documents "Reason for visit: sick, Skin: Left Great Toe, Nursing Concerns: Left great Toe open area Polymem dressing. History Physical: Patient recent trauma on left toe from new shoes. Increase swelling, full skin in photos and increased pain in toe. More swelling, redness improved. Diagnosis: Stage 2 Toe New. Improving with Keflex and dressing changes. New orders: Norco 5/325mg three times a day as needed for pain." There is no documentation of wound measurements on this form. There was no documentation is R44's Progress Notes for the initial measurements of the wound to R44's toe. On 3/5/2026 at 12:05PM, V5 (Licensed Practical Nurse/ LPN) was observed performing treatment to R44's left great toe. R44's old dressing was removed with a small amount of drainage noted to dressing that was yellow in color. The open area was cleansed with normal saline. R44's left toe was swollen and red in color with the open area noted to have 2 circular areas with dark yellow in the center of the wound. R44 stated the toe is still really painful and really swollen. V5 measured the wound at 2.5 cm (centimeters) in length, by 1.5 cm in width. V5 was unable to measure the depth of the wound due to R44 verbalizing pain during the assessment. The most recent Pressure Wound Log provided by the facility was dated 2/19/2026 and did not document R44 having any wounds. On 3/9/2026 at 9:00AM, V3 (Assistant Director of Nursing), stated R44 came up and showed her his toe on 2/28/26 and she immediately took a picture of it and sent the picture to the physician and the physician then gave orders for Keflex and a polymem dressing. V3 was asked if she got measurements at that time of the wound and V3 stated "no, this happened during my medication pass and R44 put his sock right back on so I did not get measurements." V3 stated, I know the toe was swollen and red and had an open area on the top. On 3/6/2026 at 2:44PM, V21 (Physician) stated he			S9999			04/03/2026

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S9999	Continued from page 28 had received a photo of R44's toe a few days back and he ordered Keflex antibiotics for 10 days. R44 stated the toe looked pretty rough in the photos but he didn't actually see the toe until he made rounds on 3/4/2026 and it looked a little worse than the photos. V21 stated he would keep R44 on is rounds until the toe was healed. V21 was asked if he felt the toe was pressure related and V21 stated "yes, it is definitely from his shoe." 2. R33's Admission Record documented an initial admission date of 11/9/23 with diagnoses including morbid obesity, paraplegia, and spial stenosis. R33's MDS dated 12/29/2025 documents a BIMS score of 11 indicating R33 has moderate cognition impairment. Section GG of the same MDS documents R33 is dependent on staff for oral hygiene, toileting hygiene, sit to lying, lying to sitting on side of bed, sit to stand, chair to bed to chair, and toilet transfer. Section H-Bladder and Bowel documents R33 is not on a toileting program for urinary or bowel toileting. Section M-Skin Conditions documents R33 does not have an unhealed pressure ulcer and no Venous Arterial Ulcers and documented R33 has a pressure reducing device for chair and bed, application of nonsurgical dressings, applications for ointments/medication and application of dressing for feet. R33's Care Plan documents a Focus area of "(R33) has the potential for impairment to skin integrity related to decreased mobility, paraplegia requires assist with Activities of Daily Living, and Depression. Open areas to right and left lower leg, venous (on admission) right neck abscess, finished antibiotics MASD (Moisture Associated Skin Damage) to penis" dated 8/23/2024 with revision date of 2/26/2026. Interventions in place include: keeping skin clean and dry. Use lotion on dry skin. Low Air Loss Mattress (initiated 2/27/2026), Monitor/document location, size, and treatment of skin injury. Report abnormality, failure to heal, signs and symptoms of infection, maceration etc. (initiated 9/18/2024 with revision date of 12/11/2025), Roho Cushion at all times when up in chair to promote wound healing/protection (initiated 8/29/2024 with revision date of 12/11/2025), Una boots to bilateral lower extremities at all times for edema (initiated 12/4/2025 with a revision date of 12/11/2025). R33's Progress Note dated 10/31/25 at 4:54PM			S9999			04/03/2026

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S9999	Continued from page 29 documents a Braden evaluation with a score of 18. R33's Progress Notes dated 2/22/26 at 11:38PM and 3/1/26 at 11:46 pm documents a note type of "Skin Check." Both notes document venous wounds to the right and left leg, an abscess to the neck, and excoriation to the penis. There is no documentation of wounds to the buttocks, sacral, or coccyx area. On 2/24/2026 at 10:41AM, R33 was observed sitting in his room in his wheelchair. R33 was alert and oriented to person place and time. An air loss mattress was observed on R33's bed. R33 was asked if he had a sore on his bottom and R33 stated yes, I do and they hurt, R33 was asked if he had a cushion in his wheelchair and R33 stated I have a flat one and my butt hurts a lot. R3 was asked if he gets treatment to his bottom, R33 stated no they don't take care of my bottom at all. R33 was asked if he had a cushion in his chair and R33 stated "I do but it is flat, and it makes my butt hurt. I have asked for a long time for a new cushion that is not flat, but they will not get me one." R33 was asked if he is up in his wheelchair most of the day and R33 stated "I stay up in my wheelchair all day long." R33 stated they use a lift to get him out of bed and into his wheelchair. R33 was asked if the staff help him reposition himself in the wheelchair and R33 stated "well, I can't really reposition myself and the only time I get repositioned is when I must go to the bathroom and have a bowel movement a couple of times a day and I have a catheter for my urine." R33's Order Summary Report dated 2/27/2026 documents an order dated 10/31/25 for a Pressure Reducing Mattress to bed very night shift for reduce risk for skin breakdown, an order dated 10/31/25 for Roho Cushion (air-filled neoprene cushion) at all times when up in chair for protection every shift, and an order dated 10/31/25 for a low air loss mattress to promote wound healing/protection every shift to promote wound healing/protection. On 2/27/2026 at 1:20PM, R33 was observed being assisted to the bathroom by V13 (Certified Nurse Assistant/ CNA). The cushion observed in R3's wheelchair is noted to be small for the wheelchair and was flat. R33 stated he had been asking for a new chair cushion for a long time because the one he had was flat and hurts his butt. V13 stated she would get R33 a Roho Cushion.			S9999			04/03/2026

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3001061		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/11/2026	
NAME OF PROVIDER OR SUPPLIER Southgate Health Care Center				STREET ADDRESS, CITY, STATE, ZIP CODE 900 EAST NINTH STREET PO BOX 843, METROPOLIS, Illinois, 62960			
(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
S9999	Continued from page 30 On 3/4/2026 at 9:03 AM, R33 was observed in the bathroom and being assisted by V14 (CNA). The cushion observed in R33's wheelchair was the same flat cushion which was observed on 2/27/2026. V14 was asked if she was aware that R33 had orders for a Roho cushion and V14 stated "I thought he used to have one, but I can't be absolutely sure." On 3/4/2026 at 3:45 PM, R33 was assisted to the bathroom for assessment of new wounds to the right and left buttocks with V21 (Physician) and V20 (Licensed Practical Nurse/V21's Nurse) present. V21 stated he was not notified of R33's wounds to his buttocks until today 3/4/2026. V21 stated R33 needed a better cushion in his wheelchair to help with pressure reduction. V21 stated R33 definitely needs a Roho cushion in his chair. V21 explained that he had ordered a Roho cushion for R33 on 10/31/2025 according to R33's Order summary. V21 also stated R33 has a stage 1 Pressure Area to his sacral area. V21 stated he will write orders for a treatment for the sacral area pressure so the wound will hopefully not get worse. On 3/5/2026 at 9:30 AM, R33's Physician Visit form dated 3/4/2026 document nursing concerns of wounds to bilateral lower extremities and buttocks. Chief Complaint is marked as "new." Under Diagnosis documents Sacral stage 1 pressure, New and a new order for "Pressure Ulcer Sacrum: on skin with Polymem." The facility's revised November 2024 Prevention of Pressure Injuries policy documented in part "... The purpose of this procedure is to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors... Review the resident's care plan and identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable... Risk Assessment... 1. Assess the resident on admission (within eight hours) for existing pressure injury risk factors. Repeat the risk assessment weekly and upon and changes of condition... Skin Assessment... 3. Inspect the skin on a daily basis when performing and assisting with personal care and ADLs (Activities of Daily Living). A. Identify any signs of developing pressure injuries..." (B)			S9999			04/03/2026