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	03/27/2026

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interventions, and record reviews, the facility failed to provide appropriate incontinence care and oral care to 3 (R1, R2, R3) of 4 residents reviewed for Activities of Daily Living (ADL's) in a sample of 4. Findings include:.1. R2's admission Record documents an admission date of 2/26/2022 and includes diagnoses of Multiple Sclerosis, local Infections of the skin and subcutaneous tissue, Type 2 Diabetes Mellitus, Paralytic Syndrome following Cerebrovascular Disease, Convulsions, Major Depressive Disorder, and Dysphagia. R2s Physician Order sheet documents R2 was placed on hospice on 2/27/26.R2's Minimum Data Set (MDS) dated [DATE] includes a Brief Interview for Mental Status (BIMS) score of 12 suggesting moderate cognition impairment. Section GG documents R2 is dependent for all activities of daily living including oral care. Section H- Bladder and Bowel documents R2 has an ileostomy, and is always incontinent of bowel, and urinary continence is not rated. R2's Care Plan documents R2 has an ADL self-care performance deficit related to limited mobility, limited range of motion, and Multiple Sclerosis date initiated 12/22/2022.On 3/17/2026 at 10:05AM, V4 (Certified Nurse Assistant/CNA with Hospice) was observed in R2's room preparing supplies for a bed bath. V4 proceeded to remove the depends and R2 was noted to have a medium size bowel movement with noted dried bowel movement on R2's buttocks. V4 stated, This is really dried on there and it will take a bit to get this off. V4 used warm soap and water to get the dried bowel movement off R2. V4 asked R2 if he was checked all night or early this morning and R2 stated, no I do not believe so. Observation of bed bath and personal care did not include oral care for R2. On 3/18/2026 at 12:29PM, V4 was asked if she had ever seen dried bowel movements on residents on hospice patients that she cares for at this facility. V4 stated, all the time. V4 stated, I always find dried poop on R2, every time I come in to give R2 a bed bath, it never fails and his stools are normally formed. On 3/18/2025 at 1:00PM, R2 was asked if he has dried poop left on him very often. R2 stated, I believe so, at least that is what they tell me anyway. Sometimes I have to wait awhile to be changed, and it just dries. R2 stated he does not get oral care very often and he is not able to do it himself.2. R1's admission Record documents an admission date of 10/16/2025 and an admission date to hospice care on 2/27/2026 with diagnoses of Multiple Myeloma and Pulmonary Embolism. Other documented diagnoses include Asthma, Spinal Stenosis, Chronic Pain, Gastro-Esophageal Reflux Disease, Hyperlipidemia, Hypertension, Osteoporosis with pathological fractures, Acute Respiratory Failure, and Fibromyalgia. R1's admission Record documents a date of discharge of 3/9/26.R1's Minimum Data Set (MDS) dated (2/27/2026) documents a Brief Interview for Mental Status (BIMS) score of 7, indicating R1 has moderate cognitive impairment. Section GG- Functional Abilities documents R1 required partial to moderate assistance with transfers and substantial/maximal assistance with position changes from sitting to lying and lying to sitting. Section H -Bladder and Bowel documents R1 is always incontinent of bowel and occasionally incontinent of urine. R1's Care plan documents R1 has actual/potential for ADL functional decline, diagnosis of multiple myeloma, asthma and respiratory failure.On 3/17/2026 at 12:34PM, V9 (Family member) stated while visiting R1on 3/8/26 it was noted that R1 had had a bowel movement and it was pasted to her bottom. On 3/19/2026 at 1:54PM, V17 (CNA) stated she worked on 3/8/2026 and helped take care of R1. V17 stated we figured she was dying. V17 stated we (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tried to go in and turn her and when I seen her she was resting. On 3/18/2026 at 12:29PM, V4 (CNA with Hospice) V4 was asked if she had ever seen dried bowel movement on R1 and V4 stated, I sure have and that was sort of a normal thing. V4 stated R1 was usually complaining of pain off and on during her care and V4 stated she would report the pain to the charge nurse. V4 stated she is in the facility on Tuesdays and Thursdays to provide personal care to her hospice patients. V4 stated, it is heartbreaking to see the patients in the condition that I find them in some days. 3. R3's admission record documents R3 was admitted to the facility on [DATE] and was admitted to hospice care on 7/26/2025. R3's admission record documents diagnoses of Parkinson's Disease, Dementia Severe, Palliative Care, Heart Failure, Major Depressive Disorder, Anxiety Disorder, and Adult Failure to Thrive. R3's Minimum Data Set (MDS) dated [DATE] includes a Brief Interview for Mental Status (BIMS) score of 3 indicating R4 has severe cognition impairment. Section GG-functional abilities documents R3 is dependent on staff for Activities of Daily Living including transfers and oral care. Section H-Bladder and Bowel documents R3 is always incontinent of urinary continence and R3 is always incontinent of bowels. R3 MDS documents R3 is not on a bowel program. R3's care plan documents R3 has an ADL self-care performance deficit related to confusion, dementia, impaired balance and Parkinson's. R3 is totally dependent on 1 staff for personal hygiene and oral care. R3 is not toileted. On 3/17/2026 at 11:37AM, R3 was sitting in a geri chair outside of his room. R3 was unable to answer questions at that time. R3 had poor oral hygiene noted. Teeth were covered in whitish yellow fuzzy like substance all over teeth. R3 was observed with flinching in his legs and was grimacing and gritting his teeth. R3 had just received personal care which did not include oral care.On 3/18/2026 at 12:29PM. V4 (CNA with Hospice) stated she has found dried poop on R3 several times. V4 stated R3 is usually soaked in urine too. On 3/19/2026 at 2:19, V18 (CNA) was asked if she has ever found dried bowel movement on any of the residents and V18 stated yes but not too often but it does happen from time to time. V18 stated oral care should be part of AM care for the residents. On 3/19/2026 at 1:30PM, V15 (CNA) was asked if he has ever came in and found residents with dried bowel movements on the residents, V15 stated yes I have come in and found that on different residents. V15 was asked if he felt that was because of staffing, V15 stated no it is because some do not have compassion for the residents and do not need to work in this field. Policy named Perineal Care dated February 2018 documents the purpose of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin.

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety 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** Based on observations, interviews, and record reviews, the facility failed to provide effective pain management for 3 of 3 residents (R1, R2, and R3) reviewed for pain in a sample of 4. This failure resulted in R1, who has a diagnosis of Multiple Myeloma and at the end-of-life stage, not receiving an ordered narcotic pain medication for 6 hours and R1 experiencing intense pain and suffering prior to her death.This failure resulted in Immediate jeopardy, which was identified to have begun on [DATE] when the facility ran out of R1's oral Dilaudid pain medication resulting in R1 experiencing uncontrolled pain. V1 (Administrator), V21 (Regional Clinical Coordinator), V2 (Director of Nursing, and V3 (Assistant Director of Nursing) were notified of the Immediate Jeopardy on [DATE] at 2:10PM. The immediacy was removed on [DATE], but non-compliance remained at a Level Two because additional time is needed to evaluate the implementation and effectiveness of In-service training.Findings Include:1.R1's admission Record documents an admission date of [DATE] and an admission date to hospice care on [DATE] with diagnoses of Multiple Myeloma and Pulmonary Embolism. Other documented diagnoses include Asthma, Spinal Stenosis, Chronic Pain, Gastro-Esophageal Reflux Disease, Hyperlipidemia, Hypertension, Osteoporosis with pathological fractures, Acute Respiratory Failure, and Fibromyalgia. R1's admission Record documents a date of discharge of [DATE].R1's Minimum Data Set (MDS) dated ([DATE]) documents a Brief Interview for Mental Status (BIMS) score of 7, indicating R1 has moderate cognitive impairment. Section J- Health Conditions documents no for the following: Received scheduled pain medication regimen; received PRN (as needed) pain medications or was offered and declined; and received non-medication intervention for pain? Section N- Medications documents that R1 is taking an Opioid medication. Section O- Special Treatments, Procedures, and Programs documents that R1 is receiving hospice care.R1's Care Plan documents a Focus area of R1 has actual/potential for pain (date initiated [DATE]) with a Goal of R1 will report satisfactory pain control (date initiated [DATE].) Documented interventions include evaluate for non-verbal indicators of pain, evaluate pain, evaluate the effectiveness of pain interventions every shift, review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impacted on functional ability and impact on cognition, monitor for factors/activities that precipitate or aggravate pain, monitor/record pain characteristics every shift and as needed, monitor/report/record complaints of pain or request pain treatment, monitor/record/report signs and symptoms of nonverbal pain: changes in breathing, vocalizations, and mood/behavior (date initiated [DATE] and revision date of [DATE].)R1's Physician's Orders documents the following orders for pain management: Fentanyl Patch 25MCG/HR every 72 hours with order date of [DATE], Dilaudid oral liquid give 2 milliliters every 2 hours with order date of [DATE], Hydrocodone 5/325mg every 12 hours as needed for breakthrough pain dated [DATE].On [DATE] at 12:34PM, V9 (Family Member) stated R1 was dying on [DATE] and the facility could not get her medication Dilaudid in all that day and R1 suffered all day because she was out of her medications. V9 stated it was so bad and other family members were there like my aunt and R1's son. V9 stated R1 was in so much pain that she kept crawling out of the bed and we were having to hold her as best we could to keep her from falling out of the bed. V9 stated it was absolutely the worst thing I have ever seen. V9 stated we kept calling hospice ourselves to see when they could bring her medications and we kept getting told that they were on their way. This went on all day long. V9 stated this was all so bad and not only hard on R1, but it was also hard on the family to watch.On [DATE] at 12:42PM, V11 (Family Member) stated she was with R1 a lot and was there on [DATE] in the afternoon. V11 stated the staff said they thought they had more Dilaudid for R1, but they didn't. V11 stated she knows the hospice nurse called a local pharmacy, we waited and waited. V11 stated R1 was thrashing all over the bed, trying to get out of bed and she was not comfortable at all, and we could not make her comfortable. V11 stated R1's nurse, V14, was trying but she stated she worked for (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	a different company and was just filling in there for the day. V11 stated R1 was dying, and she died roughly because she did not have her medications she needed, and nobody was doing anything for a long time. V11 stated even after the medications came that evening it took a long time to get R1 settled back down to rest and then she died later.On [DATE] at 1:22PM, V10 (Family Member) stated he was there on [DATE] as R1 was in the process of dying and other family members were present as well. V10 stated it was so horrible, and I will never forget the suffering my mother had to endure because people did not do what they should and provide her with medication to relieve the pain. V10 stated we normally did not leave R1 alone because if she wouldn't ask for medications when R1 was in pain then she would not have ever gotten any pain medications. V10 stated R1 had a pain pump with Dilaudid for 5 years due to back pain. V10 stated they had been cutting down the dose because they were substituting the Dilaudid with the liquid form because R1 was no longer going to be on the pump due to hospice providing the medications. V10 stated the pump was barely delivering any medication if any so that is why R1 needed the liquid Dilauudid by mouth. V10 stated when R1 died it was the worst thing to watch, and it was so bad that he would not let R1's grandchildren come and say their goodbyes because it would have been hard for them to see, and they would not understand. V10 stated the thrashing in the bed was so bad and R1 was so miserable. V10 stated this was no way to treat a human being and let them suffer like that. V10 stated the nurse on [DATE] was V14 and she was trying her hardest to get the medication brought to the facility. V10 stated he even called local hospital emergency room to see if there was anything they could do to help R1 get some pain control. V10 stated he was told by the hospital that R1 could be sent to the emergency room, but they transferred the phone call to the hospice department, but nobody answered. V10 stated hospice came to the facility that morning and stated they were trying to figure out why the Dilaudid did not come in. V10 stated this was an experience that no resident or family should ever have to go through. V10 stated we did everything we knew to do and called hospice and even hospitals to try to get R1 some help but nothing helped. V10 stated finally in the evening the medicine came in and the nurse gave it to her. V10 stated it still took a few hours to get R1 settled down and then about midnight R1 passed away, she was just worn out from struggling all day long. V10 stated R1 should not have had to struggle like that while dying.On [DATE] at 3:40PM, V20 (Hospice Registered Nurse) stated she was R1's hospice nurse for [DATE] and [DATE]. V20 stated when she was in the facility to see R1 on [DATE] she noted that R1's Dilaudid was almost empty and would not have enough available to make it through [DATE]. V20 stated she talked with the nurse and was told by the facility nurse if she got the orders to the facility's pharmacy by 3:00PM that the pharmacy would deliver the medication that evening. V20 stated I sent the orders to the facility's pharmacy before noon and instructed the nurse that if the medication did not get delivered that evening to notify hospice immediately so they could get the medication from another pharmacy and get it to the facility in time for there to be no breaks in the medication's availability for the resident. V20 stated she never received a call, so she assumed the medication had arrived as planned. V20 stated she was not made aware the medication did not get delivered until the medication was depleted. V20 stated she went to the facility as soon as she was notified and checked on R1 and at that time R1 was resting and had no signs of pain, but this was right after the 10:00AM dose of Dilaudid was given. V20 stated she instructed V14 to give R1 a dose of her Hydrocodone around 11:00AM to help with pain until she could get the medication (Dilaudid) in the facility. V20 stated it took a while to get the medications back in the facility and felt so bad for R1 and the family. V20 stated without R1 getting the Dilaudid it caused R1 to be in pain and uncomfortable. V20 stated she also told V14 to increase the Fentanyl Patch to 25mcg/hr (micrograms/hour) but was unsure if they had the 25mcg/hour in their emergency drug kit. V20 stated the family had called her that morning and was asking for an increase in R1's anxiety medications so she got the Ativan increased. V20 stated the family was also calling about the Dilaudid not being available. V20 stated it took a while to find a pharmacy open then I had to get a signed script from the doctor then I headed out of town to get the medication. V20 stated when I finally got to that pharmacy, (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the pharmacist was on lunch, so I had to wait for them to get back. V20 said once I finally got the meds I headed back to the facility, and we initiated a dose of the Dilaudid as soon as I got the medication checked in. V20 stated it must have been a little after 3:00PM or so when I got the medication back to the facility. V20 stated the family was very upset and rightly so and V20 stated she apologized several times to the family, and she felt bad that this had happened. V20 stated she knew R1 had to be in pain and feeling discomfort without her pain medications. V20 stated R1 then started relaxing about 5:30ish and another dose was given at 6:00PM. V20 stated she knew R1 had a Dilaudid pump but the medication in the pump was being tapered down and was to be discontinued on [DATE]. V20 stated R1 passed away a little after midnight.On [DATE] at 6:20 PM, V23 (LPN) stated she worked on [DATE] on day shift. V23 stated that V20 came in on [DATE] between 12:45PM and 1:00PM and they checked R1's Dilaudid and there was 12-14mL remaining. V23 said that R1 was mottled and anxious so V20 increased R1's Dilaudid to 2mL every 2 hours. V23 said that V20 thought R1 would expire before her Dilaudid ran out but ordered more to be safe. V23 said she called the pharmacy and they stated as long as they had the script for the Dilaudid by 3:00PM, it would be delivered with that days shipment. V23 sometimes their medication deliveries do not arrive until midnight or 1:00 am. V23 said during shift report, she told the night shift nurse to notify hospice if R1's Dilaudid was not delivered. V23 said she could not recall the nurse's name that she reported it to but is was a nurse from the staffing agency.On [DATE] at 7:08PM, V24 (Agency Licensed Practical Nurse) said that she worked the night shift on [DATE]. V24 stated that she does not recall being told in report to notify hospice if R1's Dilaudid was not delivered. V24 said that if she would have known that, she would have notified hospice because pain medication is important for hospice patients.On [DATE] at 1:37PM, V14 (Licensed Practical Nurse/LPN) stated she was the nurse in charge of R1 on [DATE]. V14 stated that she gave R1 what was left of her Dilaudid for 10:00AM on [DATE] and sated it was probably not a full dose at all. V14 stated R1's Dilaudid 2 milliliters (ml) was ordered every 2 hours routinely. V14 stated she searched for another bottle of Dilaudid but there was none. V14 stated she was in contact with hospice requesting Dilaudid be delivered to the facility. V14 said hospice had told her they would see why R1 was out of Dilaudid and get her some to the facility. V14 stated the hospice nurse came to the facility and saw R1 and then started working on finding a pharmacy available to fill the prescription of Dilaudid. V14 stated V20 (Hospice Registered Nurse) stated she would have to run to an out-of-town pharmacy to get the medication due to the Pharmacy in town being closed. V14 stated this was right around 10:00AM on [DATE]. V14 stated she kept waiting on V20 to bring the medication, but it was taking a long time. V14 stated while they were waiting, she felt so bad for R1 because she was throwing her legs out of the bed and trying to get out of bed. V14 stated the family was at bedside and were really upset at the lack of pain control for their loved one. V14 stated she works through an agency so she is not in the facility too often but was unsure how the resident's medications could just run out without being refilled in a timely manner. V14 stated she spoke to a nurse manager at one point for direction, but she wasn't sure who it was and no solution to the problem was given. V14 stated she even gave R1 a pain pill (Hydrocodone-Acetaminophen 5/325 milligrams) that was ordered every 12 hours but that did not offer hardly any pain relief and only settled R1 for a very short time. V14 stated she felt so bad for R1 as she was so uncomfortable and agitated due to pain. V14 stated she really thought about just calling an ambulance to send R1 out to the nearest emergency room for some pain relief but R1 was in such pain. V14 felt it would make R1's pain even worse and R1 would not tolerate the move very well, so V14 stated she just kept waiting and hoping the medication would be delivered soon. V14 said that finally 6 hours later, V20 walked through the door, and it was around 4:00PM and V14 stated, I grabbed the medicine and ran to (R1's) room and administered her dose of Dilaudid. V14 stated it still took an hour and a half to two hours to get R1 settled down and rest a little bit. V14 stated she kept thinking that if this would have been one of her loved ones that she would have been having a fit and this was hard on the family as well. V14 stated R1 was receiving Ativan as ordered every 2 hours but was not making a difference with the (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	resident status. (V2 Director of Nursing/DON) notified. CNA to complete postmortem care on residents. No further issues at this time. Authored be V22 (Licensed Practical Nurse/LPN.) R1's Narcotic count sheet for Dilaudid 1mg/ 1ml solutions documents on [DATE], R1 received Dilaudid 2 milliliters as ordered at 8:00AM and 10:00AM and documents that 10:00AM was the last dose with V14's initials.R1's Medication Administration Record (MAR) dated [DATE]-[DATE] documents on [DATE] at 10:00 AM R1 was administered Dilaudid 2mL as ordered with a pain level of 0 and V14's initials. R1's 12:00 PM and 2:00 PM dose on [DATE] documents an administration code of 9 and document a X for R1's pain level and V14's initials. The Chart Codes on the MAR documents that a 9 indicates Other/ See Progress Notes Ineffective. The 4:00 PM dose on [DATE] of Dilaudid is documented as being administered by V14 and documents a pain level of 0.On [DATE] at 2:00PM, V3 Assistant Director of Nursing (ADON) was asked if she was made aware of the situation on [DATE] and V3 stated she was not made aware of the situation of the Dilaudid on [DATE]. V3 was asked if the nurse could have sent the resident to the emergency room to get some pain control and V3 stated (R1) was hospice and if she had gotten sent out, (R1) would have lost her services from hospice. V3 stated we generally do not send hospice patients to the hospital because they are under the care of hospice. V3 stated she was not on call that weekend so she will have to look into this issue. V3 said pain assessments are documented on the MAR and are done every shift or three times a day.On [DATE] at 9:30AM, V13 (R1's primary physician/medical director) was asked if he was notified on [DATE] of R1 being out of her Dilaudid medication and having increased pain. V13 checked his phone and his computer and stated, no, I was not notified and was not aware of that occurrence at all. V13 stated the notification I do have is that R1 expired on [DATE]. The facility policy titled Pain Assessment and Management dated [DATE] documents the purpose of this procedure are to help the staff identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs that address the underlying causes of pain. Recognizing Pain 2. Possible Behavioral Signs of Pain, include negative verbalizations and vocalizations such as groaning, crying, screaming; facial expressions such as grimacing, frowning, clenching of the jaw, set., behaviors such as resisting care, distressed pacing, irritability, depressed mood, participation in usual physical and/or social activities, guarding, rubbing or favoring a particular body part. 5. Review the medication administration record to determine how often the individual request and receives PRN (as needed) pain medication, and to what extent he administered medications relieve the resident's pain.A Pharmaceutical Service Agreement dated [DATE], documents under section Pharmacy Supplies and Services C. Pharmacy agrees to deliver to Facility once daily, six days a week, Monday through Saturday, and any emergency deliveries 24 hours a day seven days per week; except for circumstances and conditions beyond its control, which shall expressly include, but not limited to, out-of-stock situations, to which Facility will notify. 2. R2's admission Record documents an admission date of [DATE] and includes diagnoses of Multiple Sclerosis, Local Infections of the skin and subcutaneous tissue, Type 2 Diabetes Mellitus, Paralytic Syndrome following Cerebrovascular Disease, Convulsions, Major Depressive Disorder, and Dysphagia.R2's MDS dated [DATE] documents a BIMS score of 12 indicating R2 has moderate cognitive impairment. Section J- Medical Conditions documents that R2 receives a scheduled pain medication regimen. Section N- Medications documents that R2 receives an opioid medication.R2's Care Plan documents R2 has potential for pain and discomfort and pain to bilateral feet/toes related to contractures dated [DATE]. Documented interventions include administering medications as ordered dated [DATE], anticipating the resident's need for pain relief and responding immediately to any complaint of pain, monitor/record/report to nurse any signs or symptoms of nonverbal pain, monitor record and report to nurse resident complaints of pain, turn and reposition every 2 hours to help alleviate pain dated [DATE].On [DATE] at 9:58AM, R2 was observed sitting in bed. R2 stated he is on Hospice care. R2 was asked if he has pain and R2 stated yes. R2 stated they will give me a pain pill when I ask for it, and sometimes I forget to ask then my pain gets really bad. R2 was asked if the staff usually ask him if he is in pain (continued on next page)

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	03/27/2026

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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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	and R2 stated no, I don't remember them asking me and I have to ask them.On [DATE] at 10:05AM, V8 (Registered Nurse/treatment nurse) came into R2's room and stated she would be changing out R2's dressing during his bath. R2 was complaining of pain during care.On [DATE] at 12:29PM, V4 (Hospice Certified Nursing Assistant) stated she always asks R2 about his pain and he always states that he is in pain, and he said she is the only one that ever asks him about his pain. R2's MAR dated [DATE]-[DATE] documents R2 receives Norco Oral Tablet 10/325mg, give 1 tablet by mouth three times a day for pain. Scheduled times of medication are 6:00AM, 2:00PM, and 10:00PM. Pain level for these doses for [DATE]st through [DATE]th show 0 for pain level throughout the entire days documented. R2 has an order for Dilaudid Oral Liquid 1mg/ml, give 2 ml by mouth every 3 hours as needed for moderate to severe pain, dyspnea dated [DATE]. R2's MAR documents no dosages were administered for the dates of [DATE]-[DATE].3. R3's admission Record documents R3 was admitted to the facility on [DATE] and was admitted to hospice care on [DATE] with diagnoses of Parkinson's Disease, Dementia Severe, Palliative Care, Heart Failure, Major Depressive Disorder, Anxiety Disorder, and Adult Failure to Thrive.R3's MDS dated [DATE] documents a BIMS score of 3 indicating R4 has severe cognitive impairment. Section J-Health Conditions documents that R3 receives PRN (as needed pain medication or was offered and declined. Section N- Medications documents that R3 is taking opioid medications. R3s undated Care Plan documents R3 has the potential for pain and discomfort related to Parkinson's Disease and Diabetes with interventions of: Monitor/record/ pain characteristics every shift and as needed; monitor/report/record to nurse residents' complaints of pain or request for pain treatment; notify the physician of interventions are unsuccessful or if current complaints is significant change from residents past experience from pain; nursing to administer medications as ordered; observe/record/report to nurse any signs or symptoms of non-verbal pain changes in breathing, vocalization, facial expression (sad, crying, worried, scared, clinching teeth and grimacing).R3's MAR dated [DATE] to [DATE] documents an order for Hydromophone HCL 1mg/ml every 4 hours as needed with no doses recorded for the month of [DATE]. R3's MAR also has order for Oxycodone HCL 10mg four times a day for pain every 6 hours with start date of [DATE]. R3's MAR dated [DATE]-[DATE] documents Pain assessments every shift for days, evenings, and night shift with documentation of pain scale at 0 for all three shifts from [DATE]-[DATE] dayshift.On [DATE] at 12:29 PM, V4 stated R3 has complaints of pain at times with her and she always has to go tell the nurses.On [DATE] at 11:37AM, R3 was sitting in a geri chair outside of his room. R3 was observed with flinching in his legs and was grimacing and gritting his teeth. R3 was noted to be trying to adjust both feet. R3 was unable to answer any questions at this time. The Immediate Jeopardy that began on 38/26 was removed on [DATE] when the facility took the following actions to remove the immediacy.At 12:00 pm on [DATE], V2(Director of Nursing/DON, V3 (Assistant Director of Nursing/ADON), and floor nurses immediately began assessing residents for pain using standardized scale. Residents with pain received immediate intervention. Physicians notified and new orders obtained as needed.V2, DON began to re-educate the licensed staff on [DATE]. Education included medication inventory and physician notification. V2, DON educated licensed staff that they are to notify Physician if any medication is not available. Nurses are to notify V2, DON immediately if mediation is not available or if there will be a delay in receiving ordered and reordered medications immediately upon discovery of medication shortage. All notifications and order changes are to be documented in real time.V2, DON and V3,ADON will complete medication audits on Monday and Thursday to ensure residents always have an adequate amount of pain medications available. If less than four days of medications are noted, then an order/reorder will be submitted to the physician, this audit to include hospice residents.Licensed staff that were unable to attend were education via phone per V2, DON and V3, ADON as a witness. On [DATE] a message was sent out to all licensed staff via Mediprocity with the education.V2, DON/designee initiated real-time audits.On [DATE] V2, DON and V3, ADON completed a 100% house wide audit completed with pharmacy dispensed medication orders for pain management. Inventory checked and reorders processed and delivered. Orders (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	clarified/updated, if needed. Care plans revised, if needed.V2, DON/Designee will complete biweekly audits x 4 weeks.V1, Administrator and V2,DON will submit plan to QA (Quality Assurance) for monthly review.QAPI (Quality Assurance and Performance Improvement) committee will review and offer recommendations, if needed, until compliance is met. This committee is made up of Administrator, DON, ADON, MDS, Maintenance, Social Services, Therapy, Admin Assistant, Housekeeping Supervisor, Dietary Manager, Activity Director, and Business Office Manager.