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	06/02/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and record review the facility failed to notify a medical provider of abnormal vital signs for 1 (R1) of 3 residents reviewed for change in condition in a sample of 6.Findings include:R1's admission Record documented an admission date of 3/19/24 with diagnoses including Parkinson's disease, dementia, and anxiety disorder. R1's 5/8/26 Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 3, indicating R1 was severely cognitively impaired.R1's 5/19/26 at 12:30 AM progress noted authored by V6 (Licensed Practical Nurse/ LPN) documented in part . BP (Blood Pressure) 89/82, P (Pulse) 45, R (Respirations) 20, T (Temperature) 102.3 (degrees Fahrenheit), O2 (Oxygen Saturation) 90 (90%) . Sweating, shallow breathing, bilat (bilateral) arm tremors noted. Pupils equal reactive to light and accommodation. Minimal repose when addressing, no words given, only audible gasps made. Tylenol 500 mg given, fluids encouraged.R1's 5/19/26 at 6:12 AM progress note documented in part .: BP 113/84, P 62, R 17, T 98.1, O2 93. Sweating, shallow breathing, bilat arm tremors no longer observed. Pupils equal reactive to light and accommodation. Fully responsive when addressed, able to speak when spoken to.On 5/28/26 at 2:44 PM, V6 said she was the nurse taking care of R1 during the night shift on 5/19/26. V6 said the CNA reported to V6 R1 had a fever and V6 had administered Tylenol to R1. V6 said the CNAs had obtained the first set of vital signs and when they were reported V6 thought they were exaggerated and I thought all of it was strange with the vital signs. V6 stated When I went back to check her, her fever was gone and I thought they were making a bigger deal than it was. I waited about an hour and a half before checking on her again but forgot to chart until I was about to leave and that is why they are charted at 6:12 AM.On 5/28/26 at 9:15 AM, V12 (Regional Clinical Consultant) said she was reviewing R1's Electronic Medical Record (EMR) and noted R1's 5/19/26 progress note authored by V6. V12 said she called V6 to get a statement. V12 presented a typed statement signed by V2 (Director of Nursing/ DON) and V12. The statement documented in part . on 5/19/2026 at 0030 (12:30 AM), CNA alerted nurse of resident's temperature being 102.3, Nurse (V6) assessed resident to find bilateral tremors, which are normal for resident related to diagnosis of Parkinson's, sweating, and shallow breathing. Nurse assessed pupils to find reacting to light and accommodation. Nurse administered Tylenol. About an hour later nurse went to re-assess resident to find resident resting peacefully with prior symptoms subsided. Nurse stated that she did not feel like this was a significant change for the resident as she slept and rested well throughout the shift. On 5/29/26 at 11:26 AM, V4 (Physician) was read R1's 5/19/26 at 12:30 AM progress note and was asked if V4 would have expected that nurse to contact him and V4 said yes. V4 said he was contacted on 5/19/26 at 10:25 AM about R1's change in condition and gave orders for a chest x-ray and a urinalysis. V4 said he did not think there would have been a change in R1's outcome if V6 had contacted him on 5/19/26 at 12:30 AM except he would have told V6 to wake R1 up and check the vital signs because he did not believe they were accurate. R1's 5/19/26 at 10:25 AM progress note documented in part .Resident's voice is hoarse and cough noted during breakfast. MD (Medical Doctor) notified and gave new orders as follows: Chest x-ray encouraged; oxygen nc (nasal cannula) keep 90-98% start 2L (Liters). Resident's POA (Power of Attorney) at bedside and notified or new orders and resident's current condition.R1's 5/20/26 at 3:54 (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PM progress note documented in part . MD in the facility to see resident and gave new orders as follows: CBC (Complete Blood Count) & Cipro 250mg BID x 7 days (2 times a day for 7 days) if worse send to ER (Emergency Room). POA at bedside and aware of new orders and resident's current condition.R1's 5/20/26 at 8:15 PM progress note documented in part . This nurse went to give resident HS (bedtime) medication. Prior to pulling medication, this nurse went into room to assess resident and get vitals. Upon assessment, resident is noted to be pale, diaphoretic. Resident did not respond to verbal ques and could not open eyes upon request. This nurse was able to ask resident if she was in pain and she muttered no. This nurse tried to give resident a drink of water with a straw and resident was unable to drink. This nurse then completed vitals. Resident was exhibiting lethargy and labored breathing at this time. Vitals completed manually and documented as so. Blood pressure 88/38mmhg, 100.8 temp, respirations 24, pulse, 79bp O2 sat on 2 liters of O2 via nasal canula 83%. This nurse encouraged resident to take some deep breaths. Unable to get a pulse ox reading higher than 88% on oxygen. This nurse had CNAs sit with resident while this nurse called (V4) about status and decline of patient. (V4) advised to send resident out.R1's 5/24/26 hospital Discharge Summary documented in part . admission Diagnoses: 1. Acute Hypoxic Respiratory Failure in setting of CAP (Community-Acquired Pneumonia) 2. CAP 3. UTI (Urinary Tract Infection) . Summary of History and Physical . Husband at bedside to provide HPI (History of Present Illness). States that on Saturday (5/16/26) he noticed the patient had developed a dry cough. Over the past several days, the cough has persisted and felt that she was more pale than normal. (V4) saw the patient on 5/19. A chest x-ray was obtained and showed cardiomegaly with mild CHF (Congestive Heart Failure). Patient does not have a hx (history) of CHF and no signs present. Chest x-ray showed left sided pneumonia.The facility's revised February 2021 Change in a Resident's Condition or Status policy documented in part . Out 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. 1. 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.