(X6) DATE

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		A. BUILDING:		C		
		IL6006118	B. WING		1	, 0/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
METROF	OLIS REHAB & HCC		ROPOLIS S			
(X4) ID	METROPOLIS, IL 62960 (4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION				(X5)	
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE DATE
S 000	Initial Comments		S 000			
	Complaint Investiga	ation: 2453434/IL172643				
S9999	Final Observations		S9999			
	Statement of Licens	sure Violations				
	300.610a) 300.1210a) 300.1210b) 300.1210c) 300.1210d)3)					
	Section 300.610 R	esident 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 (Nursing and Person	General Requirements for nal Care				
	facility, with the par the resident's guard	nsive Resident Care Plan. A ticipation of the resident and dian or representative, as evelop and implement a				

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 05/21/24

TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		IL6006118	B. WING			C 10/2024
	PROVIDER OR SUPPLIER	2299 MET	DRESS, CITY, S ROPOLIS S OLIS, IL 629			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
\$9999	comprehensive car includes measurable meet the resident's and psychosocial nesident's comprehallow the resident to practicable level of provide for dischargestrictive setting baneds. The assess the active participal resident's guardian applicable. (Section b) The facility care and services to practicable physical well-being of the reeach resident's complan. Adequate and care and personal cresident to meet the care needs of the recard he knowledges respective resident to nursing care shall infollowing and shall seven-day-a-week and objective consident's condition emotional changes determining care refurther medical evaluations.	e plan for each resident that le objectives and timetables to medical, nursing, and mental eeds that are identified in the ensive assessment, which attain or maintain the highest independent functioning, and ge planning to the least ased on the resident's care sment shall be developed with tion of the resident and the or representative, as a 3-202.2a of the Act) shall provide the necessary of attain or maintain the highest light mental, and psychological sident, in accordance with an accordance with a properly supervised nursing care shall be provided to each the total nursing and personal esident. care-giving staff shall review able about his or her residents' care plan. subsection (a), general and and the practiced on a 24-hour, basis: observations of changes in a provided and the need for luation and treatment shall be aff and recorded in the	S9999			

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		IL6006118	B. WING		C 05/10/2024	
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 00/1	0/2024
METROF	POLIS REHAB & HCC		ROPOLIS S			
			OLIS, IL 629			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	.D BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 2	S9999			
	These Requiremen	ts were not met evidenced by:				
	failed to provide per 1 of 2 residents (R1 sample of 7. This fa with a change in co admitted to the hos	and record review the facility ritoneal dialysis treatments for) reviewed for dialysis in a silure resulted in R1 presenting ndition of confusion and being pital with lethargy and sis during R1's hospital stay.				
	Findings include:					
	admission date to the same document list but not limited to: E Dependence on Re Collapse, Muscle W	ecord" documents R1's initial ne facility as 03/25/24. The is diagnoses for R1 including nd Stage Renal Disease, nal Dialysis, Syncope and /eakness (Generalized), Other in, and Type 2 Diabetes implications.				
	revision date of 4/19 hemodialysis relate	an, with an initiation and 6/24, documents a need of d to renal failure. There was of the need for peritoneal date upon request.				
	documents in section Mental Status (BIM R1 is cognitively introdocumented in section moderate assistate sitting to lying, lying stand, chair to bed would do less than	a Set (MDS) dated 4/10/2024 on C, a Brief Interview for S) score of 13, indicating that act. The same MDS tion G, that R1 requires partial ance, with rolling left to right, to sitting on a bed, sit to transfer, indicating the helper half the effort. The same MDS tion O. Special Treatments.				

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AND DIAN OF CORRECTION INDENTIFICATION NUMBER		, ,	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING.			C
		IL6006118	B. WING			10/2024
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
METRO	POLIS REHAB & HCC		ROPOLIS S [.] DLIS, IL 629			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
\$9999	Programs and Prodialysis upon admist the facility. R1's "Discharge Platocal hospital docur 3:44 PM, that R1 was can meet her need her family about he document has an each that "Patient (Ringerral sent to faciliat 12:10 PM, docur Coordinator) acceptorers prior for performers prior for performers prior to patient arrivated 3/28/2024 at on 3/25/2024 at 2:0 agreeable to bringing equipment and 2 dafacility while V9 (Falling and V3 (Admission going to the facility R1's Electronic Heach documentation of preceived upon admission proceived upon admission of preceived upon admission of precei	cedures, that R1 receives sion and while a resident at anning Summary" from the ments an entry on 3/22/2024 at as informed that this facility and that R1 wanted to talk to roptions. This same entry dated 3/25/2024 at 10:22 1) was agreeable to rehab and ity." An entry dated 3/25/2024 enents "(V3-Admission ted patient (R1) to facility with toneal dialysis prior to (R1) are they can get the equipment real. This same document 9:01am has a late entry note 10pm stating that "(R1) was ang her peritoneal dialysis ays' worth of fluids with her to simily Member) was at bedside Coordinator) agreeable to R1 today."	S9999	DEFICIENCY		

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ((X3) DATE SURVEY COMPLETED	
			7. BOILDING.			;
		IL6006118	B. WING		1	0/2024
NAME OF I	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
METROF	OLIS REHAB & HCC		ROPOLIS ST			
			DLIS, IL 629			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 4	S9999			
	V8 (Dialysis Registed dialysis provider regorders. V8, states the cycler to run 2 6-lited every night. V10, no own dialysis treatments. R1's Nurse's Note of documents, "(R1) is condition related to	egistered Nurse/RN) contacted ered Nurse) at R1's current garding peritoneal dialysis hat resident is to use dialysis er bags over 9-hour period otified R1 who can provide ent. dated 3/27/2024 at 8:18 PM is experiencing a change in (R1) being confused and				
	needing dialysis." R1's Nurse's Note dated 3/27/2024 at 8:46 PM documents, "(V10 RN) notified (V17 Nurse Practitioner) that (R1) was having periods of confusion and unable to set up her peritoneal dialysis treatment. (V10) received orders from (V17) to send (R1) to (out of state) emergency room. (V10) attempted to notify family."					
	Coordinator) stated the facility with the aware R1 needed pwas understood by R1 would need to cindependently while to be discharged to dialysis supplies cofacility for R1. V3 st management arranhave a family member and then bring the pfacility. V3 stated R her supplies and mhad a handful of padialysis over the year	:56 AM, V3 (Admissions she arranged admission to discharging hospital and was peritoneal dialysis. V3 stated it the discharging hospital that complete peritoneal dialysis in the facility and would wait the facility until peritoneal uld be ordered and in the rated the hospital case ged with R1 and R1's family to ber stop at R1's house to pick alysis machine with supplies patient and supplies to the 1 arrived at the facility without achine. V3 stated they have tients receiving peritoneal ars and could not confirm if trained to assist R1 with her				

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NAME OF PROVIDER OR SUPPLIER METROPOLIS REHAB & HCC IL6006118 B. WING O5/10/2024 STREET ADDRESS, CITY, STATE, ZIP CODE 2299 METROPOLIS STREET METROPOLIS, IL 62960	IDENTIFICATION NUMBER:	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	
NAME OF PROVIDER OR SUPPLIER METROPOLIS REHAB & HCC STREET ADDRESS, CITY, STATE, ZIP CODE 2299 METROPOLIS STREET METROPOLIS, IL 62960	IL6006118		
METROPOLIS REHAB & HCC METROPOLIS, IL 62960	LIER STREET ADI	NAME OF PROVIDER OR SUPPLIER	
	HCC	METROPOLIS REHAB & HCC	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG (EACH CORRECTIVE ACTION SHOULD BE COMPL TAG (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	IENCY MUST BE PRECEDED BY FULL	PREFIX (EACH DEFICIENCY	
Sepsentional dialysis. On 5/03/2024 at 12:10 AM, V5 (Director of Nursing/DON) stated that she has taken care of R1. V5 stated, her understanding was R1 missed one day of dialysis when she arrived at the facility because she did not have her supplies. V5 stated, R1's medical provider was notified of R1 not having her supplies and R1 was monitored through the night. V5 stated that V2 (Social Services Director) went the next day to meet family to pick up R1's supplies and dialysis machine. On 5/07/2024 at 11:08 am, V5 stated she was the educate for the peritoneal dialysis training for the facility. V5 stated that she used a power point to educate nursing staff. V5 stated she is not aware that a dialysis center staff came to the facility to train the staff and the staff did not have a peritoneal dialysis machine to demonstrate/practice on. On 5/03/2024 at 1:21pm, V2 (Social Services Director) stated he was asked to go meet R1's family at her home to get R1's peritoneal dialysis supplies and machine. V2 stated he did get the supplies and machine. V2 stated he did get the supplies and returned to the facility with them but cannot recall what day. V2 stated that R1 did review her dialysis orders with V10 (RN). On 5/03/2024 at 1:45 PM, V7 (Administrator of local Dialysis Company) and V8 (Nurse of local Dialysis Company) both stated, that R1 has been a peritoneal dialysis patient since April 2020 and was completing her treatments independently at home prior to her hospital admission at the end of March. V7 and V8 both stated, R1 would not be able to complete her treatments independently with R1 having a decrease in her physical abilities.	Asis. at 12:10 AM, V5 (Director of stated that she has taken care of her understanding was R1 missed ysis when she arrived at the facility id not have her supplies. V5 edical provider was notified of R1 supplies and R1 was monitored to yet. V5 stated that V2 (Social tor) went the next day to meet up R1's supplies and dialysis /07/2024 at 11:08 am, V5 stated ducator for the peritoneal dialysis facility. V5 stated that she used a educate nursing staff. V5 stated to et hat a dialysis center staff came of train the staff and the staff did not eal dialysis machine to ractice on. at 1:21pm, V2 (Social Services of he was asked to go meet R1's peritoneal dialysis nachine. V2 stated he did get the esturned to the facility with them but what day. V2 stated that R1 did yesis orders with V10 (RN). at 1:45 PM, V7 (Administrator of Company) and V8 (Nurse of local any) both stated, that R1 has been alysis patient since April 2020 and go her treatments independently at her hospital admission at the end of V8 both stated, R1 would not be te her treatments independently	peritoneal dialysis. On 5/03/2024 at 12 Nursing/DON) state R1. V5 stated, her use one day of dialysis is because she did not stated, R1's medicated, R1's medicated, R1's medicated in the result of the result of the facility to pick up R1 machine. On 5/07/2 she was the educated training for the facility power point to educate the facility to train have a peritoneal didemonstrate/practice. On 5/03/2024 at 1:2 Director) stated her family at her home supplies and maching supplies and return cannot recall what directly review her dialysis of the family significant of the family at her home supplies and return cannot recall what directly her dialysis computed in the family of the family at her home prior to her home of the family at having a definition of the family at her home prior to her home with R1 having a definition of the family at her home prior to her home prior to her home prior to her home prior to her home with R1 having a definition of the family at her home prior to her home p	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	I \ /	(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	·		
METROPOLIS REHAB & HCC		ROPOLIS S [.] OLIS, IL 629				
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S9999 Continued From page 6 On 5/07/2024 at 9:34am, V9 (Fa stated that she brought R1 to the stopping at R1's house to retrieve complete dialysis in the facility. Notified the next day that they for V9 stated she was unable to get the facility until the next day. V9 come to meet her at R1's house solution on the third day of R1's On 5/3/2024 at 9:39AM, V1 (Adrithat R1 arrived at the facility with peritoneal dialysis supplies. V1 s (Admissions Coordinator) discus hospital prior to discharging R1 transport R1 would have to be able to comperitoneal dialysis, independently need all supplies brought to the arrival. V1 stated that R1 arrived without her supplies. V1 stated monitored through the night and Services Director) went to meet R1's home to get the peritoneal and supplies the next day. V1 stated machine and supplies were tracility, R1 could not complete the her dialysis. V1 stated R1's med notified and R1 was sent to the revaluation. V1 stated if they knew bringing her supplies, they would accepted R1. V1 stated there was V9's (family member) car when so the next day, they needed her to solutions to the facility. On 5/07/2024 at 11:43 am, V10 Nurse/RN) stated she had direct R1. V10 stated she cared for R1	e facility after e her supplies to /9 stated she was rget the solution. the solution to stated that V2 did to pick up the admission. ministrator) stated rout her stated that V3 ssed with the to the facility that replete the y, and would facility upon d at the facility that R1 was then V2 (Social R1's family at dialysis machine ated that once brought to the resteps to start rical provider was responsible for w she was not d not have as an issue with she was notified bring R1's (Registered patient care with	S9999				

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	NT OF DEFICIENCIES		(Y2) MI II TIDI	E CONSTRUCTION	(X3) DATE	QLID\/EV
	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				LETED
			A. BUILDING:			
		IL6006118	B. WING		05/1	0/2024
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
		2299 MET	ROPOLIS S	TREET		
METROF	POLIS REHAB & HCC		DLIS, IL 629			
()(4) ID					(VE)	
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				DEFICIENCY)		
S9999	Continued From pa	ae 7	S9999			
		supplies and the facility was in				
		nily the next day to arrange				
		. V10 stated on the third day,				
		the supplies and machine in				
		ated she was under the				
		was going to direct the staff				
		lialysis machine, however that				
		(RN) went to help R1, R1 was aff on how to assist. V10				
		n sent out to the hospital since				
		ut a dialysis treatment for 3				
		at she did have peritoneal				
		ear ago by the facility staff,				
		remember the exact date.				
		es not feel comfortable				
		neal dialysis and does not				
		by a dialysis facility faculty.				
	recam semig trained	by a dialysis rasility rasalty.				
	On 5/08/2024 at 6:5	51 AM, V16 (RN) stated that				
	she had direct patie	ent care with R1. V16 stated				
	she was the nurse t	that took care of R1 when she				
	arrived at the facility	y her first night around 11:30				
	pm. V16 stated that	R1 had a lot of bags with her				
		with her, however, R1 refused				
		nent and stated she did not				
		vening. V16 stated she came				
		night and was told that R1's				
		that R1 forgot her solution at				
		ner treatments and V9 (family				
		acted to bring the solution to				
	_	ed that V9 notified the facility				
		oken down and had no				
		ng the solution to the facility				
		from the facility is welcome to				
		d pick up the solution. V16				
		V17 (Nurse Practitioner) of R1				
		ents because of no solution				
	she received orders	o signs of distress. V16 stated to monitor R1 for any signs cress. V16 stated when she				

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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
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IL6006118 B. WING 05/10/2						0/2024
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
METROI	POLIS REHAB & HCC		ROPOLIS S			
	OLIMANA DV. OTA		DLIS, IL 629			0.15
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 8	S9999			
	arrived at the facility R1 had her supplies V16 stated that som R1's home that day stated R1 was phys dialysis treatment of supposed to assist solutions to be used the machine. V16 sorder was received the dialysis compart 2:00pm. V16 stated set up all supplies a R1's room. V16 stated set up all supplies a R1's room. V16 stated stated she cannot reperitoneal dialysis in V16 stated, she has peritoneal dialysis in V16 stated, she has peritoneal dialysis be member. V16 stated assisting residents they can give direct to use, etcetera. On 5/07/2024 at 1:2 that R1 was his residialysis treatments stated he was notifier from the hospital to he expects a nursin supplies and proper peritoneal dialysis residents of the proper peritoneal dialysis residents and proper peritoneal dialysis residents.	y for the third night in a row, is to complete her treatment. The cone from the facility went to to get her solution. V16 sically unable to complete her in her own and staff were by giving directions on what did and buttons to be pushed on tated R1's peritoneal dialysis by the day shift nurse from any on 3/27/2024 around at the day shift nurse and R1 and her machine that day in the day shift nurse and R1 and her machine that day in the day shift nurse and R1 and sent R1 to the hospital. The shift of the hospital and sent R1 to the hospital and sent R1 to the hospital and the peritoneal dialysis by V5 sometime in 2023. V16 ecall if she was trained on a machine during that training. It is not been trained on an achine during that training in the shift of the peritoneal dialysis when in the peritoneal dialysis when in the facility of the peritoneal dialysis when in the facility to have a training prior to accepting a thome facility without her the facility without her				

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back to the hospital to receive treatment or R1 to

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		IL6006118	B. WING		05/1	0/2024
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
METROF	POLIS REHAB & HCC		ROPOLIS S			
	T		DLIS, IL 629			
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S9999	Continued From pa	ge 9	S9999			
	her home to get all her supplies to complete her treatment. On 5/08/2024 at 9:24 AM, V17 (Nurse Practitioner/NP) stated R1 arrived at the facility					
	Practitioner/NP) stated R1 arrived at the facility on 3/25/2024 without her dialysis supplies to complete her treatment. V17 stated she was notified the next evening when R1 still had not received her supplies at the facility. V17 stated when she was contacted by the nurse that R1 was unable to complete her treatments the next evening (day 3), she had R1 sent out to the emergency room for evaluation. V17 stated the understanding upon admission to the facility was that R1 was able to complete her dialysis treatments independently, however, R1 was unable to complete the steps or direct the staff on what was needed to initiate the peritoneal dialysis treatment.					
	Sheet" for peritonea Nursing/DON) with (Continuous Ambul and had V10 (Regis	vice Education Signature al training by V5 (Director of "Peritoneal Dialysis atory) procedure was reviewed stered Nurse/RN) and V16 RN) signatures as having g.				
	of state hospital dar R1 was admitted to chief complaint of " "Cumulative Hospit documents that R1 (ESRD) and is on F presented to the en center due to lethar peritoneal dialysis in to the rehab center	harge Summary" from an out ted 4/3/2024 documents that the hospital on 3/27/24 with a no dialysis in 2 days." The al Course and Treatment" has End Stage Renal Disease Peritoneal Dialysis (PD) and nergency room from the rehabing and R1 had not received in at least 2 days. R1 was new neal dialysis needs. R1 was				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	(X3) DATE SURVEY COMPLETED	
		IL6006118	B. WING			C 1 0/2024
	PROVIDER OR SUPPLIER	2299 MET	DRESS, CITY, S ROPOLIS ST DLIS, IL 629			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
\$9999	admitted to the hos where a decision was modality to hemodia permodialysis treatmedischarged in stable R1 was to continue days a week. The documents under "I principal problem of active problems of "	pital with nephrology consult as made to change dialysis alysis (HD) and a placed. R1 completed a ment on 4/03/2024 and was be condition to the rehab facility. The hemodialysis treatments, 3 same discharge summary Discharge Problem List" a fees "ESRD needing dialysis" and "Lives in a long-term custodial kidney injury, and acute"	S9999			

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