STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006118	A. BUILDING: _____ B. WING _____	C 12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 000	Initial Comments Complaint Investigation 2459706/IL181635 Facility Reported Incident of 10/28/24/IL180942 Facility Reported Incident of 10/16/24/IL180941	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210a) 300.1210b) 300.1210c) 300.1210d)6) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and	S9999		

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S9999	Continued From page 1	S9999		

the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

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

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S9999	Continued From page 2 and assistance to prevent accidents. These Requirements were not met evidenced by: A. Based on observation, interview and record review the facility failed to provide assistance in a manner to prevent falls for 2 (R5 and R10) of 6 residents reviewed for falls in a sample of 16. This failure resulted in R10 sustaining a large intracranial hematoma, left eyebrow laceration and a left periorbital hematoma and R5 sustaining a skin tear to right shin and right shoulder along with a forehead laceration requiring 4 sutures. Findings include: 1. R10's Admission Record documents an admission date of 12/02/2019 with diagnoses including: acute cystitis without hematuria, unspecified Escherichia coli as the cause of diseases classified elsewhere, encephalopathy, hemiplegia affecting left non-dominant side, history of transient ischemic attack and cerebral infarction without residual deficits, osteoarthritis right shoulder, cerebral infarction, other abnormalities of gait and mobility, other lack of coordination, blepharoconjunctivitis of the left eye, third nerve palsy of left eye, history of covid-19, anxiety disorder, schizophrenia, aphasia following cerebral infarction, other symptoms and signs involving cognitive functions following other cerebrovascular disease, dysarthria following other cerebrovascular disease, muscle weakness, repeated falls, other symptoms and signs involving the nervous system, disorientation, altered mental status, restlessness and agitation, weakness, history of malignant neoplasm of the brain, and epilepsy.	S9999		

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S9999	Continued From page 3	S9999		

R10's Minimum data Set (MDS) quarterly review dated 07/02/24 documents a Brief Interview of Mental Status (BIMS) of 14 indicating R10 is cognitively intact. R10's eating assistance is documented as: setup or clean-up assistance, oral hygiene as: supervision or touching assistance, upper body dressing as: substantial/maximal assistance and roll to right or left as: dependent.

R10's Fall risk data collection form dated 9/24/24 documents a score of 29 indicating R10 was a high risk for falls.

R10's hospital's discharge summary with an admission date of 09/10/24 and a discharge date of 09/24/24 documents: Hospital Course: Patient (R10) is 55-year-old with past medical history of brain tumor, seizure disorder, dementia, hyperlipidemia and hypothyroidism. She had a recent episode of nonresponsiveness at a SNF (Skilled Nursing Facility) unit and was sent in for altered mental status. Patient's (R10) baseline is that she is unable to ambulate and is wheelchair-bound. ER (emergency room) evaluation included CT (computed tomography) of the brain and CT brain perfusion with no evidence of ischemia chest x-ray no acute process CTA (computed tomography angiography) head neck indicated acute ischemia to the left anterior cerebral artery distribution could not be excluded. Her blood glucose was initially 60 (milligrams/deciliter) and she was given D10 (dextrose 10%) patient was admitted to the hospitalist service and neurology was consulted. She was also found to have a UTI (urinary tract infection) and antibiotics were started. MRI (magnetic resonance imaging) of the brain recommended by neurology showed no acute abnormalities, EEG (electroencephalography)

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	IL6006118	A. BUILDING: _____ B. WING _____	C 12/05/2024

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S9999	Continued From page 4	S9999		

showed generalized slowing, echo indicated normal LV (left ventricular) size with an EF (ejection fraction) of 55-60 (%). Neurology felt patient was suffering from encephalopathy related to covid infection. Feeding tube was placed due to continual failure of swallowing eval. She is to have a video swallow eval today. Video swallow evaluation revealed no aspiration. Diet recommendations in dc (discharge) summary. Pt will transition back to snf.

R10's MDS significant change review dated 09/29/24 documents a BIMS of 05 indicating severely impaired. R10's eating assistance is documented as: dependent, oral hygiene as: dependent, upper body dressing as: dependent and roll to right or left as: dependent.

R10's Care Plan documents a focus area of: R10 is at risk for falls with a date initiated of 04/03/2021. Interventions included: dated 07/24/2024 of anti-slip mat in seat of wheelchair and dated 07/08/24 of do not leave resident alone when sitting on the side of the bed. R10's care plan documents a focus area of: R10 has a history of CVA (cardiovascular accident) with a date initiated of 04/12/2021 and interventions including: monitor/document communication skills, document baseline if resident is presenting problems with cognitive function and communication, obtain order for speech therapy consult to evaluate and treat dated 03/23/2022, monitor/document residents abilities for ADLs (activities of daily living) and assist resident as needed. Encourage resident to do what he/she is capable of doing for self dated 04/12/2021, and monitor/document/report to MD (medical doctor) PRN (as needed)) for neurological deficits: level of consciousness, visual function changes, aphasia, dizziness, weakness, and restlessness

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	IL6006118	A. BUILDING: _____ B. WING _____	C 12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 5	S9999		

dated 04/12/2021. R10's care plan documents a focus area of: R10 has left hemiplegia/hemiparesis related to stroke with an initiated date of 07/29/2022 and interventions of: give medications as ordered, monitor/document for side effects and effectiveness dated 07/29/2022, obtain and monitor lab/diagnostic work as ordered, report results to MD and follow up as indicated dated 07/29/2022, pain management as needed, see MD order, provide alterative comfort measures PRN dated 07/29/2022, and PT, (physical therapy) OT (occupational therapy), ST (speech therapy) evaluate and treat as ordered dated 07/29/2022. New interventions added 10/7/24 include, resident is working with therapy in tilt/reclining chair with anti-skid mat in place, dated 10/07/24 of will reassess for safety upon resident's return from the hospital, and dated 10/08/24 of: keep resident's tilt/recline chair in reclined position until staff is ready to assist with meals. Interventions also included: dated 07/24/2024 of anti-slip mat in seat of wheelchair and dated 07/08/24 of do not leave resident alone when sitting on the side of the bed.

R10's final investigation report submitted to IDPH (Illinois Department of Public Health) dated 10/10/24 documents: (R10) age 55 with diagnoses of Cerebral infarction, hemiplegia affecting left side, encephalopathy, personal history of TIA (transient ischemic attack), osteoarthritis of right shoulder, epilepsy, major depressive disorder, aphasia, schizophrenia, and personal history of malignant neoplasm of the brain. On 10/7/24 R10 sustained a fall when she sat forward in her tilt/recline chair and fell to the floor. Licensed staff initiated a head-to-toe assessment. The resident voiced complaints of pain to her face and head. Logged rolled to her

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	IL6006118	A. BUILDING: _____ B. WING _____	C 12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 6	S9999		

back to monitor airway. Laceration noted to forehead. First aid administered. No loss of consciousness. Resident left in position d/t (due to) potential for FX (fracture). V31 (Medical Director) notified and an order received to send to ER for evaluation. POA (power of attorney) notified of occurrence and pending transfer. Resident transferred per ambulance to ER for evaluation and treatment. Resident admitted to hospital with DX (diagnosis) of intracranial hematoma without loss of consciousness. Returned to facility on 10/9/24 with hospice referral. Laceration above left eyebrow closed with steri -strips. Care plan reviewed and updated

On 11/27/24 at 8:24 AM, V22 (Certified Nurse Aide) stated, R10 could sit up, she had head and neck control, she would also scoot herself forward in her chair. V22 stated, on the day R10 fell out of her wheelchair (10/07/24) everyone was in the dining room. V22 stated she pushed R10 up to the table and positioned her up so that she could eat without choking. V22 stated she was up at the kitchen window getting R10's food so she could assist her and she heard R10 fall. V22 stated, she thought R10 fell sideways out of her chair because she didn't hit the table and the way she was laying on the floor. V22 stated, there were other CNAs in the dining room, but no one right next to R10. V22 stated, when R10 came back after, she believes she had a stroke, she was not as good, she was more confused, her speech was more slurred, she would fall asleep when they were assisting her to eat and she was switched to a thickened liquid and puree diet. V22 stated, she was educated after R10 fell to have her food in front of her before she puts her in the upright position.

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	IL6006118	A. BUILDING: _____ B. WING _____	C 12/05/2024

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METROPOLIS REHAB & HCC	2299 METROPOLIS STREET METROPOLIS, IL 62960

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S9999	Continued From page 7	S9999		

On 11/26/24 at 4:05 PM, V6 (Physical Therapy) stated she would expect someone to be there when R10's chair was in the fully inclined position. V6 stated R10 returned to the facility after her last stroke on 09/24/24 with multiple declines, she had low motivation to bend forward also.

On 11/27/24 at 9:56 AM, V4 (Director of Rehabilitation) stated prior to 10/07/24 when R10 had her last fall, speech language was working with R10 due to her decline after her last stroke. R10 was lethargic and they changed her diet to honey thick liquids and puree food. R10 could support her head and trunk to a degree.

On 11/27/24 at 10:10 AM, V25 (Therapy) stated she had evaluated R10 on 09/25/24. R10 would ebb and flow and sometimes she could be lethargic and obstinate during mealtime. She would expect her to have her food and then be put in the upright position in her wheelchair. They were currently working on core strength and reaching abilities with her. V25 stated R10 had recently been hospitalized just prior to her fall and she had more limited abilities. R10 was out for over 10 days, her wheelchair was changed to a wheelchair that looks like a recliner on wheels that the feet platform does not raise, her swallow function changed, she was no longer the same after the hospital stay. After the hospital stay she was deconditioned, she was very different than she was prior to her hospital stay from the stroke.

R10's therapy note dated 09/26/24 documents: patient (R10) demonstrates L (left) lateral lean, sacral sitting, occasional anterior leaning forward in w/c (wheelchair) increasing fall risk. R10 presents with decreased alertness and does not respond to verbal cures for adjusting self in w/c, therapist can readjust and as day progresses R10

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	IL6006118	A. BUILDING: _____ B. WING _____	C 12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROPOLIS REHAB & HCC	2299 METROPOLIS STREET METROPOLIS, IL 62960

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S9999	Continued From page 8	S9999		

will have to have multiple repositioning in standard w/c. Provided R10 with tilt in space w/c and feature of recline back. R10 has foot board to provide support for BLE (both lower extremities) in neutral position. Staff education provided on patient to be tilted back when not in line of sight, when R10 is at mealtime, or in line of sight, may be placed in a neutral position. Provided nonskid mat under bottom in order to prevent sliding forward with chair having an anti thrust cushion feature in chair. Response to session interventions: presented with decreased alertness, not following verbal cues or tactile cues.

R10's progress note dated 10/07/24 at 5:20 PM documents: staff heard a loud crash and found resident laying on the floor face down. Chair had been reclined back in main dining room awaiting meal but when staff turned around chair was straight up.

R10's progress note dated 10/07/24 at 5:30 PM documents: EMS (emergency medical services) here to transport resident to ER for evaluation and treatment for fall.

R10's progress note dated 10/08/24 at 12:38 AM documents: called ER and spoke with nurse on update of resident. ER nurse reports resident is being admitted to the unit due to a brain bleed.

R10's progress note dated 10/08/24 at 6:29 AM documents: spoke with ICU (intensive care unit) nurse. Resident admitted with intracranial hematoma without loss of consciousness.

R10's hospital daily progress note dated 10/08/24 documents: subjective: has had some headaches but no new neurologic deficits from her baseline.

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S9999	Continued From page 9	S9999		

Summary: 55 year old female with remote history of right temporal lobe tumor resection, previous stroke with residual speech and cognitive deficit, residual left-sided weakness, seizure disorder, dysphagia on modified diet, recently hospitalized with encephalophy in setting of covid infection, hyponatremia, UTI (urinary tract infection) found to have adrenal insufficiency, presenting back from nursing facility after sustaining a traumatic fall with noted large intracranial hematoma, along with left eyebrow laceration, and a left periorbital hematoma, Laceration repair in ED (emergency department). (R10's) aspirin and Plavix was stopped. (R10) was given platelets and DDAVP (desmopressin) following initial presentation. Neurosurgery consulted. Monitored further with serial neuro (neurological) checks. Follow-up CT (computed tomography) head appeared stable.

R10's neurosurgery consultation dated, 10/08/24 at 7:21 AM documents: the patient (R10) is a 55 y.o. (year old) female who presented to the ED (emergency department) on 10/2024 after she fell out of a chair in her nursing home striking her head. She has a neurosurgical history that is significant for prior brain tumor resection, though no records are available and no family is at bedside to provide further information and she is a very poor historian. She apparently resides in a nursing home due to chronic left hemiparesis and cognitive difficulty. She fell from a chair to the floor at her facility, striking her head and sustaining a laceration. She was brought to the ED where a CT revealed intracranial hemorrhage, prompting neurosurgical consultation. She has been observed overnight in the ED due to a lack of beds in the ICU. She currently endorses headaches, however she has delayed speech and difficulty expressing herself at baseline. She will follow commands in all extremities with

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	IL6006118	A. BUILDING: _____ B. WING _____	C 12/05/2024

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S9999	Continued From page 10	S9999		

baseline left-sided weakness. Records from the nursing home state she takes ASA (acetylsalicylic acid (aspirin)) and Plavix, though the reasons are unclear. She was given Platelets and DDAVP in the ED.

R10's progress note dated 10/09/2024 at 5:41 PM documents, Res (resident) back from hospital and nonverbal. EMS said res had not said a word the whole transport. Res v/s (vital signs) wnl (within normal limits). Left eyebrow laceration dried blood noted and bruised face and eye with left eye swollen shut. Res to have hospice consult and DNR. Noted DNR signed by her sister and not her POA. Res made comfortable in bed.

R10's progress note dated 10/13/24 documents: EMS here to transport resident to hospice center.

On 11/27/24 at 2:08 PM, V27 (Family) stated, R10 was diagnosed with Covid and a UTI and they had got her back to the facility and she fell in the dining room. They (the family) decided to send her to hospice in another state due to brain bleed causing seizures.

On 11/27/24 at 3:06 PM, V1 (Administrator) stated when R10 fell in the dining room on 10/07/24 she was put in the upright position for eating and then the staff went to get her food from the window and she fell. V1 stated, she would have expected them to get her food, come back, and then put her in the upright position.

R10's Death Certificate documents R10 died on 10/23/24 with the cause of death listed as intracranial hemorrhage. Other significant condtions contributing to death include: temporal lobe tumor, cerebrovascular accident with sided residual weakness and seizer disorder. The

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	IL6006118	A. BUILDING: _____ B. WING _____	C 12/05/2024

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METROPOLIS REHAB & HCC	2299 METROPOLIS STREET METROPOLIS, IL 62960

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S9999	Continued From page 11	S9999		

manner of death is marked as natural.

On 12/04/24 at 11:38 PM, V30 (Nurse Practitioner) stated, her and V31 (Medical Director) had looked at R10's diagnoses and medical history extensively prior to taking R10 on as a patient. R10 has had a couple brain bleeds prior to the fall on 10/07/24. R10 had CVA residual affects from how the body heals and reroutes, therefore it was likely that she would have another CVA. R10 had CVA's prior. V30 stated, no she does not believe the fall on 10/07/24 hastened or exacerbated R10's death. R10 had a personal history of brain cancer, CVA's, and schizophrenia and that would probably lead R10 to have another cerebral infarction. Another CVA would cause her to fall. After her last hospital visit her and V31 were going to discuss with R10's family hospice care for R10. There is no way she would say the fall hastened or caused her death. R10's brain neoplasm was affecting her ocular nerve. Based on her history and disease process there is no way she can say that fall caused her death. Due to her past diagnoses with her current prognoses and the recent encephalopathy due to covid they can not say what all that would cause and would affect. There are many different variables with covid and how it has affected systems and exacerbated disease processes. V30 stated based on R10's history, disease processes and recent diagnoses there is no way she can say that event (the fall) caused her death her diagnoses and disease process was an affecting factor.

2. R5's Admission Record documents an admission date of 09/11/2024 with diagnoses including: dementia, xerosis cutis, other atrophic disorders of skin, muscle weakness, acute kidney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006118	A. BUILDING: _____ B. WING _____	C 12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROPOLIS REHAB & HCC	2299 METROPOLIS STREET METROPOLIS, IL 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) COMPLETE DATE
S9999	Continued From page 12	S9999		

failure, full incontinence of feces, lack of coordination, urinary incontinence, altered mental status, and cognitive communication deficit. R5's MDS dated 09/17/24 documents a BIMS score of 00 indicating severe impairment.

R5's care plan documents a focus area of: R5 has an ADL self care performance dated 09/12/2024 with interventions to include: Bed Mobility: the resident requires 1 staff participation to reposition and turn in bed with date initiated of 9/12/24, Transfer: The resident requires 1 staff participation with transfers with date initiated 9/12/24. A new intervention dated 10/18/24 included Side rails: quarter rails up as per V31's order for safety during care provision, to assist with bed mobility. Observe for injury or entrapment related to side rail use. Reposition PRN to avoid injury. R5's care plan documents a focus area of R5 is at risk for falls and has had an actual fall d/t generalized weakness, poor nutritional status, incontinence, history of falls with a date initiated of 09/12/2024 and an intervention of: place quarter rails to bed that can be placed in upright position during cares to prevent falls from air mattress. Until bedrails placed two CNAs at a time when giving incontinence care with a date of 10/17/2024. R5's Care plan also lists a focus are, (R5) has limited physical mobility date initiated 9/12/24. Interventions included, Mobility: the resident requires 1 staff participation for mobility with date initiated 9/12/24.

R5's final report to IDPH dated 10/22/24 documents: On October 16th approximately 1850 (6:50 PM) the C.N.A was assisting the resident with incontinence care, the resident scooted to the side of the bed and rolled off and hit her head. The C.N.A called for the nurse. The resident was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006118	A. BUILDING: _____ B. WING _____	C 12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROPOLIS REHAB & HCC	2299 METROPOLIS STREET METROPOLIS, IL 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) COMPLETE DATE
S9999	Continued From page 13	S9999		

noted with a cut to her right forehead, skin tear to right shin and right shoulder. The resident denied any other pain or discomfort, ROM (range of motion) assessed and was WNL (within normal limits). MD/POA informed. Orders to have resident evaluated in ER. The resident returned from ER with four sutures to her forehead. Orders to remove sutures in 5-7 days. Follow up with left ovarian mass. Investigation: The resident was seen in ER as stated above and returned to facility. During ER visit a CT scan of head, spine and pelvis was completed and was negative for any acute intercranial abnormality. CT of spine was negative for any acute cervical fracture. CT scan of pelvis incidentally showed an ovarian mass and constipation. Orders received to remove sutures in 5-7 days, order placed to remove on 10/25/24. The resident has had a pain level of 1-2 and denied need for any PRN (as needed) medications. Bruising is noted to forehead and beneath eye fading in color. The resident did have a BM (bowel movement) on 10/17/24. The resident has resumed her normal activities. The resident prefers to stay in bed and receive her meals and care in her room. The DON (Director of Nursing) had a discussion with the POA regarding the air mattress and changing her mother to a regular pressure reduction mattress, POA did not want to change mattress due to age and weight to prevent any skin issues. The DON offered quartered side rails up during provision of care. POA/daughter agreeable to quarter side rails. Bed kept in low position and call light in reach. Care plan updated with interventions.

On 11/22/24 at 1:57 PM, V8 (Certified Nurse Aide/CNA) stated, she was providing care for R5 when she fell out of bed. V8 stated, R5 was in the middle of the bed and she rolled R5 onto her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006118	A. BUILDING: _____ B. WING _____	C 12/05/2024

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(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) COMPLETE DATE
S9999	Continued From page 14	S9999		

side, she is little and has never moved when providing care for R5 until she got these sores on her bottom. Previously when she would wipe her she would twitch or grunt but never move much. The day when she fell she was wiping her bottom because she had a bowel movement and she jerked and moved and rolled off of the bed. She would never roll before when providing care. R5 had always been a one person assist when providing care. After R5 fell, a second person would always go in to assist when providing care until she got her siderails. R5 can hold on to the side rails fine while providing care. R5's sores on her bottom have healed a lot so she does not jerk or twitch while providing care anymore. R5's bed is raised higher than the 18 inches or so off the floor when providing care, she would guess the bed would be approximately 2.5 feet off the ground.

On 11/22/24 at 2:20 PM, V8 demonstrated to this surveyor the height of the bed when care would be provided, which was approximately 2.5 feet off the ground.

On 11/22/24 at 2:20 PM, R5 was laying in the center of her bed she had approximately seven inches from her shoulders to the edge of the bed.

On 11/22/24 at 4:25 PM, V9 (CNA) stated she had provided care for R5 before, and she had never moved before while providing care but she would swat at you on occasion. R5 did not have any sores when she had provided care for her.

R5's progress note dated 10/16/24 at 6:50 PM documents: resident (R5) had rolled off the bed while CNA providing incont (incontinence) care, resident has laceration to R (right) forehead, skin tear to R shin, and skin tear to R shoulder.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006118	A. BUILDING: _____ B. WING _____	C 12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROPOLIS REHAB & HCC	2299 METROPOLIS STREET METROPOLIS, IL 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) COMPLETE DATE
S9999	Continued From page 15	S9999		

R5's hospital note dated 10/16/24 at 10:36 PM documents: CT of the head was negative for any acute intracranial abnormality. CT of the chest was negative for anything acute. CT of the cervical spine was negative for any acute cervical spine fracture. CT of the abdomen pelvis did show a left ovarian mass and constipation as well. Laceration to the right forehead was repaired. Patient will be discharged back to the nursing home. Sutures should be removed in 5 to 7 days. Will advise nursing home staff of constipation and left ovarian mass as well. Patient will be discharged shortly in stable condition.

R5's hospital note dated 10/17/24 at 1:45 AM documents: subjective: history of present illness: 94 year old patient who presents to the emergency department status post fall. The patient is unable to give any history. It is reported that the patient fell from bed. She was lying in bed at (the facility) and fell approximately 2 feet onto the floor. No LOC (loss of consciousness) reported. The patient has a bandage on her head.

R5's progress note dated 10/17/24 at 1:25 AM documents: resident (R5) returned to facility with orders to remove sutures in 5 -7 days. Follow up with left ovarian mass.

R5's progress note dated 10/22/2024 at 3:33 PM documents: left message for (family) regarding the need to order side rails. Informed (her) that two CNAs will provide incontinence care for safety until quarter side rails placed.

On 11/27/24 at 3:06 PM, V1 stated she was not at the facility when R5 fell from her bed, therefore she did not do the investigation. V1 stated she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006118	A. BUILDING: _____ B. WING _____	C 12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROPOLIS REHAB & HCC	2299 METROPOLIS STREET METROPOLIS, IL 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) COMPLETE DATE
S9999	Continued From page 16	S9999		

would not expect residents to fall out of bed during care. V1 stated, they put an intervention in of two CNAs to provide care for R5 until she was evaluated and received the siderails.

The undated facility policy titled, "Fall Prevention" documents: the facility shall ensure that a fall management program will be maintained to reduce the incidence of falls and risk of injury to the resident and promote independence and safety A fall is the unintentional coming to rest on the ground, floor, or other lower level. If a resident loses balance and would have otherwise fallen if not for someone intervening is considered a fall, includes witnessed and unwitnessed falls, includes with or without injury. Serious injury includes but not limited to: fracture, laceration requiring sutures, any falls related to injury requiring an evaluation in the emergency room or admission to the hospital.

B. Based on interview, observation, and record review the facility failed to provide adequate supervision to prevent elopement for 1 (R6) of 3 residents reviewed for elopement in a sample of 16.

Findings include:

R6's Admission record documents an admission date of 09/28/21 with diagnoses including: dementia, cerebral ischemia, generalized anxiety disorder, muscle weakness, lack of coordination, difficulty in walking, and cognitive communication deficit. R6's Minimum Data Set (MDS) dated 10/22/24 documents a Brief Interview of Mental Status (BIMS) score of 07 indicating cognition is severely impaired.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006118	A. BUILDING: _____ B. WING _____	C 12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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) COMPLETE DATE
S9999	Continued From page 17	S9999		

R6's Care plan contains a focus area date initiated 7/8/24 documenting: R6 is an elopement risk/wanderer AEB (As Evidenced by) due to anger with placement within the facility. Interventions include distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Resident prefers: sitting in her room with her husband, also church activities dated 07/15/24 and wander alert device # model 4221-8698 dated 07/10/2023. A recent intervention includes: assist R6 to ambulate to her room or the common area in her hallway after meals in main dining room to prevent attempts of elopement dated 10/30/24.

R6's elopement assessment dated 10/22/24 documents: section: 1. Elopement Risk: a. is the resident cognitively impaired and independently mobile (with or without a device)? with "yes" marked. 'History of Elopement': b1. Does the resident have; with 1. A history of elopement, 2. A desire to leave the facility, and 4. Wandering activity all marked. 'Elopement Risk Factors': b2. Does the resident 6. Have a diagnosis of Alzheimer's disease or dementia marked. C. documents 'yes' for is the resident at risk for elopement, d. documents: 1. Application of electronic monitoring bracelet 3. Picture in elopement book for: 'what interventions were put in place to prevent resident from eloping. The area 'Elopement Needs' area documents: focus: R6 is an elopement risk/wanderer AEB (As Evidenced by) due to anger with placement within the facility. The resident is an elopement risk/wanderer AEB with Goals marked as R6 will not leave facility unattended through the review date and R6's safety will be maintained through the review date, 'intervention' distract resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006118	A. BUILDING: _____ B. WING _____	C 12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROPOLIS REHAB & HCC	2299 METROPOLIS STREET METROPOLIS, IL 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) COMPLETE DATE
S9999	Continued From page 18	S9999		

from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Resident prefers sitting in her room with her husband, also church activities; intervention of wander alert and intervention of elopement/wandering risk, anger with placement within the facility. Intervention: 1. Offer to turn the tv to a station that R6 likes 2. Offer to sit and talk with R6 and see if you are able to calm her down 3. Call V26 (family) to talk with R6 to calm her down.

R6's incident report dated 11/01/24 documents: The resident (R6) was last seen by staff approximately 1800-1810 (6:00 PM - 6:10 PM) in the main dining area. The resident did not mention leaving the facility to staff. The staff working with the resident were all interviewed, and statements obtained and reviewed. Unable to interview roommate as roommate has Alzheimer's diagnosis. Approximately 1800 -1810 on October 28th was the last time staff was able to state they saw the resident in the dining room. The temperature was approximately 72-75 degrees and clear with a breeze per weather service at 6pm on the 28th. The resident was wearing a short-sleeved t-shift, a wind breaker type jacket, pants, socks and her rainbow crocs. She was also carrying a blanket on her rollator walker. The resident was located by a staff members spouse less than 100 feet from the facility walking with her rollator near the adjacent business. The staff member's spouse called the staff member who was working at the facility at the time and notified her that he is with a resident from the facility, and he is next door. The staff member's spouse stayed with the resident until staff came out to assist her back to the facility. At approximately 1844 (6:44 PM), the staff went out to assist the resident back to the facility. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006118	A. BUILDING: _____ B. WING _____	C 12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 19	S9999		

resident's wander guard went off when re-entering the facility. 100% head count was completed. All doors in the facility were checked by staff who verified that alarms were working. Elopement education was initiated immediately. The resident (R6) was unable to state which door she may have gone through to leave the facility. During investigation the resident's blanket was found on the picnic table just outside the breakroom door. A nurse leaving the facility at approximately 1838 noted the blanket on the table. The call to inform the facility of the resident outside was at approximately 1844 (6:44 PM). A 100% audit of all elopement assessments was completed and 100% of the residents were reassessed for elopement and care plans were updated as needed. The elopement books at each nurse station were reviewed for accuracy and a new picture of the resident placed in book. 100% of the wander guards were checked and verified for function. 100% of staff were in-serviced on the elopement policy, where the elopement binders are kept and how to react to an alarm sounding. A care plan was scheduled on 10/29 at 2pm with the POA but she was unable to make it to care plan meeting during this busy time of year. The medical director was updated regarding the investigation results. An elopement drill was completed on 10/31/2024.

R6's progress note dated 10/28/24 at 6:40 PM documents: this nurse (V16, Licensed Practical Nurse) was notified by CNA (V15,Certified Nurse Aide) that (R6) was outside at storage facility next door. When I got outside (R6) was standing by the storage facility with 3 CNAs (V13, V14, V21) and 2 kitchen (Dietary) staff (V26 and V28). (R6) has been refusing to walk back to the facility with CNA's. I was able to talk R6 into coming back to facility. It was about 70 degrees outside still and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006118	A. BUILDING: _____ B. WING _____	C 12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROPOLIS REHAB & HCC	2299 METROPOLIS STREET METROPOLIS, IL 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) COMPLETE DATE
S9999	Continued From page 20	S9999		

resident was wearing a t-shirt, jacket, pants, slipper socks and shoes. She had a blanket at the picnic table and her walker with her. Once back in the building R6 went to bed. (R6's) wander device is on and working. A skin assessment was completed with no issues noted.

On 11/26/24 at 11:05 AM the door R6 exited to the location where R6 was located was observed and was approximately 65 feet with no hazards observed.

On 11/26/24 at 10:55 AM, V5 (Dietary) stated she received a call from V24 (Family of Employee) at 6:28 PM stating R6 was outside of the facility on the side of the storage units with him. V5 stated she asked V24 to stay with her and she would let staff know.

On 11/26/24 at 10:58 AM, V24 (Family of Employee) stated he was over at the storage units on 10/28/24 at just after 6:00 PM when he came out of his unit at approximately 6:25 PM and saw R6. V24 then stated he called V5 at 6:28 PM to tell her R6 was with him and to let staff know. V24 stated he waited by the tree with R6 and staff came out minutes later to get R6 and convince her to go back inside.

On 11/27/24 at 8:14 PM, V23 (CNA) stated she was working the day R6 eloped, she stated the last time she saw R6 was approximately between 6:15 and 6:30 PM she believes. One of the kitchen staff came out of the kitchen and said R6 was outside. R6 went out the double doors towards the breakroom is what she was told. V23 stated, she was in a room assisting another resident when R6 got out. They brought R6 back in the same way she went out and she thinks the alarm sounded, she does not specifically

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006118	A. BUILDING: _____ B. WING _____	C 12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROPOLIS REHAB & HCC	2299 METROPOLIS STREET METROPOLIS, IL 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) COMPLETE DATE
S9999	Continued From page 21	S9999		

remember. V23 stated, usually there is a nurse by that nurse's station around that time. V23 stated she has been in-serviced about checking the doors quickly after hearing an alarm sound.

On 11/26/24 at 2:40 PM, V13 (CNA) stated the day R6 eloped, the alarm went off while she was assisting a resident, then she believes the alarm was no longer going off and she did not see R6 in the hallway. She stated she did not know R6 was outside until a few minutes later.

On 11/26/24 at 2:45 PM, V14 (CNA) stated she was on the hall the day R6 eloped. The last time she saw R6 was in the dining room at approximately 5:50 PM, she believes R6 was still eating then.

On 11/26/24 at 2:53 PM, V15 (CNA) stated she was in the dining room the day R6 eloped (10/28/24), she saw the front door and knew R6 did not go out the front door, that is the door she typically will like to go to. Then she went to the hall and assist another resident, she does not know what time it was that she last seen R6, sometime after dinner.

On 11/27/24 at 3:00 PM, V1 (Administrator) stated on previous times to R6's elopement on 10/28/24 R6 would like to try to go out the facility doors, but staff knew to watch her, she typically would be redirected before she got to the door or outside. She cannot say if the alarm went off for R6's wandering device during her elopement on 10/28/24 because she was not at the facility, but during her investigation staff stated they heard an alarm go off and checked the front door. This happened around shift change and apparently R6 was able to get out the side door by the break room. She checked the phone log of when staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006118	A. BUILDING: _____ B. WING _____	C 12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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) COMPLETE DATE
S9999	Continued From page 22	S9999		

was notified R6 was outside, which was 6:28 PM then stated V26's (Dietary) phone log was checked which showed 6:32 PM was when the staff member was notified by V5 that R6 was outside. V1 stated, from her investigation she had concluded R6 had to be outside approximately 15 minutes and at most around 20 minutes. V1 stated she has since observed R6 and it typically takes her approximately 5 minutes to get from where she sits in the dining room to the area of the double doors and it would take her about the same to reach the door to the outside because it is about the same distance. All the doors were checked with R6's wander device and they all sounded. Since that event every door was checked the next day and has been checked three times a week for two weeks and the doors have always sounded. She has educated all staff that if they hear an alarm to check all the doors immediately and make sure they know where R6 is. V1 stated, to her knowledge R6 has never left the facility previously that a staff member did not have a visualization of her and was right behind her.

On 11/22/24 at 4:35 PM, V7 (Registered Nurse) stated she was not working when R6 eloped but R6 tries to go to doors but she can be easily redirected, she has never seen her leave the facility unsupervised.

On 11/22/24 at 3:12 PM, V12 (Licensed Practical Nurse) stated she was not working when R6 eloped and she has never seen her get out but she will try. V12 stated they are always able to stop her and redirect her.

On 11/22/24 at 3:55 PM, V10 (CNA) stated R6 will try to get out a lot they always have to redirect her. It is the front door mainly, they will hear an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006118	A. BUILDING: _____ B. WING _____	C 12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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) COMPLETE DATE
S9999	Continued From page 23	S9999		

alarm sound and they will run and go get her. They will get her before she gets outside but she can be persistent.

On 11/22/24 at 4:05 PM, V11 (CNA) stated she was not working when R6 eloped. V11 then stated but R6 she will try any door and this happens mostly after meals. She is pretty quick and persistent. She has never seen R6 get outside unsupervised.

On 11/22/24 at 10:10 AM, R12 stated, she has seen R6 try to go towards doors but she never gets outside. R12's MDS dated 10/14/24 documents a BIMS score of 15, indicating cognitively intact.

On 11/22/24 at 9:40 AM, R11 stated, she doesn't remember what time R6 was in the dining room the day she got out but R6 does try to go outside all the time but staff catch her before she gets outside. R11's MDS dated 11/18/24 documents a BIMS score of 15, indicating cognitively intact.

R6's progress note dated 10/29/24 at 1:45 AM documents: this nurse has spoken with overnight nurse several times throughout the night and R6 has been on 1 on 1 with staff member at all times since elopement.

R6's progress note dated 10/29/24 at 1:43 PM documents: R6 has been supervised on 1:1 supervision during day shift. R6 stated, "I'm going to make a break for it."

The facility policy dated 05/2023 titled, "Elopements" documents: Policy: it is the policy of this facility that all residents are afforded adequate supervision to provide the safest environment possible. All residents will be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006118	A. BUILDING: _____ B. WING _____	C 12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 24	S9999		

assessed for behaviors or conditions that put them at risk for elopement. All residents so identified will have these issues addressed in their individual care plans. Definitions: for the purpose of this policy, "missing resident" shall be defined to mean a resident who has left the facility grounds without signing him/herself out of the facility. The resident shall not be designated as "missing" or "eloped" if he/she is seen leaving the buildings or is seen walking away as a result of responding to a door alarm. "Wandering" is defined as aimless travel within the facility and enclosed courtyard areas. Procedure: 1. Residents who are at risk for elopement shall be provided at least one of the following safety precautions by the facility: door alarms on facility exits and/or a personal safety device that will alert facility staff when the resident has left the building without supervision and/or staff supervision. 2. As part of the facility's preventative maintenance program, all door alarms will be checked for proper function on a weekly basis. 3. At no time shall a personal safety alarm or door alarm be turned off without the continual supervision of the exit. The person responsible for turning off the personal safety alarm or door alarm shall be responsible for resetting the alarm and ensuring that it is in working condition. Failure to reset and test exit alarms will result in serious employee disciplinary action, which can include immediate termination. Routine procedures for prevention of missing residents and elopements or attempted elopements: 4. When a door alarm sounds, staff shall immediately respond to and determine the cause of the alarm. The staff person responding to the alarm will check the outside of the building to determine if a resident has exited the building. If upon investigation, no reason can be found for the sounding of that alarm the charge nurse shall initiate an accounting of all residents at risk for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006118	A. BUILDING: _____ B. WING _____	C 12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROPOLIS REHAB & HCC	2299 METROPOLIS STREET METROPOLIS, IL 62960

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S9999	Continued From page 25 elopement. If, after all at-risk residents are accounted for, the cause of the alarm is still undetermined, a complete head count of all residents will be conducted. (A)	S9999		