STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145813	A. Building B. Wing	05/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Metropolis Rehab & Hcc	2299 Metropolis Street Metropolis, IL 62960

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49663 Based on interview and record review the facility failed to provide peritoneal dialysis treatments for 1 of 2 residents (R1) reviewed for dialysis in a sample of 7. This failure resulted in R1 presenting with a change in condition of confusion and being admitted to the hospital with lethargy and receivng hemodialysis during R1's hospital stay. Findings include: R1's Admission Record documents R1's initial admitted to the facility as 03/25/24. The same document lists diagnoses for R1 including but not limited to: End Stage Renal Disease, Dependence on Renal Dialysis, Syncope and Collapse, Muscle Weakness (Generalized), Other Lack of Coordination, and Type 2 Diabetes Mellitus Without Complications. R1's current care plan, with an initiation and revision date of 4/16/24, documents a need of hemodialysis related to renal failure. There was no documentation of the need for peritoneal dialysis prior to this date upon request. R1's Minimum Data Set (MDS) dated [DATE] documents in section C, a Brief Interview for Mental Status (BIMS) score of 13, indicating that R1 is cognitively intact. The same MDS documented in section G, that R1 requires partial to moderate assistance, with rolling left to right, sitting to lying, lying to sitting on a bed, sit to stand, chair to bed transfer, indicating the helper would do less than half the effort. The same MDS documented in section O, Special Treatments, Programs and Procedures, that R1 receives dialysis upon admission and while a resident at the facility. R1's Discharge Planning Summary from the local hospital documents an entry on 3/22/2024 at 3:44 PM, that R1 was informed that this facility can meet her needs and that R1 wanted to talk to her family about her options. This same document has an entry dated 3/25/2024 at 10:22 AM that Patient (R1) was agreeable to rehab and referral sent to facility. An entry dated 3/25/2024 at 12:10 PM, documents (V3-Admission Coordinator) accepted patient (R1) to facility with orders prior for peritoneal dialysis prior to (R1) transferring to ensure they can get the equipment prior to patient arrival. This same document dated 3/28/2024 at 9:01am has a late entry note on 3/25/2024 at 2:00pm stating that (R1) was agreeable to bringing her peritoneal dialysis equipment and 2 days' worth of fluids with her to facility while V9 (Family Member) was at bedside and V3 (Admission Coordinator) agreeable to R1 going to the facility today. (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 0698 Level of Harm - Actual harm Residents Affected - Few	R1's Electronic Health Record (EHR) has no documentation of peritoneal dialysis orders received upon admission. R1's Nurse's Note dated 3/26/2024 at 6:05 PM, by V16 (Registered Nurse/RN), documents called and notified (V17 Nurse Practitioner/NP) that (R1) wouldn't be getting her peritoneal dialysis tonight due to not having all supplies available. Resident (R1) was supposed to bring 2 days supplies but forgot the fluids needed. Resident (R1) vital signs stable and will continue to monitor resident throughout the night. R1's Nurse's Note dated 3/27/2024 at 2:08 PM, documents V10 (Registered Nurse/RN) contacted V8 (Dialysis Registered Nurse) at R1's current dialysis provider regarding peritoneal dialysis orders. V8, states that resident is to use dialysis cycler to run 2 6-liter bags over 9-hour period every night. V10, notified R1 who can provide own dialysis treatment. R1's Nurse's Note dated 3/27/2024 at 8:18 PM documents, (R1) is experiencing a change in condition related to (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. On 5/03/2024 at 10:56 AM, V3 (Admissions Coordinator) stated she arranged admission to the facility with the discharging hospital and was aware R1 needed peritoneal dialysis. V3 stated it was understood by the discharging hospital that R1 would need to complete peritoneal dialysis independently while in the facility and would wait to be discharged to the facility until peritoneal dialysis supplies could be ordered and in the facility for R1. V3 stated the hospital case management arranged with R1 and R1's family to have a family member stop at R1's house to pick up the peritoneal dialysis machine with supplies and then bring the patient and supplies to the facility. V3 stated R1 arrived at the facility without her supplies and machine. V3 stated they have had a handful of patients receiving peritoneal dialysis over the years and could not confirm if staff were currently trained to assist R1 with her peritoneal 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 educator 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 returned to the facility with them but cannot recall what day. V2 stated that R1 did review her dialysis orders with V10 (RN). (continued on next page)

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F 0698 Level of Harm - Actual harm Residents Affected - Few	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. On 5/07/2024 at 9:34am, V9 (Family Member) stated that she brought R1 to the facility after stopping at R1's house to retrieve her supplies to complete dialysis in the facility. V9 stated she was notified the next day that they forget the solution. V9 stated she was unable to get the solution to the facility until the next day. V9 stated that V2 did come to meet her at R1's house to pick up the solution on the third day of R1's admission. On 5/3/2024 at 9:39AM, V1 (Administrator) stated that R1 arrived at the facility without her peritoneal dialysis supplies. V1 stated that V3 (Admissions Coordinator) discussed with the hospital prior to discharging R1 to the facility that R1 would have to be able to complete the peritoneal dialysis, independently, and would need all supplies brought to the facility upon arrival. V1 stated that R1 arrived at the facility without her supplies. V1 stated that R1 was monitored through the night and then V2 (Social Services Director) went to meet R1's family at R1's home to get the peritoneal dialysis machine and supplies the next day. V1 stated that once the machine and supplies were brought to the facility, R1 could not complete the steps to start her dialysis. V1 stated R1's medical provider was notified and R1 was sent to the hospital for evaluation. V1 stated if they knew she was not bringing her supplies, they would not have accepted R1. V1 stated there was an issue with V9's (family member) car when she was notified the next day, they needed her to bring R1's solutions to the facility. On 5/07/2024 at 11:43 am, V10 (Registered Nurse/RN) stated she had direct patient care with R1. V10 stated she cared for R1 on day shift, 3/26/2024, after R1 arrived at the facility. V10 stated, that R1 arrived late the prior evening without her dialysis supplies and the facility was in contact with the family the next day to arrange getting the supplies. V10 stated on the third day, V10 and R1 set up the supplies and machine in R1's room. V10 stated she was under the impression that R1 was going to direct the staff on how to use the dialysis machine, however that evening when V16 (RN) went to help R1, R1 was not able to direct staff on how to assist. V10 stated, R1 was then sent out to the hospital since she had been without a dialysis treatment for 3 days. V10 stated that she did have peritoneal dialysis training a year ago by the facility staff, however, could not remember the exact date. V10 stated, she does not feel comfortable assisting with peritoneal dialysis and does not recall being trained by a dialysis facility faculty. (continued on next page)

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F 0698 Level of Harm - Actual harm Residents Affected - Few	On 5/08/2024 at 6:51 AM, V16 (RN) stated that she had direct patient care with R1. V16 stated she was the nurse that took care of R1 when she arrived at the facility her first night around 11:30 pm. V16 stated that R1 had a lot of bags with her dialysis equipment with her, however, R1 refused to set up the equipment and stated she did not need dialysis that evening. V16 stated she came in to work the next night and was told that R1's family was notified that R1 forgot her solution at home to complete her treatments and V9 (family member) was contacted to bring the solution to the facility. V16 stated that V9 notified the facility that her car was broken down and had no transportation to bring the solution to the facility however someone from the facility is welcome to go to her house and pick up the solution. V16 stated she notified V17 (Nurse Practitioner) of R1 missing her treatments because of no solution and was showing no signs of distress. V16 stated she received orders to monitor R1 for any signs of symptoms of distress. V16 stated when she arrived at the facility for the third night in a row, R1 had her supplies to complete her treatment. V16 stated that someone from the facility went to R1's home that day to get her solution. V16 stated R1 was physically unable to complete her dialysis treatment on her own and staff were supposed to assist by giving directions on what solutions to be used and buttons to be pushed on the machine. V16 stated R1's peritoneal dialysis order was received by the day shift nurse from the dialysis company on 3/27/2024 around 2:00pm. V16 stated the day shift nurse and R1 set up all supplies and her machine that day in R1's room. V16 stated around 7:00 pm, she went into R1's room to assist with dialysis and R1 was unable to give directions on how to set up and start treatments. V16 stated she notified the V17 (Nurse Practitioner) and sent R1 to the hospital. V16 stated she attended the peritoneal dialysis training instructed by V5 sometime in 2023. V16 stated she cannot recall if she was trained on a peritoneal dialysis machine during that training. V16 stated, she has not been trained on peritoneal dialysis by a certified dialysis staff member. V16 stated she feels comfortable assisting residents with peritoneal dialysis when they can give directions on their set up, solutions to use, etcetera. On 5/07/2024 at 1:27 pm, V11 (Physician) stated that R1 was his resident completing peritoneal dialysis treatments at home, independently. V11 stated he was notified after R1 was discharged from the hospital to this rehab facility. V11 stated he expects a nursing home facility to have supplies and proper training prior to accepting a peritoneal dialysis resident. V11 stated he would expect if R1 arrived at the facility without her supplies then the facility should have sent her back to the hospital to receive treatment or R1 to 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 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. The facility's Inservice Education Signature Sheet for peritoneal training by V5 (Director of Nursing/DON) with Peritoneal Dialysis (Continuous Ambulatory) procedure was reviewed and had V10 (Registered Nurse/RN) and V16 (Registered Nurse/RN) signatures as having attended the training . (continued on next page)

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F 0698 Level of Harm - Actual harm Residents Affected - Few	R1's Hospital Discharge Summary from an out of state hospital dated 4/3/2024 documents that R1 was admitted to the hospital on 3/27/24 with a chief complaint of no dialysis in 2 days. The Cumulative Hospital Course and Treatment documents that R1 has End Stage Renal Disease (ESRD) and is on Peritoneal Dialysis (PD) and presented to the emergency room from the rehab center due to lethargy and R1 had not received peritoneal dialysis in at least 2 days. R1 was new to the rehab center, and they were not made aware of her peritoneal dialysis needs. R1 was admitted to the hospital with nephrology consult where a decision was made to change dialysis modality to hemodialysis (HD) and a permcatheter was placed. R1 completed a hemodialysis treatment on 4/03/2024 and was discharged in stable condition to the rehab facility. R1 was to continue hemodialysis treatments, 3 days a week. The same discharge summary documents under Discharge Problem List a principal problem of ESRD needing dialysis and active problems of Lives in a long-term custodial care facility, acute kidney injury, and acute post-hemorrhagic anemia.