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	12/05/2024

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41610 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 admitted [DATE] 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. R10's Minimum data Set (MDS) quarterly review dated [DATE] 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 [DATE] documents a score of 29 indicating R10 was a high risk for falls. (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 0689 Level of Harm - Actual harm Residents Affected - Few	R10's hospital's discharge summary with an admitted [DATE] and a discharge date of [DATE] documents: Hospital Course: Patient (R10) is [AGE] 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) showed generalized slowing, echo indicated normal LV (left ventricular) size with an EF (ejection fraction) of ,d+[DATE] (%). 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. Patient had trouble with hyponatremia but that has improved with fluid restriction and urea sodium after hypertonic NICU (neonatal intensive care unit). She was transition to p.o. (per oral) Cortef . Pts (patient's) sodium is normalized. 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 [DATE] 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 [DATE]. Interventions included: dated [DATE] of anti-slip mat in seat of wheelchair and dated [DATE] 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 [DATE] 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 [DATE], 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 [DATE], 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 dated [DATE]. R10's care plan documents a focus area of: R10 has left hemiplegia/hemiparesis related to stroke with an initiated date of [DATE] and interventions of: give medications as ordered, monitor/document for side effects and effectiveness dated [DATE], obtain and monitor lab/diagnostic work as ordered, report results to MD and follow up as indicated dated [DATE], pain management as needed, see MD order, provide alterative comfort measures PRN dated [DATE], and PT, (physical therapy) OT (occupational therapy), ST (speech therapy) evaluate and treat as ordered dated [DATE]. New interventions added [DATE] include, resident is working with therapy in tilt/reclining chair with anti-skid mat in place, dated [DATE] of will reassess for safety upon resident's return from the hospital, and dated [DATE] of: keep resident's tilt/recline chair in reclined position until staff is ready to assist with meals. Interventions also included: dated [DATE] of anti-slip mat in seat of wheelchair and dated [DATE] of do not leave resident alone when sitting on the side of the bed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R10's final investigation report submitted to IDPH (Illinois Department of Public Health) dated [DATE] 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 [DATE] 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 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 [DATE] with hospice referral. Laceration above left eyebrow closed with steri -strips. Care plan reviewed and updated On [DATE] 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 ([DATE]) 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. On [DATE] 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 [DATE] with multiple declines, she had low motivation to bend forward also. On [DATE] at 9:56 AM, V4 (Director of Rehabilitation) stated prior to [DATE] 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 [DATE] at 10:10 AM, V25 (Therapy) stated she had evaluated R10 on [DATE]. 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. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R10's therapy note dated [DATE] 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 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 [DATE] 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 [DATE] 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 [DATE] 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 [DATE] 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 [DATE] documents: subjective: has had some headaches but no new neurologic deficits from her baseline. Summary: [AGE] 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. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R10's neurosurgery consultation dated, [DATE] at 7:21 AM documents: the patient (R10) is a 55 y.o. (year old) female who presented to the ED (emergency department) on ,d+[DATE] 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 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 [DATE] 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 [DATE] documents: EMS here to transport resident to hospice center. On [DATE] 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 [DATE] at 3:06 PM, V1 (Administrator) stated when R10 fell in the dining room on [DATE] 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 [DATE] 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 manner of death is marked as natural. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On [DATE] 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 [DATE]. 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 [DATE] 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 admitted [DATE] with diagnoses including: dementia, xerosis cutis, other atrophic disorders of skin, muscle weakness, acute kidney failure, full incontinence of feces, lack of coordination, urinary incontinence, altered mental status, and cognitive communication deficit. R5's MDS dated [DATE] 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 [DATE] with interventions to include: Bed Mobility: the resident requires 1 staff participation to reposition and turn in bed with date initiated of [DATE], Transfer: The resident requires 1 staff participation with transfers with date initiated [DATE]. A new intervention dated [DATE] 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 [DATE] 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 [DATE]. R5's Care plan also lists a focus are, (R5) has limited physical mobility date initiated [DATE]. Interventions included, Mobility: the resident requires 1 staff participation for mobility with date initiated [DATE]. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R5's final report to IDPH dated [DATE] documents: On [DATE]th 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 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 , d+[DATE] 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 , d+[DATE] days, order placed to remove on [DATE]. The resident has had a pain level of ,d+[DATE] 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 [DATE]. 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 [DATE] 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 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 [DATE] 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 [DATE] 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 [DATE] 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 [DATE] 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. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R5's hospital note dated [DATE] 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 [DATE] at 1:45 AM documents: subjective: history of present illness: [AGE] 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 [DATE] 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 [DATE] 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 [DATE] 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 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 admitted [DATE] 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 [DATE] documents a Brief Interview of Mental Status (BIMS) score of 07 indicating cognition is severely impaired. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R6's Care plan contains a focus area date initiated [DATE] 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 [DATE] and wander alert device # model ,d+[DATE] dated [DATE]. 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 [DATE]. R6's elopement assessment dated [DATE] 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 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. (continued on next page)

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	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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F 0689 Level of Harm - Actual harm Residents Affected - Few	R6's incident report dated [DATE] documents: The resident (R6) was last seen by staff approximately , d+[DATE] (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 [DATE]th was the last time staff was able to state they saw the resident in the dining room. The temperature was approximately ,d+[DATE] 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 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 , d+[DATE] 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 [DATE]. R6's progress note dated [DATE] 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 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 [DATE] 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 [DATE] 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 [DATE] at 10:58 AM, V24 (Family of Employee) stated he was over at the storage units on [DATE] 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. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On [DATE] 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 remember. V23 stated, usually there is a nurse by that nurse's station around that time. V [TRUNCATED]