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	09/10/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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

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	09/10/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free from abuse for two of four residents (R1 and R4) reviewed for abuse on the sample list of eleven. Findings Include:1. R1's electronic health record (EHR) documented R1 has resided at the facility since 5/3/22. R1's EHR documented R1 has diagnoses including, but not limited to cerebral infarction, major depressive disorder, muscle wasting and atrophy, difficulty in walking, and dysphagia.R1's most recent Minimum Data Set (MDS) dated [DATE] documented R1 has a brief interview for mental status (BIMS) score of 9 indicating R1 is not cognitively intact. R1's MDS also documented R1 is mostly a partial to moderate assistance for all her activities of daily living (ADLs) except a few indicating R1's weakness and difficulty walking. R1's care plan (CP) dated 7/2/25 documents R1 has impaired cognitive function due to history of a stroke. R1's CP also documents R1 has limited physical mobility. R3's admission Record printed 9/9/25 documents R3 was admitted to the facility on [DATE] with diagnosis to include unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, depression, unsteadiness on feet, cognitive communication deficit. R3's MDS dated [DATE] documents R3 has a BIMS score of 6 documenting R3 has moderately impaired cognition, is independent with mobility in wheelchair and has no impairment to the upper or lower extremities. R3's Care Plan documents R3 has a behavior problem, verbal arguing with other resident. R3 will hit other resident when angry all with date initiated 8/25/25. Facility's final investigation report dated 8/31/25 received by Illinois Department of Public Health (IDPH) documents that as R1 was watching television in the dining room R3 came up to R1 in his wheelchair and stated he would like to have her big titties. The investigation report continued to document R3 then reached over and grasped R1's left breast. Facility's investigation report goes on to document at that time R1 instructed R3 to stop touching her and removed R3's hand from R1's left breast. Facility's final investigation report documented that based on the consistent account of the staff interview statements, the incident was substantiated for sexual misconduct of groping R1's left breast by R3. Facility's risk assessment form dated 8/31/25 documented it was determined R3 did grab R1's breast.On 9/9/25 at 9:54 AM, R1 stated she doesn't remember who assaulted her, but does remember the assault. R1 stated the incident happened after a meal. R1 stated a man wheeled up in his wheelchair and reached over and grabbed her breast. R1 stated she couldn't remember if he said anything before the incident. R1 stated she did tell the man to stop and pushed the man's hand away. R1 also stated she told the man to never to do that again. R1 stated she doesn't ever remember being assaulted in this facility before or after this incident. R1 stated she is not afraid of any person in this facility and if a similar incident happened again, she would stop it and tell someone. R1 stated she hasn't stopped doing the things she likes or going where she wants because of the assault. On 9/9/25 at 9:42 AM, R3 stated he doesn't remember the incident or allegedly touching R1. R3 stated he never touched any female's breast by accident or on purpose. On 9/9/25 at 9:23 AM, V4, (Licensed Practical Nurse/LPN) stated she witnessed the incident between R1 and R3 that occurred on 8/31/25 in the dining room. V4 stated she was walking down the hall when she heard talking coming from the dining room. V4 stated when she looked in the dining room, she observed R3 grab R1's breast and then rub it. V4 stated she immediately told R1 to stop what he was doing, and he did. V4 stated R3 appeared confused at the time. V4 stated she then had R1and R3 separated and removed from the dining room. V4 stated R1 didn't appear afraid but did appear angry about the incident. V4 stated she had never witnessed that type of behavior from R3 before or after this incident. V4 stated after separating R1 and R3 she checked on their immediate safety and for obvious injuries. V4 stated she notified V1, Administrator and Abuse Coordinator for guidance and to report the incident. V4 stated V1 instructed her to place R3 on immediate one to one supervision for the next seventy-two hours. V4 stated she then notified R1 and R3's nurses of the incident and personally conducted a head-to-toe assessment on R1 at which time she found no injuries. On 9/9/25 at 11:46 AM, V6 (LPN) stated he notified R1's power of attorney, police, and medical doctor of the incident the same date of the incident - 8/31/25. 2. R4's electronic health record (EHR) documents R4 has resided at the facility since 3/16/22. R4's EHR documents R4 has diagnoses including, but not limited to adjustment disorder with mixed anxiety, history of traumatic brain injury, chronic obstructive pulmonary disease, abnormal posture, muscle weakness, and abnormalities of gait and mobility. R4's most recent MDS dated [DATE] documents R4 has a BIMS of 8 indicating he is not cognitively intact. R4's MDS also documents R4 has impairment of his range of motion (ROM) of both lower