STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145813	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/05/2026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review the facility failed to update and implement interventions to care plans for one (R1) of three residents reviewed for care plans in a sample of 8.Findings include:R1's admission record documents an admission date of 05/14/24 with diagnoses including: Alzheimer's disease with late onset, dementia, chronic obstructive pulmonary disease, acute and chronic respiratory failure with hypoxia, pleural effusion, abnormal posture, and body mass index 19.9 or less. R1's minimum data set (MDS) dated [DATE] documents R1 is severely impaired in making decisions regarding tasks of daily life.R1's care plan documents: R1 has impaired cognitive function/dementia or impaired thought processes Alzheimer's, Dementia. Date initiated 5/14/24. R1 has a behavior problem with agitation, she often rejects care and becomes physically/verbally aggressive with staff, physically and verbally aggressive during cares. Date initiated 5/21/24. Interventions listed of: behavior #2: agitation: being physically aggressive towards staff or refusing care Interventions: 1. offer to come back at a later time to do care 2. offer to call R1's family to talk to her 3. Redirect R1 if need be to her room to prevent an accident revised date of 03/18/2025. Administer medications as ordered, date initiated 5/21/24. Monitor/document for side effects and effectiveness dated 05/21/2024. R1 is at risk for falls due to confusion with interventions listed as: be sure resident's call light is within reach and encourage the resident to use it for assistance as needed dated 05/14/24, non traditional call light while up in the recliner dated 01/12/25, and when resident is up in wheeled recliner resident needs to be out of her room dated 02/01/26. R1's care plan does not contain any focus area or interventions on R1's behaviors with going to bed or methods used to get her to go to bed or stay in bed or what to do if she refuses.On 02/27/26 at 9:04 PM, R1 was sitting at the nurses' station in her wheeled recliner asleep with her head leaning against the wall.On 02/27/26 at approximately 9:50 PM, V6 (Certified Nursing Assistant/CNA) came and took R1 to her room, at approximately 9:56 PM, V6 returned to the nurses' station with R1, R1's clothes were changed and R1 was awake and mumbling to herself.On 02/27/26 at 9:56 PM, V6 stated, R1 didn't want to go to bed. V6 stated, she doesn't think R1 could use a call light.On 03/02/26 at 1:12 PM, V12 (CNA) stated, she does not think R1 could use a call light appropriately.On 03/03/26 at 2:24 PM V7 (CNA) stated, she does not think R1 could use a call light appropriately.On 03/04/26 at 11:19 AM, V9 (Care plan Coordinator/Minimum Data Set Coordinator) stated, R1's care plan states if R1 is in her room in her recliner unattended she is to have an alternate call light within reach. V9 stated, she does not know if R1 can use a call light. V9 stated, if R1 is in her recliner, she is not to be left unattended and should be brought to the nurses' station. On 03/04/26 at 11:40 AM, V2 (Director of Nursing) stated, they have discussed R1 in relation to her being put to bed in morning meeting. V2 stated, they have discussed when R1 starts looking tired to try to put her to bed and if she gets agitated to call her daughter and let her daughter talk to her for a bit and see if that calms her down. V2 then stated if R1 is still agitated and does not calm down to bring her back to the nurse's station until she seems tired and try again. V2 stated this information should go on the care plan and staff members should be made aware. V2 stated R1 cannot cognitively use a call light and she should not be left in her room in (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	her recliner unattended even with a call light. V2 stated, R1 does not take any medications for agitation, R1 only takes a Lasix and occasionally a Tylenol. V2 stated, R1's care plan needs cleaned up and updated.On 03/04/26 at 5:12 PM, V8 (Family) stated the facility did not call her 02/27/26 at night. V8 stated, she would like the facility to really make an attempt to get R1 to lay down because she had acquired a pressure sore on her bottom and she sits in that chair all day and she would like to see if she can help alleviate it. V8 stated, R1 does not take any medication for any behaviors or agitation, R1 only takes Lasix, an inhaler, and some Tylenol sometimes.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on interview, observation, and record review the facility failed to provide enough staff to meet the needs of the residents timely. This failure has the potential to affect all 62 residents residing at the facility.Findings include:The facility Assignment location list dated 02/27/26 documents 62 residents residing at the facility.On 02/27/26 at 9:04 PM, R1 was sitting at the nurses' station in her wheeled recliner asleep with her head leaning against the wall.On 02/27/26 at 9:15 PM, V5 (Licensed Practical Nurse) was passing medications. V5 was the only staff member visualized on the 100 and 200 hall.On 02/27/26 at 9:15 PM, V5 stopped her medication pass and responded to a resident that was yelling out then went back to her med (medication) cart and attempted to start med pass again when another call light went off. V5 stopped med pass to attend to the call light again. After attending to that call light she started med pass again.On 02/27/26 at 9:17 PM another call light was activated, V5 finished giving the medication she was working on to a resident and went and checked the call light. After V5 tended to the resident two more residents were herd yelling for a nurse and CNA (Certified Nursing Assistant) and V5 went and checked on them.On 02/27/26 at 9:20 PM, V5 started prepping medications for another resident when another call light was activated. V5 completed giving the resident their medication and checked on the call light.On 02/27/26 at 9:31 PM, V5 went back to her med cart to start prepping medication for another resident when another resident was herd yelling they needed a nurse. After V5 finished giving that resident their medications she checked on the resident that was yelling.On 02/27/26 at approximately 9:50 PM, V6 (CNA) went to the Nurses Station and took R1 to her room. At approximately 9:56 PM, V6 returned to the nurses' station with R1. R1's clothes had been changed and R1 was awake and mumbling to herself.On 02/27/26 at approximately 9:57 PM, two call lights were activated and R5 was yelling in the hallway needing attention.On 02/27/26 at approximately 9:59 PM, two residents were heard yelling for assistance.On 02/27/26 at 10:07 PM, two call lights were activated.On 02/27/26 at 10:07 PM, R5 was in the hall yelling, she needed to talk to someone, would someone help her.On 03/01/26 at 7:10 PM, R6 who was alert to person, place and time, stated there are times he has had to wait over 30 minutes to go to the bathroom and be changed, he stated, there are times they did not have time to give him a bed bath so he will take wipes and try to do it himself the best he can.On 03/04/26 at 12:46 PM, R8 who was alert to person, place ant time, stated there are times in the afternoon and evening she has had to wait quite a while for someone to come help her.On 03/04/26 at 1:28 PM, V6 (CNA) stated on 02/27/26 there was one CNA on the 100 hall and one CNA on the 200 hall. V6 stated she was down on 200 hall assisting with a resident that takes two people to change him so she finished with that and came back to the 100 hall and started assisting there again. V6 stated sometimes it is challenging to answer everything timely but they do the best they can. V6 stated sometimes V5 can require a lot of assistance and R1 can be the same way. Somedays R2 will stay in bed all night and sometimes she is up and down. There are several residents that will stay up past 9:00 PM. V6 stated, they have several residents that use a brief but will still toilet and the others need changed. V6 stated, they do have probably at least three residents that will commonly yell out for assistance. V6 stated, they do the best they can, it can be challenging but they try.On 03/04/26 at 2:33 PM, V7 (CNA) stated the facility typically puts one CNA on the 100 hall and two CNAs on the 200 hall but sometimes there can be one CNA on each hall. V7 stated, it can be challenging at times to get all the needs met timely. V7 stated, there are days that residents on the 100 hall and the 200 hall can require more assistance. R1 and R5 can have their days where they need more time and there are other residents also. V7 stated, on 02/27/26 there was one CNA on each hall and we would have to go back and forth and help each other out for the safety of the residents. V7 stated, it can be challenging but we do the best we can do. V7 stated that night all the care needs might not have been met as timely as they should have but they did their best.On 03/02/26 at 2:35 PM, V17 (Regional Nurse) stated, the CNA staffing is based (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	off of the census, if the resident's needs would potentially require something different V2 could reach out and they could discuss potentially recalculating.On 03/04/26 at 5:14 PM, V5 stated she gives medications to half the building so she needs to keep going to hopefully get them done on time. V5 stated, if she did not stop her med (medication) pass so many times on 02/27/26 the medications might have been on time or they would have been close. V5 stated, if the CNA on the 100 hall is on break, on lunch, or helping the other CNA it is the expectation that the nurse will check the call lights. V5 stated, the call light should be checked timely because you don't know why it is going off until you go check, that resident could have fallen, you don't know.On 03/04/26 at 11:19 AM, V2 (Director of Nursing) stated sometimes there are call ins or no call no shows and they will end up with one CNA on 100 hall and one CNA on the 200 hall, but that is not what is intended. V2 stated that situation can be very challenging to get everything done timely. V2 stated, they try to have one CNA on the 100 hall and 2 on the 200 hall typically. V2 stated, the duties that should be met include answering call lights, toileting residents, changing residents, during meal times the CNAs prepare the drinks and deliver the drinks, deliver the food, assist any residents with eating or cueing and supervision of dining, they pass the hall trays. When the CNAs are in the dining room or passing trays the nurse can watch the hall. V2 stated, they also give some showers on the 2:00 PM to 10:00 PM shift, where another CNA or nurse could watch the hall. V2 stated, there are times some residents can need more attention than others including R1 and R5. V2 stated, there are approximately two residents requiring two-person assists on the 100 hall and most of the others would need at least a one person assist with toileting and transferring. V2 stated, it could be challenging at times especially around dining times or if residents are having behaviors.R6's grievance form dated 02/17/26 documents: call light not being answered in a timely manner.The Daily Breakdown Schedule dated 2/14/26, 02/15/26, 02/17/26, 02/27/26, and 02/28/26 document one CNA on the 100 hall and one CNA on the 200 hall.

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. Based on interview, observation, and record review the facility failed to provide drinks with meals for 4 (R1, R2, R3, and R4) of four residents reviewed for hydration in a sample of 8.Findings include:On 03/01/26 at 5:28 PM during the evening meal, R1 was seated in the dining room at a table with her food in front of her and did not have a drink in front of her.On 03/01/26 at 5:28 PM during the evening meal, R2 was seated in the dining room at a table with her food in front of her with approximately one third of her food eaten with no drink in front of her.On 03/01/26 at 5:28 PM during the evening meal, R3 was seated in the dining room at a table with her food in front of her with approximately one third of her food eaten with no drink in front of her.On 03/01/26 at 5:28 PM during the evening meal, R4 was seated in the dining room at a table with his food in front of him with approximately three quarters of his food eaten and no drink in front of him. On 03/01/26 at 5:44 PM R1, R2, R3, and R4 still did not have drinks in front of them and they still had food in front of them and they were eating.On 03/01/26 at 5:45 PM, V3 (Certified Nursing Assistant/CNA) stated she does not know why R1, R2, R3, and R4 did not have drinks, maybe they came late.On 03/01/26 at 5:46 PM, V3 asked R2 if she would like something to drink and R2 said Yes!On 03/01/26 at 7:12 PM, V2 (Director of Nursing) stated all residents should receive a drink with their meals, it does not matter if the resident comes to the dining room late or if they move tables.On 03/02/26 at 2:36 PM, V4 (Dietary Manager) stated all residents should get drinks with their meal, most residents should probably have two drinks with their meal. V4 stated, the CNAs prepare the drinks and deliver the drinks to the residents. The kitchen only prepares the pitchers of beverages for the CNAs.The undated facility policy titled, 24 hour Dining documents: 3. Staff will monitor the resident's food and fluid intake for adequate consumption and offer appropriate meal substitutions to resident when needed, for a noted poor intake of a food item or an expressed concern about the taste, temperature, quality or appearance of the meal. 4. Any staff member that observes a resident experiencing problems with chewing, swallowing, eating independently or consuming inadequate amounts of food/fluids at meals will refer the resident to the Director of Nursing and Dining Services Manager for follow-up.