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	04/03/2026

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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and record review, the facility failed to notify a medical provider of elevated blood glucose levels for 1 (R4) of 3 residents reviewed for glucose monitoring. This failure resulted in R4 having blood glucose levels greater that 600 putting R4 at risk to develop Diabetic Ketoacidosis (DKA) which could result in coma and possible death.The Immediate Jeopardy began on 3/2/26 at approximately 8:00 AM when R4's blood glucose reading was not obtained and sliding scale insulin was not administered per Physician orders. V1 (Administrator), V11 (Assistant Director of Nursing/ ADON), V2 (Director of Nursing/ DON), V12 (Licensed Practical Nurse/ LPN/ Wound Nurse), V22 (Regional Clinical Director), and V23 (Regional Director of Operations) were notified of the Immediate Jeopardy on 3/20/26 at 9:06 AM. The surveyor confirmed by observation, interview, and record review that the Immediate Jeopardy was removed on 3/19/26, but noncompliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training.Findings include:R4's admission Record documented an admission date of 2/3/26 with diagnoses including: type 2 diabetes mellitus, need for assistant with personal care. R4's 2/10/26 Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 14, indicating R4 was cognitively intact.R4's Care Plan Report documented a 2/4/26 Focus of diabetes mellitus with a 2/4/26 intervention documenting in part .diabetes medication as ordered by doctor. Monitor/ documents for side effects and effectiveness. R4's Medication Review Report documented a 2/11/26 order for Insulin Lispro (Humalog) Injection Solution 100 UNIT/ML (milliliter) (Insulin Lispro) Inject as per sliding scale: if 80 - 150 = 0; 151 - 200 = 2; 201 - 250 = 6; 251 - 300 = 12; 301 - 350 = 16; 351 - 400 = 20; Over 400 Call MD (medical doctor), subcutaneously before meals and at bedtime for DM 2 (type 2 Diabetes Mellitus).R4's Electronic Medical Record (EMR) documented a 3/2/26 at 10:47 AM progress note documenting in part .Lispro Injection Solution 100 UNIT/ML (Insulin Lispro) Inject as per sliding scale: if 80 - 150 = 0; 151 - 200 = 2; 201 - 250 = 6; 251 - 300 = 12; 301 - 350 = 16; 351 - 400 = 20; Over 400 Call MD, subcutaneously before meals and at bedtime for DM 2. Pt BG>600, 20U Hum given at this time (Patient's Blood Glucose greater than 600, 20 units Humalog (Lispro) given at this time.).R4's EMR documented a 3/2/26 at 7:49 PM progress note authored by V4 (Registered Nurse/ RN) documenting in part .Resident having hyperglycemia issues today. Resident BG was >600 and received 20U humalog and 14U Lantus at 1047 (10:47 AM) and then she was still >600 at 1157 (11:57 AM), so this nurse contacted staff to obtain instructions to speak with the provider. At 1259 (12:59 PM) I was able to call the telemed group after receiving their contact information. (V6/Physician Assistant) asked to recheck and pt BG was 531. VORB (Verbal Order Read Back) to give 22U Humalog, SQ (subcutaneous), x1, once, now and recheck BG (blood glucose) in 2 hours. Resident was checked again around 1600 (4:00 PM) and she was down to 272 and within the scope of her ordered sliding scale.R4's provider progress note dated 3/2/26 authored by V6 documented in part .Notified by nursing that patient blood sugar was given late in the morning around 10:50 am. Glucose was over 600. Recheck an hour later was over 600. Nursing notified me of results two hours later. Patient asymptomatic. Request nursing to recheck glucose. Nurse called back blood sugar reading of 531. Patients sliding scale for breakfast cover is 20 units Humalog at a blood sugar reading of 400. (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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Recommended nurse give a total of 22 units (additional 2 units). Nursing to continue to monitor and recheck blood sugar in 2 hours and notify of abnormal value. Nursing to notify of any symptoms.On 3/13/26 at 10:51 AM, V4 (RN) said she was still passing 8:00 AM medications and I never have my meds passed on time. V4 said on 3/2/26 she was running late passing medications and R4's morning accu check read HI on the glucometer so V4 knew R4's blood glucose was over 600. V4 said she administered the highest does on insulin on R4's insulin sliding scale at that time. V4 said R4 did not have any signs or symptoms of Diabetic Ketoacidosis (DKA) so V4 knew R4 did not need to be sent to the hospital. V4 said she rechecked R4's accu check an hour later and it still read HI on the glucometer. V4 said she then had to find out how to contact a medical provider. V4 said she contacted a medical provider as soon as she could (2 hours later) because R4 was not in any distress.On 3/13/26 at 1:26 PM, V3 (Physician/ Medical Director) said if an accu check was obtained and the glucometer read HI he expected staff to contact a medical provider within 15 minutes and that's giving them time to walk to the phone, it should be immediately. V3 said most glucometers registered blood glucose up to 600 and if the glucometer read HI you would not know how high the blood glucose actually was, you would just know it was greater than 600. V3 said if an hour after treatment with insulin the glucometer reads HI again the resident should be sent to the emergency room (ER) due to the high likelihood the resident could develop DKA. V3 said a person developing DKA did not always show any signs or symptoms in the early stages and the likelihood of developing DKA was high if not treated quickly. V3 said DKA was life threatening. V3 said he expected staff to call 911 for an ambulance if they did not know how to reach a provider if a medical emergency occurred. V3 also said he was not sure why staff would not know how to get in touch with him because his number was listed in the EMR of the resident.R4's March 2026 Medication Administration Record did not document a 3/2/26 order for Lispro 22 units.R4's March 2026 Medication Administration Record documented on 3/5/26 at 8:00 AM R4's blood glucose was 411 and at 11:00 AM R4's blood glucose was 434. Both of those entries included a #6 that directs you to see Administration notes.R4's Orders Administration Note dated 3/5/26 at 12:01 PM documents sliding scale insulin was administered. This nurse contacted the physician.The facility's Medication Admin Audit Report printed 3/20/26 at 11:56 AM documented R4's 3/5/26 at 8:00 AM Insulin Lispro was scheduled for 8:00 AM, Administered at 12:01 PM, and Documented at 12:11 PM.R4's Orders Administration Note dated 3/5/26 at 12:13 PM documented in part, This nurse contacted (V3) regarding blood glucose readings.The facility's Medication Admin Audit Report printed 3/20/26 at 11:56 AM documented R4's 3/5/26 at 11:00 AM Insulin Lispro was scheduled for 11:00 AM, Administered at 12:33 PM, and Documented at 12:37 PM.R4's Orders Administration Note 3/5/36 at 12:33 PM documented in part . Sliding scale insulin administered.On 3/19/26 at 1:06 PM, V5 (RN) said he had contacted V3 about R4's 411 and 434 accu checks after talking to R4 about using an automated insulin delivery system. V5 was asked how much insulin V5 administered to R4 after obtaining the 411 accu check and V5 said, I gave the 20 units because that was the highest dose on the sliding scale. V5 was asked how much insulin V5 administered to R4 after obtaining the 434 accu check and V5 said again, I gave the 20 units because that was the highest dose on the sliding scale. V5 was asked why the 8:00 AM accu check was not completed until 12:01 PM and V5 said he was not sure. V5 said he made a progress note about his conversation he had with the MD about R4's high accu checks.On 3/16/26 at 2:48 PM, V2 (Director of Nursing/ DON) said she expected staff to obtain blood glucose readings and administer medications as ordered. V2 said blood glucose should be checked prior to the resident eating. V2 said if the resident's order was to contact a medical provider if the blood glucose is greater than 400 she expected staff to contact a medical provider as soon as possible for new orders.The facility's 12/2024 Significant Condition Change and Notification policy documented in part . medical practitioner are notified of resident changes such as those listed below. abnormal blood glucose results, or above or below set parameters. The facility's revised 3/24 Blood Glucose Monitoring System User's Guide documented in part . Solving Problems. This section details the significant display screen messages (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	and error codes you will encounter. what you see. HI. What it means. Test result is higher than 600 mg/ dl (milligram per deciliter). What should you do. Wash and dry your hands and repeat the test on a different fingertip with a new test strip. If the result is still HI, contact your physician or a healthcare professional immediately.The Immediate Jeopardy that began on 3/2/26 was removed on 3/19/26 when the facility took the following actions to remove the immediacy and correct the deficient practice as confirmed through observation, interview, and record review:1). Immediate Resident Safety:The identified resident (R4) discharged from the facility to home on 3/6/26.A house-wide review of all current residents with blood glucose monitoring was completed to ensure no other critical values required physician notification (completed by Nurse Managers: V2 (Director of Nursing/DON), V11 (Assistant Director of Nursing/ADON), V12 (LPN/ Wound Care Nurse) and V13 (RN/ MDS Coordinator) on 3/19/26).2). Immediate Staff Education:All licensed nurses were immediately re-educated on change in condition and physician notification requirements under F 580, with emphasis on timely reporting of abnormal/critical blood glucose results, required timeframes and documentation standards. Physician notification will be made immediately for any emergencies regardless of the time of day. Non-emergency notifications may be made the next morning if the situation occurs on the late evening or night shift. This applies to any day of the week including holidays. Education includes verbal competencies (Education was completed by Nurse Managers: V2, V11 and V12 on 3/19/26.). All nurse managers received education. Licensed staff will not be permitted to work until education is complete.3). Clarification of Parameters:The facility reinforced change in condition and clear parameters for physician notification of blood glucose results (physician's will be notified if blood glucose above 400), including defined critical values and required escalation timeframes (Nurse Managers: V2, V11 and V12 educated with verbal reinforcement on 3/19/26). 4). Audit and Monitoring:The facility initiated a 100 % audit of all Accu-Check results each shift to ensure abnormal/critical values are timely reported to the physician and documented appropriately (Nurse Managers: V2, V11, V12 and V13 completed 100 % audit on 3/19/26). Audits will occur daily x14 days, weekly x4 weeks then monthly through QAPI (Quality Assurance and Performance Improvement). The audits will be completed by V2 DON or V11 ADON, in the DON absence. (Audit will be initiated 3/19/26 to completion date).5). Leadership Oversight:The Director of Nursing/designee will review all abnormal glucose results and corresponding physician notifications daily to ensure compliance (monitoring during clinical QA meeting. The QA clinical meeting is in addition to the QAPI process). The QA clinical meeting reviews will occur daily Monday through Friday. Saturday and Sunday review will take place the following Monday as this is an internal process that will remain ongoing per policy and procedure.6). Accountability:Licensed staff found non-compliant with timely physician notification will be subject to progressive discipline and/or up to termination as per facility policy.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review the facility failed to provide Activities of Daily Living (ADL) care for dependent residents for 1 (R9) of 3 residents reviewed for ADL care for dependent residents in a sample of 14.Findings include:R9's admission Record documented an admission date of 1/26/20 with diagnoses including: insomnia, adult failure to thrive, and type 2 diabetes mellitus with diabetic polyneuropathy.R9's 1/14/26 Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 15, indicating R9 was cognitively intact.R9's Care Plan Report documented a revised 6/8/22 focus area documenting in part .(R9) has an ADL self care performance deficit activity intolerance, hemiplegia. with a revised 6/1/22 intervention documenting in part . bathing: ther resident requires 1 staff participation with bathing. and a revised 2/27/24 intervention documenting in part . Transfer: the resident requires 2 staff participation with transfers.On 3/17/26 at 11:29 AM, V19 (Certified Nursing Assistant/ CNA) said resident shower sheets are prefilled out with the resident's name and shower day on them. V19 said if staff do not have time to get the resident's bath completed they place the shower sheet back in the shower sheet box and the next shift is supposed to complete them. V19 said when she arrived for her shift on 3/17/26 R9's 3/16/26 shower sheet was in the shower sheet box and V19 had assisted R9 to get cleaned up.On 3/17/26 at 11:47 AM, R9 was lying in bed watching television. R9 was observed to have whiskers around her chin area that were approximately 0.5 inch long. R9 was asked when she had last received a shower and R9 said it had been a week. R9 said when the facility does not have the staff to take her to the shower, they will give her a bed bath, but she would prefer to take a shower. R9 was asked when the last time the facility had assisted her with shaving the whiskers on her chin was and R9 said staff would only shave her chin when she was in the shower so it had been a week. R9 said 3/16/26 was supposed to be her shower day but no one had asked her if she wanted to go to the shower but V19 had assisted her to get cleaned up with a bed bath earlier that day.The Shower List for the hall R9 resided on documented R9's shower days were during evening shift on Mondays and Thursdays.R9's Skin Monitoring: Comprehensive CNA Shower Review sheets documented R9 received a bed bath on 3/9/26, a shower on 3/11/26, and a bed bath on 3/17/26 with the documented date to be completed to be 3/16/26.On 3/17/26 at 3:10 PM, V2 (Director of Nursing/ DON) said the facility did not have a policy for ADL care for showering / bathing. V2 said showering/ bathing should be offered twice a week per the Shower List.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation, interview, and record review the facility failed to provide enough staff to perform Activities of Daily Living (ADL) care for dependent residents for 2 (R9 and R14) of 3 residents reviewed for ADL care in a sample of 14. This failure has the potential to affect all 13 residents residing on the 100 hall.Findings include:1. R9's 1/14/26 Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 15, indicating R9 was cognitively intact.R9's Care Plan Report documented a revised 6/8/22 focus area documenting in part .(R9) has an ADL self care performance deficit activity intolerance, hemiplegia. with a revised 6/1/22 intervention documenting in part . bathing: this resident requires 1 staff participation with bathing. and a revised 2/27/24 intervention documenting in part . Transfer: the resident requires 2 staff participation with transfers.On 3/17/26 at 10:59 AM, V19 (Certified Nursing Assistant/ CNA) said she had worked the hall R9 resided by herself within the week prior to this interview. V19 said if a staff member is working the hall that R9 resided on alone that staff member had to wait for staff on another hall to finish what they were doing to come and help you with the 2 residents that required a mechanical lift for transfer and the residents that required a 2 person assist. V19 said the facility had started sending CNA's home throughout their shift claiming the census was not high enough to justify 2 CNA's working on the hall R9 resided on. V19 said she always worked day shift but evening shift was short staffed and day shift would stay over a lot because no one will show up.On 3/17/26 at 11:29 AM, V19 said resident shower sheets are prefilled out with the resident's name and shower day on them. V19 said if staff do not have time to get the resident's bath completed they place the shower sheet back in the shower sheet box and the next shift is supposed to complete them. V19 said when she arrived for her shift on 3/17/26, R9's 3/16/26 shower sheet was in the shower sheet box and V19 had assisted R9 to get cleaned up.On 3/17/26 at 11:47 AM, R9 was lying in bed watching television. R9 was observed to have whiskers around her chin area that were approximately 0.5 inch long. R9 was asked when she had last received a shower and R9 said it had been a week. R9 said when the facility does not have the staff to take her to the shower, they will give her a bed bath, but she would prefer to take a shower. R9 was asked when the last time the facility had assisted her with shaving the whiskers on her chin was and R9 said staff would only shave her chin when she was in the shower so it had been a week. R9 said 3/16/26 was supposed to be her shower day but no one had asked her if she wanted to go to the shower but V19 had assisted her to get cleaned up with a bed bath earlier that day. R9 said the facility was short staffed and they could not always get her baths completed on her scheduled days. R9 said the girls (the CNAs) do the best they can and I don't want to get anyone in trouble but sometimes you have to wait a long time because they are busy helping someone else.The Shower List for the hall R9 resided on documented R9's shower days were during evening shift on Mondays and Thursdays.R9's Skin Monitoring: Comprehensive CNA Shower Review sheets documented R9 received a bed bath on 3/9/26, a shower on 3/11/26, and a bed bath on 3/17/26 with the documented date to be completed to be 3/16/26.The Daily Breakdown Schedule for 3/16/26 documented the 2:00 PM - 10:00 PM CNA for R9's hall documented the scheduled CNA left early with V2 (DON) and V11 (ADON) working the hall as CNAs until another CNA came in to take over at 6:30 PM through 10:00 PM. The Daily Breakdown Schedule from 3/6/26 through 3/16/26 documented 1 CNA scheduled on 3/8/26, 3/14/26, and 3/15/26. On 3/17/26 at 3:10 PM, V2 (Director of Nursing/ DON) said the facility did not have a policy for ADL care for showering / bathing. V2 said showering/ bathing should be offered twice a week per the Shower List. On 3/17/26 at 8:48 AM, V20 (Licensed Practical Nurse/ LPN) said the hall R9 resided on and another hall adjacent to that hall sometimes only one 1 CNA on both halls. V20 said the facility worked short staffed more often than not. 2. R14's admission Record documented an admission date of 2/25/26 with diagnoses including need for assistance with personal care, quadriplegia, cord compression.R14's 3/4/26 MDS documented a BIMS (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	score of 14, indicating R14 was cognitively intact.R14's Care Plan report documented a revised 3/9/26 focus area documenting in part . (R14) has an ADL self care performance deficit. with revised 2/26/26 interventions documenting in part . Transfer: The resident requires 2 staff participation with transfers. and .Transfer: The resident requires mechanical aid, hoyer, for transfers .On 3/17/26 at 2:32 PM, R14 was sitting in a wheelchair in his room watching television with a mechanical lift sling under him. R14 said he preferred to stay up in his wheelchair through the day. R14 said at night when it is time to assist R14 to bed sometimes it is late sometimes as late as 10:00 PM before staff can find someone to help them use the mechanical lift to transfer R14 to the bed from his wheelchair. R14 stated I know they are short staffed a lot and they have to go find someone to help them.On 3/17/26 at 3:20 PM, V21 (CNA) said she almost didn't clock in when she learned she was working as the only CNA on the hall R14 resided on, the same hall R9 resided on. V21 said she was agency and did not have to take a shift if she did not feel like the assignment was safe. V21 said the facility had assured her there would be another CNA coming in at 6:00 PM to assist her with getting residents cleaned up and assisted to bed, so V21 had clocked in and taken the assignment. V21 said she told facility management she was not going to transfer any resident that required the use of a mechanical lift by herself or any resident that required a 2 person assist by herself and take the chance of a resident getting hurt.On 3/17/26 at 6:42 PM, the facility was re-entered after hours. V21 said everyone on R9 and R14's hall that was a two person assist was still up because no staff arrived at 6:00 PM as V21 had been told. V21 said when she asked V11 (Assistant Director of Nursing/ ADON) why no one showed up to help her V11 said she was not aware of anyone coming in. V21 said all the residents that were 2 person assists would have to wait until the CNA's on the adjacent hall finished with their residents. V21 said it was sad she could not get several residents changed until she got some help.On 3/17/26 at 8:05 PM, V21 assisted a resident to the shower room with another CNA from the adjacent hall leaving 1 CNA to answer call lights for 2 halls.On 3/17/26 at 8:12 PM, R14 was sitting in his wheelchair in his room watching television.On 3/18/26 at 3:01 PM, V6 (Licensed Practical Nurse/ LPN) said she did not think 1 CNA working R9 and R14's hall could complete all of the tasks required to adequately care for the residents residing on that hall. V6 said that hall is pretty heavy for 1 person to do alone, it has 2 residents that require mechanical lifts and several residents that require 2 person assist. V6 said she had brought this up to V1 (Administrator) and V2 (Director of Nursing/ DON) several times but was told due to census they can't staff it with 2 CNA's. V6 said if R9 and R14's hall is staffed with 1 CNA, when the CNA took a resident to the shower it would leave the nurse responsible to answer all the call lights for the hall and V6 said it was not always possible for the nurse to do that if they are passing medications or if the nurse is dealing with an emergency situation. The facility's 3/12/26 Assignment Location List Report documented 13 residents residing on the 100 hall.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review the facility failed to administer medications within the ordered times and had a medication error rate of 96.8% medication error rate for 4 (R5, R11, R12, and R13) of 8 residents reviewed for medication administration.Findings include:On 3/13/26 at 10:51 AM, V4 (Registered Nurse/ RN) said she was still passing the 8:00 AM medications. V4 said she never had her medications administered on time. V4 said there was no limit on how many residents a nurse could have and it was not realistic to get all the medications passed.1. R11's admission Record documented an admission date of 3/4/22 with diagnoses including major depressive disorder, schizophrenia, and epilepsy.On 3/13/26 at 11:21 AM, V4 was observed administering R11's lamotrigine 25 mg 1 tablet, levetiracetam 500 mg/ 5ml 5ml oral liquid, risperidone 0.25 mg 1 tablet, sennosides- docusate 8.6 - 50 mg 1 tablet, and topiramate 25 mg 1 tablet.R11's March 2026 Medication Administration Record documented the following medication orders with the start date proceeding: 2/11/26 lamotrigine 25 mg 1 tablet by mouth every morning at 8:00 AM, 2/10/26 levetiracetam 500 mg/ 5ml give 5 ml by mouth every morning at 8:00 AM and at bedtime 8:00 PM, 2/10/26 risperidone 0.25 mg 1 tablet by mouth every morning at 8:00 AM and at bedtime 8:00 PM, 2/10/26 sennosides- docusate 8.6 - 50 mg 1 tablet by mouth every morning at 8:00 AM and at bedtime 8:00 PM, and 2/11/26 topiramate 25 mg 1 tablet by mouth every morning at 8:00 AM.2. R12's admission Record documented an admission date of 8/7/21 with diagnoses including chronic pain due to trauma, low back pain, and recurrent depressive disorders.On 3/13/26 at 11:33 AM, V4 was observed administering R12's amlodipine 10 mg 1 tablet, pregabalin 100 mg 1 tablet, sertraline 25 mg 1 tablet, aspirin 81 mg 1 tablet, docusate 100 mg 1 tablet, dorzolamide 2-0.5% 1 drop to both eyes, tylenol 325 mg 2 tablets, V4 said she did not have R12's esomeprazole 40 mg 1 tablet, fluticasone 50 mcg 2 sprays 1 spray to each nostril nasal spray, and multivitamin plus iron 1 tablet.R12's March 2026 MAR documented the following orders with the start date proceeding: 8/4/25 amlodipine 10 mg 1 tablet by mouth every morning at 8:00 AM, 3/22/26 pregabalin 100 mg 1 tablet by mouth 3 times a day at 8:00 AM, 1/2/26 sertraline 25 mg 1 tablet by mouth every morning at 8:00 AM , 8/4/25 aspirin 81 mg 1 tablet by mouth every morning at 8:00 AM ,8/4/25 docusate 100 mg 1 tablet by mouth every morning at 8:00 AM and at bedtime 8:00 PM, 8/4/25 dorzolamide 2-0.5% 1 drop to both eyes every morning at 8:00 AM, 8/4/25 esomeprazole 40 mg 1 tablet by mouth every morning at 8:00 AM, 8/4/25 fluticasone 50 mcg 2 sprays in both nostrils every morning at 8:00 AM, and 8/4/25 multivitamin plus iron 1 tablet by mouth every morning at 8:00 AM. R12's MAR had an 8/3/25 tylenol 325 mg 2 tablets by mouth every 4 hours as needed for mild pain order with no documentation Tylenol had been given on 3/13/26.3. R13's admission Record documented an admission date of 10/10/25 with diagnoses including type 2 diabetes, metabolic encephalopathy, and hypertension.On 3/13/26 at 12:14 PM, V4 was observed administering R13's diltiazem 120 mg 1 tablet, Lasix 20 mg 1 tablet, synthriod 50 mcg 1 tablet, magnesium oxide 400 mg 1 tablet, metformin 500 mg 1 tablet, Plavix 75 mg 1 tablet, pravastatin 40 mg 1 tablet, sodium chloride 1 gm 1 tablet, duloxetine 40 mg 1 tablet, iron sulfate 325 mg 1 tablet. V4 said she did not have R13's folic acid 1 mg 1 tablet to administer.R13's March MAR documented the following medication orders with the start date proceeding: 2/4/26 diltiazem 120 mg 1 tablet by mouth every morning 8:00 AM, Lasix 20 mg 1 tablet, 2/4/26 synthriod 50 mcg 1 tablet by mouth every morning 8:00 AM, 2/4/26 magnesium oxide 400 mg 1 tablet by mouth every morning at 8:00 AM, 2/4/26 metformin 500 mg 1 tablet by mouth every morning 8:00 AM, 2/7/26 Plavix 75 mg 1 tablet by mouth every morning 8:00 AM, 2/4/26 pravastatin 40 mg 1 tablet by mouth every morning 8:00 AM, 2/3/26 sodium chloride 1 gm 1 tablet by mouth 4 times a day 8:00 AM, 12:00 PM, 4:00 PM, and 8:00 PM, 2/4/26 duloxetine 40 mg 1 tablet by mouth every morning 8:00 AM, 2/4/26 iron sulfate 325 mg 1 tablet every morning 8:00 AM, and 2/4/26 folic acid 1 mg 1 tablet by mouth every morning at 8:00 AM. V4 said she did not have R13's folic acid 1 mg 1 tablet to administer.4. R5's admission Record documented an admission date of 7/2/24 with diagnoses including heart failure, atrial (continued on next page)

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	145813	A. Building B. Wing	04/03/2026

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	fibrillation, and hypertension.On 3/13/26 at 11:51 AM, V4 was observed administering R5's Eliquis 5 mg 1 tablet, enalapril 20 mg 2 tablets, ferrous gluconate 324 mg 1 tablet, omeprazole 20 mg 1 tablet, potassium 20 meq 1 tablet, and sodium chloride 1 gm 1 tablet.R5's March 2026 MAR documented the following orders with the start date proceeding: 1/28/25 Eliquis 5 mg 1 tablet by mouth every morning 8:00 AM and at bedtime 8:00 PM, 1/24/26 enalapril 20 mg 2 tablets by mouth every morning at 8:00 AM, 1/24/26 ferrous gluconate 324 mg 1 tablet by mouth every morning at 8:00 AM, 1/28/25 omeprazole 20 mg 1 tablet by mouth every morning 8:00 AM, 1/28/25 potassium 20 meq 1 tablet by mouth every morning 8:00 AM and at bedtime 8:00 PM, and sodium chloride 1 gm 1 tablet by mouth with meals at 8:00 AM, 12:00 PM, and 5:00 PM.R5's Electronic Medical Record (EMR) documented a 3/13/26 at 3:24 PM progress note authored by V2 (Director of Nursing/ DON) documenting in part . residents morning medications were administered late. MD (Medical Doctor) in facility made aware. Residents POA (Power of Attorney) aware as well.R5's EMR documented a 3/16/26 progress note authored by V2 documenting in part . Upon conclusion if (sic) investigation it was determined that the root cause of the late medication pass was that the (agency) nurse (V4) was ineffective and had poor communication skills. The immediate intervention was to assist the nurse in finishing her daily task/ medication pass and this particular (agency) nurse will not be allowed to return.On 3/13/26 at 1:12 PM, V2 said medications could be given an hour before and an hour after their scheduled time. V2 said any medication given outside of that time frame would be considered a medication error and the resident's Physician and POA (Power of Attorney) should be notified.The facility's revised April of 2021 Administration of Medications policy documented in part . C. Immediately after a drug is ingested, it should be recorded on the MAR: 1. If for any reason a physician's order cannot be followed, the physician shall be notified as soon as is reasonable. 2. Nursing staff will report immediately to the attending physician any medication errors, or adverse drug reactions. E. The facility shall check the Physician's Order Sheet and MAR against the current Physician's Orders, to assure proper administration of medication to each resident. The facility's medication error rate was 30 out of 31 opportunities, indicating a 96.8% medication error rate.

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observation, interview and record review the facility failed to ensure residents are free from significant medication errors for 5 (R4, R5, R9, R12, and R11) of 8 residents reviewed for medication administration in a sample of 14. This failure resulted in R9 experiencing a lack of sleep and feeling exhausted throughout the day.Findings include:1. R9's admission Record documented an admission date of 1/26/20 with diagnoses including: insomnia, adult failure to thrive, and type 2 diabetes mellitus with diabetic polyneuropathy.R9's 1/14/26 Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 15, indicating R9 was cognitively intact.R9's Care Plan report documented a revised 8/20/24 focus area documenting in part . (R9) has diabetes mellitus (R9) is non-compliant with her diet. with 5/31/22 intervention documenting in part . Diabetes medication as ordered by doctor. Monitor/ document for side effects and effectiveness. and a revised 12/12/25 focus area documenting in part . disturbed sleep pattern, insomnia. with a 12/12/25 intervention documenting in part .Administer hypnotic as ordered.R9's Medication Review Report printed 3/20/26 documented a 12/11/25 order for belsomra 5 mg tablet give 1 tablet by mouth at bedtime for insomnia and 6/6/25 order for glyburide 5 mg tablet give 1 tablet by mouth 1 time a day for antidiabetics.On 3/26/26 at 12:48 PM, R9 was lying in bed watching television. R9 said the week prior to this interview she had not been receiving her sleeping medication. R9 stated without her sleeping medication I can't fall asleep and I just lay here all night and then feel bad the next day because I'm so tired. I just felt exhausted. R9 said she was not able to nap though the day and had always had trouble sleeping then stated that's why I take medication to sleep. R9 said she had type 2 diabetes and took medication for it but was not sure what medication she was prescribed or if she was receiving it.R9's February 2026 Medication Administration Record (MAR) documented R9 received a Belsomra 5 mg tablet by mouth at bedtime 8:00 PM every day and glyburide 5 mg tablet by mouth every morning at 8:00 AM throughout February 2026.R9's March 2026 Medication Administration Record (MAR) documented R9 had received a Belsomra 5 mg tablet by mouth at bedtime at 8:00 PM 3/1/26-3/15/26 and 3/21/26-3/24/26 and R9 had received a Glyburide 5 mg tablet by mouth every morning at 8:00 AM from 3/1/26- 3/14/26 and 3/16/24-3/24/26.On 3/26/26 at 1:10 PM, V2 (Director of Nursing/ DON) said she had called the pharmacy to ask when and how many of R9's Belsomra and glyburide had been delivered to the facility and was told R9's Belsomra 5 mg tablets were delivered in packages of 10 tablets and had been delivered to the facility on 2/10/26, 3/3/26, and 3/20/26. V2 said the pharmacy told V2 that R9's glyburide was not covered by R9's insurance and 7 tablets were delivered to the facility on 1/30/26 and 3 tablets were delivered on 2/10/26. V2 was asked why the nursing staff were documenting they were giving medications to a resident when that resident's medication was not in the building and not kept in the emergency kit and V2 responded she was unsure. V2 said if a nurse did not have a resident's medication she expected staff to call a medical provider.R9's Weights and Vitals Summary printed 4/1/26 documented R9's blood glucose results from 1/30/26-2/14/26 fluctuated with the highest on 2/1/26 at 258 and the lowest on 2/12/26 at 98. R9's blood glucose results from 2/15/26- 3/26/26 gradually started to increase consistently being greater than 300 on 2/27/26 at 351, 3/9/26 at 302, 3/13/26 at 383, 3/14/26 at 346, 3/16/26 at 340, 3/20/26 at 398, 3/22/26 at 344, and 3/24/26 at 337.2. R4's admission Record documented an admission date of 2/3/26 with diagnoses including: type 2 diabetes mellitus, need for assistant with personal care. R4's 2/10/26 MDS documented a BIMS score of 14, indicating R4 was cognitively intact. R4's Care Plan Report documented a 2/4/26 Focus of diabetes mellitus with a 2/4/26 intervention documenting in part .diabetes medication as ordered by doctor. Monitor/ documents for side effects and effectiveness. R4's Medication Review Report documented an order for Insulin Lispro (Humalog) Injection Solution 100 UNIT/ML (Insulin Lispro) Inject as per sliding scale: if 80 - 150 = 0; 151 - 200 = 2; 201 - 250 = 6; 251 - 300 = 12; 301 - 350 = 16; 351 - 400 = 20; Over 400 Call MD, subcutaneously before meals and at bedtime for DM 2 (type 2 Diabetes Mellitus) with an order date of 2/11/26.R4's (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Medication Admin Audit Report printed 3/20/26 at 11:56 AM for medications administered 3/1/26 to 3/8/26 documented the Insulin Lispro sliding scale was administered greater than an hour late for the 8:00 AM scheduled dose on 3/2/26, 3/4/26, 3/5/26, and 3/6/26. R4's 11:00 AM Insulin Lispro sliding scale was administered greater than an hour late on 3/2/26, 3/3/26, 3/4/26, 3/5/26, and 3/6/26. R4's 5:00 PM Insulin Lispro sliding scale was administered greater than an hour late on 3/4/26, 3/5/26, and 3/6/26.3. R5's admission Record documented an admission date of 7/2/24 with diagnoses including heart failure, atrial fibrillation, and hypertension.On 3/13/26 at 10:51 AM, V4 (Registered Nurse/ RN) said she was still passing the 8:00 AM medications. V4 said she never had her medications administered on time. V4 said there was no limits on how many residents a nurse could have and it was not realistic to get all the medications passed.On 3/13/26 at 11:51 AM, V4 was observed administering R5's sodium chloride 1 gm 1 tablet.R5's March 2026 MAR documented an order of sodium chloride 1 gm 1 tablet by mouth with meals at 8:00 AM, 12:00 PM, and 5:00 PM.On 3/13/26 at 12:51 PM, V12 (Licensed Practical Nurse/ LPN/ Wound Care Nurse) said V4 had been called to V2's (Director of Nursing/ DON) office and V12 had taken over V4's assignment and medication cart. V12 said she was going to finish V4's noontime medication pass. V12 started to pop medications out of a medication card into a medication cup when V12 was asked if a resident had a medication that was supposed to be administered 3 or 4 times a day how would V12 know when the medication was last administered due to V4 being so late administering resident's 8:00 AM medications and V12 stated I don't know how to give the noon meds for any QID (4 times a day) or TID (3 times a day) because I don't know when they were last given for the 8 AM dose. I guess we will have to skip all these doses. It'll be more med errors but the only safe thing to do is just give them at their next scheduled time.R5's March 2026 MAR documented the 3/13/26 at 12:00 PM dose of sodium chloride 1 gm by mouth with meals (3 times a day) with a 5. The Chart Codes on the MAR documents that 5 indicates Hold-See Progress Notes.R5's 3/12/26 Historical Lab Specimen Inquiry collected on 3/10/26 documented a sodium level of 122.0.On 3/19/26 at 9:21 AM, V24 (Hospital Lab Director) said R5's 3/12/26 sodium was measured in their lab. V24 said a critical sodium is less than 120 mmol/l (millimole/ liter) with a normal reference range between 134.5 - 145 mmol/l.R5's Electronic Medical Record (EMR) documented a 3/13/26 at 3:24 PM progress note authored by V2 (Director of Nursing/ DON) documenting in part . residents morning medications were administered late. MD (Medical Doctor) in facility made aware. Residents POA (Power of Attorney) aware as well.R5's EMR documented a 3/16/26 progress note authored by V2 documenting in part . Upon conclusion if [sic] investigation it was determined that the root cause of the late medication pass was that the (agency) nurse (V4) was ineffective and had poor communication skills. The immediate intervention was to assist the nurse in finishing her daily task/ medication pass and this particular (agency) nurse will not be allowed to return.4. R12's admission Record documented an admission date of 8/7/21 with diagnoses including chronic pain due to trauma, low back pain, and recurrent depressive disorders.On 3/13/26 at 11:33 AM, V4 was observed administering R12's pregabalin 100 mg 1 tablet.R12's Medication Review Report with a print date of 3/31/26 documents an order for pregabalin 100 mg 1 tablet by mouth 3 times a day for nerve pain dated 3/22/26.R12's March 2026 MAR documented R12's 2:00 PM dose on 3/13/26 of Pregabalin 100 mg give 1 tablet by mouth 3 times a day documents a 5. The Chart Codes on the MAR documents that 5 indicates Hold-See Progress Notes.R12's March 2026 MAR had an order with a start date of 8/3/25 ordering tylenol 325 mg 2 tablets by mouth every 4 hours as needed for mild pain order with no documentation Tylenol had been given on 3/13/26.5. R11's admission Record documented an admission date of 3/4/22 with diagnoses including major depressive disorder, schizophrenia, and epilepsy.R11's Medication Review Report with a print date of 3/31/26 documented the following medication orders: lamotrigine 25 mg 1 tablet by mouth every morning at 8:00 AM dated 2/11/26, levetiracetam 500 mg/ 5ml give 5 ml by mouth every morning at 8:00 AM and at bedtime 8:00 PM dated 2/10/26, and topiramate 25 mg 1 tablet by mouth every morning at 8:00 AM dated 2/11/26.On 3/13/26 at 11:21 AM, V4 was observed administering R11's (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	lamotrigine 25 mg 1 tablet, levetiracetam 500 mg/ 5ml oral liquid, and topiramate 25 mg 1 tablet all ordered to be administered at 8:00 AM.The facility's revised April of 2021 Administration of Medications policy documented in part . C. Immediately after a drug is ingested, it should be recorded on the MAR: 1. If for any reason a physician's order cannot be followed, the physician shall be notified as soon as is reasonable. 2. Nursing staff will report immediately to the attending physician any medication errors, or adverse drug reactions. E. The facility shall check the Physician's Order Sheet and MAR against the current Physician's Orders, to assure proper administration of medication to each resident.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review the facility failed to follow accepted standards of practice in maintaining infection control while providing incontinence care to 1 (R5) of 3 residents reviewed for Activities of Daily Living (ADL) in a sample of 14.Findings include:R5's admission Record documented at admission date of 7/21/24 with diagnose including need for assistance with personal care, reduced mobility, and cognitive communication deficit.R5's 2/21/26 Minimum Data Set (MDS) section H documented R5 was always incontinent of bowel and bladder and section GG documented R5 required substatntial/ maximal assistance with toileting hygiene.On 3/20/26 at 3:48 PM, the surveyor entered R5's room and observed V11 (Assistant Director of Nursing) and V18 (Certified Nursing Assistant) to have R5's pants down around his knees with R5's incontinence brief wet with urine. Using her gloved hands, V18 took R5's pants off and threw them onto the floor. V11 and V18 removed R5's urine soiled incontinence brief and V18 threw it on the floor. V18 picked up a wet washcloth draped it over the bedrail and cleaned R5's buttocks in a circular motion without folding the washcloth, wiped front to back up one side of the gluteal fold then wiped front to back up the other side of the gluteal fold. V18 then placed the soiled washcloth on top of the other wet washcloth hanging on R5's bedrail. Without preforming hand hygiene or changing gloves, V18 touched the chuck and draw sheet under R5 to assist V11 in repositioning R5. V18 then picked up the soiled washcloth and handed the wet washcloth from beneath it to V11. V11 wiped around R5's mons pubis and down both groin folds, folded the washcloth and cleaned R5's scrotum and penile shaft. V11 then retracted R5's foreskin but did not reveal the coronal ridge, wiped around the glans penis and returned R5's foreskin. V11 then looked around the room and said we didn't bring a trash bag in with us. V11 placed the soiled washcloth in the seat of chair in R5's room. Without performing hand hygiene or changing her gloves, V11 assisted V18 to place a clean incontinent brief on R5 and using the chuck and draw sheet repositioned R5 in bed. V11 then covered R5 touching the top sheet and blanket. V18 picked up the soiled washcloth from R5's bed rail, R5's pants from the floor, and the urine soiled incontinence brief and walked to the trash can placing the items in plastic bags and lifted the bags out of the trash can. V11 picked up the soiled washcloth from the chair and placed it in the bag V18 was holding. V18 then removed her right glove and opened the door by the knob and opened the soiled linen hamper to deposit the bags. V18 then removed her left glove and proceeded to push the soiled linen hamper down the hallway. V11 removed her gloves and opened the bathroom door by the knob and washed her hands and exited the room.On 4/1/26 at 2:32 PM, V1 (Administrator) said the facility did not have an incontinence care policy. On 4/1/ 26 at 3:18 PM, V1 was asked since the facility did not have an incontinence care policy would she expect staff to perform hand hygiene and change their gloves when going from soiled to clean and V1 stated oh, absolutely.