STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145813	A. Building B. Wing	05/26/2026

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, interview, and record review the facility failed to prevent, identify, and treat Moisture Associated Skin Damage (MASD) and failed to follow physician orders for lab testing after a change in condition for 2 (R1 and R2) of 3 residents reviewed for change in condition in a sample of 7. This failure resulted in R2 developing wounds that caused pain due to MASD.Findings include:1. R2's admission Record documented an admission date of 7/19/17 with diagnoses including multiple sclerosis, abnormalities of gait and mobility, and abnormal posture.R2's 4/7/26 Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 11, indicating moderate cognitive impairment. Section GG documented R2 was dependent for toileting hygiene and section H documented R2 was always incontinent of bowel and bladder.R2's Care Plan documented a revised 5/24/23 focus area of (R2) has potential/ actual impairment to skin integrity r/t MS (related to multiple sclerosis), decreased mobility with a 5/24/23 intervention of Monitor pressure areas for changes in color, sensation, temperature and report any change to nurse.R2's Order Summary Report documented a 4/22/26 order to .gently cleanse buttocks and upper posterior thighs with wound spray and pat dry, apply zinc paste to buttocks and thighs, attach (incontinence brief) loosely when in bed per (Wound Treatment Company).R2's weekly skin assessment documented on 5/19/26 at 10:12 AM by V5 (Licensed Practical Nurse/LPN), prior to skin check, MASD (Moisture Associated Skin Damage) with no open areas.On 5/19/26 at 9:52 AM, V3 (Certified Nursing Assistant/ CNA) said she thought R2 had open wounds that were not documented and were not being treated.On 5/19/26 at 4:06 PM, V3 and V4 (CNA) were assisting R2 to bed and performing incontinence care. Upon removal of R2's incontinence brief, R2 was observed to have MASD to her inner upper thighs and buttocks with 3 open areas. 1 open area to the right buttock, 1 open area to the right posterior thigh, and 1 open area to the right front groin fold. V2 (Director of Nursing/ DON) was alerted by the surveyor of R2's open wounds and V2 said she would have V5 (Licensed Practical Nurse/ LPN) reassess R2.R2's weekly skin assessment documented on 5/19/26 at 5:40 PM by V5, documented MASD with an open wound to the pubis measuring 1.81 cm x 3.09 cm x 0 cm (length x width x depth), an open wound to the right gluteal fold measuring 0.76 cm x 1.27 cm x 0 cm, and an open wound to the right rear thigh measuring 0.45 cm x 0.82 cm x 0 cm. With the accompanying progress note documenting in part .resident does not wish to use appropriate cream treatment as ordered and only wishes to use barrier cream r/t (related to) the zinc paste being thicker and harder to wash off. Educated resident on the difference in the cream treatments and will continue to monitor area.On 5/20/26 at 10:00 AM, V5 said she did not initially see R2's open areas due to R2 have scar tissue that was lighter than the surrounding tissue. R2's 5/20/26 progress note at 8:19 AM documented in part . This nurse notified (Nurse Practitioner) with (Wound Treatment Company) r/t (related to) resident refusing zinc Tx (treatment) and has some small open area r/t MASD, pending reply at this time.On 5/19/26 at 8:04 PM, V4 (CNA) said R2 had the open areas for about a month and R2's perineal area had been macerated for at least a couple weeks. V4 said the facility did not have any cloth incontinence pads and all incontinent residents wore an incontinence brief at all times. V4 said instead of cloth incontinence pads, staff folded up a bath blanket to use as an incontinence pad in case the resident's incontinence brief leaked so staff would not have to change the whole bed.On 5/21/26 at 1:47 PM, R2 stated my goodness, when I'm lying 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 0684 Level of Harm - Actual harm Residents Affected - Few	bed my bottom gets to hurting real bad for about the last month. R2 said she liked the cream with the blue top (barrier cream) and not the one with the orange top (zinc paste). R2 was asked why she didn't like the cream with the orange top and R2 stated I think it eats away at you. R2 said she wore an incontinence brief at all times. R2 was asked if she ever asked for her incontinence brief to be taken off and R2 said no, but one night staff put on her incontinence brief but didn't fasten the sides and she thought her bottom was a little bit better that day. On 5/22/26 at 10:49 AM, V2 said the Wound Treatment Company did not see residents with MASD, only residents with pressure wounds stage 3 and 4. V2 said she had a conversation with the medical provider with the Wound Treatment Company and was told they would order zinc paste for someone with MASD and open wounds associated with MASD. V2 was asked if R2 was refusing the treatment, what was the facility going to do and V2 said she was going to have a conversation with V11 (Physician/ Medical Director) later that day when he rounded to attempt to change R2's orders.On 5/26/26 at 2:07 PM, V11 (Physician/ Medical Director) said if new wounds are discovered staff would notify him or the on call medical provider company and the wound consultant company. V11 said he could not recall if he had changed R2's orders from zinc paste to something else but had told the facility to refer R2 to the wound consultant company which was completed on 5/22/26.2. R1's admission Record documented an admission date of 4/10/26 with diagnoses including intertrochanteric fracture of right femur, dysphagia, need for assistance with personal care. R1's 4/17/26 MDS documented a BIMS score of 15, indicating R1 was cognitively intact. R1's 4/17/26 MDS section GG documented R1's Prior Functioning: Everyday Activities were Need Some Help- Resident needed partial assistance from another person to complete any activities for Self-Care and Independent with Indoor Mobility, Stairs, and Functional Cognition. R1's 4/17/26 MDS section GG also documented Functional Abilities, assessment period is the first 3 days of the stay, R1 was dependent for toilet hygiene, substantial/ maximal assist with shower/ bathe self, lower body dressing, putting on/ taking off footwear, partial/ moderate assist with oral hygiene, upper body dressing, personal hygiene, and independent with eating. R1's 5/16/26 BIMS assessment documented a score of 3, indicating R1 was severely cognitively impaired.On 5/20/26 at 9:00 AM, R1 was sitting in the recliner in his room talking to V6 (Registered Nurse/ RN). R1's speech did not make sense and R1 was becoming frustrated with V6. R1 was very agitated and confused. Upon entry to R1's room for interview R1 refused to be interviewed.On 5/20/26 at 9:04 AM, V6 said R1 had a severe decline in his mental state. V6 said she was not sure if R1 had been sent to the hospital for further evaluation and testing. V6 said R1 had been seen by a doctor but was unsure what treatments had been ordered. V6 said she would review R1's medical record.R1's 5/12/26 physician progress note documented in part . being seen for regulatory H&P (History and Physical). He currently is without any specific complaints. However, staff has voiced concerns thathis [sic] mental status has deteriorated over the last couple days. Patient is alert and oriented to time place in [sic] person. According to staff, he?s [sic] been off at times. Patient was a little slow to respond, but ultimately answered questions appropriately. Confusion was noted per staff. He also initially stated that I was the one that got hospice in it involved with him. Which is not true. Disorientation, unspecified: There has been a change from his baseline according to the nursing staff. Will need to check a urinalysis, chest, x-ray [sic] and some blood work. Other relevant intervention: We?ll [sic] get some bloodwork and check a magnesium level.R1's Order Summary Report documented R1 was not receiving hospice services. R1's Order Summary Report under Laboratory documents orders for a Complete Blood Count (CBC), Complete Metabolic Panel (CMP), and Magnesium levels with an order date of 5/12/26 and an order for a CBC, CMP, and Magnesium level on 5/20/26.On 5/20/26 at 9:35 AM, V2 (Director of Nursing/ DON) said she reviewed R1's medical record during morning meeting and had found the 5/12/26 progress note. V2 said the facility had missed ordering the labs for R1. V2 said she had called the doctor and obtained orders for a CBC, CMP, and Magnesium level to be drawn.On 5/20/26 at 9:40 AM, V2 was asked when a medical provider is rounding, who puts in the orders and V2 said usually V6 (RN) rounds with medical (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	providers and puts their orders in. V2 was asked how R1's lab orders were missed and V2 said the medical provider was new and had rounded on his own or with floor nurses. V2 was asked who is responsible for ensuring orders are accurately taken and completed and V2 said she was responsible.On 5/20/26 at 2:47 PM, V6 was asked if R1's labs that had been drawn earlier that day had been faxed back to the facility and V6 said she just spoke with the lab to have them faxed over. V6 said while she was talking to the laboratory technician they asked if V6 wanted the urine culture faxed over too and V6 told them she had not sent any urine. V6 said she was told R1 had a urine culture from 5/10/26 and V6 told them to fax it as well because she was not aware of a urinalysis.On 5/26/26 at 2:07 PM, V11 (Physician/ Medical Director) said he expected the facility to follow Physician orders. V11 said he expected staff to review Physician progress notes and if it was unclear what labs the Physician wanted, the facility should contact them to get clarification.The facility's 2/2026 Skin Identification, Evaluation, and Monitoring Policy documented in part . A licensed nurse will evaluate skin integrity through a physical skin evaluation upon admission, weekly, and when a significant change is identified. Licensed nurses will evaluate the resident's risk for skin breakdown using the Braden Risk Assessment tool upon admission. and when a significant change is identified. Licensed Nurse Weekly: A. Complete a Weekly Skin Check to evaluate for changes in skin integrity. B. Document in medical record the finding of weekly skin assessment. b. If new wound is identified: i. Initiate protective dressing. ii. Notify health care provider of findings and for further treatment orders. C. Document evaluation in the medical record. Identification of Skin Conditions. B. Moisture Associated Skin Damage (MASD) is a general term for skin damage that occurs when the skin is exposed to moisture such as perspiration, urine or feces or both. for a prolonged period. b. MASD can be presented as mild, moderate, or severe and can occur in all client age groups; i. Mild MASD presents as irritation and inflammation of the skin. ii. Moderate to severe MASD presents with blistering and erosion and/ or denudation of the epidermal layer to the dermis. c. Secondary fungal and bacterial infections may occur. Interventions and Prevention: Skin. Incontinence Management. e. Utilize properly fitting incontinence briefs that are absorbent and wick moisture away from the skin on incontinent residents.The facility's 12/2024 Significant Condition Change and Notification policy documented in part . To ensure that the resident's family and/ or representative and medical practitioner are notified of resident changes such as those listed below: A significant change in the resident's physical, mental or psychosocial status (See below for examples). new wounds, bruises or skin tears. change in level of consciousness such as agitation, lethargy, sudden lack of responsiveness or manic behavior. a need to significantly alter treatment. When any of the above situations exists, the licensed nurse will contact the resident's representative and their medical practitioner. the medical practitioner will e contacted 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. All significant changes will be recorded. in the resident record. Change of condition is reviewed by DON or designee for the continued need for additional documentation.

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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 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide prescribed pain medication to 1 (R5) of 3 residents reviewed for medication administration in a sample of 7. This failure resulted in R5 experiencing lower back pain that radiated down her legs causing increased pain and insomnia. Findings include:R5's admission Record documented an admission date of 12/30/25 with diagnoses including hemiplegia and hemiparesis following other cerebrovascular disease affecting left dominant side, hypertensive urgency, hyperosmolality and hypernatremia, personal history of transient ischemic attack and cerebral infarction without residual deficit, type 2 diabetes mellitus, unspecified viral hepatitis C without hepatic coma, borderline personality disorder, mild persistent asthma, unsteadiness on feet, muscle weakness, hypokalemia, essential hypertension, hypoxemia, and weakness. R5's Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15, indicating R5 is cognitively intact. Section J, Health Conditions, documents that R5 takes a PRN (as needed) pain medication and documents R5 has pain frequently. R5's Care Plan includes a Focus area of R1 has pain Fibro-myalgia (initiated on 1/6/26) with a corresponding intervention to monitor/record/report to nurse resident complaints of pain or requests for pain treatment (initiated 1/6/26). On 5/20/26 at 2:47 PM, R5 asked this surveyor if something could be done about her medications as she had not had any pain medication in 4 days. R5 said when she asks for her pain medication, the nurses tell her they don't have any pain medication to give her. R5 stated she was told they had called the pharmacy and the doctor but still had not received any pain medication. R5 said her back pain was really bad and rated her pain to be 10 on a scale of 0-10. R5's Order Summary Report documented a 12/31/25 order for Tramadol 50 mg (milligrams), 1 tablet by mouth every 8 hours as needed for pain. On 5/20/26 at 2:56 PM, the medication cart that served R5's room was observed to have no tramadol tablets present for R5. V6 (Registered Nurse/RN) said R5 did not have any tramadol available. V6 said R5 had asked for a tramadol that morning and V6 told R5 we don't have any for her. V6 said the facility had emailed V11 (Physician/ Medical Director) again that morning requesting a tramadol prescription for R5 but had not heard back. V6 said she had not called the on-call medical provider because she was waiting to see if V11 responded. V6 said she could not obtain any tramadol out of the emergency backup supply because R5 did not have an active order for tramadol. V6 was asked if R5 rated her pain to be a 10 out of 10, could V6 offer R5 a Tylenol and V6 said yes if R5 had an order for Tylenol. R5's Controlled Substances Proof of Use documented 15 tablets of tramadol 50 mg were delivered to the facility on 5/2/26, with the last administration of those 15 tablets being given on 5/15/26. R5's Medication Administration Record (MAR) dated 5/1/26 - 5/31/26 documented 5/15/26 was the last administration of R1's PRN (as needed) tramadol 50 mg until 5/21/26. The MAR shows there were no administrations of R1's PRN tramadol from 5/16/26 through 5/20/26. On 5/20/26 at 2:10 PM, V12 (Regional Clinical Consultant) was alerted of R5 not having any tramadol available and of V6's interview (above) and V12 sighed heavily and said she would have V6 call the on-call provider immediately to obtain a prescription. V12 stated the on-call provider should have already been contacted. On 5/21/26 at 1:53 PM, R5 said she was thankful for getting her pain medication back. R5 said she had a fall prior to her admission to the facility and had an injury to her spine that caused chronic lower back pain that radiated down her legs. R5 said she can't go without pain medication and the days the facility did not have any tramadol for her she could not sleep because she was hurting so bad and at times was in tears. On 5/26/26 at 2:07 PM, V11 (Physician/ Medical Director) said if a resident reported pain and did not have an active prescription for pain medications, he expected staff to call him and he would sign the order or to call the on-call medical provider company to get a prescription. A facility policy for pain/pain management was requested. V12 provided the undated facility policy titled Medication Administration Policy for Senior Living under PRN Medication Guidelines documents Pro Re Nata (PRN/as needed) medication may (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	only be administered based on a written and signed order from a licensed healthcare professional. The order must include medication name, dosage, route of administration, frequency, and any necessary precautions or contraindications. PRN medications shall only be administered as prescribed following the provided instructions and guidelines.Staff members administering the medication must adhere to the ?Five Rights.' Medication administration shall be documented promptly and accurately, including the dateof administration, time of administration, name of medication, dosage, route, and reason for administration. Controlled substances must be signed out on an inventory sheet and counted during shift change with on-coming nurse. Resident's response to medication must be documented within 30 - 60 minutes, along with any observed or reported side effects or reactions. Significant changes in the resident's condition in response to the PRN medication must be documented and reported to the appropriate licensed healthcare professional immediately. There was no reference to the management of pain documented in this policy.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure timely acquisition of medication refills for 2 (R4 and R5) of 3 residents reviewed for medications in a sample of 7.Findings include:1. R4's admission Record documented an original admission date of 11/8/23 with diagnoses including early onset cerebral ataxia, anxiety disorder, and depression. R4's 4/8/26 Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 13, indicating R4 was cognitively intact.R4's Care Plan Report documented a revised 1/7/26 focus area of R4 has anxiety and currently takes anxiety medications with a 2/12/24 intervention of administer medication as ordered and monitor/ document for side effects and effectiveness. R4's Order Summary Report documented a 3/30/26 order for Ativan 0.5 mg 1 tablet every morning and at bedtime for anxiety.On 5/21/26 at 1:32 PM, R4 said a couple weeks ago the facility ran out of her Ativan and did not tell R4. R4 said she had experienced withdrawal symptoms like sweating and shaking, feeling like she was very hot and then would be ice cold. R4 said there were several nights she couldn't sleep and felt like my insides were trembling. R4 said she had been taking Ativan for a long time. R4 said she was not sure of the name of the nurse she talked to about her symptoms, but that was the nurse that informed R4 the facility had run out of R4's Ativan and would try to reach the doctor to get it refilled. On 5/19/26 at 11:31 AM, V9 (Licensed Practical Nurse/ LPN) said R4 did not have any Ativan for several days and V2 (Director of Nursing/ DON) was aware. V9 said R4 was very tearful during that time but was not aware of R4 having any withdrawal symptoms. V9 said she could not obtain any Ativan for R4 from the emergency backup stock because R4 did not have an active Ativan prescription at that time but had called the pharmacy several times. V9 said the nursing staff were not allowed to call V11 (Physician/ Medical Director) for medication prescriptions. V9 said if a prescription is needed for a resident nursing staff were to alert V2 and V2 would call V11 to get the prescription.On 5/19/26 at 12:22 PM, V2 said she was not aware R4 was not receiving her Ativan. V2 said if a nurse documents a 5 or 6 on the Medication Administration Record (MAR) the system does not flag it for V2 to review. V2 said if a resident did not have a medication, she expected staff to contact the on call medical provider company to obtain an order. V2 said once the order is received the staff could obtain the medication from the emergency backup medication supply and if the medication was not available, she expected staff to contact the pharmacy for an emergency medication delivery. On 5/19/26 at 3:12 PM, V7 (LPN) said if a resident did not have a medication, she would call the on call medical provider company. V7 said the on call medical provider company would give a 3 day prescription for medications until V11 could be contacted to give a longer prescription. On 5/26/26 at 2:07 PM, V11 said if they did not have an active prescription for anxiety medications he expected staff to call him and he would sign the order or to call the on call medical provider company to get a prescription. V11 said if a resident has been taking Ativan and stops it suddenly the resident could experience withdrawal symptoms such as headache, muscle pains, nausea and vomiting, tremors, etc.R4's Controlled Substances Proof of Use form documented the facility received 4 Ativan 0.5 mg tablets on 5/3/26 with the last tablet being administered on 5/5/26 at 8:00 AM.R4's Controlled Substance Proof of Use form documented the facility received 6 Ativan 0.5 mg tablets on 5/12/26 with the first one being administered on 5/13/26 at 8:00 AM, 8 days after the last dose of Ativan was administered indicating R4 had missed 15 doses of Ativan.R4's 5/1/26-5/31/26 Medication Administration Record (MAR) documented R4's Ativan 0.5mg tablet had been administered from 5/5/26-5/13/26 twice a day, the morning dose on 5/9/26 documented a 5 with the key indicating hold, the morning and even dose on 5/10/26 documented a 6 with the key indicating other- see progress note, the bedtime dose on 5/11/26 documented a 6, and the morning dose on 5/12/26 documented a 6.2. R5's admission Record documented an admission date of 12/30/25 with diagnoses including hemiplegia and hemiparesis (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	following other cerebrovascular disease affecting left dominant side, hypertensive urgency, hyperosmolality and hypernatremia, personal history of transient ischemic attack and cerebral infarction without residual deficit, type 2 diabetes mellitus, unspecified viral hepatitis C without hepatic coma, borderline personality disorder, mild persistent asthma, unsteadiness on feet, muscle weakness, hypokalemia, essential hypertension, hypoxemia, and weakness. R5's Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15, indicating R5 is cognitively intact. On 5/20/26 at 2:47 PM, R5 asked this surveyor if something could be done about her medications as she had not had any pain medication in 4 days. R5 said when she asks for her pain medication, the nurses tell her they don't have any pain medication to give her. R5 stated she was told they had called the pharmacy and the doctor but still had not received any pain medication. R5 said her back pain was really bad and rated her pain to be 10 on a scale of 0-10. R5's Order Summary Report documented a 12/31/25 order for Tramadol 50 mg (milligrams), 1 tablet by mouth every 8 hours as needed for pain. On 5/20/26 at 2:56 PM, the medication cart that served R5's room was observed to have no tramadol tablets present for R5. V6 (Registered Nurse/RN) said R5 did not have any tramadol available. V6 said R5 had asked for a tramadol that morning and V6 told R5 we don't have any for her. V6 said the facility had emailed V11 (Physician/ Medical Director) again that morning requesting a tramadol prescription for R5 but had not heard back. V6 said she had not called the on-call medical provider because she was waiting to see if V11 responded. V6 said she could not obtain any tramadol out of the emergency backup supply because R5 did not have an active order for tramadol. R5's Controlled Substances Proof of Use documented 15 tablets of tramadol 50 mg were delivered to the facility on 5/2/26, with the last administration of those 15 tablets being given on 5/15/26. R5's Medication Administration Record (MAR) dated 5/1/26 - 5/31/26 documented 5/15/26 was the last administration of R1's PRN (as needed) tramadol 50 mg until 5/21/26. The MAR shows there were no administrations of R1's PRN tramadol from 5/16/26 through 5/20/26. On 5/20/26 at 2:10 PM, V12 (Regional Clinical Consultant) was alerted of R5 not having any tramadol available and of V6's interview (above) and V12 sighed heavily and said she would have V6 call the on-call provider immediately to obtain a prescription. V12 stated the on-call provider should have already been contacted. On 5/21/26 at 1:53 PM, R5 said she can't go without pain medication and the days the facility did not have any tramadol for her she could not sleep because she was hurting so bad and at times was in tears. On 5/26/26 at 2:07 PM, V11 (Physician/ Medical Director) said if a resident reported pain and did not have an active prescription for pain medications, he expected staff to call him and he would sign the order or to call the on-call medical provider company to get a prescription. The facility's pharmacy policy and procedures were requested from V12. V12 provided a document/sign from the facility's contracted pharmacy dated 2024 that documents the heading Medication Not Available. What Now? and further states Check: Check eMAR (electronic medication administration record) for last order/fill date. Verify transmission to pharmacy for new orders and refills. Check fax machine or eMAR for communication from pharmacy. Obtain: Obtain from (emergency medication kit), if available. Call: Call the pharmacy for order status (e.g., prior authorization pending, refill too soon, order clarification). Notify prescriber if dose is missed. Follow facility process if additional notifications are required. Documentation: Document steps taken to obtain medication and prescriber notification. Prevention: Reorder 3-5 days prior to last remaining dose. Check pharmacy placard for cut-off times. Receive delivered medications in eMAR.The undated facility policy titled Medication Administration Policy for Senior Living was also provided. Under PRN Medication Guidelines documents Medication administration shall be documented promptly and accurately, including the date of administration, time of administration, name of medication, dosage, route, and reason for administration.

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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 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 administer an antianxiety medication for 1 (R4) of 3 residents reviewed for medication administration in a sample of 7. This failure resulted in R4 developing withdrawal symptoms including insomnia, sweating, and shaking.Findings include:R4's admission Record documented an original admission date of 11/8/23 with diagnoses including early onset cerebral ataxia, anxiety disorder, and depression. R4's 4/8/26 Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 13, indicating R4 was cognitively intact.R4's Care Plan Report documented a revised 1/7/26 focus area of R4 has anxiety and currently takes anxiety medications with a 2/12/24 intervention of administer medication as ordered and monitor/ document for side effects and effectiveness.R4's Order Summary Report documented a 3/30/26 order for Ativan 0.5 mg 1 tablet every morning and at bedtime for anxiety.On 5/21/26 at 1:32 PM, R4 said a couple weeks ago the facility ran out of her Ativan and did not tell R4. R4 said she had experienced withdrawal symptoms like sweating and shaking, feeling like she was very hot and then would be ice cold. R4 said there were several nights she couldn't sleep and felt like my insides were trembling. R4 said she had been taking Ativan for a long time. R4 said she was not sure of the name of the nurse she talked to about her symptoms, but that was the nurse that informed R4 the facility had run out of R4's Ativan and would try to reach the doctor to get it refilled.On 5/19/26 at 11:31 AM, V9 (Licensed Practical Nurse/ LPN) said R4 did not have any Ativan for several days and V2 (Director of Nursing/ DON) was aware. V9 said R4 was very tearful during that time but was not aware of R4 having any withdrawal symptoms.On 5/19/26 at 12:22 PM, V2 said she was not aware R4 was not receiving her Ativan.On 5/26/26 at 2:07 PM, V11 (Physician/ Medical Director) said if a resident has been taking Ativan and stops it suddenly the resident could experience withdrawal symptoms such as headache, muscle pains, nausea and vomiting, tremors, etc.R4's Controlled Substances Proof of Use form documented the facility received 4 Ativan 0.5 mg tablets on 5/3/26 with the last tablet being administered on 5/5/26 at 8:00 AM.R4's Controlled Substance Proof of Use form documented the facility received 6 Ativan 0.5 mg tablets on 5/12/26 with the first one being administered on 5/13/26 at 8:00 AM, 8 days after the last dose of Ativan was administered indicating R4 had missed 15 doses of Ativan.R4's 5/1/26-5/31/26 Medication Administration Record (MAR) documented R4's Ativan 0.5mg tablet had been administered from 5/5/26-5/13/26 twice a day, the morning dose on 5/9/26 documented a 5 with the key indicating hold, the morning and even dose on 5/10/26 documented a 6 with the key indicating other- see progress note, the bedtime dose on 5/11/26 documented a 6, and the morning dose on 5/12/26 documented a 6.The undated facility policy titled Medication Administration Policy for Senior Living under Medication Administration documents Medications should be administered according to the ?five rights' of medication use: right resident, right drug, right time, right dose, and the right route.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145813	A. Building B. Wing	05/26/2026

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 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure meals were served at the scheduled times posted. This failure has the potential to affect all 62 residents residing in the facility. Findings include: R2's admission documented an admission date of 7/19/17. R2's Minimum Data Set (MDS) assessment documented a Brief Interview for Mental Status (BIMS) score of 11, indicating moderate cognitive impairment. R5's admission Record documented an admission date of 12/30/25. R5's MDS assessment dated [DATE] documented a BIMS score of 15, indicating R5 was cognitively intact. R7's admission Record documented an admission date of 11/25/25. R7's MDS assessment dated [DATE] documented a BIMS score of 14, indicating R7 was cognitively intact. On 5/20/26 at 2:47 PM, R5 and R7 stated they always eat in their room and the meals are always delivered late. R7 said breakfast was usually on time but the noontime and evening meals are sometimes 30 minutes to an hour and a half late. On 5/21/26 at 1:47 PM, R2 said she always eats in the big dining room and the noontime and evening meals are often served late. On 5/21/26 at 12:08 PM, V10 (Licensed Practical Nurse/ LPN) said meals are served late often. V10 said a couple weeks prior to this investigation a meal had been served an hour and a half late. V10 said there is a posted schedule of when meals are to be served. V10 said she was not sure why meals were served late so often. On 5/20/26 at 12:35 PM, V8 (Certified Nursing Assistant/ CNA) stated the noontime meal was over 30 minutes late at the time of this interview. V8 said this was a common occurrence and when meals are late it makes staff get behind in completing other tasks. The facility's undated The Dining Experience posted documented the noontime meal was to be served as follows: Small Dining Room at 12:00 PM, Large Dining Room at12:20 PM, 400 Hall Cart at 12:35 PM, 300 Hall Cart at 12:40 PM, 100 & 200 Hall Cart at 12:50 PM. On 5/20/26 at 12:33 PM, residents were sitting in the small dining room waiting for the noontime meal to be served. On 5/20/26 at 12:49 PM, the meal cart for the small dining room arrived, 49 minutes late, and staff started serving resident meal trays. On 5/20/26 at 1:10 PM, the 400 hall meal cart arrived, 35 minutes late. On 5/20/26 at 1:17 PM, the 300 hall meal cart arrived, 37 minutes late. On 5/20/26 at 1:32 PM, the 100 and 200 hall meal cart arrived, 42 minutes late. The last meal tray on the 100 and 200 hall meal tray cart was delivered at 1:38 PM. On 5/21/26 at 12:07 PM, residents were sitting in the small dining room waiting for the noontime meal to be served. At 12:30 PM, the small dining room meal cart arrived, 30 minutes late. The facility's 5/19/26 Assignment Location List Report documented 62 residents residing in the facility.