FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING IL6006118 06/15/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2299 METROPOLIS STREET **METROPOLIS REHAB & HCC** METROPOLIS, IL 62960 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID. PROVIDER'S PLAN OF CORRECTION (X5)(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE **PRÉFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE DEFICIENCY) S 000 Initial Comments S 000 Facility Reported Incident of 5/26/23/IL160738 S9999 **Final Observations** S9999 Statement of Licensue Violations 300.1210b) 300.1210c) 300.1210d)6) Section 300.1210 General Requirements for **Nursing and Personal Care** The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour. seven-day-a-week basis: . All necessary precautions shall be taken to assure that the residents' environment remains Attachment A as free of accident hazards as possible. All Statement of Licensure Violations nursing personnel shall evaluate residents to see

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

that each resident receives adequate supervision

TITLE

(X6) DATĘ

PRINTED: 07/27/2023 FORM APPROVED Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING IL6006118 06/15/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2299 METROPOLIS STREET **METROPOLIS REHAB & HCC METROPOLIS, IL 62960** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) S9999 Continued From page 1 S9999 and assistance to prevent accidents. These requirements were not met as evidenced by: Based on interview and record review, the facility failed to apply a gait belt while transferring and ambulating 1 of 3 residents (R1) reviewed for falls in the sample of 3. This failure resulted in R1 falling to the floor which resulted in a fracture of the L2 vertebrae. Findings include: R1's "Admission Record" in the medical record documents that R1 admitted to facility on 6/08/2022 with a diagnosis of cerebral infarction, unspecified. R1's Minimum Data Set (MDS) assessment dated 5/05/2023 documents in Section C a "Brief Interview for Mental Status" (BIMS) score of 15, indicating that R1 is cognitively intact. Section G, "Functional Status" documents "Limited assistance with one-person physical assist" with bed mobility, transfers. ambulating, dressing, toilet use, and personal hygiene. R1's "Care Plan" documents under "Focus" that R1 is at risk for falls with an initiation date of

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6/09/2022 and revision date of 12/13/2022. Under the section "Goal" it documents that R1 will be free from falls through the review date with an initiation date of 6/09/2022 and revision date of 12/20/2022 and target date of 5/08/2023. Interventions documented include: be sure the resident's call light is within reach and encourage the resident to use it for assistance with an initiation date of 6/09/2022 and revision date of 6/20/2022, ensure personal items are within

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
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METROPOLIS REHAB & HCC 2299 METI			DRESS, CITY, S' ROPOLIS ST DLIS, IL 6296			
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S9999	that the resident is ambulating or mobil initiation date of 8/3 9/19/2022. R1's "Fa	ge 2 ion date of 6/09/2022, ensure wearing appropriate footwear izing in wheelchair with an 1/2022 and revision date of all Risk Assessment" dated s score: 9 (Low Risk).	S9999			
	documents "It was a Practical Nurse) by experienced a fall la purple bruise on conhaving problems training when they try that she was using (V5-Certified Nurse blankets back for (Fibalance and landed Practitioner) notified	es" dated 5/27/2023, reported to V4 (Licensed (R1) that (R1) had ast night, (R1) has a deep ccyx and (V4) noted (R1) is insferring, (R1) stated "It only and stand up". (R1) explained rollator (wheeled walker) with Aide), (V5) went to pull R1) to get in bed, (R1) lost I on buttocks. (V9-Nurse I and ordered (R1) to revaluation. Family made				
	dated 5/27/2023, do 94-year-old white for emergency room w"(R1) had a fall ye support her back ar buttocks""(R1) had buttocks and low ba	epartment Provider Notes" ocuments in part"(R1) is a emale present to the ith complain of low back pain" esterdayperson did not nd (R1) fell on the floor on her as a bruise on her lower ack""Final Impression, 1. In fracture of L2 lumbar ounter".				
	stated that it was refall on 5/26/2023 are back from the bath bedding back and Fon her buttocks. V1	00 a.m. V1 (Administrator) ported that R1 experienced a ld V5 (CNA) was assisting R1 room and went to pull her R1 lost her balance and landed stated that V5 was educated of care and to use a gait belt	s	# # # # # # # # # # # # # # # # # # #	% 1 1 2 2	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

7: 16:5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED				
			A. BUILDING:		177	9			
IL6006118		B. WING		C 06/15/2023					
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE									
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE			
S9999	Continued From page 3		S9999						
	when transferring o requires assistance ambulation.	r ambulating a resident that with transfers and		* 1		i i			
	Practical Nurse), st 5/27/2023 and was was having difficulty noticed a bruise on she went in to asse purple bruise to her area. V4 stated than ight before. V4 stated having pain and R1 little pain. V4 stated medication at that the physician and made primary physician of the emergency deptreatment. V4 stated local hospital and relower back. V4 stated with assistance of cambulates with a recombination of the emergency deptreatment. V4 stated local hospital and relower back. V4 stated with assistance of cambulates with a recombination of the period when R1 was combined when R1 was combined when R1 was combined when R1 was combined when he turned floor on her buttock was fine. V5 stated and she came in to after V8 looked her and put her into be	2:00 a.m., V5 (Certified Nurse is working the evening of helping R1 get ready for bed. It R1 go to the bathroom and ing out of the bathroom, he id to pull down the bedding It around R1 had fallen to the s. V5 stated R1 told him she he notified V8 (Agency LPN), look at R1. V5 stated that over, he helped R1 get up It. V5 stated that he did not R1 when he was helping R1 to							

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71.10 PRINTED: 07/27/2023 FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C B. WING IL6006118 06/15/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2299 METROPOLIS STREET **METROPOLIS REHAB & HCC** METROPOLIS, IL 62960 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) S9999 Continued From page 4 S9999 On 6/13/2023, at 10:15 a.m., V8 (Agency LPN) stated that she was working the evening of 5/26/2023 and was notified by V5 (CNA) that R1 had fallen to the floor while coming back from the bathroom. V8 stated she went into R1's room and assessed R1. V8 stated that R1 did not have any complaints of pain or discomfort at that time and R1 was able to move her extremities with no problems and denied hitting her head. V8 stated that R1 was assisted up and put back to bed with no problems noted. On 6/12/2023, at 10:00 a.m., R1 stated she had a fall recently. R1 stated she was walking back from the bathroom with her walker and V5 (Certified Nurse Aide/CNA) was over at her bed pulling down the bedding on her bed to help assist her get ready for bed. R1 stated she lost her balance and fell into her closet and sat down to the floor. R1 stated that the nursing staff usually have a gait belt on her and walk with her when she is walking with her walker. R1 stated that V5 did not put a gait belt on her at that time. R1 stated she did not have any sudden pain until she got up the next morning and noticed her back was sore. R1 stated that she told the nurse she had back pain and had fallen the night before, R1 stated the nurse checked her out and noticed a bruise on her lower back/bottom. R1 stated she was sent out to the hospital and was told her lower back had a fracture in it. R1 stated she was brought back to the facility after her hospital visit. The facility's "Final Report" dated 5/27/2023

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in the future ".

documents in parts ... "Staff were educated in the use of a gait belt, the proper way to complete the transfer and the task of preventing any incidents

STATE FORM

(B)