

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0046276		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/03/2026	
NAME OF PROVIDER OR SUPPLIER METROPOLIS REHAB & HCC				STREET ADDRESS, CITY, STATE, ZIP CODE 2299 METROPOLIS STREET , METROPOLIS, Illinois, 62960			
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S0000	Initial Comments Complaint Investigation Survey: 2652990/2802567- F580, F759, and F760			S0000			04/06/2026
S9999	Final Observations Statement of Licensure Violations: (1 of 2) 300.610a) 300.1010h) 300.1210b) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care			S9999			04/06/2026

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 b) 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. These regulations were not met as evidence by: 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 than 600 putting R4 at risk to develop Diabetic Ketoacidosis (DKA) which could result in coma and possible death. Findings include: R4's Admission Record documented an admission date of 2/3/26 with diagnoses including: type 2 diabetes mellitus, need for assistance 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.)..."			S9999			04/06/2026

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S9999	Continued from page 2 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. 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			S9999			04/06/2026

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S9999	Continued from page 3 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			S9999			04/06/2026

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S9999	Continued from page 4 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 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..." (B) (2 of 2) 300.610a) 300.1210b) 300.1210d)1)2) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the	S9999				04/06/2026	

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S9999	Continued from page 5 facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility. Section 300.1210 General Requirements for Nursing and Personal Care b) 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. d) 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: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. 2) All treatments and procedures shall be administered as ordered by the physician. These regulations were not met as evidence by: 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.			S9999			04/06/2026

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S9999	Continued from page 6 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			S9999			04/06/2026

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S9999	Continued from page 7 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 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			S9999			04/06/2026

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S9999	Continued from page 8 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	S9999				04/06/2026	

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S9999	Continued from page 9 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 lamotrigine 25 mg 1 tablet, levetiracetam 500 mg/ 5ml oral liquid, and topiramate 25 mg 1 tablet all ordered to be			S9999			04/06/2026

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0046276		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/03/2026	
NAME OF PROVIDER OR SUPPLIER METROPOLIS REHAB & HCC				STREET ADDRESS, CITY, STATE, ZIP CODE 2299 METROPOLIS STREET , METROPOLIS, Illinois, 62960			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
S9999	Continued from page 10 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..." (B)		S9999			04/06/2026	