DEPART	MENT OF HEALTH	AND HUMAN SERVICES			·		APPROVED	
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0	-	0938-0391	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		145813	B. WING				C 04/2015	
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
METROP	POLIS REHAB & HCC				299 METROPOLIS STREET IETROPOLIS, IL 62960			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 000	INITIAL COMMEN	rs	F 0	00				
F 157 SS=D	Complaint #15541 483.10(b)(11) NOT (INJURY/DECLINE	IFY OF CHANGES	F 1	57				
	consult with the res known, notify the re- or an interested fan accident involving t injury and has the p intervention; a sign physical, mental, or deterioration in hea status in either life clinical complication significantly (i.e., a existing form of trea consequences, or t treatment); or a deo	ediately inform the resident; sident's physician; and if esident's legal representative nily member when there is an he resident which results in potential for requiring physician ificant change in the resident's r psychosocial status (i.e., a lith, mental, or psychosocial threatening conditions or ns); a need to alter treatment need to discontinue an atment due to adverse o commence a new form of cision to transfer or discharge ne facility as specified in						
	and, if known, the r or interested family change in room or specified in §483.1 resident rights under regulations as speci this section.	so promptly notify the resident esident's legal representative member when there is a roommate assignment as 5(e)(2); or a change in er Federal or State law or cified in paragraph (b)(1) of						
	the address and ph	cord and periodically update one number of the resident's e or interested family member.						
	This REQUIREME	NT is not met as evidenced						
LABORATORY	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE	

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.

PRINTED: 08/11/2015

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION		. 0938-039 E SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:		NG		IPLETED
		145813	B. WING _			C / <b>04/2015</b>
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		04/2010
METROF	POLIS REHAB & HCC			2299 METROPOLIS STREET METROPOLIS, IL 62960		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 157	failed to timely notif and increased acite	v and record review, the facility by the physician of weight gain es for 1 of 1 resident (R2) bian notification in the sample	F 15	57		
	R2 called him before stated that he was a breathing and need stated that he went E10 (Registered Nut the hospital immed breathe and his about stated that he dema ambulance immedi PM, E2 (Director of admitted with Cong were no orders for R2's abdomen. E2 beginning to have a measure the nurse his abdominal girth aware of the 14.6 p stated that if a resid gain within two or th physician should be 12:35 PM, E8 (Reg Liason) stated that 07-28-2015 and R2 nasal cannula and breathing and was R2's abdomen was	2:00 AM, Z4 (family) stated that re lunch on 07-29-2015 and sick and was having trouble led to go to the hospital. Z4 to the nurses station and told urse) that R2 needed to go to iately because he couldn't domin was very swollen. Z4 anded that E10 call an ately. On 08-04-2015 at 12:15 Nursing) stated that R2 was jestive Heart Failure and there daily weights or measuring also stated that R2 was ascites and as a nursing s were supposed to measure . E2 stated that she wasn't bound weight gain and E2 also dent had a 14 pound weight nree weeks, the resident's e notified. On 08-04-2015 at istered Nurse/Wound Care he worked the night shift of 2 was on 3 liters of oxygen per was not having problems n't complaining. E8 stated that getting larger and at the eeting on 07-28-2015, they				

Facility ID: IL6006118

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		AND HUMAN SERVICES				FORM	: 08/11/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		145813	B. WING				C 04/2015
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
METROP	POLIS REHAB & HCC				299 METROPOLIS STREET IETROPOLIS, IL 62960		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 157	measured. E8 state abdomen measured seem concerned. E should have been of he had given report 07-29-2015. On 08 stated that she thou already contacted Z 14.6 pound weight R2's abdomen. E10 contact R2's physic hospital because Z her to send R2 out. E3 (Assistant Direc was admitted with a Azotemia and verifi contacted R2's physic 07-29-2015. R2's Progress Note documents that R2 with a diagnosis of edema of both feet Notes also docume 2/3 liters per nasal breathing upon exe admission docume pounds and on 07-2 273.6 pounds. R2's 07-09-2015 docume ordered Zaroxolyn 2 increased edema. F 07-11-2015 and 07- continued to have r lower extremities an elevated. R2's Prog at 3:05 AM docume was getting larger a	age 2 ed that during the night, R2's d 62 inches, but R2 didn't 8 stated that R2's physician called the next morning after t to E10 the morning of 8-04-2015 at 1:25 PM, E10 ught the other nurses had 25 (R2's physician) about R2's gain and the increasing size of 0 also stated that she didn't cian prior to sending him to the 4 was yelling and cursing at On 08-04-2015 at 12:18 PM, tor of Nursing) stated that R2 a diagnosis of Prerenal ed that E10 should have sician the morning of es dated 07-08-2015 was admitted to the facility Congestive Heart Failure and and legs. R2's Progress ent that R2 was on oxygen at cannula and he had difficulty ortion. R2's weight record at ints that R2 weighed 259 29-2015 R2's weight was a Progress Notes dated ents that Z5 visited R2 and 2.5 milligrams 1 daily for R2's Progress Notes dated -16-2015 document that R2 edness and edema of both ind his legs needed to be gress Notes dated 07-28-2015 ents that R2's abdominal girth and measured 62 inches, and cerned about it and wasn't	F 1	157			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING       (X3) DATE SURVEY COMPLETED         NAME OF PROVIDER OR SUPPLIER       145813       Image: Complete complet			AND HUMAN SERVICES				FORM	: 08/11/2015 APPROVED . 0938-0391
145813     B. WING     08/04/2015       NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE     2299 METROPOLIS STREET       METROPOLIS REHAB & HCC     STREET ADDRESS, CITY, STATE, ZIP CODE     2299 METROPOLIS, IL 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)     (%5) COMPLET DEFICIENCY       F 157     Continued From page 3 having shortness of breath or discomfort. R2'S Progress Notes dated 07-29-2015 at 13:06 PM, documents that R2 was sent to the local hospital because Z4 demanded R2 be sent to the hospital. There is no documentation in the progress notes that R2's physician was notified about the 14.6 pound weight gain or R2's abdominal girth increasing.     F 469       F 469     483.70(h)(4) MAINTAINS EFFECTIVE PEST SS=C     F 469	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	` '		E CONSTRUCTION	(X3) DATE COM	E SURVEY IPLETED
<b>METROPOLIS REHAB &amp; HCC 2299 METROPOLIS STREET</b> <b>METROPOLIS, IL 62960</b> (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 CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       COMPLETI DATE         F 157       Continued From page 3 having shortness of breath or discomfort. R2's Progress Notes dated 07-29-2015 at 13:06 PM, documents that R2 was sent to the local hospital because Z4 demanded R2 be sent to the hospital. There is no documentation in the progress notes that R2's physician was notified about the 14.6 pound weight gain or R2's abdominal girth increasing.       F 169         F 469       483.70(h)(4) MAINTAINS EFFECTIVE PEST SS=C       F 469			145813	B. WING				
METROPOLIS REHAB & HCC       METROPOLIS, IL 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 SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       COMPLETI DATE         F 157       Continued From page 3 having shortness of breath or discomfort. R2's Progress Notes dated 07-29-2015 at 13:06 PM, documents that R2 was sent to the local hospital because Z4 demanded R2 be sent to the hospital. There is no documentation in the progress notes that R2's physician was notified about the 14.6 pound weight gain or R2's abdominal girth increasing.       F 169         F 469       483.70(h)(4) MAINTAINS EFFECTIVE PEST SS=C       F 469	NAME OF F	PROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·		S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
PREFIX TAG(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)PREFIX TAG(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)COMPLETI DATEF 157Continued From page 3 having shortness of breath or discomfort. R2's Progress Notes dated 07-29-2015 at 13:06 PM, documents that R2 was sent to the local hospital because Z4 demanded R2 be sent to the hospital. There is no documentation in the progress notes that R2's physician was notified about the 14.6 pound weight gain or R2's abdominal girth increasing.F 469 SS=CF 469F 469 SS=CKA3.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAMF 469	METROP	OLIS REHAB & HCC						
having shortness of breath or discomfort. R2's Progress Notes dated 07-29-2015 at 13:06 PM, documents that R2 was sent to the local hospital because Z4 demanded R2 be sent to the hospital. There is no documentation in the progress notes that R2's physician was notified about the 14.6 pound weight gain or R2's abdominal girth increasing. F 469 483.70(h)(4) MAINTAINS EFFECTIVE PEST SS=C CONTROL PROGRAM	PRÉFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP	) BE	COMPLETION
control program so that the facility is free of pests and rodents.         This REQUIREMENT is not met as evidenced by:         Based on observation, interview and record review the facility failed to ensure the facility was free from flies. This has the potential to affect all 63 residents living in the facility.         The findings include:         On 08-03-2015 at 9:00 AM, Z4 (family) stated that R2 had lots of flies in his room. On 08-03-2015 at 9:30 AM, R1 stated that there are a lot of flies in his room and when he gets ready to eat a meal, that is when he gets his fly swatter out. On 08-03-2015 at 12:05 PM, Z1 (R4's family member) and Z2 (R5's family member) stated that the facility has a lot of flies and both Z1 and Z2 were fanning the flies away from R4 and R5's food. On 08-03-2015 at 11:05 AM, E1 (Administrator) stated that she hasn't had any complaints regarding the flies and the facility has	F 469	having shortness of Progress Notes dat documents that R2 because Z4 deman hospital. There is no progress notes that about the 14.6 pour abdominal girth incu 483.70(h)(4) MAINT CONTROL PROGE The facility must ma control program so and rodents. This REQUIREMEN by: Based on observat review the facility fa free from flies. This 63 residents living i The findings include On 08-03-2015 at 9 R2 had lots of flies 9:30 AM, R1 stated his room and when that is when he gets 08-03-2015 at 12:00 member) and Z2 (F that the facility has Z2 were fanning the food. On 08-03-201 (Administrator) stat	f breath or discomfort. R2's ted 07-29-2015 at 13:06 PM, was sent to the local hospital ded R2 be sent to the o documentation in the t R2's physician was notified nd weight gain or R2's reasing. TAINS EFFECTIVE PEST RAM aintain an effective pest that the facility is free of pests NT is not met as evidenced tion, interview and record ailed to ensure the facility was a has the potential to affect all n the facility. e: 0:00 AM, Z4 (family) stated that in his room. On 08-03-2015 at I that there are a lot of flies in he gets ready to eat a meal, s his fly swatter out. On 5 PM, Z1 (R4's family R5's family member) stated a lot of flies and both Z1 and e flies away from R4 and R5's I5 at 11:05 AM, E1 red that she hasn't had any	F 4				

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		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	: 08/11/2015 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COM	E SURVEY PLETED
		145813	B. WING			C 04/2015
NAME OF	PROVIDER OR SUPPLIER	·	S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
METROP	POLIS REHAB & HCC			299 METROPOLIS STREET IETROPOLIS, IL 62960		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 469	a Pest Control prog Pest Control contra take care of the fly 2:45 PM, Z3 (Pest 0 this surveyor via tel are fly traps in the k biggest problem, ar fly problem he will k 08-04-2015 to spot 08-03-2015 at 12:4 Supervisor) stated of the Pest Control co chemicals into the of infestation and ther door to take care of 08-04-2015 at 1:55 that Z3 was contact checking for flies in he was going to put and dining rooms at the dining room wir eliminate the fly pro- resident rooms. On 08-03-2015 at 1 flies noted in the lat R6, R7, R8 and R9 their plates, and in There was a trash of room that E5 (Certi (Certified Nurses Af food into and there around that trash ca PM, flies were seer around the trash ca The facility's agreen "EcoPro, Scope of	gram. E1 also stated that the actor had recently been in to problem. On 08-03-2015 at Control Technician) spoke with lephone and stated that there kitchen where the flies are the nd now that he is aware of this be going to the facility on spray in the facility. On 5 PM, E4 (Food Service that there are a lot of flies and ontractor comes in and pours drains to treat the fly re is a fly trap near the back f the house flies. On 5 PM, E9 (Maintenance) stated ted after this surveyor was n the facility and Z3 stated that t more fly traps in the kitchen and will put chemicals around holdows and doorways to oblem and target some of the 12:10 PM, there were several rge dining room. R1, R4, R5, had flies landing on them, their food during the meal. can in the corner of the dining ified Nurses Aide) and E6 ide) were scraping plates of a were six flies swarming an. On 08-03-2015 at 12:30 n over the steam table and				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES					FORM	08/11/2015 APPROVED 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	COM	(X3) DATE SURVEY COMPLETED C	
		145813	B. WING _		08/04/2015		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
METROPOLIS REHAB & HCC				2299 METROPOLIS STREET METROPOLIS, IL 62960			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 469	long-lasting residua surfaces such as ge building entryways Under Interior: Eco service Stealth Fly service will include glue boards each a and bulbs as neede applied to interior fl The facility's Facility 08-03-2015 docum	br: Ecolab will appy fast-acting, al products to fly resting arbage storage areas and during the months of services. lab will strategically place and Traps on a monthly basis. This the replacement of Stealth ctive month of the program ed. Residual products will be y resting surfaces as needed.	F 46				

Facility ID: IL6006118

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