Printed: 09/27/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145387	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Anthony's Nsg & Rehab Ctr	767 30th Street Rock Island, IL 61201

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 32061 Based on interview and record review, the facility failed to implement its abuse policy of protecting a resident from further potential abuse during an abuse investigation, for one of three residents (R1) reviewed for abuse in the sample of 3. Findings include: The facility policy, Resident Abuse and Neglect Prevention Policy, dated 6/3/2000 directs staff, An Owner, Licensee, Administrator, Licensed Nurse, Employee or Volunteer of a nursing home shall not physically, mentally,or emotionally abuse, mistreat or neglect a resident. Protection: It is the policy of this facility that the resident will be protected from the alleged offenders. Procedures must be in place to provide the resident with a safe, protected environment during the investigation. The alleged perpetrator will immediately be removed and resident protected. Employees accused of alleged abuse will be immediately removed from the facility and will remained removed pending the results of a thorough investigation. The facility Investigation, dated 7/9/24 documents, (R1) reported during third shift to V5/Certified Nursing Assistant (CNA) at 2:15 A.M. that a CNA on the previous second shift had been 'rough' with her during cares. POA (Power of Attorney) and Physician notified. Investigation initiated and identification of time/persons involved to be determined. On 7/11/24 at 8:30 A.M., V1/Administrator stated, I received a telephone call from (V5/CNA) on 7/9/24 around 2:30 in the morning. She told me that (R1) reported to her that a CNA on the previous second shift had been rough with her. (R1) told (V5) that the CNA had grabbed her face and chin. The next morning, (V5/CNA) and (V3/CNA) both left notes under my door. (V3) stated she had answered (R1's) call light on last rounds and (R1) wanted her dentures taken out. When (V3) gathered the supplies and went to take (R1's) dentures out, (R1) told her no, to get her own teeth and leave hers alone. (V3) left the room and was so concerned about the situation, (V3) left a note under my door to report it. I called (R1's) granddaughter and told her about the situation and she said she thought her grandmother had been becoming more confused lately. Because of the inconsistencies in the story, we didn't suspend (V3). I just moved her to another floor. My investigation is still incomplete. I have a couple more interviews to finish V3's facility Time Card report, provided by V1/Administrator documents that V3/Certified Nursing Assistant continued to work in the facility on 7/9/24 from 1:45 P.M. until 2:45 P.M; and on 7/10/24 from 1:45 P.M. until 10:15 P.M.

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