

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145387	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/24/2025
NAME OF PROVIDER OR SUPPLIER  St Anthony's Nsg & Rehab Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>Based on interview and record review the facility failed to administer medication as ordered by the physician for one resident (R3), reviewed for respiratory treatments, in a sample of three residents. The facility's Medication Administration Policy dated 10/14/24 documents, The facility will provide pharmaceutical services, including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all medications, to meet the needs of each resident.R3's medical record documents R3 was admitted to the facility 9/15/25 with the following diagnoses: Acute respiratory failure with hypoxia, pneumonia, chronic obstructive pulmonary disease (with acute exacerbation), chronic systolic (congestive) heart failure, atrial fibrillation, and hypertension. R3's hospital discharge order documents the following: Albuterol (2.5milligrams/ 3 milliliters) 0.083% nebulizer solution, take 2.5 milligrams by nebulization every six hours.A review of R3's Order Summary Report and Medication Administration Records dated September 2025 document, Albuterol Sulfate Nebulization Solution (2.5 milligrams/ 3 milliliters) 0.083%, 2.5 milligrams inhale orally via nebulizer every six hours as needed for SOB (shortness of breath), does not show staff documentation of medication being administered as ordered.R3 stated that R3 admitted to the facility 9/15/25 from the hospital and he did not receive any nebulizer treatments while residing at facility (1 day). R3 stated that he has been prescribed continuous oxygen therapy and nebulizer treatments for many years. R3 stated that he asked to be discharged on 9/16/25 because he was not getting the medication he needed. V15 (Facility Nurse Practitioner) verified R3's nebulizer treatment orders were not transcribed or administered as ordered.</p>

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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