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 03/09/2026
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)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on interview and record review, the facility failed to ensure that a resident at moderate risk for skin impairment received interventions to prevent and properly manage an unstageable pressure ulcer, resulting in deterioration of the wound and osteomyelitis for one (R2) of three residents reviewed for pressure ulcers. This failure resulted in R2's wound progressing to a painful facility acquired an unstageable pressure ulcer with tunneling and osteomyelitis, requiring intravenous antibiotics and debridement. Findings include:The facility's Pressure Ulcer Policy revised 4/18/25 documents the facility is committed to the prevention, early identification, and evidenced based treatment of pressure ulcers. All residents will receive comprehensive skin assessments, risk evaluations, and appropriate skin interventions to promote skin integrity and prevent deterioration. Reassessment will occur with any change in condition or following identification of skin breakdown. New wounds, signs of infection, or wound deterioration must be reported promptly to the Nurse Supervisor and Medical provider. The wound Nurse must be notified to reassess and update treatment orders. Ongoing training will be provided to nursing staff on pressure ulcer prevention and wound care protocols. The facility's Notification of Change in Condition policy revised 9/17/25 documents notification to resident's physician and representative by the interdisciplinary team when there is a significant change in the resident's physical, mental, or psychosocial condition. Notification will also be made if there are any changes that may impact the residents plan of care or prognosis. The interdisciplinary team will review the change in condition and determine whether modifications to the care plan are necessary.R2's Braden Risk Assessments dated 8/1/25 and 1/2/26 documented that R2 was at moderate risk for skin impairment.R2's care plan did not include pressure-relieving interventions, repositioning schedules, or documentation of pressure ulcer care.R2's MDS (Minimum Data Set) dated 1/19/26 documents R2 has one unstageable pressure ulcer due to slough or dead tissue. This same MDS documents R2 is severely cognitively impaired.On 3/8/26 at 11:45 AM, R2 was lying in bed with eyes closed. R2 has a feeding pump next to his bed which is not connected. R2 has an abdominal binder in place. G tube visualized and in place.R2's Wound Note dated 2/10/2026 documents R2 was evaluated by V20 (Wound Physician), V12 mechanically debrided wound to R2's coccyx, bone scraping obtained to confirm diagnosis of osteomyelitis after topical analgesic applied to wound bed. R2 has Copious amount of bright red blood observed from debridement site. V20 documents in R2's Wound Evaluation and Management Summary R1's wound is a stage 4. Staff applied direct pressure with gauze and covered the wound bed with calcium alginate, blood stop granules applied to wound bed and secured with abdominal pad. V2 advised leaving R2 lying supine with direct pressure to wound bed to stop bleeding. R2 was positioned with green foam wedges, and head of bed elevated due to tube feeder. R2 tolerated procedure well and Measurements obtained. New order to discontinue collagen dressing to wound bed and utilize calcium alginate only, orders updated. Wound culture sample labeled, order written and sample placed for lab pick up. POA to be made aware of above findings.R2's Wound Notes dated 2/10/26 documents R2's wound measurements Pressure ulcer staging for R2's coccyx is Stage 3 Pressure ulcer / injury with full thickness skin loss. R2' Wound was acquired in-house, and it is unknown how long the wound has been present. The coccyx wound Length (centimeters/cm): 5.57 Width (cm): 4.82 Depth (cm): 0 Area (cm2): 19.53 with Tunnel length (continued on next page)

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

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 03/09/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	(cm): 2.2 Tunnel location 1: 12 o'clock.R2's Nurse Progress Note dated 2/17/2026, documents Call placed to infectious disease in regard to R2's bone specimen results as V12 (Wound Doctor) does not want to dose antibiotics due to R2 being in kidney failure. V12 (Nurse Practitioner) made aware, and order was received to follow up with infectious disease. R2's Labs faxed to V21 (Infectious Disease Physician) office awaiting further instruction. Bone debridement performed this shift by V20, wound cleansed with normal saline solution, packed with 4x4 gauze to assist with stopping bleeding. Area applied with firm pressure and will continue to monitor for active bleeding. Clean dressing to be applied to wound bed.R2's Nurse Progress Note dated 2/19/2026, documents R2 in bed this shift, coccyx wound bed cleansed with normal saline solution, bone particle appears to be showing through wound bed, no active signs and symptoms of infection noted, wound bed displays with copious amounts of serosanguineous drainage, no foul odor, peri wound is clean, dry an intact.R2's Physician Orders document on 02/26/26 may draw blood from feet if necessary and start Vancomycin Intravenous Solution 500 milligrams per milliliter(mg/ml) infuse intravenously one time a day every Monday, Wednesday, and Friday for wound infection for six weeks given at dialysis.On 3/9/26 at 9:30 AM, V17 (Licensed Practical Nurse/Wound Nurse) stated R2's Coccyx Ulcer is a stage three pressure ulcer developed at the facility. V17 confirms that R2's wound was cultured and R2 has osteomyelitis in his bone of his coccyx and was started on IV Vancomycin approximately two weeks ago. V17 confirms the Wound Doctor follows R2 for wound care and orders. V17 further stated R2 is dependent on staff for all cares. V17 stated that R2 will often grimace or pull away during dressing changes and debridement's.On 3/9/26 at 10:50 AM, V17 stated she was unable to locate the initial assessment for when R2's pressure ulcer developed. V17 stated she documented the pressure developed in July of 2025 because that's when she took over the position.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review, the facility failed to ensure the nursing department was directed by a qualified Director of Nursing responsible for oversight of nursing services and coordination of care, resulting in a lack of direction and communication within the nursing department and therapy regarding resident care needs for one (R1) of three residents reviewed for gastrostomy tube (G-tube) management. This failure has the potential to affect all 81 residents residing in the facility. Findings include:The facility's Resident Roster dated 3/6/26 documents 81 residents reside at the facility. On 3/7/26 at 11:45 AM, V1 (Administrator) stated the facility has not had a Director of Nursing for several months. During the same interview, V1 stated there had been communication issues between departments and the facility plans to improve this process. On 3/8/26 at 10:22 AM, V1 stated nursing staff did not have access to therapy documentation and there was no defined communication process for therapy recommendations.On 3/6/26 at 10:30 AM, V2 (Assistant Director of Nursing/Licensed Practical Nurse) stated the former Director of Nursing had left approximately eight months ago and the facility had not replaced the position. V2 stated that she has been doing her best to address nursing needs. 1.R1's Speech therapy documentation dated 9/30/25 through 11/24/25 documented R1 had a feeding tube in place and recommended puree consistencies with therapeutic feedings with the Speech Language Pathologist (SLP) only.R1's Nurse Progress Note dated 8/30/25 documents R1 pulled out her G-tube, and a progress note dated 8/31/25 documented enteral feeding orders were discontinued per V12 (Nurse Practitioner), and G-tube site care was initiated.On 3/6/26 at 2:45 PM, V11 (Speech Language Pathologist) stated that at the time R1 was discharged from therapy on 11/24/25, V11 understood that R1 continued to have a feeding tube in place and was not informed R1 had pulled out her G-tube and a new feeding tube was not inserted.2. R2's Wound Notes dated 2/10/26 documents R2's wound measurements Pressure ulcer staging for R2's coccyx is Stage 3 Pressure ulcer / injury with full thickness skin loss. R2' Wound was acquired in-house, and it is unknown how long the wound has been present. The coccyx wound Length (centimeters/cm): 5.57 Width (cm): 4.82 Depth (cm): 0 Area (cm2): 19.53 with Tunnel length (cm): 2.2 Tunnel location 1: 12 o'clock.R2's Nurse Progress Note dated 2/17/2026, documents Call placed to infectious disease in regard to R2's bone specimen results as V12 (Wound Doctor) does not want to dose antibiotics due to R2 being in kidney failure. V12 (Nurse Practitioner) made aware, and order was received to follow up with infectious disease. R2's Labs faxed to V21 (Infectious Disease Physician) office awaiting further instruction. Bone debridement performed this shift by V20, wound cleansed with normal saline solution, packed with 4x4 gauze to assist with stopping bleeding. Area applied with firm pressure and will continue to monitor for active bleeding. Clean dressing to be applied to wound bed.On 3/9/26 at 9:30 AM, V17 (Licensed Practical Nurse/Wound Nurse) stated R2's Coccyx Ulcer is a stage three pressure ulcer developed at the facility. V17 confirms that R2's wound was cultured and R2 has osteomyelitis in his bone of his coccyx and was started on IV Vancomycin approximately two weeks ago. V17 confirms the Wound Doctor follows R2 for wound care and orders. V17 further stated R2 is dependent on staff for all cares. On 3/9/26 at 10:50 AM, V17 stated she was unable to locate the initial assessment for when R2's pressure ulcer developed. V17 stated she documented the pressure developed in July of 2025 because that's when she took over the position.

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. Based on interview and record review, the facility failed to ensure the nursing department was directed by a qualified Director of Nursing responsible for oversight of nursing services and coordination of care, resulting in a lack of direction and communication within the nursing department and therapy regarding resident care needs for one (R1) of three residents reviewed for gastrostomy tube (G-tube) management. This failure has the potential to affect all 81 residents residing in the facility. Findings include:The facility's Resident Roster dated 3/6/26 documents 81 residents reside at the facility. On 3/7/26 at 11:45 AM, V1 (Administrator) stated the facility has not had a Director of Nursing for several months. During the same interview, V1 stated there had been communication issues between departments and the facility plans to improve this process. On 3/8/26 at 10:22 AM, V1 stated nursing staff did not have access to therapy documentation and there was no defined communication process for therapy recommendations.On 3/6/26 at 10:30 AM, V2 (Assistant Director of Nursing/Licensed Practical Nurse) stated the former Director of Nursing had left approximately eight months ago and the facility had not replaced the position. V2 stated that she has been doing her best to address nursing needs. R1's Speech therapy documentation dated 9/30/25 through 11/24/25 documented R1 had a feeding tube in place and recommended puree consistencies with therapeutic feedings with the Speech Language Pathologist (SLP) only.R1's Nurse Progress Note dated 8/30/25 documents R1 pulled out her G-tube, and a progress note dated 8/31/25 documented enteral feeding orders were discontinued per V12 (Nurse Practitioner), and G-tube site care was initiated.On 3/6/26 at 2:45 PM, V11 (Speech Language Pathologist) stated that at the time R1 was discharged from therapy on 11/24/25, V11 understood that R1 continued to have a feeding tube in place and was not informed R1 had pulled out her G-tube and a new feeding tube was not inserted.