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	06/06/2026

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

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review the facility failed to ensure a resident was transferred in a safe manner. This applies to 1 of 3 residents (R2) reviewed for safety in the sample of 8.The findings include:R2's face sheet lists her diagnoses to include: dementia, muscle weakness, need for assistance with personal care, depression, osteoarthritis and weakness. R2's injury of unknown cause report dated 6/5/26 shows, Nursing description: CNA (V9 Certified Nursing Assistant/CNA) notified writer (V6 Licensed Practical Nurse/LPN) of the report that resident has a skin tear at R (right) forearm. On assessment, resident has a skin tear of the size of 4.5 cm (centimeters) at his [her] R forearm. Wound is cleansed with normal saline, clean and dry dressing with steri strips applied. Predisposing Situation Factors: during transfer. Report shows, the injury was unknown however, it was known it happened during a transfer as stated in the report itself. On 6/6/26 at 11:59 AM, R2 was sitting in her wheelchair in her room. She had a gauze bandage on her right forearm. She stated, last night her arm got slashed when the certified nursing assistant (CNA) was putting her in her chair. The CNA (V9 CNA) had the belt around her higher than normal and she didn't like it. Her arms were up there too and the belt slashed her arm. She screamed in pain. It was a nasty looking thing. The nurse (V6 - LPN) had to put those fly things (steri-strips) on it and covered it with the gauze.On 6/6/26 at 1:28 PM, V6 LPN stated, R2 got a skin tear while the CNA (V9) was transferring her. V6 wasn't sure if the gait belt got her or what, but it was during the transfer. On 6/6/26 at 4:21 PM, V9 CNA stated, she was transferring R2, when R2 became agitated and fidgety during the process. Her arm grazed the gait belt and she got a skin tear. She thought she should be a two-person transfer since she can become anxious at times during transfers. She also stated, she felt R2 was alert and oriented but really anxious. R2's skilled evaluation progress note dated 6/5/26 shows, Resident is alert and oriented x 3. Oriented to person. Oriented to time. Oriented to place. Mood is pleasant no unwanted behaviors witnessed. R2's care plan dated 5/18/26 shows, I have a diagnosis of muscle weakness (generalized), other abnormalities of gait and mobility, other lack of coordination, unspecified osteoarthritis, unspecified site and weakness. The facility's resident transfer policy dated 7/28/25 shows, Purpose: The purpose of this policy is to provide safe and consistent guidance for assisting residents with transfers within the facility, including but not limited to bed-to-chair, chair-to-bed, wheelchair, toilet, shower chair, and sit-to-stand transfers. This policy is intended to promote resident safety, dignity, independence, and reduce the risk of injury to residents and staff. Conclusion: This policy is intended to ensure that resident transfers are performed safely, consistently, and respectfully while promoting resident independence and reducing the risk of injury to residents and staff.

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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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. Based on interview and record review the facility failed to ensure a wound culture was picked up in a timely manner. This applies to 1 of 3 residents (R1) reviewed for lab services in the sample of 8. The findings include:R1's un-witnessed fall report dated 5/8/26 shows, he had a fall and obtained a skin tear to his leg. On 6/6/26 at 9:16 AM, V10 R1's Power of Attorney (POA) stated, R1 had a fall and scraped his leg. The wound ended up getting infected and she was concerned that the resident had a MRSA (Methicillin-resistant Staphylococcus aureus) infection. She requested a swab to be done to check for MRSA. V7 Wound Care Nurse did the swab in front of her and put it in the top drawer of her treatment cart. She forgot it was there. V10 stated, she asked for several days what the results were and no one knew. Finally, they got results that it was inconclusive because she left the sample in her cart for 5 days and then sent it off. R1's progress notes dated 5/18/26 shows, New orders obtained to swab wound to r/o (rule out) MRSA. Orders written, swab to be obtained for collection in the am. R1's progress notes dated 5/19/26 shows, .Wound swab completed at this time placed for collection. POA at bedside pictures of wound taken by her. R1's progress notes do not show any further information about the wound culture until 5/26/26.R1's progress notes dated 5/26/26 by V8 Nurse Practitioner (NP) shows, LATE ENTRY Lab notified facility that the wound culture sample collected 5/19/26 had sample integrity issues and that the specimen will need to be recollected. Examined the patient at bedside wound is healing as desired no s/s (signs/symptoms) of infection at time of assessment. No drainage, redness, or warmth noted. R1 denies pain at time of assessment. The patient was prescribed Doxycycline (antibiotic) which has broad coverage no ATB (antibiotic) change or duration extension required. No new orders. No culture recollection required at this time. R1's progress notes dated 5/27/26 shows, Wound culture still pending, POA advised of wound progression and wound culture remaining pending. Previous progress notes, show the NP did not re-order further cultures and the first culture had integrity issues. R1's progress notes dated 5/28/26 by V7 Wound Care Nurse shows, Received call from lab wound culture was not able to be processed d/t (due to) sample expiration. Pt leg wound has healed and no further testing needs to be completed at this time, order cancelled. R1's wound was never cultured to rule out MRSA. On 6/6/26 at 12:59 PM, V7 Wound Care Nurse stated, R1 had a fall in his room and slid underneath a nightstand or table ending up with an abrasion on his right lower extremity area. The area ended up looking like cellulitis, so they treated him with antibiotics. They wanted to rule out MRSA. On 5/18/26 she got the orders to check for MRSA and did the actual swab on 5/19/26. The lab comes Monday, Wednesdays and Fridays. The swab was to be picked up on 5/20/26. They have a binder at the nurses station that lab signs when they pick up the labs. She didn't check anything else after she took the sample and put it where it needed to be for lab pick up. A few days later they received a call about the integrity of the sample and needing a new one. She let the lab know at that time, the wound was healed and they wouldn't be re-collecting the sample. She denied forgetting about the sample and said she did put it in the top drawer of her cart but only until she got back to her office to get the paperwork ready. The laboratory standing order daily log shows, R1's wound culture was picked up on 5/22/26 (3 days after collection). The log is initialed by a lab associate. On 6/6/26 at 2:06 PM, V7 Wound Care Nurse stated, she was not aware that the culture/sample was not picked up on 5/20/26. On 6/6/26 at 10:00 AM, R1 was up in his wheelchair self-propelling around the facility. His right lower leg had a few scabs on it and was red on the shin area. The facility's laboratory services policy dated 9/8/25 shows, Purpose: The purpose of this policy is to ensure that laboratory services are ordered, obtained, reported, reviewed, and followed up in a timely and appropriate manner to support resident care and safety. Procedure: . 14. If lab results are not received within the expected timeframe, the licensed nurse shall follow up with the laboratory provider and document the follow-up.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation, interview, and record review the facility failed to ensure call lights were within reach and working for residents. This applies to 4 of 8 residents (R1, R2, R4, & R8) reviewed for call lights in the sample of 8. The findings include:On 6/6/26 at 9:35 AM, R1's call light was on the floor behind his recliner. His bed was alongside his recliner. R1 also had a wireless call light that was tied to the bed post on the other side/furthest side from his recliner. R1 could not reach either call light. R2 was in her wheelchair in her room. She had two call lights. Both were draped over her night stand out of reach. She stated, she didn't have a way to call for help because they told her the call lights weren't working. She stated, she did not have a wireless call light. She never received one. R4 was in bed with the head of the bed up. His call light was draped over a chair that was up against the wall at the head of his bed. R4 could not reach the call light with the head of bed raised. His wireless call light was also tied to the same chair hanging down towards the floor. His bed was raised up and not lowered. R4 stated, he doesn't have a way to call for help besides to yell for help. R8's call light was on the floor next to his bed. His bed was also raised up. When asked how he calls for help from the staff he yelled, HELP. His wireless call light was tied to his bedside table. He had a mat on the floor and then his bedside table was next to his bed. He could not reach either call light. On 6/6/26 at 12:06 PM, V4 & V5 both Certified Nursing Assistants (CNAs) stated, residents use the call lights to call for help. They should always be within reach. On 6/6/26 at 1:51 PM, V1 Administrator stated, he was having some issues with call lights not working or being within reach. All residents have a traditional call light in their room as well as a wireless call light they can take with them wherever they are in the building. They should always have a call light with them. This surveyor showed V1 Administrator the placement of R1, R2, R4, & R8's call light and how they were not within reach. He stated, staff needed re-education. The facility's call light response policy dated 9/12/25 shows, Policy Statement: The facility is committed to ensuring prompt and appropriate response to all resident call lights to promote safety, dignity, and quality of care. All residents will have access to a functioning call light system, and staff will respond in a timely manner in accordance with facility standards and regulatory requirements. Purpose: To ensure timely response to resident needs and requests. To promote resident safety and prevent adverse events such as falls. To maintain compliance with federal and state regulations. To enhance resident satisfaction and quality of life. 1. Accessibility of Call Lights: All residents will have a functioning call light. Call lights must be checked at the beginning of each shift and after any resident repositioning or transfer. Non-functioning call lights must be reported immediately and repaired promptly. 4. Rounding and Proactive Care: Staff will conduct routine rounds (at minimum every 2 hours) to anticipate resident needs. During rounding, staff will ensure: Call light is within reach, Resident is comfortable and safe.