

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145950	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2024
NAME OF PROVIDER OR SUPPLIER Generations at Rock Island		STREET ADDRESS, CITY, STATE, ZIP CODE 2545 24th 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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>31283</p> <p>Based on interview, observation and record review, the facility failed to ensure an allegation of verbal abuse was immediately reported to the Administrator for one of six residents (R4) reviewed for abuse in the sample of six.</p> <p>Findings include:</p> <p>The facility's Abuse Prevention Guidance Policy (revised 10/2022) documents the following: Employees are required to report any incident, allegation, or suspicion or potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property they observe, hear about, or suspect to the administrator immediately, to an immediate supervisor who must then immediately report it to the administrator or to a compliance hotline or compliance officer. In the absence of the administrator, reporting can be made to an individual who has been designated to act in the administrator's absence.</p> <p>(continued on next page)</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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's Abuse Investigation (dated 06/06/24) documents the following: (V2 former Director of Nursing) reported to this administrator that when she gave (V12 Certified Nursing Assistant/CNA) a write-up for improper time clock usage/break times, (V12) became angry saying that she was being picked on. (V12) went on saying that she was bringing her cell phone to record people when she works. When (V2) explained why she wasn't allowed to do that, (V12) stated that 'Everyone here is calling people f*cking b*tches and I'm going to record them.' When (V2) asked who was doing this and who was being called names, (V12) stated, 'There's a lot of people and it's toward the residents.' (V2) explained that this was an abuse allegation and she needed (V12) to be specific and give the employee names and the resident names, (V12) said, 'I am not telling you anything,' and (V12) left the facility. (V2) notified (V1 Administrator) and the investigation was started immediately. This same investigation documents, (V1) interviewed (V12). (V12) was very upset with the write-up that was given to her. (V12) was observed sitting outside for over 40 minutes while she was still clocked in. (V12) admitted to having already taking all three breaks and said she was trying to 'make up her time' she had missed. (V1) explained to (V12) that the write-up was a warning and that if it happened again, she would be suspended. (V12) became very angry saying, 'There's CNAs calling residents f*cking b*tch, but I get written up for this?' When (V12) was asked which CNAs and which residents, she said it was (V5 Unit Manager/CNA). When asked if there were other CNAs doing this, (V12) said no. When asked which resident (V5) had called names, (V12) said (R4). When (V12) was asked when this happened, she said she couldn't remember exactly. (V1) then re-educated (V12) on the abuse policy including identifying what, when and how to report allegations of abuse. This investigation also documents the following staff were interviewed and indicated they had witnessed V5 verbally abuse R4: V18, V22 and V23 (Certified Nursing Assistants).</p> <p>On 06/20/24 at 02:40 PM, V12 (CNA) stated she has heard V5 (CNA) swear at R4, It was a few weeks ago. I cannot remember the exact date. We were cleaning (R4's) room up. (V5) called (R4) a b*tch. (R4) cannot hear, but she can read your body language. I reported this to (V2 Former Director of Nursing) and (V3 Assistant Director of Nursing) a few days later. V12 confirmed that she did not immediately report her concern to V1 (Administrator).</p> <p>On 06/25/24 at 09:55 AM, V18 (CNA) stated she heard V5 (Unit Manager/CNA) mumble under her breath, The b*tch need a shower. V18 stated, Her (V5) comment was directed at (R4), and (R4) is confused. (R4) is very hard of hearing, but she can pick up on body language. V18 stated this incident occurred approximately 3-4 months ago, and she did not immediately report what she had observed to anyone, and eventually reported this to V1 (Administrator).</p> <p>V22 and V23 (CNA) were unable to be reached for telephone interview regarding the allegations of abuse that they reported witnessing.</p> <p>On 06/25/24 at 01:20 PM, R4 was sitting at the table in the fourth floor's day room with V12 (CNA) and several other residents. R4 was dressed, groomed, and pleasantly confused. Due to R4's impaired cognition, she was unable to answer interview questions. R4 appeared well-cared for and did not appear in any distress. V12 stated that R4 is, Very hard of hearing.</p> <p>On 06/25/24 at 02:00 PM, V1 (Administrator) stated, All of these allegations began after (V12 and V18) were written up in early June. Then those CNAs, as well as V22 and V23 (CNAs) reported allegations of abuse that they did not immediately report to me (V1).</p>		