

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 07/22/2025
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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to implement interventions to ensure a resident was free from physical abuse resulting in potential injury for 2 of 3 residents (R2, R11) reviewed for abuse in the sample of 12. The immediate jeopardy began on 6/11/25 at 6:50 PM when R1 returned to the facility from being evaluated at the acute care hospital after grabbing R11 by the neck. R1's care plan was updated to include 1:1 supervision on 6/11/25. No evidence was found of R1 being on 1:1 supervision until 6/18/25 after the second incident when R1 pushed R2 to the floor. V1 (Administrator) was notified of the Immediate Jeopardy on 7/18/25 at 11:23 AM. The surveyor confirmed by observation, interview, and record review that the Immediate Jeopardy was removed, and the deficient practice corrected, on 6/18/25, prior to the start of the survey and was therefore Past Noncompliance or removed on 6/18/25 and the deficient practice corrected on 6/18/25, prior to the start of the survey and was therefore Past Noncompliance. Based on observation, interview, and record review the facility failed to implement interventions to ensure a resident was free from physical abuse resulting in potential injury for 2 of 3 residents (R2, R11) reviewed for abuse in the sample of 12. The immediate jeopardy began on 6/11/25 at 6:50 PM when R1 returned to the facility from being evaluated at the acute care hospital after grabbing R11 by the neck. R1's care plan was updated to include 1:1 supervision on 6/11/25. No evidence was found of R1 being on 1:1 supervision until 6/18/25 after the second incident when R1 pushed R2 to the floor. V1 (Administrator) was notified of the Immediate Jeopardy on 7/18/25 at 11:23 AM. The surveyor confirmed by observation, interview, and record review that the Immediate Jeopardy was removed, and the deficient practice corrected, on 6/18/25, prior to the start of the survey and was therefore Past Noncompliance or removed on 6/18/25 and the deficient practice corrected on 6/18/25, prior to the start of the survey and was therefore Past Noncompliance. The findings include: R1's face sheet showed she was admitted to the facility 7/2/23 with diagnoses to include severe dementia with agitation, Alzheimer's Disease, Type 2 Diabetes, generalized anxiety disorder, psychotic disorder not due to a substance or known physiological condition, insomnia, and depression. R1's facility assessment dated [DATE] showed she had been experiencing physical and verbal behavioral symptoms directed toward others 4-6 days of the 7-day review period. This same assessment indicated these behaviors had become worse since compared to R1's prior assessment. R1's Care Plan initiated 2/6/25 showed, Coping Psychotic Disorder. Resident has dementia and confusion. Can get angry and lash out at other residents and staff, both verbally and physically. Most times, there is no obvious trigger. Interventions: 6/11/25: 1 on 1 until at baseline for mood and behavior. R2's face sheet showed she was admitted to the facility 7/2/20 with diagnoses to include dementia with other behavioral disturbance, vascular dementia, heart failure, cerebrovascular disease, chronic kidney disease, peripheral vascular disease difficulty in walking, lack of coordination, and a history of falling. R2's facility assessment dated [DATE] showed she has severe cognitive impairment. R11's face sheet showed she was admitted to the facility on [DATE] with diagnoses to include Alzheimer's Disease with late onset, cerebral infarction, vascular dementia with agitation, hypertension, psychophysiologic insomnia, nontraumatic subdural hemorrhage, anxiety disorder, and major depressive disorder. R11's facility assessment showed she has severe cognitive impairment. R1's Incident Report dated 6/11/25 at 2:50 PM showed, Resident to Resident Altercation. Statement from the CNA (Certified Nursing Assistant) was that this resident became agitated by another resident [R11] when [R11] banged her walker on the floor, which made [R1] stand up and grab the resident [R11] by the neck. R11's Incident Report dated 6/11/25 at 2:50 PM showed, This nurse was told by the CNA that this resident was banging her walker against the floor when another resident stood up and grabbed this resident by the neck. R1's Nursing Note dated 6/11/25 at 6:50 AM showed, Resident returned to the facility with no changes to her medication. Information packet on managing stress was attached to discharge orders. R1's Incident Report dated 6/18/25 at 4:01 AM showed, Resident to Resident Altercation. Nursing Description: At 3:45 AM, this nurse was called by CNA at doors to locked area while nurse was a nurse's station to come help because [R1] was agitated in her room. While quickly walking the 20 or so feet to the door to assist CNA this nurse and CNA witnessed resident quickly charge out of her room and self-ambulate across the lounge. CNA and myself hurried to [R1] and before we reached [R1] she reached another resident who was walking with a cane in the hallway next to the lounge and shoved her over causing her to fall back. CNA and myself separated [R1] and the other resident. [R1] continued to be aggressive swinging at and pinching staff while</p>		

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to assess respiratory status for one resident (R3) who displayed respiratory changes of three residents reviewed for change of condition in the sample of five. This deficient practice resulted in a delay in the assessment of the resident's respiratory status and subsequent need for additional medical intervention. The findings include: Physician Order Summary Report indicates R3 was admitted to the facility on [DATE] with diagnoses that include, Dysphagia, Cerebral infarction, Generalized Anxiety Disorder, Gastrostomy, Acute Respiratory Failure with Hypoxia. On [DATE] V7, LPN (Licensed Practical Nurse) stated that she was R3's assigned nurse on [DATE]. V7 stated that R3 was more anxious than usual, had a persistent dry non-productive cough and was obsessed with wiping his tongue with toilet paper. V7 stated R3 appeared to be trying to clear his throat or cough something up. V7 stated R3's mouth was dry, and she gave R3 mouth swabs. V7 stated she did not assess R3's lungs or obtain an oxygen saturation level but did obtain vitals and they were ok. There are no vital signs or oxygen saturation levels documented for [DATE]. Progress Note dated [DATE] at 8:08pm indicates V34 (LPN) went to assess resident due to increased lethargy and pale color; found oxygen saturation at 78% on room air; unable to obtain blood pressure; administered oxygen via nasal cannula and R3 became unresponsive. Note indicates Code Blue was called at 8:10pm and chest compressions initiated by staff; 911 dispatched at 8:12pm and EMS (Emergency Medical Services) arrived at 8:20pm and took over compressions. Note indicates R3 was then transferred to the hospital. On [DATE] at 9:50am V34 stated she was R3's assigned nurse on [DATE]. V34 stated she gave R3 his 3pm bolus tube feeding and noticed R3 was phlegmy, throaty. V34 stated at that time R3 was talking and asked for a pain pill. V34 stated when she went in to give R3 his 8pm tube feeding, R3's color was off pale and R3's oxygen saturation was 78%. V34 stated she went to get the portable oxygen and when she returned R3 was going unresponsive. V34 stated she did a sternal rub and yelled for the CNA to call a Code Blue. Staff immediately arrived assisted R3 to the floor and started CPR (Cardiopulmonary Resuscitation). V34 stated she did not know if there was a protocol for listening to a resident's lungs. V34 stated she did not listen to R3's lungs as R3 was not spitting anything up. On [DATE] at 9:25am V36, RT (Respiratory Therapist) stated that she was asked by V2, RDCO (Regional Director of Clinical Operations) to see R3. V36 stated there was no reason given (R3) was just on my list. I only saw him one time. V36 stated R3 was not gurgly at that time. and did not need any further respiratory support. V36 stated if R3 became gurgly she would think she would be contacted to reassess. R3's Care Plan indicated R3 received enteral nutrition via gravity or bolus with interventions that included to monitor/document/report as needed any signs/symptoms of dysphagia, choking, coughing, drooling. On [DATE] at 9:50am V4, ADON (Assistant Director of Nursing) stated e performed a respiratory assessment on R3 once per V2, RDCO request. V4 confirmed that assessment was completed on [DATE]. V4 stated there were no abnormal findings. V4 stated he had heard R3 had been congested before and thought that's why V2 wanted R3 assessed. V2 also stated that he had heard in passing that R3 frequently spit phlegm up into napkins. V4 stated if R3 were to become more gurgly or phlegmy or any other respiratory changes from baseline or just seemed different a respiratory assessment should be done, and physician should be notified. Facility Policy/ Guidelines for Enteral Feeding Adult dated [DATE] documents: The nurse will assess the following prior to initiating the tube feeding, each time the tube is accessed, every eight hours or as needed: Respiratory status, observe for signs of aspiration (i.e. sudden intense cough, increased amount of secretions, cyanosis or decreased breath sounds). Facility Policy/Change in Condition Guidelines 5/2025 documents: Change in Condition: Any deviation from a resident's baseline status, including physical, mental, or psychosocial changes. Immediate Response: Perform a nursing assessment; Notify the Charge Nurse and/or attending physician immediately if warranted; Initiate appropriate clinical interventions. Facility Policy/Respiratory assessment Guidelines dated 6/2025 documents: Purpose: To ensure best practices and (Federal) expectations for ongoing monitoring, early identification of deterioration and documentation for residents' respiratory status. Frequency of Assessment Guidelines: As needed for any change in condition (this may include increased cough, fever, confusion, shortness of breath, decreased oxygen saturation levels. All respiratory assessments and interventions/outcomes should be documented in the resident's health record.</p>		