

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 10/28/2025
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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement interventions to assess a non-removable lower extremity cast for one of one residents (R1) reviewed for casts in a sample of three. Findings include: The facility's Cast Care policy, undated, documents to assess the cast every shift after the first 24 hours of application for the following: tightness or looseness (able to slip one finger between the cast and skin), circulation, motion, sensation, drainage, odor, and assess the skin for any signs of irritation. This form also documents to report and abnormal findings to the physician and document assessments regarding cast care in the nurses notes.R1's Treatment Administration Record, dated 9/19/25, documents to check CMST's (circulation, movement, sensation, and temperature) to right lower extremity for any abnormal findings and notify the MD (medical doctor) every shift. This order was discontinued on 10/7/25.R1's readmission orders, from the local hospital, dated 10/7/25, does not document any orders for the care of R1's cast on her right lower extremity.R1's Progress Notes, dated 10/11/25, documents that R1 offers complaints of increased pain to RLE (right lower extremity). Resident (R1) states that when she was in physical therapy on Thursday that is was relayed to her (R1) that her casting is damp and smells. Resident (R1) refuses repositioning. Resident (R1) is wondering if she could be seen at the clinic at an earlier date. Relayed a message to oncoming shift. R1's Orthopedic Note, dated 10/13/25, documents that R1 presents with increased right heel pain, and her splint is wet. R1 has increased right lower extremity pain, concern for neurovascular compromise, infected pressure ulcers, and sepsis, status post right closed reduction and transcalsaneal talus distal tibia pinning with use of C-arm fluoroscopy and placement of soft short leg splint pinning on 9/8/25. This form documents that R1's vitals are concerning for sepsis. Her foot discoloration is concerning for neurovascular compromise. It is recommended that R1 go to the emergency room for further evaluation. On 10/28/25 at 10:45am, V10, Certified Medical Assistant, stated that if R1's cast was assessed every shift, the wound on her foot could have been found sooner. V10 verified that R1 was seen in the orthopedic clinic, then was sent to the hospital on [DATE]. V10 stated that R1's cast was found to be saturated. On 10/28/25 at 11:00am, V9, Wound Nurse/Registered Nurse, verified that R1's readmission orders, dated 10/7/25, did not have orders for the care of the cast on her right lower extremity. V9 also stated that staff did not call to obtain orders for R1's cast care. V9 stated that she noticed on 10/12/25 that R1 did not have orders concerning the cast care, after she was told about R1 having a wound inside her cast. V9 stated that R1's original orders concerning her cast should have been continued when she was readmitted on [DATE].</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 145950
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