STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0049866	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Generations at Rock Island	**2545 24TH STREET , ROCK ISLAND, Illinois, 61201**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S0000	Initial Comments initial Complaint Investigation 2527126/IL2578255 Initial Complaint Investigation 2527150/IL2579440 A partial extended survey was conducted.	S0000		09/03/2025
S9999	Final Observations STATEMENT OF LICENSURE VIOLATIONS: 300.610a) 300.1210b) 300.1210d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be	S9999		09/03/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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S9999	Continued from page 1 provided to each resident to meet the total nursing and personal care needs of the resident. d)Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. THESE REQUIREMENTS WERE NOT MET EVIDENCED BY: Based on observation, interview, and record review, the facility failed to adequately supervise a known wandering resident (R1), failed to have systems in place to monitor the front door alarms after hours and failed to have interventions in place for a known faulty (electronic wandering device) door alarm system for one (R1) of twenty-two residents reviewed for elopement/wandering. These failures resulted in R1, a moderately cognitively impaired resident with the diagnosis of Vascular Dementia, eloping from the facility to a grassy area out front of the building, by a curb, close to a busy road attempting to get on a city bus. This failure has the potential to affect all seven (R4-R10) Elopement Risk residents who reside off the secured floor in the facility. These failures resulted in an Immediate Jeopardy. While the Immediate Jeopardy was removed on 8/28/25, the facility remains out of compliance at a severity level two. Additional time is needed to monitor the effectiveness of the implementation of protocols and oversight visits. Findings include: The facility policy titled “Door Alarm Policy”, reviewed 8/22/25, documents but not limited to, “It is the policy of Generations at Rock Island to ensure resident safety and security through the use of door alarms. All doors leading to the outside MUST meet these requirements: 1. The alarm must only be disengaged at the door itself, either by push button code or key. No alarm may be disengaged from the nurse’s station or any other location without physical evidence gathered by a staff member of reason for trigger reported directly to the person silencing the alarm. 2. The alarm must ring continuously until	S9999		

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S9999	Continued from page 2 physically disengaged through key or code. 3. Exit doors MUST NOT have the alarm codes posted. Door alarms require immediate attention and response by facility staff to ensure the safety of all residents…3. Immediate response requires any employee to physically go to the door that has an alarm sounding to establish why the alarm was triggered… 5. Testing (including actual activation) and documentation of testing will be completed weekly. Any malfunctions are to be reported to the Administrator and repaired as quickly as possible." R1's Admission record documents R1's date of admission to the facility was 8/9/24 and his diagnoses include but are not limited to: Type 2 Diabetes Mellitus with Diabetic Neuropathy, Chronic Obstructive Pulmonary Disease, Acute on Chronic Systolic (congestive) Heart Failure, Anxiety Disorder and Vascular Dementia Unspecified Severity with Agitation. R1's Minimum Data Set (MDS) Assessment, dated 6/2/25, documents R1 has a Brief Interview for Mental Status (BIMS) score of 10/15, indicating moderate cognitive impairment, documents R1 has non-Alzheimer's dementia and documents R1's ambulation for distances over 10 feet as supervision or touching assistance. R1's physician orders dated 4/6/25, documents R1 has an order for a (electronic wandering device) ankle bracelet to prevent elopement from facility and orders dated 4/7/25 to check/record (electronic wandering device) placement and function every shift. R1's current care plan documents R1 "Has cognitive deficits related to vascular Dementia and non-traumatic intracerebral hemorrhage" and "at risk for wandering r/t (related to) dx (diagnosis) of dementia. At times will wander around without purpose. Has entered other rooms and easily redirected. (electronic wandering device) in place." R1's current Care Plan contains no documentation of R1's elopement risk prior to 8/1/25. R1's elopement risk assessment dated 6/2/25, documents R1 is an elopement risk with a score of four (4). On 8/26/25 at 3:00pm, V1 (Administrator) stated, "We do not have any documentation stating what the elopement risk assessment score means but anything greater than a one (1) means they are at risk so probably the higher the score the greater risk." R1's Risk Management Report, dated 7/31/25, documents, "Exit behavior actively attempting to leave building staff successful in redirecting" and "(V14/Licensed	S9999		

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S9999	Continued from page 3 Practical Nurse/LPN) statement: I (V14/LPN) received a phone call from dispatch around 8:33pm making us aware that a resident was trying to get on the bus. I was outside bringing him (R1) back in the facility when the police arrived. The resident was still on the facility property in the grass near the smoking patio/courtyard. He did not leave the property. He was easily redirected back inside. We moved him to the 4th floor for heightened supervision and increased security." On 8/22/25 at 1:30pm, V14 (Licensed Practical Nurse/LPN) stated on 7/31/25 around 8:30pm he (V14) was getting off the elevator onto the first floor when he noted the front lobby door alarm was going off and the reception phone ringing. V14 (LPN) answered the phone, and the local police dispatch was calling to inform the facility of a suspected resident attempting to get on the bus. V14 (LPN) went outside and found R1 in a grassy area, next to the curb in front of the facility attempting to get on a city bus. On 8/22/25 at 1:50pm V1 (Administrator) and V2 (Administrator in Training/AIT) stated that the front door alarm will alarm on the panel at the nurse's station on the second floor. On 8/22/25 at 1:55pm observation of alarm panel on second floor at the nurse's station shows no door alarm sounding when V1 (Administrator) set off the door alarm. V14 (Licensed Practical Nurse/LPN) was present at second floor nurse station and verified that the front door alarm was not sounding on the panel at the nurse's station. On 8/22/25 at 2:00pm, V16 (Maintenance Director) stated that he became aware approximately the middle of July 2025 of an issue with the facility's (electronic wandering device) door alarm system not always working as it should, meaning it should alarm at the nurse's station on the second floor if set off but it does not always do this. V16 verified V16 did not notify V1 (Administrator) or attempt to contact the electronic wandering device company regarding the faulty system. At this time, V16 showed the panel on the second floor at the nurse's station where the electronic wandering device system will sometimes alarm if set off. When asked about the door alarm going off not related to the (electronic wandering device), V16 stated, "I don't know of any panel except for the front reception desk that will alarm if the front door is alarming." V16 verified that the front door alarm cannot be heard over the alarm panel at the second-floor nurse's station. 8/22/25 at 2:10pm V13 (Human Resources) stated, "No, if	S9999		

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S9999	Continued from page 4 the front door alarm goes off and it is not because of a (electronic wandering device) then I am not aware that it is heard on any of the floors except the reception desk." On 8/22/25 at 2:30pm, V1 (Administrator) was noticeably frustrated and stated today is the first she has heard anything about there being issues with the door alarms. V1 verified V16 did not report the facility's (electronic wandering device) door alarm system not always working as it should to V1. On 8/26/25 at 11:55am, V17 (Registered Nurse/RN) stated, "I was R1's nurse the evening he got out of the building. Approximately 8:30pm I received a phone call on my personal cell phone from V14 (Licensed Practical Nurse/LPN) stating he (V14) was outside with R1 because he (R1) was trying to get on the bus. I went down to assist getting R1 back into the building and then called V2 (Administrator in Training/AIT) and told her what had occurred and was advised to move R1 to the 4th floor to the secured unit for increased safety. R1 was fully dressed in only socks on his feet when he was found but did have his (electronic wandering device) in place to his ankle. The (electronic wandering device) was checked to make sure it was functioning, and it showed that it was but unsure why the door did not stop him from going out. I do not recall hearing any door alarms sounding from the panel at the second-floor nurse's station. I don't know how V14 (LPN) knew R1 was outside but if it wasn't for him, I'm not sure when we would have known R1 was gone since there is no one watching the front door after 8:00pm. I was informed a few days later that there is a glitch to the door system when it comes to the (electronic wandering device)." On 8/26/25 at 11:44am, V18 (Certified Nursing Assistant/CNA) stated, "I saw (R1) around 7:30pm-8:00pm when I was doing rounds on (R1's) roommate. (R1) had asked me if his shirt looked like it fit so I helped him button it up and then started telling him how nice he looked. He was wearing that button up shirt, a pair of boxers and socks sitting on the side of his bed. He then laid down in bed. I did not hear any door alarms go off on the panel at the nurse's station but was informed by V17 (Registered Nurse/RN) that (R1) was outside, so I ran down the stairs to assist getting him in the building and then realized he needed his wheelchair, so I went back up to get it. Once I got back downstairs, they had him in the building. I assisted him into the wheelchair, and he (R1) was yelling at me "I told you I was going to the tavern to see the ladies." (R1) never said anything to me about	S9999		

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S9999	Continued from page 5 going to the tavern prior to that statement." On 8/26/25 at 10:17am, V37 (City Bus Head of Security) stated, "It is documented that our driver called 911 at 8:32pm stating there was a confused man in socks trying to get on the bus." On 8/26/25 at 10:39am, V38 (Front desk Clerk of Police department) stated, "(City Bus) called around 8:21pm, police dispatched but no need to engage due to staff had resident and were taking him back to the building." On 8/26/25 at 12:25pm, V20 (Licensed Practical Nurse/LPN) stated, "There is no way to hear the front door alarm up here on the third floor. Just the stairwell door alarms are heard here. I was not aware of an issue with the alarm system until (R1) got out. If a (electronic wander device) is near the doors, they lock down so you can't go out, so I don't know at what point it stopped working." On 8/27/25 at 9:15am, V1 (Administrator) stated, "The alarms, front door alarm and (electronic wander device) are supposed to be sounding on the second-floor alarm panel." On 8/26/25 R4, R5, R6, R7, R8, R9 and R10's elopement risk assessments reviewed indicating they are all at risk for elopement and facility census report documents they all live on the second and third floors of the building which are not secured units. V1 (Administrator) and V2 (Administrator in Training/AIT) were notified of the Immediate Jeopardy on 8/27/25 at 11:32am. The surveyor confirmed through observation, interview, and record review that the facility took the following actions to remove the Immediate Jeopardy: 1. R1 was immediately assessed by nursing and moved to the 4th floor secured unit on 7/31/2025. 2. Staff were in-serviced/trained on elopement precautions and facility's policy and procedure for monitoring residents at risk for elopement on 8/1/2025 by facility management. 3. Resident elopement assessments for all residents reviewed and updated accordingly on 8/1/2025 by the IDT/Interdisciplinary Team. Elopement care plans reviewed and updated by the IDT team. 4. Staff educated by QAT (Quality Assurance Team)	S9999		

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S9999	Continued from page 6 members on 8/1/2025 on identifying residents at risk for elopement and policy and procedure for reporting to leadership to ensure proper interventions/care plans are initiated timely. Residents at risk were placed/updated in missing resident binder at the reception desk. 5. Social services assessed current residents for elopement precautions on 8/1/2025 and ensured all at risk residents have updated care plan and intervention in place. 6. Code Green (Elopement-missing person) drill was performed on 8/1/25 and ongoing by Administration. 7. Maintenance Director (V16) completed an immediate audit of door security systems on 8/1/2025 and daily thereafter. 8. On 8/1/2025 Local Vendor was in facility to check over the Access and Wander guard and noted it to be working with a low volume and inconsistently. Quote for upgrade was being drafted for wander guard system. 9. 8/22/2025 Facility implemented 24/7 reception area observation until such time that all staff are educated on the camera monitoring process and/or the repairs are completed. 10. 8/22/2025 facility placed a designated camera alert system at the main entrance to alert 2nd floor staff when the (electronic wandering system) and or main entrance door alarm sounds. This system will remain in place until (electronic wandering system) is fully operational. (V1) will conduct random audits every shift to ensure that the camera alert system at the main entrance functions appropriately. 11. 8/22/2025 Local Vendor and (electronic wandering system) Vendor in communication with Maintenance Director and Facility V1 (Administrator)/V2 (Administrator in Training) in relation to repairs vs replacement. On 8/25/25 after communications with vendors it was determined that repair was not feasible, and system replacement would be required. On 8/26/2025 Quote for replacement of system was approved and signed for installation. 12. 8/29/25 Vendor representatives are scheduled to be on-site to coordinate final installation details and requirements. Installation will be initiated promptly thereafter. 13. On 8/22/2025 all staff in all departments were	S9999		

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S9999	Continued from page 7 in-serviced on Elopement prevention, Missing residents and Door Alarm Policies and procedures by QAT members. No staff will be allowed to work after 8/22/2025 without the listed training. 14. Code Green (Elopement-missing person) drill will be performed randomly for one month and monthly thereafter for 6 months by QAT members. 15. Maintenance Director/Designee will do daily door alarm audits for 30 days and then weekly and as needed going forward. 16. V1/V2 will enforce the interventions of plan of removal of immediacy and assurance of continued compliance. 17. V1/V2 and QAT will ensure that monitoring interventions are implemented immediately, and care planned appropriately. (B)	S9999		