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 **08/07/2025**

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

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S0000	Initial Comments Annual Licensure and Certification Survey	S0000		08/13/2025
S9999	Final Observations Statement of Licensure violations: 300.610a) 300.1210b) 300.1210d)5 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 provided to each resident to meet the total nursing and personal care needs of the resident.	S9999		08/13/2025

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

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S9999	Continued from page 1 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: 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. These Requirements were not met as evidenced by: Based on observation, interview, and record review the facility failed to identify a pressure wound at a stage 1. This failure resulted in R68's pressure wound not being identified until it was a stage 4 full thickness wound. This applies to 1 of 1 residents (R68) reviewed for pressure in the sample of 18. The findings include: On 8/5/25 at 1:45 pm, R68 was sitting in his wheelchair with a blue boot to his right foot. R68 stated he was getting into the shower, and V14 Certified Nursing Assistant (CNA) had a hard time getting his sock off and when she did get it off, she said his heel was black. The wound nurse was called and the wound doctor. The Progress Notes for R68 from 4/23/25 through 7/14/25 did not show any problems with his right heel. There was no documentation of any skin breakdown, deep tissue injury or treatments being provided. The Progress Note dated 4/23/25 at 7:39 PM for R68 showed he was on an antibiotic for cellulitis of his right lower leg. R68 was wearing his shoes properly this shift and his heel was within normal limits. The Skin/Wound Note dated 7/15/25 at 3:52 PM for R68 showed, resident has a new wound to the right heel; identified today and seen by the wound doctor. R68 was found in his wheelchair without shoes, no heel protectors. The wound was debrided. R68 tolerated well. Power of attorney notified - no answer. Orders in place; will continue the plan of care. The Wound Care Physician note dated 7/15/25 for R68 showed, R1 has a wound on his right heel. Review of	S9999		

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S9999	Continued from page 2 systems: feet - no specialty support surface. Etiology: pressure; duration > 1 days; wound size (L x W x D): 8 x 8.5 x not measurable. Depth is not measurable due to presence of nonviable tissue necrosis. Peri wound status: erythema; Exudate: moderate serous. Thick adherent black necrotic tissue (eschar): 75%. Thick adherent devitalized necrotic tissue: 25%. R68's previous Care Plan dated 7/11/25 showed, the resident has potential impairment to skin integrity related to impaired mobility. Identify/document potential causative factors and eliminate/resolve where possible. Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes of observations. Encourage heel boot to right side while in bed. On 8/6/25 at 2:28 PM, V8 Registered Nurse/Wound Nurse (RN) stated on 7/15/25 was when the wound to R68's heel was discovered. R68's sock was stuck to his foot because of the drainage from his heel. R68's foot was riding on the foot pedal. R68 had a deep tissue injury (DTI) that skin prep was being applied to before it opened. R68 has a boot now but sometimes doesn't want to wear it. V8 stated she goes around and reminds residents in the morning if she sees their boots off. V8 stated R68 had uncontrolled blood sugars during that time and his heel deteriorated quickly. V8 stated daily skin checks were being done. V2 Director of Nursing was present and stated wounds are supposed to be identified when they are pink and blanchable. On 8/6/25 at 3:07 PM V8 submitted the July 2025 Treatment Administration Record (TAR) for R68 that was highlighted to show he had daily skin checks being done on the day shift. The TAR showed "3" marked for every day of the entire month. A "3" means existing skin condition remains, no new skin conditions-see notes. If a "2" is marked it means, there is a new skin condition and to see the notes. V8 did not comment as to why the TAR did not show the change in R68's heel on 7/15/25 and was still marked with the "3." The July 2025 TAR did not show skin prep treatments ordered or being done to his right heel. V8 stated R68 has had a wound to his right heel in the past that was considered a diabetic ulcer before, and she did not know why it is considered a pressure ulcer now. On 8/7/25 at 9:51 AM, V13 Wound Care Physician stated R68 has a heel wound. R68 is not nutritionally compromised; he is diabetic. DTI doesn't always show right away. V13 stated it was full blown when she saw his heel. There was eschar to the heel, it was draining	S9999		

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S9999	Continued from page 3 around the edges, and he had wet necrosis that she started treating. It was unlikely that it occurred the day before or even two days before. V13 stated she would think someone had to see something before it got to this point. The wound is pressure related. V13 stated it was unstageable necrosis when she saw it. V13 stated because he has had a previous wound to his right heel that healed it had to be staged at what that wound was previously. V13 stated she had to stage it as a stage 4. For prevention, they should do skin prep to the heel and offloading. R68 never had a problem before wearing his boot. No orders were given for skin prep. V13 stated she didn't know about the wound until it was open. The Physician Order Summary for R68 for July 2025 showed a heel protector was ordered for his right heel. The Care Plan updated on 7/16/25 for R68 showed, impaired skin integrity related to prolonged pressure, impaired circulation, and hyperglycemia as evidenced by a stage 4 pressure ulcer to the right heel with exposed necrotic tissue and delayed wound healing. Evaluate skin for areas of blanching or redness. Heel protector to right heel. Provide skin care per facility guidelines and as needed. Refer to specialized practitioner for wound management. The Face Sheet dated 8/7/25 for R68 showed diagnoses including hypertensive chronic kidney disease, type 2 diabetes mellitus with foot ulcer, absence of left leg above knee, anemia, atherosclerotic heart disease, intellectual disabilities, hypertension, hyperlipidemia, hypo-osmolality and hyponatremia, chronic kidney disease, deficiency of other specified B group vitamins, vitamin D deficiency, muscle weakness, depression, hypokalemia, non-pressure chronic ulcer of right heel and midfoot with fat layer exposed (11/19/24), personal history of other disease of circulatory system, and thrombocytopenia. The Minimum Data Set (MDS) dated 7/10/25 for R68 showed no cognitive impairment; partial/moderate assistance needed for bathing, dressing, and putting on/taking off footwear. The facility's Wound Treatment Management Guidelines (5/2025) showed the policy it to promote wound healing of various types of wounds, it is the policy of this facility to provide evidenced based treatments in accordance with current standards of practice and physician orders. In the absence of treatment orders, the licensed nurse will notify physician to obtain treatment orders. Treatments will be documented on the	S9999		

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S9999	Continued from page 4 Treatment Administration Record or in the electronic health record. On 8/7/25 at 12:00 PM V1 Administrator stated the Wound Treatment Management Guidelines is the policy that corporate sent regarding wounds including pressure ulcers. (B)	S9999		