

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0057406		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/09/2026	
NAME OF PROVIDER OR SUPPLIER ST ANTHONY'S NSG & REHAB CTR				STREET ADDRESS, CITY, STATE, ZIP CODE 767 30TH 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			S0000			
	Complaint Investigation 25212825/2703120 and 2620469/2715685						
S9999	Final Observations			S9999			
	Statement of Licensure Violations:						
	1 of 2						
	300.610a)						
	300.1210b)						
	300.1210d)3)						
	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.						
	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:						
	3) Objective observations of changes in a resident's condition, including mental and emotional changes,						

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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S9999	Continued from page 1 as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. These requirements were not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a resident received the necessary care and services to maintain the highest practicable physical well-being, monitor and ensure appropriate nutritional support and swallowing precautions for a resident with dysphagia and a history of tube feeding, accurately monitor and communicate the resident's feeding tube status between departments, follow speech therapy recommendations, ensure safe nutrition management for a resident at high risk for aspiration for one (R1) of three residents reviewed for Gastrostomy tube (G-tube) maintenance . These failures resulted in R1 receiving oral feeding despite dysphagia and absence of a functioning G-tube, contributing to aspiration pneumonia, severe dehydration, and critical electrolyte imbalance requiring hospitalization and intubation. Findings include: The facility's Tube Feeding policy revised 6/9/25 documents The interdisciplinary team with physician guidance is responsible for assuring the ongoing review, evaluation and decision-making regarding the continuation of all treatment, devices or approaches implemented to care for the residents while involving family, resident, and the residents representative in discussions about indications, use, potential benefits and risks of tube feedings, types of approaches, and alternatives support the residents rights to make decisions. This policy further documents the rationale for use of tube feeding includes but is not limited to assessment of nutritional status, Assessment of clinical status, which may include the ability to chew, swallow, and digest food and fluid; underlying diagnosis affecting the ability to eat and factors affecting appetite and intake. Benefits of using a feeding tube may include addressing malnutrition and dehydration. Notify the Physician when the need for a tube change arises unexpectedly. The facility's Notification of Change in Condition policy revised 9/17/25 documents notification to resident's physician and representative by the interdisciplinary team when there is a significant change in the resident's physical, mental, or psychosocial condition. Notification will also be			S9999			

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S9999	Continued from page 2 made if there are any changes that may impact the residents plan of care or prognosis. The interdisciplinary team will review the change in condition and determine whether modifications to the care plan are necessary. R1's Census line documents R1 admitted to the facility on 5/15/24. R1's Minimum Data Set (MDS) assessment dated 2/20/26 documents R1 is severely cognitively impaired. The facility's Resident Roster dated 3/6/26 documents R1 resides in the facility, and the census line documented R1 was admitted to hospice on 1/21/26. R1's Speech Therapy Evaluation dated 9/30/25 recommended puree consistencies and therapeutic feedings with a Speech-Language Pathologist only. R1's Speech Therapy Encounters dated 10/2/25, 10/6/25, 10/11/25, and 10/14/25 documented R1's current diet as puree consistencies with therapeutic feedings with SLP (Speech Language Pathologist) only. R1's Speech Therapy Encounter dated 10/16/25 documented R1's swallowing abilities were not assessable and therapeutic feedings with SLP only continued. Additional Speech Therapy Encounters for R1 dated 10/20/25 through 11/7/25 documented a mechanical soft texture with therapeutic feedings with SLP only. R1's Speech Therapy Encounter dated 11/10/25 documented mechanical soft texture, puree consistency, therapeutic feedings with SLP only, and parameters for nectar thick and thin liquids. R1's swallow study dated 11/11/25 documented R1's diet was not upgraded due to positioning concerns, and pureed "pleasure foods" continued along with tube feedings. R1's Speech Therapy discharge note dated 11/24/25 documented R1 had a tube in place, a pureed diet, and nectar thick pleasure foods. R1's Therapy Progress Note dated 9/4/25 documents R1 had oropharyngeal dysphagia post-Cerebral Vascular Accident (CVA) requiring a pureed diet with nectar thick liquids, close supervision, and nutritional and hydration supplementation through a Percutaneous Endoscopic Gastrostomy (PEG) tube. R1's Nurse Progress Note dated 12/9/25 at 1:35 PM documented a speech therapy evaluation for decline in swallow, difficulty swallowing during lunch, repositioning in a reclining wheelchair while eating, head-of-bed elevation, and coughing during the meal, and that V12 (Nurse Practitioner) was aware of			S9999			

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S9999	Continued from page 3 request for speech evaluation. On 3/6/26 at 2:45 PM V11(Speech Language Pathologist) stated that V11 did an initial Speech evaluation on 11/22/24 and at that time R1 had a G tube in place and was not eating food by mouth. On 12/3/24 R1 had a swallow evaluation to try advance R1's diet. V11 stated at that time R1 was advanced to receive a pureed diet with nectar thick liquids as pleasure feedings with nurse supervision. R1 still was receiving G tube feedings as well. V11 went on to state that on 9/30/25 R1 was referred again to have another swallow study because the facility was requesting a diet upgrade. V11 stated R1 had a swallow study done on 11/11/25 and at that time a diet upgrade was not recommended due to R1's difficulty arousing and poor positioning in chair. V11 stated it was the recommendation that R1 not be upgraded and continue with a pureed pleasure feeding diet. V11 was under the impression that R1 still was receiving G tube feedings at this time. V11 stated that R1 was discharged from speech therapy on 11/24/25 because insurance stated R1 was not progressing. V11 stated at the time of discharge, V11 continued to understand that R1's G tube was still in place and R1 was receiving a pureed diet with nectar thick liquids as pleasure feeding. V11 further stated R1 returned from the Hospital to the facility on 1/1/26 and was not evaluated by therapy until 1/20/26, V11 stated she thinks this is because the facility was discussing Hospice with R1's family. V11 stated that typically therapy does not wait that long to evaluate after they receive an order. R1's Nurse Progress Note dated 8/30/25, documents R1 pulled out her G-tube and V12 Nurse Practitioner was notified. R1's electronic medical record did not contain documentation that V5 (R1's Family Member) was notified that R1 pulled out her G-tube. R1's Nurse Progress Note dated 8/30/25 documented R1's G-tube remained out, site care was provided, and R1 consumed more than 50 percent of dinner with assistance. R1's Progress Note dated 8/31/25 documents discontinuation of enteral feed orders and initiation of G-tube site wound care. On 3/6/26 at 2:30 PM, V12, (Nurse Practitioner) stated she believed R1's feeding tube was removed in August 2025, after R1 pulled it out and V12 didn't feel it needed replaced because R1 was eating. At 2:45 PM, V12 stated that when R1 returned from the			S9999			

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S9999	Continued from page 4 hospital at the beginning of December 2025, R1 did not have a G-tube in place, and facility staff may have assumed the hospital removed it. On 3/6/26 at 1:30 PM, V8 (Certified Nursing Assistant/CNA) stated R1 had pulled out her G-tube multiple times and was taken off tube feeding because she was eating well. V8 further stated shortly before R1's December hospitalization, R1 began choking more during meals and nursing staff were notified. On 3/6/26 at 1:45 PM, V9, (CNA) stated R1 had pulled out her G-tube before, although dates were not recalled, and R1 was eating well prior to the December hospitalization. On 3/6/26 at 2:43 PM, V10, (Licensed Practical Nurse/LPN) stated R1 did not have a G-tube from 12/7/25 through 12/23/25 and was eating at the assisted dining table. V10 stated she observed food rolling out of R1's mouth in November and December but did not document R1's transfer to the hospital on 12/23/26 because V12 Nurse Practitioner documented it. V10 stated that R1 was very hard to arouse on assessment on 12/23 and was very weak so V10 had V12 assess R1, and the decision was made to send R1 to the local emergency room by V12. On 3/7/26 at 10:08 AM, V13 (Registered Dietitian) stated R1's oral intake declined during late November and December. V13 stated she did not routinely check G-tube sites unless residents were receiving tube feedings and that reinsertion of the tube was considered a decision for the resident's power of attorney because R1 was eating. V13 stated R1 pulled out her G-Tube in August of 2025 and the G-tube and the facility did not have G-tube replaced since R1 was eating food. R1's Nurse Progress Note dated 12/23/25 documented R1 experienced an acute change in condition, including minimal responsiveness, pallor, copious mustard-yellow emesis, decreased oral intake, and difficulty swallowing. R1 was a full code and was transferred to the Emergency Department due to concern for sepsis. R1's Hospital Records dated 12/23/25 documents altered mentation, history of dysphagia and PEG placement, hypoxia requiring intubation, possible aspiration and vomiting, and severe electrolyte abnormalities including potassium 1.9, magnesium 0.8, hypernatremia 147, bicarbonate 11, glucose 62, low ionized calcium, hypoalbuminemia 1.6, and			S9999			

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S9999	Continued from page 5 hemoglobin 6.7. Gastroenterology (GI) was consulted for PEG tube replacement. R1's Hospital Records dated 12/29/25 documented R1 had aspiration and a history indicating the PEG tube had fallen out at some point, with possible oral feeding (unconfirmed). R1 had been intubated for respiratory failure, extubated on 12/26/25, and Gastroenterology was consulted for PEG replacement on 12/28/25. On 3/6/26 at 1:40 PM, V7, (V6's Medical Assistant), stated V6 was on vacation, but V6's physician notes documented R1 was evaluated on 12/29/25 for respiratory failure due to aspiration and that R1 had pulled out her G-tube almost a month prior. V7 stated the PEG tube was replaced on 12/30/25 because R1 could not safely take nutrition orally. On 3/6/26 at 10:30 AM, V4 (Registered Nurse, Surgical Intensive Care Unit) stated R1 arrived with aspiration pneumonia, required intubation, and required PEG tube reinsertion. V4 stated R1 did not have a feeding tube in place upon arrival from the facility, and the family had not been informed the tube had been removed until R1's hospitalization on 12/23/26. V4 further stated R1 appeared severely malnourished with significant electrolyte imbalance. On 3/6/26 at 11:05 PM, V5 (R1's Family Member) stated the family was unaware R1's G-tube had been removed until informed by hospital staff on 12/23/25. V5 stated the family believed R1 was receiving nutrition through the feeding tube in addition to oral intake. V5 further stated R1 arrived at the hospital extremely weak and ill, required PEG reinsertion and intubation, and the family later elected hospice services after R1 returned to the facility because they believed R1 required increased monitoring and care. On 3/7/26 at 11:45 AM, V1 (Administrator) confirmed speech therapy documentation indicated R1 had a feeding tube in place and stated the facility should have communicated changes more effectively. V1 stated the facility had been without a Director of Nursing for several months, which contributed to communication issues between departments. On 3/8/26 at 10:22 AM, V1 confirmed therapy notes documented "Puree Consistencies; Therapeutic feedings with SLP only." V1 stated nursing staff did not have access to therapy documentation and that therapy will go to the floor and give updates to the nursing staff and the nurses are supposed to make			S9999			

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S9999	Continued from page 6 therapy aware of any changes. V1 confirmed this process needs improved. NO VIOLATION 2 of 2 300.610a) 300.1210a) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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	S9999					

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S9999	Continued from page 7 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. 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 interview and record review, the facility failed to ensure that a resident at moderate risk for skin impairment received interventions to prevent and properly manage an unstageable pressure ulcer, resulting in deterioration of the wound and osteomyelitis for one (R2) of three residents reviewed for pressure ulcers. This failure resulted in R2's wound progressing to a painful facility acquired unstageable pressure ulcer with tunneling and osteomyelitis, requiring intravenous antibiotics and debridement. Findings include: The facility's Pressure Ulcer Policy revised 4/18/25 documents the facility is committed to the prevention, early identification, and evidenced based treatment of pressure ulcers. All residents will receive comprehensive skin assessments, risk evaluations, and appropriate skin interventions to promote skin integrity and prevent deterioration. Reassessment will occur with any change in condition or following identification of skin breakdown. New wounds, signs of infection, or wound deterioration must be reported promptly to the Nurse Supervisor and Medical provider. The wound Nurse must be notified to reassess and update treatment orders. Ongoing training will be provided to nursing staff on pressure ulcer prevention and wound care protocols. The facility's Notification of Change in Condition policy revised 9/17/25 documents notification to			S9999			

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S9999	Continued from page 8 resident's physician and representative by the interdisciplinary team when there is a significant change in the resident's physical, mental, or psychosocial condition. Notification will also be made if there are any changes that may impact the residents plan of care or prognosis. The interdisciplinary team will review the change in condition and determine whether modifications to the care plan are necessary. R2's Braden Risk Assessments dated 8/1/25 and 1/2/26 documented that R2 was at moderate risk for skin impairment. R2's care plan did not include pressure-relieving interventions, repositioning schedules, or documentation of pressure ulcer care. R2's MDS (Minimum Data Set) dated 1/19/26 documents R2 has one unstageable pressure ulcer due to slough or dead tissue. This same MDS documents R2 is severely cognitively impaired. On 3/8/26 at 11:45 AM, R2 was lying in bed with eyes closed. R2 has a feeding pump next to his bed which is not connected. R2 has an abdominal binder in place. G tube visualized and in place. R2's Wound Note dated 2/10/2026 documents R2 was evaluated by V20 (Wound Physician), "V12 mechanically debrided wound to R2's coccyx, bone scraping obtained to confirm diagnosis of osteomyelitis after topical analgesic applied to wound bed. R2 has Copious amount of bright red blood observed from debridement site. V20 documents in R2's Wound Evaluation and Management Summary R1's wound is a stage 4. Staff applied direct pressure with gauze and covered the wound bed with calcium alginate, blood stop granules applied to wound bed and secured with abdominal pad. V2 advised leaving R2 lying supine with direct pressure to wound bed to stop bleeding. R2 was positioned with green foam wedges, and head of bed elevated due to tube feeder. R2 tolerated procedure well and Measurements obtained. New order to discontinue collagen dressing to wound bed and utilize calcium alginate only, orders updated. Wound culture sample labeled, order written and sample placed for lab pick up. POA to be made aware of above findings." R2's Wound Notes dated 2/10/26 documents R2's wound measurements Pressure ulcer staging for R2's coccyx is Stage 3 Pressure ulcer / injury with full thickness skin loss. R2' Wound was acquired in-house, and it is unknown how long the wound			S9999			

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S9999	Continued from page 9 has been present. The coccyx wound Length (centimeters/cm): 5.57 Width (cm): 4.82 Depth (cm): 0 Area (cm2): 19.53 with Tunnel length (cm): 2.2 Tunnel location 1: 12 o'clock. R2's Nurse Progress Note dated 2/17/2026, documents "Call placed to infectious disease in regard to R2's bone specimen results as V12 (Wound Doctor) does not want to dose antibiotics due to R2 being in kidney failure. V12 (Nurse Practitioner) made aware, and order was received to follow up with infectious disease. R2's Labs faxed to V21 (Infectious Disease Physician) office awaiting further instruction. Bone debridement performed this shift by V20, wound cleansed with normal saline solution, packed with 4x4 gauze to assist with stopping bleeding. Area applied with firm pressure and will continue to monitor for active bleeding. Clean dressing to be applied to wound bed." R2's Nurse Progress Note dated 2/19/2026, documents "R2 in bed this shift, coccyx wound bed cleansed with normal saline solution, bone particle appears to be showing through wound bed, no active signs and symptoms of infection noted, wound bed displays with copious amounts of serosanguineous drainage, no foul odor, peri wound is clean, dry an intact." R2's Physician Orders document on 02/26/26 may draw blood from feet if necessary and start Vancomycin Intravenous Solution 500 milligrams per milliliter(mg/ml) infuse intravenously one time a day every Monday, Wednesday, and Friday for wound infection for six weeks given at dialysis. On 3/9/26 at 9:30 AM, V17 (Licensed Practical Nurse/Wound Nurse) stated R2's Coccyx Ulcer is a stage three pressure ulcer developed at the facility. V17 confirms that R2's wound was cultured and R2 has osteomyelitis in his bone of his coccyx and was started on IV Vancomycin approximately two weeks ago. V17 confirms the Wound Doctor follows R2 for wound care and orders. V17 further stated R2 is dependent on staff for all cares. V17 stated that R2 will often grimace or pull away during dressing changes and debridement's. On 3/9/26 at 10:50 AM, V17 stated she was unable to locate the initial assessment for when R2's pressure ulcer developed. V17 stated she documented the pressure developed in July of 2025 because that's when she took over the position. (A)			S9999			