

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6006761	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 03/06/2018
NAME OF PROVIDER OR SUPPLIER HOPE CREEK CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4343 KENNEDY DRIVE EAST MOLINE, IL 61244		
(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) COMPLETE DATE
S 000	Initial Comments Complaint Investigation: #1821319/IL100650	S 000			
S9999	Final Observations STATEMENT OF LICENSURE VIOLATIONS: 300.610a) 300.1010h) 300.1210b) 300.1210c) 300.1210d)2)3) 300.3240a) (1 of 1) 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.	S9999			

Attachment A
Statement of Licensure Violations

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

03/23/18

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6006761	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/06/2018
---	---	--	--

NAME OF PROVIDER OR SUPPLIER HOPE CREEK CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 4343 KENNEDY DRIVE EAST MOLINE, IL 61244
---	--

(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) COMPLETE DATE
S9999	Continued From page 1 Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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: 2) All treatments and procedures shall be administered as ordered by the physician. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6006761	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 03/06/2018
NAME OF PROVIDER OR SUPPLIER HOPE CREEK CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4343 KENNEDY DRIVE EAST MOLINE, IL 61244			
(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) COMPLETE DATE
S9999	Continued From page 2 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. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) THESE REQUIREMENTS WERE NOT MET AS EVIDENCE BY: Based on interview and record review, the facility failed to monitor daily weights for one of one resident (R1), reviewed for daily weights in a sample of three. This failure resulted in repeated hospitalizations for R1 and eventual death. FINDINGS INCLUDE: The facility policy, Weight Policy, dated (revised) 6/17/14 directs staff, "It is the policy of this facility that weekly weights are to be obtained at the time of the resident's shower. In the event a resident refuses their shower, the weight is still required. Weights are to be taken on all new admissions within the first 72 hours of admission and then weekly thereafter for 4 weeks, then monthly. Additional weights shall be taken at the discretion of the nursing staff, food service director, or physician." R1's facility Admission Record, documents that R1 was admitted to the facility on 12/4/17 from a local hospital, after being hospitalized for Chest	S9999			

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6006761	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/06/2018
---	---	--	--

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

HOPE CREEK CARE CENTER **4343 KENNEDY DRIVE**
EAST MOLINE, IL 61244

(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) COMPLETE DATE
S9999	Continued From page 3 Pain and a Congested Heart Failure (CHF) Exacerbation. R1' facility New Admission/Readmission CNA (Certified Nursing Assistant) Checklist, dated 12/4/17 documents R1's weight as 151.3 pounds. R1's Physician Transfer Order Report, dated 12/4/17 includes the following diagnoses: Chest Pain, Acute on Chronic Congestive Heart Failure, Essential Hypertension, Atherosclerotic Heart Disease and Type 2 Diabetes Mellitus. Also included are the following prescribed medications: Carvedilol (Beta Blocker) 25 MG (milligrams) one tablet two times daily, Clonidine (Alpha 2 Agonist) 0.1 MG one tablet two times daily, Furosemide (Diuretic) 20 MG one tablet daily and Nifedipine (Calcium Channel Blocker) 60 MG one tablet two times daily. This same document includes the following physician orders: Follow up with (V6) Cardiologist on December 7, 2017; Heart Health Diet; Activity as tolerated. Also included in My Action Plan- Heart Failure is the following instructions: Weight daily, Check for swelling in hands, legs, feet and stomach, Call Physician if greater than a 3 pound weight gain in one day or a 5 pound weight gain in one week. R1's facility Nursing Admission form, dated 12/4/17 documents, "Edema-none." R1' Admission Care Plan includes the following Focus and Interventions, "Cardiac (R1) has Congestive Heart Failure, Hypertension and Coronary Heart Disease. (R1) has chest pain at times and edema to BLE (bilateral lower extremities). Daily weight." R1's Progress Notes document on 12/7/17, "(R1) out with daughter to appointment at CVM (Cardio	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6006761	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 03/06/2018
NAME OF PROVIDER OR SUPPLIER HOPE CREEK CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4343 KENNEDY DRIVE EAST MOLINE, IL 61244		
(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) COMPLETE DATE
S9999	Continued From page 4 Vascular Medicine). Returned to the facility with no problems. N.O. (New physician's order) received and noted for obtaining (R1)'s B/P (blood pressure) and pulse daily for 4 weeks, fax results to CVM after each week. (R1) also to keep legs elevated when at rest. Daughter (also) reports (R1) is to wear TED (Anti-Embolism Stockings) hose daily." On 12/16/17 at 7:15 P.M., R1's Progress Notes document, "(R1) complains of dyspnea. Lungs coarse with scattered wheezes. Weak, non-productive cough. Orders received to send to ER (Emergency Room) for evaluation and treatment." R1's facility Weights and Vitals Summary includes the following daily weights for R1 for 12/5/17 through 12/16/17: December 9th-148 pounds, December 11th-144 pounds. There are no weights documented for December 5, 6, 7, 8, 10, 12, 13, 14, 15 or 16. R1's hospital Emergency Room report, dated December 16, 2017 documents R1's weight in the Emergency Room as 153 pounds. This same ER report documents R1's Pro-BNP (Brain Natriuretic Peptide) as 2,675 (Normal Range 5-450 pg/ml) (picograms/milliliter). (At any age, a pro-BNP value of <300 pg/ml excludes Acute Congestive Heart Failure.) R1's Physician Transfer Order Report, dated 12/22/17 documents the following diagnoses: CHF Exacerbation, COPD (Chronic Obstructive Pulmonary Disease) and Chronic Back Pain. This same document includes the following physician orders: Weight yourself without clothing at the same time each day. Call (the) Physician with a sudden weight gain, 2 pounds in a day or 5	S9999			

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6006761	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/06/2018
---	---	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HOPE CREEK CARE CENTER

**4343 KENNEDY DRIVE
EAST MOLINE, IL 61244**

(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) COMPLETE DATE
S9999	Continued From page 5 pounds in a week. R1's facility Monthly Weight Sheet documents R1's weight on readmission as 145 pounds. R1's Care Plan Conference Report, dated 1/11/18 documents, "Family present. Concerns with swelling (edema). Not being weighed daily." R1's facility Weights and Vitals Summary includes the following daily weights for R1 for December 23, 2017 to January 11, 2018: 1/2/18= 158 pounds and 1/4/18= 157 pounds. There are no weights documented by facility staff for December 23, 24, 25, 26, 27, 28, 29, 30, 31 or January 1, 3, 5, 6, 7, 8, 9, 10 or 11. R1's Progress Notes, dated 1/17/18 document, "(R1) to be seen in ER." R1's hospital Emergency Room Report, dated 1/17/18 at 5:14 P.M. documents, "(R1) presents to the ED (Emergency Department) for shortness of breath, and extremity swelling that began 4-5 days ago. R1's weight is 163 pounds (18 pound weight gain). Pro-BNP is 3,467. Active Problems: Acute combined systolic and diastolic congestive heart failure with accelerated hypertension. Patient is in fluid over load." R1's hospital Internal Medicine Report, dated 1/18/18 documents, "(R1) with a CHF ejection fraction (volumetric fraction of blood ejected from a ventricle of the heart with each heart beat; a measure of the pumping efficiency of the heart) of 55-60% in November 2017. Presents from a (local) nursing home with shortness of breath and lower extremity swelling." R1's hospital General Cardiology Progress Note,	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6006761	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 03/06/2018
NAME OF PROVIDER OR SUPPLIER HOPE CREEK CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4343 KENNEDY DRIVE EAST MOLINE, IL 61244			
(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) COMPLETE DATE
S9999	Continued From page 6 dated 1/21/18 documents, "Current weight 140 pounds. Plan: Acute on chronic combined systolic and diastolic heart failure. Repeat Echo (Echogram) revealed newly diagnosed decreased LVEF (left ventricular ejection fraction) of 35-40%. (R1) is discharging to Hospice. No follow up is needed at this time." R1's facility Progress Notes, dated 1/21/18 document, "(R1) returned to the facility at this time via ambulance for comfort and end of life care." On 2/3/18 these same Progress Notes document, "(R1) pronounced dead at 4:45. Family at bedside." On 3/5/18 at 2:20 P.M., V4/Registered Nurse stated, "I was (R1)'s full-time day shift nurse. (R1) was not on daily weights. (R1)'s grand daughter requested that we weigh (R1). (R1) had gained more than twenty pounds. I don't know why (R1) didn't get weighed everyday and the doctor notified." On 3/5/18 at 2:30 P.M., V5/Registered Nurse stated, "I was the second shift nurse for (R1). I don't remember if (R1) was a daily weight. I don't think (R1) was." On 3/5/18 at 2:40 P.M., V2/Director of Nurses stated, "The Physician Order Transfer Report contains information such as diet orders, transfer status, follow up appointments, medications and daily weight status. The (physician) orders are supposed to be placed on the medication administration record. Some (facility) units have weight books, or the chart. We also use a weight record form. The physician is supposed to be notified of any weight gain. (R1) was not a daily weight. We had a care plan meeting with the family and they were concerned because of	S9999			

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6006761	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 03/06/2018
NAME OF PROVIDER OR SUPPLIER HOPE CREEK CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4343 KENNEDY DRIVE EAST MOLINE, IL 61244		
(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) COMPLETE DATE
S9999	Continued From page 7 (R1)'s weight gain and edema. I don't know why the staff didn't follow the transfer orders for (R1)." On 3/6/18 at 9:00 A.M., V6/Cardiologist stated, "If (I) order a resident to have daily weights, it is to monitor for fluid over-load. (I) expect daily weights to be done and to be notified of established parameters of weight gain." (B)	S9999		