Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006761	A. BUILDING: ______ B. WING ______	C 05/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE CREEK NURSING & REHAB	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 FRI of 5/6/2022/IL147125	S 000		
S9999	Final Observations Statement of Licensure Violation 300.610a) 300.1210b) 300.1210c) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006761	A. BUILDING: ______ B. WING ______	C 05/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE CREEK NURSING & REHAB	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 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: 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 as evidenced by: Based on interview and record review, the facility failed to properly transfer one of three residents (R1) reviewed for falls in the sample of three. This failure resulted in R1 receiving nine staples to the right side of her head. Findings include: The facility's Mechanical Lift Transfer (Full size/Hoyer Type Lift) documents the following: "Purpose: To assure that all residents that are assessed to require total assistance in transfer are transferred safely with no injury to resident or care handler. The operating of the lift requires a minimum of two trained operators. Slings are to be used with their respective mechanical lifts with	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006761	A. BUILDING: ____ B. WING ____	C 05/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE CREEK NURSING & REHAB	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	S9999		

Continued From page 2

the appropriate size per patient and weight capacity. Check patients sling size in point of care and mechanical lift weight limit on the mechanical lift prior to using the mechanical lift on a patient. Choose the appropriate sling to be used to transfer the resident per POC (plan of care) Staff using the sling will visually inspect for loose stitching, bleached, torn, cut, and/or frayed to prevent resident injury. The lift slings should be inspected by staff using the sling before and after use for wear and tear. Slings that are unsafe to use could result in injury and should not be used."

The facility's fall incident report dated 5/6/2022 at 9:57 pm documents the following: "Nursing Description: Nurse (R3, LPN, Licensed Practical Nurse) was called to resident's room at 7:15 pm, (R1) was laying on the floor on right side, resident was vomiting on floor and CNA was holding towel to back of head. Nurse immediately called 911. Nurse got on floor in front of resident and spoke to her, resident was alert, residents pupils were pinpoint, nurse took over holding pressure to back of right side of residents head. Resident had a head wound that was bleeding (mechanical lift) was still sitting around resident. Staff stated to nurse that they were lifting resident to transfer her to bed and she fell out of (mechanical lift). (R1) told nurse 'it broke.' (R1) was alert and talking with nurse until ambulance arrived. (R1) did complain of mid back pain. (R1) was sent to (local hospital). MD (medical doctor) contacted about (R1) being sent to the emergency department. Administrator and DON (Director of Nursing) aware it broke."

This same form documents the following under a section titled witnesses. "I (R4, CNA, Certified Nursing assistant) was putting (R1) back to bed. I was in the back, (R5, CNA) was in the front. I

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006761	A. BUILDING: ______ B. WING ______	C 05/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE CREEK NURSING & REHAB	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 (R4) tried to save her (R1) from falling out but I couldn't save her from falling." I (R5, CNA) was going in to assist with transfer. As we were lifting (R1) at the time we thought she flipped back out of sling due to sling being wrong size and shower sling placed by first shift. Later it snapped off (mechanical lift). Nurse (R3, LPN, Licensed Practical Nurse) was immediately notified and while nurse was assessing I called supervisor to notify of injury." The facility's final report documented the following: "Incident date: 5/6/2022. Brief description of Incident: (R1) had a witnessed fall by two staff members. Immediate Action taken: Upon assessment the nurse noted (R1) with bleeding to the back of her head. (R1) was stabilized and had minimal complaints of pain until EMS (emergency medical service) arrived. (R1) left facility in stable condition. (R1) was sent to the ER (emergency room) for evaluation and kept overnight for observation. (R1) returned from hospital with sutures to the back of her head and care plan updated. Conclusion: Upon investigation, resident was being transferred by staff and was unable to complete transfer. (R1) was sent to the ER for evaluation. She (R1) was kept overnight for observation and returned to the facility the next day with sutures to the back of her head. Resident (R1) care plan updated and pain is being managed." R1's current care plan documents the following: initiated 9/13/2021, "I (R1) am dependent with 2 staff members as I require full staff performance and support for transfers. I may use a (mechanical lift), sling size extra large to provide a full staff transfer. Requires 2 staff members to operate (mechanical lift) and to complete the transfer."	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006761	A. BUILDING: ______ B. WING ______	C 05/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE CREEK NURSING & REHAB	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	S9999		

R1's ED (Emergency Department) physician notes dated 5/6/2022 document the following: "The patient (R1) presents with mechanical fall. (R1) is a 69 year old female presenting to the ED via EMS (Emergency Medical Service) from a (facility), after a 2 to 3 ft mechanical fall that occurred PTA (prior to arrival). (R1) was in a (mechanical lift). She flipped out of the lift and fell to the floor. (R1) hit her head. She was vomiting on the scene. She did not have LOC (loss of consciousness). (R1) has a bleeding laceration to the right side of her head. She has associated mid back pain and headache. (R1) has left sided LE (lower extremity) pain, but states that this is chronic." This same form documents the following: "Laceration repair, Laceration 4 cm (centimeters) in length. Scalp: right, shape: linear, depth: superficial, details: bleeding, skin closure: 9 staples."

R1's Physical Therapy and Occupational Therapy notes dated 5/9/2022 document the following: "(R1) had a fall during a (mechanical lift) transfer. (R1) received a head laceration requiring 9 staples. She is complaining of back and shoulder pain. Cognition-follows directions=two- step; oriented to Person, place, time, purpose and caregivers; safety awareness=intact; new learning capacity=intact."

On 5/23/2022 R1 was lying in bed, blankets pulled over her body to her neck. R1 was alert and oriented, answering questions and communicating adequately. R1 stated a Caucasian dark haired CNA was going to transfer her a couple weeks ago after dinner from the chair to bed. R1 stated she told the CNA that she better get some help and the CNA stated she could not find anyone else but reassured R1 she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006761	A. BUILDING: ______ B. WING ______	C 05/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE CREEK NURSING & REHAB	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 could do it. R1 stated when the CNA lifted her in the mechanical lift the strap broke and she hit her head. She stated she is doing pretty good now. R1 stated 2 to 3 staff always transfer her with the mechanical lift and she has never had just one CNA use the mechanical lift. On 5/23/2022 at 12:04 pm V2, DON, (Director of Nursing) stated she was notified of R1's fall the evening of 5/6/2022. V2 stated R3, LPN (Licensed Practical Nurse) was the nurse caring for R1. V2 stated R1 was vomiting and her head was bleeding/ V2, DON stated she instructed staff not to move R1 and apply pressure to her head. V2 stated R1 fell out of the mechanical lift, was sent to the emergency room, kept overnight for observation and returned to the facility with sutures in her head. V2 stated R1 was in a mechanical lift and fell out. V2 stated that all slings for the mechanical lifts were pulled and inspected. V2 stated staff training was completed on the use of mechanical lift and slings after R1's fall. V2 stated V5, CNA (Certified Nursing Assistant) reported to her that after R1's fall she noticed a strap was broken on the sling. V2 stated initially V5, CNA thought the sling was the wrong size for R1. V2, DON stated the root cause of R1's fall on 5/6/2022 was sling malfunction and the intervention was staff educations. (B)	S9999		