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 07/02/2024

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 Complaint Investigation Survey 2424751/IL174473	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610)a 300.1210b) 300.1035a)3)4)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	S9999		

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S9999	Continued From page 1 care needs of the resident. Section 300.1035 Life-Sustaining Treatments a) Every facility shall respect the residents' right to make decisions relating to their own medical treatment, including the right to accept, reject, or limit life-sustaining treatment. Every facility shall establish a policy concerning the implementation of such rights. Included within this policy shall be: 3) procedures for providing life-sustaining treatments available to residents at the facility; 4) procedures detailing staff's responsibility with respect to the provision of life-sustaining treatment when a resident has chosen to accept, reject or limit life-sustaining treatment, or when a resident has failed or has not yet been given the opportunity to make these choices; 5) procedures for educating both direct and indirect care staff in the application of those specific provisions of the policy for which they are responsible. These Requirements were NOT MET as evidenced by: Based on interview and record review the facility failed to immediately provide CPR (Cardiopulmonary Resuscitation) to one resident (R1) identified as having no Advance Directives and failed to follow their policy which documents that "Direct and non-direct care staff upon finding a resident non-responsive shall remain with that resident as is possible while signaling for assistance." The facility also failed to ensure all staff received training on the facility CPR Policy. On 6/16/24 at approximately 9:25am R1 was	S9999		

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S9999	Continued From page 2	S9999		

found unresponsive and without a pulse or respirations in his room by V7 (RN - Registered Nurse). V7 then left R1's room to make telephone calls to another nurse regarding R1's condition and to V2, (DON - Director of Nursing).

This failure resulted in R1 not receiving Cardiopulmonary Resuscitation when found without a pulse and not breathing by V7, (RN) who left R1 and did not return to R1's room until V5, (RN) and V6, (LPN - Licensed Practical Nurse) had started CPR. This failure placed 59 current residents (R2, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, R14, R15, R16, R17, R18, R19, R20, R21, R22, R23, R24, R25, R26, R27, R28, R29, R30, R31, R32, R33, R34, R35, R36, R37, R38, R39, R40, R41, R42, R43, R44, R45, R46, R47, R48, R49, R50, R51, R52, R53, R54, R55, R56, R57, R58, R59, R60, R61) identified as having Advanced Directives indicating Full Code status at risk of not receiving immediate life sustaining treatment.

Findings include:

Facility Policy/Cardiopulmonary Resuscitation (undated) documents:
It is the policy of (the facility) that Cardiopulmonary Resuscitation (CPR) shall be initiated and maintained by qualified staff in cases of recognized cardiac and/or pulmonary arrest to sustain or support a resident's cardiac and/or pulmonary function until advanced life support systems are available. Cardiopulmonary Resuscitation shall be initiated on all residents except those who have designated through advanced directives and/or have a specific physician order for "DNR (Do Not Resuscitate)", "No Code" or "No CPR."
Implementation of a code is as follows:

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S9999	Continued From page 3	S9999		

"Direct and non-direct care staff upon finding a resident non-responsive shall remain with that resident as is possible while signaling for assistance."
The facility shall provide education to all employees regarding advance directives and the implementation of such. In servicing of advance directives policy and procedure shall be conducted annually.

AHA (American Heart Association) Cardiac Arrest Treatment dated/reviewed 6/26/24 documents:
"If you think the person may be suffering cardiac arrest and you're a trained lay rescuer:
"Ensure scene safety.
"Check for response.
"Shout for help. Tell someone nearby to call 911 or your emergency response number. Ask that person or another bystander to bring you an AED (automated external defibrillator), if there's one on hand. Tell them to hurry - time is critical. If you're alone with an adult who has signs of cardiac arrest, call 911 and get an AED (if one is available).
"Check for no breathing or only gasping. If the person isn't breathing or is only gasping, begin CPR with compressions.
"Administer high-quality CPR. Push down at least two inches in the center of the chest at a rate of 100 to 120 pushes a minute. Allow the chest to come back up to its normal position after each push.
"Use an AED. As soon as it arrives, turn it on and follow the prompts.
"Continue CPR. Administer it until the person starts to breathe or move, or until someone with more advanced training, such as an EMS team member, takes over."

Progress Note dated 6/15/24 at 5:34pm indicates

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S9999	Continued From page 4	S9999		

R1 was admitted to the facility at 4:50pm with a gastric feeding tube and on dialysis. Note indicates R1 was receiving oxygen at 3L (liters).

Physician Order Summary Report (POS) indicates R1 was admitted with diagnoses that included Congestive Heart Failure, Critical Illness Myopathy, Dilated Cardiomyopathy, Diabetes Mellitus, History of Prostate Cancer, Seizure Disorder, Encephalopathy, Dysphagia, Respiratory Failure.

R1's electronic medical record did not contain Advanced Directives/Code Status.

Progress Note dated 6/16/24 at 9:00am (documented by V5, RN - Registered Nurse) indicates V5 was called to come to building/Unit 2 by V7 (Charge Nurse). Note indicates V5 arrived and initially saw a resident on the floor in the dining room. Note indicates V5 was then sent to R1's room by V7 who stated that "(R1) died." Note indicates V5 entered R1's room where family was present and noted R1 with no pulse and unresponsive. Note indicates V5 received a call at that time from V2 (DON - Director of Nursing) asking what was being done for R1. Note indicates V5 told V2 that she had just entered R1's room and did not know R1's code status but was instructed by V7 to start CPR. Note indicates another nurse (V6, LPN) arrived with the crash cart and began respirations for R1. Note indicates EMT's (Emergency Medical Technicians) arrived and took over CPR for R1.

Progress Note - Clarification note dated 6/16/24 at 2:55pm indicates V5 was called to Unit 2 by V7, RN on duty related to an emergency. Note indicates V5 immediately responded to Unit 2 and upon arrival noted a female resident on the floor

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S9999	Continued From page 5	S9999		

with a hematoma on her head. Note indicates as V5 went to assess the resident on the floor, the RN on duty (V7) informed V5 that V5 was needed down the hallway for a "code." Note indicates V5 responded to R1's room where family was present and yelling and confirmed that R1 had no pulse or respirations. Note indicates "the assigned nurse (V7)" confirmed R1 was a full code and shortly thereafter V6 (LPN) arrived with the crash cart. Note indicates EMT's arrived and took over the code.

On 6/26/24 at 1:45pm V7 (RN) stated that the night nurse told her in report that R1 had no code status identified, so R1 would be a Full Code. V7 stated "I was in same hallway passing meds, (R1's) daughter came out of room to tell me R1 was dead. I immediately went into his room, and he had no pulse, no breathing. I left (R1's) room to call the house supervisor, she then called "Code Pink." V7 stated she then called V2 (DON) and told her R1 did not have a POLST (Physician Orders for Life-Sustaining Treatment) and V2 said to start CPR. V7 stated she then went back to R1's room and V5 and V6 were placing the backboard under R1 and started CPR. V7 stated "Sometimes we have to call the DON to find out what to do."

On 6/27/24 at 9:10am V2, (DON) stated the first call she received was at 9:29am on 6/16/24 from V7, (RN) who reported "The new guy is dead." V2 reported that V7 told her that R1 had no POLST and they are going to do CPR. After confirming phone calls were made "I told (V5) to go back into the room to help the other nurses."

On 6/27/24 V5 stated that she immediately responded to the Code called and arrived on Unit 2. V5 stated that V7 (RN) was standing by the

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S9999	Continued From page 6	S9999		

nurse's station, did not appear to be on the phone and was not assisting a resident who was on the floor. V5 stated she asked V7 "where was the Emergency?" and V7 pointed toward R1's room. V5 stated R1 had no pulse, no respirations and she immediately started compressions. V5 stated she did not know why V7 left R1 to come out and make phone calls if she already knew R1 was a Full Code. V5 stated she would have stayed with the resident, started CPR and started yelling for other staff to come and help - make phone calls, etc.

On 6/27/24 at 3:37pm V18 (Medical Director) stated that it's very hard to determine if the brief delay in initiating CPR lessened chances of survivability but "of course the sooner starting the better." V18 stated staff should follow facility protocol as far as responding to CPR.

On 6/28/24 V1 (Administrator) stated, "We do not have signatures for (V5, RN) or (V7, RN -Agency staff) indicating that they received training on our CPR policy. All staff, including Agency staff should be familiar with our critical policies and I would say the CPR policy is critical. All licensed nurses should know how to respond and be familiar with CPR procedures." V1 confirmed that both V5 and V7 work regularly at the facility.

(A)