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	IL6006761	A. BUILDING: _____ B. WING _____	C 12/03/2024

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HOPE CREEK NURSING & REHAB	4343 KENNEDY DRIVE EAST MOLINE, IL 61244

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S 000	Initial Comments Investigation of Facility Reported Incident of 11/9/24 IL181072 Complaint Original Investigation #2429478/IL181203 Complaint Original Investigation #2429578/IL181375	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a 300.1210b 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	S9999		

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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:

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 provide immediate post-fall care to one resident (R1) receiving anticoagulant therapy of three residents reviewed for falls with injury. This failure resulted in delayed treatment of a subdural hematoma. The facility also failed to safely turn and position one resident (R4) of three residents reviewed for accidents with injury. This failure resulted in R4 sustaining a nasal fracture.

Findings include:

Facility Employee Education Record/Falls and Anticoagulation: What You Should Know dated 11/18/24 documents:
Key Points: Blood thinners, or anticoagulants, help prevent blood clots but can increase the risk of bleeding.
Falling is a major reason why some people

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hesitate to take blood thinners.
If you fall while on a blood thinner, contact your healthcare provider right away.
"Bleeding isn't always visible. You could bleed internally and not know it, and that's a significant concern. For example, we worry about brain bleeds when people fall and hit their heads- but if patients don't see blood, they might not realize that they're bleeding."
"If you fall while on a blood thinner: You should be assessed for bruising, and most importantly, for potential head trauma. Your doctor will want to know how you fell, what parts of your body were affected, and if you lost consciousness. Even if you think the fall was minor, you should call your doctor."

Facility Policy/Post Fall Management Protocol (undated) documents:
If fracture or head injury is suspected, Do Not Move resident, and advise resident not to move affected area, complete assessment.
Neuro checks are completed for falls where the resident hit his head or if fall was unwitnessed and a head injury is demonstrated.
Pain is assessed and addressed.
Physician notification.
Medications taken within the 24 hours before the fall; medications placing resident at risk.
Neuro Check Flowsheet instructions: Neuro Checks should be completed for unwitnessed falls or fall in which head was hit.

1. Physician Order Summary Report dated 11/1/24 to 11/30/24 indicates R1 received the following anticoagulant medications:
Aspirin 81mg (milligram) daily for Prophylaxis. Date initiated 8/16/24.
Coumadin 3mg daily on Tuesday, Wednesday, Thursday, Saturday, Sunday related to Chronic

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Atrial Fibrillation and
Coumadin 4mg daily on Monday, Friday related to Chronic Atrial Fibrillation. Date initiated 11/12/24.

R1's Order Report also indicates "Anticoagulant medication - monitor for discolored urine, black tarry stools, sudden severe headache, nausea/vomiting, diarrhea, muscle or joint pain, lethargy, bruising, sudden changes in mental status, or vital signs, shortness of breath, nose bleeds every shift for "Monitor Anticoagulant Therapy." Date initiated 8/16/24.

Incident Report indicates "Incident Date: 11/16/24 and Time of Incident reported: 11pm."
Report indicates R1 was found on the floor (in his room) on floor mat during routine cares. No evident injuries during initial assessment. Report indicates R1 began to have complaints of headache and nausea on 11/17/24 and was sent to the local ED (Emergency Department) for evaluation and treatment.

Local Hospital ED (Emergency Department) Report dated 11/17/24 at 9:43pm indicates R1 Chief Complaint: Complaint of head and neck pain "Pain scale 8." Fall from bed, had rolled off the bed during a bed change.
Report indicates "Onset: 11/16/24" and per EMS (Emergency Medical Services) R1 had an unwitnessed fall last night "11/16/24."
(Facility) staff informed medics that R1 didn't tell them about the fall until today "(R1) has a bruise to the right side of his head. Report indicates R1 is anticoagulated with Coumadin and currently bed-bound with left-side weakness from a prior stroke. Upon exam, R1 reports nausea and a very bad headache on the right side of his head. R1 states he fell last night while staff at the facility were rolling and changing him and stated he was

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unsure why they didn't have him evaluated at that time.

Hospital Radiology/Head CT (Computed Tomography) dated 11/17/24 at 10:21pm indicates Findings:
Acute large volume subdural hemorrhage with associated vasogenic edema and mass effect in the right cerebral hemisphere.
4mm (millimeter) of right-to-left midline shift.
Reevaluation/Plan: Transfer to (a) "University" hospital for further evaluation and treatment.

On 11/26/24 at 3:24pm V21, Hospital Social Worker stated that R1 was lucid and oriented when she spoke to him (on 11/17/24) and R1 stated he hit his head and rolled off the bed while being changed.

On 12/3/24 at 10:30am V11, CNA (Certified Nurse Assistant) stated that at 10pm on 11/16/24 R1 was sitting on the edge of his bed when she did initial rounds. V11 stated at approximately 12am she was doing her "check and change" rounds when she found R1 and R1's bed wet with urine so she had to change R1 and his entire bed. V11 stated she did this by rolling R1 back and forth in his bed to get the wet linen out and the dry linen on the bed. V11 stated that R1 did not fall off the bed during care for R1. V11 stated R1 was lying in the bed when she was done, but she had to leave the room to get a top sheet and when she returned a few minutes later R1 was on the floor mat next to R1's bed. V11 stated that R1 told her that he "rolled off the bed." V11 stated that she asked R1 if he was ok and R1 "touched his head." V11 stated that the area on R1's head that he touched was like a "carpet burn, about the size of a dime." V11 stated that she notified V10, RN (Registered Nurse) that R1 was on the floor

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and V10, RN and V13, CNA came into R1's room. V11 stated that V10 assessed R1, and all three staff got R1 back into bed. V11 stated she did not recall if V10 asked R1 if he had hit his head when he rolled off the bed. V11 stated that R1 stated that his head hurt and V10 gave R1 "something for pain."

R1's MAR (Medication Administration Record) dated 11/1/24 to 11/30/24 does not indicate any pain medication was administered to R1 on 11/16/24 or 11/17/24 by V10.

On 12/3/24 at 9:20am V2, DON (Director of Nursing) stated that V10, RN no longer is employed at the facility. Multiple attempts were made to contact V10 by phone without success.

On 11/27/24 at 1:34pm V13, CNA stated that she went in R1's room to help get R1 off the floor, R1 was mostly on the fall mat on the floor and R1's bed was in the lowest position it could go. V13 stated that she did hear V10 ask R1 if he hit his head. V13 stated "I did see what looked like a quarter sized area of dried blood on (R1's) upper forehead - like at the hair line. No dripping blood. (V10 and V11) said (R1) had a skin condition and that it was not new."

On 11/26/24 at 2pm V12, RN stated "I was in the hallway passing meds near (R1) room (on 11/17/24) when I overheard (R1) tell someone he was on the phone with that he had a bad headache. I went into (R1's) room and asked him if he was "ok" and if he needed Tylenol. (R1) said 'yes' so I went to get some Tylenol and when I went back in, (R1) told me he fell the night before around 11pm. I didn't ask him how he fell, but he stated he fell out of bed and pointed to the top of his head. I saw an abrasion (larger than a

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fifty-cent piece) on the top-right side of (R1's head)." V12 stated the area wasn't bleeding "but noticeable." V12 stated that R1 did also complain of nausea and wanted to go to the hospital. V12 stated she then contacted V2, DON and was told to send R1 to the hospital. V12 stated, "I did not get any report that (R1) had fallen the day before." V12 stated she was concerned when R1 told her he fell, because R1 is on Coumadin. V12 stated "I just happened to overhear him complain about a headache later that evening, or I would not have known he fell." V12 stated "If someone falls and they are on Coumadin - even if they say they are alright - they should be sent to the hospital."

On 12/3/24 at 2:45pm V22, Physician/Medical Director stated that if he had been notified when R1 initially fell or was found on the floor, it would have been an immediate 'sendout' because he was on Coumadin and Aspirin. V22 stated time is critical in reversing the effects of the anticoagulants.

R1 fell or rolled onto the mat next to his bed on 11/16/24 near midnight and was not sent to the hospital until 11/17/24 at approximately 9pm. V10, RN did not report that R1 had been found on the mat next to his bed, did not document that R1 had fallen until requested to do so by V2, DON on 11/17/24 and did not notify V22, Physician at the time of the fall.
R1 was subsequently transferred from a local hospital ED to a University hospital from 11/17/24 to 11/27/24.

2) The Facility's undated "Fall Prevention and Management" policy for documentation documents "A. Fall is documented in the medical record 1. date and time 2. location and any facts

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necessary to describe the fall 3. assessment post fall 4. any injuries and care provided 5. notification of physician and family and 6. suggested documentation up to seventy-two hours after fall."

R4's "Fall Investigation" dated 11/9/24 documents "91-year-old female, BIMS (Brief Interview for Mental Status) score of 4 (out of possible 15, indicating severe cognitive impairment) witnessed to slide/roll off the edge of her bed. Discoloration noted to head/face. Resident with daily anticoagulant use. Sent to ER (Emergency Room) for (evaluation and treatment)."

R4's hospital record dated 11/9/24 documents "CT (Computed Tomography) scan maxillofacial without contrast documents findings there is extensive soft tissue swelling surround the nose and anterior to the maxilla and right maxillary sinuses. I suspect nondisplaced fracture involving the nasal spine of the anterior maxilla at the inferior aspect of the nose. There are also possible bilateral nasal bone fractures with minimal displacement, although it is possible this appearance is due to motion."

On 11/26/24 at 10:30 AM R4 had purple bruising to both sides of her nose and under her left eye. R4 also had bruising noted in the neck area. R4 did not recall falling, when asked about her bruises she stated, "If you say they are there; I will believe you."

R4's Admission Care Plan dated 10/30/2024 documents "B. Function and Goals-Mobility: Bed Mobility 2 plus person physical assist."

R4's Admission MDS (Minimum Data Set) Assessment dated 11/05/24 documents "GG.

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S9999	Continued From page 8 Function and Mobility-A. roll left and right: the ability to roll from lying on back to left and right side and return to lying on back on bed: 02. substantial/maximal assistance- helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort." V4's (Certified Nurse Aid) written statement dated 11/9/24 documents that V4 was using an underpad to turn R4 in the bed when R4 attempted to reach out towards her bed side table. V4's statement documents "I tried to grab her hips, but she slipped under my hands and fell on the floor on her right side face down." V6 (Certified Nurse Aid) written statement dated 11/9/24 documents "I was down the hallway talking to the RN when other CNA (V4) hollered down and said she needed help. (R4) was on the floor." On 11/27/24 at 9:45 AM V2 (Director of Nursing) confirmed that R4 was performing bed mobility with just one assist and should have had two. (A)	S9999		