

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0056754		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/15/2025	
NAME OF PROVIDER OR SUPPLIER HOPE CREEK NURSING & REHAB				STREET ADDRESS, CITY, STATE, ZIP CODE 4343 KENNEDY DRIVE , EAST MOLINE, Illinois, 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) COMPLETION DATE	
S0000	Initial Comments		S0000				
	Facility Reported Incident of 9/2/25/2619940						
S9999	Final Observations		S9999				
	Statement of Licensure Violations:						
	300.610a)						
	300.1210b)6)						
	300.3210t)						
	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.						
	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.						
	6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel						

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 shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. These regulations were not met as evidence by: Based on observation, interview, and record review the facility failed to maintain a safe environment, provide adequate supervision, and implement necessary assistive interventions for three (R1, R2, and R3) of three residents reviewed for falls. These failures resulted in repeat falls or injury events, some with head trauma, lacerations, and hospitalizations. Findings include: The facility's Fall Prevention and Management Program revised 5/5/2025 documents the purpose of the Fall Management Program is to provide residents with an interdisciplinary approach to assess risk of falls and provide appropriate interventions to prevent falls. The facility will ensure that in an event a fall occurs, the fall will be investigated, appropriate treatment will be provided, and additional interventions will be implemented to prevent another fall from occurring as much as possible. 1) R1's Hospital Discharge paperwork dated 8/5/25 documents R1 had a fall prior to admission. R1 was taken to local emergency room where R1 was admitted with a subdural hematoma and subarachnoid hemorrhage. R1's census line documents R1 was admitted to the facility on 8/14/25 for therapy. R1's current care plan did not include Fall Interventions on admission. R1's Minimum Data Set (MDS) dated 8/29/25 documents R1 is severely cognitively impaired and is dependent on facility staff for toileting. R1's Fall Risk Assessment dated 8/21/25 documents R1 is		S9999				

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S9999	Continued from page 2 high risk for falls. R1's Nurse Progress Note dated 8/21/25 at 4:25 AM, documents R1 was found sitting on the floor near her bed and was assisted by two unidentified staff members to the restroom after the fall. This note further documents R1 denied hitting her head and V12 (R1's Family Member) chose to not have R1 sent to emergency room for evaluation. R1's current care plan documents on 8/25/25 a Fall Care Plan was initiated for R1 to be toileted every three hours. R1's Toileting Task was not added to the Kardex (resident information) until 9/18/25 for staff documentation. R1's medical record does not contain documentation of when R1 was last toileted on 8/21/25. On 10/9/25 at 1:00 PM, V14 (CNA), stated staff use a sit to stand to transfer R1, and there is a sign at nurses' station that shows residents' transfer status. V14 further stated if it's not on the sheet then V14 just asks someone. V14 stated she does not know how to find transfer status in the electronic charting because they are often not updated. V14 confirmed she was not aware R1 was on a toileting schedule. R1's medical record does not contain documentation of when R1 was last toileted on 9/2/25. R1's Change in Condition Evaluation dated 9/2/25 at 11:56 PM, documents R1 was found on the floor in her room in front of the bathroom door with active bleeding to the back of her head. This note further documents there was dried blood on the floor next to R1 and by the side of R1's bed. R1 was sent to the local emergency room by ambulance. R1's emergency room Physician Notes dated 9/2/25 at 11:15 PM document R1 arrived at the local emergency room after an unwitnessed fall in the facility. R1 was found crawling on the floor near her window in her room. R1 had noticeable bleeding on the back of her head. R1 is also on Eliquis for previous blood clots. R1 has dementia. R1's Computed Tomography (CT) of Head Final Report dated 9/2/25 documents R1 has a small subdural hematoma along the right anterior falx measuring two millimeters (mm) and a right posterior scalp laceration/contusion.		S9999				

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S9999	Continued from page 3 R1's Physician Final Report dated 9/3/25 documents R1 arrived at local emergency room after sustaining a fall and hitting her head. This note documents The CT scan of abdomen pelvis revealed a small intracranial bleed. R1's Nurse Progress note dated 9/3/25 documents R1 returned to the facility with a laceration of the head, subdural hematoma, and contusion to the right hip. R1 noted to have eight staples intact to back of head. R1's care plan documents on 9/3/25 R1's care plan was updated to rearrange the furniture and move the nightstand in the room to be further from the bedside On 10/9/25 at 9:01 AM, R1's nightstand was next to the head of the bed. On 10/9/25 at 10:03 AM, R1s current care plan documents on 10/9/25 care plan was updated to reflect R1 had an alteration in skin integrity related to laceration from fall on 9/2. This same care plan was also updated on 10/9 to reflect R1 has a potential for complications related to Subdural Hematoma that occurred on 9/2. R1's current care plan does not document R1s transfer status or R1s Activities of Daily Living (ADL) care plan. On 10/9/25 at 10:18 AM, V6 (Minimum Data Set/MDS Nurse) "We (facility staff) have two people who do MDS / care plans. I went through R1's care plan this morning and noticed some things were not added. The other MDS nurse is newer and is on vacation, and I realized items needed to be added to R1's care plan today, so I added them. The Kardex is how staff see/document how residents transfer, toileting, eating, bathing, and dressing, and personal hygiene cares. It's hard to keep up on updating because it changes so much." V6 further stated that R1's care plan did not include her transfer status or activities of daily living (ADL) status until that morning. V6 acknowledged that workload and staffing (e.g. training a newer MDS nurse) contributed to the delays in updating care plans accurately and timely. V6 confirms that in order for CNAs to be able to chart in the tasks the care areas must be added to the care plan first. On 10/9/25 at 11:00 AM, V10 (Certified Nursing Assistant/CNA) stated that she began her shift around 10:00 PM on 9/2/25. Three female residents were still up in the dining area, and V7 (CNA) told them to go to bed. V7 asked V10 to assist with R1's roommate, who needed a shower. V10 reported, "We were walking down the hallway and V7 said R1's roommate needed a shower, so we walked her to the shower room." V10 stated she was in the shower room with the resident when V7 left		S9999				

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S9999	Continued from page 4 to get the resident's clothes. V10 heard V7 yell out for V8 (Licensed Practical Nurse/LPN), prompting her to open the shower room door. V10 observed R1 on the floor in her room, close to the door, bleeding from the back of her head. V10 stated she remained in the shower room to assist the resident she was with but heard V8 say, "R1 was put to bed too early and may not have been toileted correctly." V10 described, "R1 fell by her bed, which is where the dried blood was on the floor. I had to clean the blood up after I was done with the shower. There was a dried puddle of blood by the bed and droplets of blood leading to the door where R1 was sitting. There was also a blood spot on the chair that's used to prop the door open, but the chair had not been in place, so the door was closed." V10 stated, "I'm pretty sure (R1) was on the floor for a while." V10 further stated she has worked at the facility since April of 2025 and feels that staff are not being trained properly on the floor and don't know where to find information on residents. V10 stated information on residents is often not on the electronic Kardex (resident information), and It makes it very hard to work here because we never know what's happening. V10 stated "Sometimes I'm concerned about losing my license." V10 further stated she was not aware that R1 was on a toileting program. On 10/9/25 at 10:47 AM, V8 (LPN) stated that her shift was ending when V7 called her to R1's room at approximately 10:00 PM on 9/2/25. V8 found R1 sitting on the floor, bleeding from the back of the head. V8 said she did not know exactly what R1 was doing; R1 was not far from the bathroom. V8 added that R1 is not supposed to get up without help. V8 stated that staff had laid R1 down in bed, though she did not recall the time this was done. V8 further stated that approximately around 8:00 PM earlier, she checked on R1 and found her in bed, sleeping. On 10/14/25 at 9:25 AM, V9 (RN) stated that at the start of her shift (as a third shift nurse) staff entered R1's room and found her lying on the floor in front of the bathroom door, in a puddle of blood. V9 stated there was a trail of blood from the bed to the bathroom, as if R1 slid across the floor. The room door was closed when staff entered; V9 noted that the door does not reliably stay open unless pushed just right, and previously staff had propped the door open with a chair. V9 said she had never seen R1 attempt to get out of bed by herself. R1 was wet when found, but V9 expressed she could not determine what led to the fall or what R1 was doing at the time. On 10/9/25 at 12:16 PM, V12 (R1's Family Member),		S9999				

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S9999	Continued from page 5 stated R1 had fallen and hit her head, and they sent her to emergency room and then transferred R1 to another hospital to monitor her brain bleed. V12 stated that the facility called me, but it wasn't until after they took R1 to the hospital. They told me "(R1) had a fall and hit her head, nobody ever gave me any details other than she fell. (R1) now has hospice when she went back to the facility, they suggested Hospice." On 10/14/25 at 9:08 AM, V15 (Physician) stated they should have a care plan in place for all new admits because data shows new admits have a high risk for falls especially since R1 already had a history of falls. R1 should have had fall precautions in place upon admission and staff should have been aware of ADL needs. 2) R2's census line documents R2 admitted to the facility on 8/7/25. R2's Medical Diagnosis list documents R2 admitted with a Diagnosis of Dementia and Lack of Coordination. R2's Fall Risk evaluation dated 8/7/25 documents R2 is high risk for falls. R2's MDS dated 9/9/25 documents R2 is severely cognitively impaired. R2's Emergency Department Physician Notes dated 9/9/25 document R2 was sent to the local emergency room after facility reports R2 sustained an unwitnessed fall and was found lying on the ground. R2 is currently taking Eliquis as a blood thinner and reports left hip pain. R2's Fall Care Plan was not created until 9/10/25 when an intervention was added for gripper strips to be placed at R2's bedside, and to remind R2 to use call light for staff assistance. R2's current Kardex (resident information) does not contain Fall Interventions for R2. R2's Nurse Progress Note dated 10/1/25 at 3:57 AM, documents R2 was found in bed with blood on his bed and on the floor with a laceration on R2s elbow that was actively bleeding. R2 stated he stood up and had fallen and hit his left elbow, left hip, and his head. R2 was sent to the local emergency room for evaluation of injuries. R2's Nurse Progress Note dated 10/1/25 at 4:41 PM, documents R2 returned to the facility with three sutures in his elbow for the laceration and no further	S9999					

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S9999	Continued from page 6 orders. R2's current care plan documents Dementia Care plan, at risk for Bleeding related to Anticoagulant Therapy, and at risk for impairment to skin Integrity related to laceration was created on 10/9/25. R2's Fall risk care plan was created on 9/10/25, and ADL care plan was created on 10/14/25. On 10/14/25 at 10:30 AM, V16 (CNA), stated R2 often is impulsive and gets up on his own. V16 stated she worked on 9/9/25 and went into R2's room to get him ready for the day. V6 stated upon entering R2's room the floor was wet in urine with a wet adult brief on the floor and R2 was lying in bed naked. R2 told V16 that he had fallen in the night. V16 stated she let V17 (LPN) know what she had seen and what R2 told her. On 10/14/25 at 1:18 PM, V17 (LPN) stated V16 came to me on 9/9/25 and said R2 had told V16 he had slipped in urine and fallen on floor in the night. V16 cleaned R2 up and brought him to the dining room. V17 looked at R2 and assessed him, R2 said his shoulder and hip was injured and sore. V16 stated she had just found out someone she knew had been murdered and her mind wasn't where it should have been, there were residents trying to get up V16 was behind on her medication pass. V16 stated she sent R2 to the local emergency room and he came back to the facility later that day with no injuries. V16 stated she does not recall notifying the family. On 10/14/25 at 12:45 PM, V18 (R2's Family Member) stated the facility called on 10/1 to let V18 know that R2 needed to go to the hospital because his elbow was bleeding. V18 stated she also been told by family that R2's roommate is also peeing on the floor, which concerns me if that's happening, and R2 is falling. V18 stated she was not made aware of R2's fall on 9/9/25 and was not aware R2 was sent to the hospital for evaluation. V18 stated prior to R2's admission to the facility R2 had been declining and getting weak and was having a hard time walking and had fallen at home which is why R2 admitted to the facility. R2 needed therapy and increased care as his dementia was getting worse. On 10/14/25 at 1:00 PM, V6 stated that she was currently updating R2's care plan and this care plan should have already been updated. V6 confirms R2 should have had a fall risk care plan upon admission. 3) R3's census documents R3 admitted to the facility on 1/7/25.	S9999					

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S9999	Continued from page 7 R3's MDS dated 8/21/25 documents R3 is severely cognitively impaired. R3's Fall Risk Review dated 1/16/25 documents that R3 is at high risk for falls. Subsequent fall risk assessments on 4/27/25, 6/30/25, 7/6/25, 7/7/25, 7/11/25, 7/28/25, and 10/9/25 continue to document R3 as high risk for falls. R3's Change in Condition Evaluation dated 10/9/25 documents R3 was sitting in his wheelchair in the hallway next to the nurse's station and staff heard a noise and R3 was sitting on the floor. R3's Change in Condition Evaluation dated 7/28/25 documents R3 was found lying on the floor mat next to his bed and was bleeding from a small laceration on the left eyebrow. Adhesive strips were applied to the laceration. R3 stated he was trying to go to the bathroom. R3's Change in Condition Evaluation dated 7/11/25 documents R3 had an unwitnessed fall and was found by staff laying on the floor. Vitals on the report are dated 7/7/25. R3's Change in Condition Evaluation dated 7/7/25 documents R3 was found lying on the floor of the shower room on his back with knees bent and hands behind his head. R3 stated he "walked". R3's Change in Condition Evaluation dated 7/6/25 documents R3 attempted to transfer self to the toilet and was found on the floor laying on the floor mat. R3's Change in Condition Evaluation dated 6/30/25 documents R3 had an unwitnessed fall and was found lying on the floor of the bathroom between the toilet and the sink. R3 stated he thinks he hit his head. R3's Care Plan documents that R3's toileting task was not added to the care plan or the Kardex (resident information) until 9/10/25. R3's current care plan does not contain documentation of new safety interventions nor ADL status after these falls. On 10/14/25 at 11:30 AM, R3 was in wheelchair sitting in the dining room. R3 is alert but confused. On 10/14/25 at 11:40 AM, V19 (CNA) stated R3 often slides out of his wheelchair so we put him in the			S9999			

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S9999	Continued from page 8 dining room in a recliner chair, so he doesn't fall. 10/14/25 at 12:13 PM, V6 stated these interventions were not put in the care plan on 8/26/25. V6 stated that she just put these in today on 10/14/25 and when they print V6 only included the initiation date. V6 Stated R3 needs a lot of help and is confused and has had a lot of falls. V6 Stated we used to train all staff upon hire regarding charting and how to find resident information and that stopped awhile back, but unsure why, we plan to restart again. V6 Stated these interventions should have already been on the care plan. On 10/14/25 at 12:45 PM, V2 (Director of Nursing) stated she was not aware that the care plans were not being updated. V2 further stated care plans are not really her area of expertise. (A)		S9999				