STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145269	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hope Creek Nursing & Rehab	4343 Kennedy Drive East Moline, IL 61244

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30678 Based on observation, interview, and record review the facility failed to ensure residents were free from physical and verbal abuse and identify and investigate a potential allegation of abuse and protect resident from further abuse from R500, with a known history of verbal and physical aggression. These failures resulted in R500 verbally yelling and physically hitting R134 and shoving both R84 and R103 to the ground. R84 sustained a bleeding laceration to posterior head, facial bruising, and hospitalization requiring three staples to R84's posterior head. R103 experienced hip and knee pain, bruising, and hospital evaluation. R134 was hit in the face. These failures have the potential to affect all 35 residents residing in the facility's Dementia unit. These failures resulted in an Immediate Jeopardy. While the immediacy was removed on 8/29/24, the facility remains out of compliance at a Severity Level 2 as additional time is needed to evaluate the implementation and effectiveness of the facility's removal plan and quality assurance monitoring. Findings include: (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	The facility's Abuse Prevention Program policy, revised 3/1/21, documents It is the policy of this facility to prohibit and prevent resident abuse, neglect, exploitation, mistreatment, and misappropriation of resident property and a crime against a resident in the facility. This policy also documents Identification of Allegations/ Internal Reporting Requirements: Employees are required to immediately report and incident, allegation or suspicion of potential abuse, neglect, exploitation, misappropriation of resident property, mistreatment or crime against a resident they observe, hear about, or suspect to the Administrator if available or an immediate supervisor who must immediately report it to the Administrator. In the absence of the Administrator, reporting can be made to the DON (Director of Nursing). Any incident, allegation or suspicion of potential abuse, neglect, exploitation, misappropriation of resident property, mistreatment or crime against a resident is reported to a covered individual; covered individuals are notified annually of these reporting requirements. Employees without fear of retaliation may also independently report to the state survey agency any allegation of abuse, neglect, exploitation, or mistreatment of resident property, and to local law enforcement if they have a reasonable suspicion that a crime was committed. Such reports may be made without fear of retaliation. Anonymous reports will also be thoroughly investigated. Reports should be documented, and a record kept of the documentation. Upon learning of the report, the Administrator or in the absence of the Administrator, the DON shall initiate an incident investigation. Investigation: All incidents, allegation or suspicion of abuse, neglect, exploitation, misappropriation of property, or crime against a resident will be documented. Any incident or allegation involving abuse, neglect, exploitation, misappropriation of resident property, or crime against a resident will result in an abuse investigation. Once the Administrator or in the absence of the Administrator the DON determines that there is an allegation or a reasonable cause for suspecting abuse, neglect, exploitation, misappropriation of property, or a crime against a resident, the Administrator or appointed investigator will investigate the allegation and obtain a copy of any documentation relative to the incident. This policy also documents Protection of Residents: The facility will take steps to prevent mistreatment while the investigation is underway. Residents who allegedly mistreated another resident will be immediately removed from contact with that resident during course of investigation. The accused resident's condition shall be immediately evaluated to determine the most suitable therapy, care approaches and placement, considering his or her safety, as well as the safety of the other residents and employees of the facility. All personnel, residents, visitors, etc. (etcetera) are encouraged to report incidents of resident abuse, mistreatment or neglect or suspected abuse, mistreatment, or neglect, without fear of retaliation or retribution from facility or its staff. Abuse: The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm or pain or mental anguish or deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental psychosocial well-being. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. This same policy also documents Procedure: Upon receiving reports of physical or sexual abuse, the Charge Nurse will immediately examine the resident. Findings of the examination must be recorded in a separate incident report and in the resident's medical record. This report shall be made immediately, but no later than two hours after the allegation is made. If the events that cause the allegation involve abuse or resulted in serious bodily injury, or not less than 24 hours if the events that cause the allegation do not involve abuse and did not result in serious bodily injury. Crimes include but may not be limited to murder, manslaughter, rape, assault and battery, sexual abuse, theft robbery, drug diversion for personal use or gain, identify theft, and fraud and forgery. When an alleged or suspected case of abuse, neglect, exploitation, or crime against a resident is reported to the facility Administrator, the Administrator, or DON in the Administrator's absence, will notify the following persons or agencies of such incident immediately. Any incident that involves crimes or significant injury to a resident will be reported within two hours of the incident. Any incident that involves a resident death will be called to the (State Agency) immediately. Abuse allegations involving one resident upon resident upon another resident will be reported to (the States Agency). (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	The Diagnosis Report for R500, documents R500 admitted to the facility on [DATE] with a diagnosis of Schizoaffective Disorder. R500 was diagnosed with Obsessive Compulsive Personality Disorder on 7/15/24 and diagnosed with Bipolar and Metabolic Encephalopathy on 7/25/23. R500 was also diagnosed with Anxiety on 8/21/24 after readmitting to the facility on [DATE] from psychological hospitalization . The facility Psychiatric service report for R500, dated 6/5/24, documents R500 with a diagnosis of Dementia. This report documents R500 with auditory hallucinations and delusions and making false accusations of staff. Psychiatric History includes multiple psychiatric hospitalization s and multiple medication changes prior to facility admission. The current Care Plan for R500 documents the following: Focus areas with goals and interventions listed: R500 has chronic health conditions, behaviors, challenges, and co-morbidities that include Schizoaffective and bipolar disorder. R500 requires the support, services and structure of the care setting and is under the care of psychiatry and receives medications and illness management through psychological services and psychosocial group programming; R500 demonstrates movement behavior that may be interpreted as wandering, pacing, or roaming the unit; R500 uses antipsychotic medications r/t (related to) behavior management; R500 displays behavioral symptoms related to Bipolar Disorder; R500 has behavior problem r/t anxiety, depression, change in mood, self-isolation, false accusations, repetitive questioning, agitation, tearful episodes, cursing, decreased socialization, delusions, hallucinations, pacing, panic, paranoia, and verbal aggression; R500 has impaired cognitive function, becomes easily confused, overwhelmed and disoriented; and R500 had chronic psychiatric illness and determined to have ineffective coping modalities that include disorganized thought processes and mood patterns, delusions, hallucinations, difficulty meeting basic physiological/self-care needs, and having reduced insight and judgement r/t Schizoaffective disorder; and R500 displays conflictual, difficult behavior with other persons with symptoms of open conflict with or repeated criticism of staff and unprovoked expressions of anger towards staff and peer. Being verbally and physically aggressive with her peers. Interventions include: Teach and remind the resident to communicate his/her feelings, including anger and frustration through means other than hitting, touching or verbally abusing another person; R500 has rapid cycling and significant shifts in mood that include mania and depression that may last for several days r/t bipolar disorder with following symptoms of hallucinations, becoming easily agitated, irritated, disturbed, having illogical thinking, and paranoid delusional thoughts about others. Goal is for R500 to seek assistance when experiencing aggressive impulses and refrain from engaging in verbal threats and loud, profane language toward others. Interventions include: Monitor/record/report to MD (medical doctor) prn (as needed) risk for harming others: increased anger, labile mood or agitation, feels threatened by others or thoughts of harming someone, possession of weapons or objects that could be used as weapons; and R500 has Behavioral Symptoms/Altercation with Roommate initiated on 4/4/24 as: R500 demonstrates behavioral distress related to: Ineffective coping mechanisms, bipolar disorder and Schizoaffective disorder. Problems are manifested by: Physically abusive behavior when agitated such as slapping or attempting to cause harm to a peer. The Behavior Monitoring Report for R500, dated 7/01/24 through 8/28/24 documents the following behaviors have been noted over the past 30 days: grabbing others, hitting others, kicking others, pushing others, physically aggressive towards others, scratching others, accusing of others, cursing at others, expressing frustration/anger at others, screaming at others, threatening others, entering other resident's rooms/personal space, disruptive sounds, repetitive motions, rummaging, agitated, anxious and restless, elopement and exit seeking, experiencing something not there, hoarding, neglecting self care, pacing, panic, refusing care, wandering and withdrawn/isolation. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	The Psychiatry Note for R500, dated 4/5/24, documents On 4/4/24 (R500) became agitated at her roommate (R134) for wandering on her (R500) side of the room and going through her (R500) belongings. When R500 attempted to take her belongings back, R134 raised their arms at R500 so (R500) struck (R134). R500 was sent to the local hospital for an evaluation and returned to the facility. On 8/27/24 at 2:47 pm, V2 DON (Director of Nursing) stated she does the Fall Investigations and V1 Administrator does the Abuse Investigations and there has only been one abuse allegation involving R500 and that was with R103. R500 is very territorial about her room and space and had just been at Geriatric psychological hospital for manic behavior, not for being aggressive. V2 DON stated That is the only incident she's had. There are no others. V2 DON stated R500 went out to the psychological hospital on 8/2/24 and just readmitted back to the facility on [DATE]. On 8/20/24 R500 pushed R103 and R103 fell to the floor. V2 stated both residents went out to the local the hospital for evaluations, returned with no injuries and R500 was placed on one-to-one staff monitoring when she returned from the hospital. On 8/27/24 at 3:15 pm, V1 Administrator stated he is the Abuse Coordinator but was not involved in the incident with R84 because he was not at the facility but was involved with the altercation between R500 and R103. V1 Administrator stated V2 DON (Director of Nursing) does all the fall investigations and did R84's investigation as a fall, it was not considered abuse and he is unaware of the incident being potential abuse. On 8/23/24 at 11:40 am, R500's door was closed, and V20 Transportation CNA was sitting outside of R500's room. Upon entering R500's room noted two mattresses on the floor with bed frames standing empty. R500 was lying on one of the mattresses and R500's personal items were randomly scattered on the other mattress on the floor. R500 stated she was not feeling very good, had recently been in the hospital, has lost weight, doesn't know why, and requested a soda to drink. 1. A facility Abuse Investigation for R500 and R134, dated 4/4/24, documents V38 CNA (Certified Nursing Assistant) heard noise and went into R500 and R134's room, (R134) had two bears and a flower in her hand. (R500) went and took the bears out of (R134's) hand. (R134) got upset and raised her hands in the air. (V38) got in between the two (R134 and R500) and tried to intervene and (R500) reached around and slapped (R134). V22 RN (Registered Nurse) witness statement documents (V22 RN) was standing at the nurses' station and was trying to get there asap (as soon as possible) because (V22 RN) was hearing a commotion. When (V22) got in the room (R500) was complaining about (R134) getting into (R500's) stuff. (R134) put her hands up in the air and (R500) slapped (R134). The local hospital ED (emergency department) Physician Notes for R500, dated 4/4/24, documents R500 is from (The Facility) and staff sent her (R500) in due to having an altercation with her roommate. The Final Abuse Investigation documents the facility is unable to substantiate this allegation as well as (R500) made contact with (R134); regardless that V38 CNA and V22 RN witnessed R500 hit R134. On 8/23/24 at 12:00 pm, V22 RN stated R500 has had some bizarre behaviors, is aggressive at times and there was an incident awhile back with another resident, her old roommate before she moved and R500 has been aggressive with the staff. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	2. A facility Fall Investigation for R84, dated 8/20/24 at 12:23 pm, documented by V29 LPN (Licensed Practical Nurse) documents staff was in the dining room at lunch when someone (R500) was heard yelling on the hallway. V29 LPN asked V41 CNA to go observe the area. V41 CNA went to the hall and started to go down the hall and observed (R84) at the end of the hall. (R84) was observed falling backwards. V41 CNA was unable to assist (R84) d/t not being close enough. V41 CNA's statement is documented as: I was serving food. I heard someone yell. I went to observe the area and resident was at the end of the hall by (R500's) room. I observed the resident falling backwards and was unable to assist d/t not being close enough. The resident in the room had yelled, stepped back into her room and slammed the door. The local hospital ED (emergency department) Physician Notes for R84, dated 8/20/24, documents R84 presented to ED with a head injury. Chief complaint was an unwitnessed fall with wound to the posterior scalp and bleeding controlled at this time. CT (computed tomography) of the cervical spine and the head were completed with small left posterior scalp contusion without hemorrhage or fractures. On 8/28/24 at 10:45 am. the facility's Video Surveillance surrounding R84's on 8/20/24 at 12:23 pm incident viewed with V1 Administrator and V2 DON and shows R84 standing in R500's doorway area. R500 cannot be seen due to recession of R500's door. V41 CNA is seen walking down the hallway towards R500's door, and at approximately 15 feet from R500's door R84 is seen quickly and forcefully falling, hitting the back of her head on the floor. V41 CNA is then seen anxiously and rapidly moving in circles and about the hallway with arms flailing about. Other Staff members are then seen going down the hallway to assist. The Video Surveillance does not show R500 at the doorway due to the surrounding walls; however, there is some shadowing movement to the left upper exterior door frame area that quickly disappears while R84 is falling backwards. R84 does not appear to have stumbled backwards as the fall was so quick and forceful. R84's walker is also noted to move in the lower middle door area but does not fall over. On 8/27/24 at 1:30 pm, V8 Anonymous Staff Member stated R500 has had a lot of behaviors lately and over the past month or so and has been in and out of the hospital because of aggressive behaviors. V8 stated on 8/20/24 around 12:30 pm she heard R500 yelling and screaming and (V8) was approximately 15 feet from R500's room when R500 took both of her hands, grabbed R84 and like a bowling ball slammed R84 to the floor. She (R500) hulk smacked her (R84's) head and R84's head was gushing blood all over the floor. V8 stated she has never seen anything like that happen before, witnessed the entire incident and wrote a witness statement stating exactly what she saw and gave it to V29 LPN. V8 stated her statement was changed to reflect something other than what she saw. V8 stated V2 DON told (V8) she watched the camera, R84 had stumbled, and V2 DON needed V8 to stop telling people that R500 slammed R84 down. V8 stated she kept telling V2 DON what (V8) saw and that there was no stumbling or (V8) would have seen that. V8 stated she also told V14 ADON (Assistant Director of Nursing) what she witnessed. On 8/28/24 at 10:45 pm, V2 DON stated R84 was startled by R500 when R500 yelled and slammed her door and R84 stumbled back and fell . R84 never said she was pushed. V2 DON stated she heard rumors that were going around about R84 being pushed down the next day (8/21/24). V2 DON stated V41 CNA was telling everyone that she saw R500 push R84 down and was told to stop telling people that because the facility cameras do not show R500 pushing R84 down. When asked if the cameras show R500 not pushing R84 down or why V2 DON didn't investigate V41 CNA's allegation of abuse; regardless of when the allegation was made, V2 DON became irritated, raised her voice and stated R500 did not push R84 down, R84 stumbled and fell back. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	On 8/28/24 at 10:50 am, V1 Administrator stated the incident with R84 was reported to the State Agency as a fall and even if it was found to be abuse after investigating, he would not have resubmitted the incident as abuse, he would document it on the five day only. V1 also stated a abuse allegations with residents with dementia, confusion or one with a UTI (urinary tract infection) would not be considered willful abuse due to the resident not having the cognition to be willful and he would not report it as abuse. V1 Administrator confirmed the video surveillance did not show that there was or was not contact between R500 and R84 due to quality of video and positioning of camera. On 8/23/24 at 11:30 am, 12:01 pm, and 12:17 pm R84 was wandering the Dementia unit hallways with a wheeled walker and with a slow and steady gait. Bruising was noted to R84's right cheek and three staples to back of her head. On this same date at 12:18 pm, R84 wandered into another resident room. On 8/27/24 at 12:57 pm and on 8/28/24 at 10:09 am, R84 was pacing the hallways with a wheeled walker with a slow steady gait. On 8/27/24 at 1:10 pm, V33 CNA stated she and other nursing staff were in the dining room on 8/20/24 at noon assisting residents with lunch and heard R500 screaming, heard a big loud bump; like something hit on the floor, and then heard a door slam. V33 CNA stated R84 was down by R500's room, in front of R500's door and then just fell back. R500's room is at the end of the hall and the camera at beginning of hall. R500's room has an entryway so her door cannot be seen unless your closer to her room. V33 CNA stated V41 CNA told (V33) that she saw R500's hands push R84 down. V33 CNA stated R84's fall was an aggressive fall. A slower fall would not have caused that to her head. On 8/23/24 at 11:58 am, V21 Restorative Nurse stated on 8/20/24, R84 lost her balance and fell backwards, hit her head and had bruising from the fall, went to the hospital and That's all I know. On 8/27/24 at 1:00 pm, V34 CNA stated on 8/20/24, during shift change report, she was informed that on day shift R84 was walking with her walker, fell , and hit her head by R500's door, but doesn't know the details. V34 stated R500 was not on one-to-one monitoring at that time. 3. A facility Physical Abuse Investigation for R500 and R103, dated 8/20/24 at 4:40 pm, documents the Nurse heard loud screaming from around the corner in the hallway and Housekeeper in the hallway witnessed physical aggression from R500 towards R103. The victim (R103) had a fall to the floor as a result of R500's Physical Aggression. The investigation includes a statement for V39 and V40 CNA's documenting witnessing R500 yelling at R103 you stay away from me and then R500 pushing R103 to the floor. There is no witness statement from a Housekeeper included in investigation. R103 fell to the floor onto left side and complained of left hip and left knee pain. R103 and R500 were both sent to the local hospital for evaluation and treatment. The Change in Condition Evaluation for R500, dated 8/20/24 at 4:44 pm documents: R500's behavioral changes as physical and verbal aggression and a danger to self and others; Dangerous behavior as pushed peer and as a result of the physical aggression receiver of the aggression fell to the floor; Behavioral changes as resident moving furniture around and had made comment of being filthy and disgusting; and Resident has new orders to be on 1:1 supervision until further notice when she returns from ED (emergency department). (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	The ED Physician Notes for R500, dated 8/20/24, documents R500 was recently discharged from local behavioral hospital yesterday (8/19/24), re- admitted to (the Facility) and altercation occurred (8/20/24) between R500 and another resident. The local hospital Emergency Department Provider Notes for R103, dated 8/20/24 documents the patient (R103) was in an altercation at (the Facility) on memory unit, was pushed hard and fell down and complained of left hip and left knee pain. On 8/28/24 at 10:45 am, the facility's Video Surveillance surrounding R103's 8/20/24 at 4:40 pm incident was reviewed with V1 Administrator and V2 DON and shows R103 and R500 at a table near the entrance of the hallway. R500 is seen standing facing R103 and appears to be talking to R103 and then R500 is seen quickly and forcefully grabbing R103 and shoving R103 towards the floor. R500 is then seen standing nearby while R103 is being assisted. On 8/23/24 at 11:48 am, R103 was in the dining room, standing next to a table talking to other residents. Between 11:50 am through 12:38 pm, R103 was walking independently around the dining room, sat in a stationary chair in the dining room, fed self lunch and at 12:38 pm remained sitting in the dining room. On 8/27/24 at 12:54 pm, R103 was pacing the hallways independently. On 8/30/24 at 2:30 pm, V3 Infection Preventionist assisted R103 with lowering her left pant leg. A large bruise measuring approximately 13 inches was noted to R103's left hip. V3 confirmed this was from R103's fall. On 8/27/24 at 1:30 pm, V8 Anonymous Staff Member stated on 8/20/24 around 4:35 pm she heard and witnessed R500 scream out at R103, grab R103 and throw R103 into the hallway wall, very forcefully. V8 stated after this incident R500 was put on one-to-one monitoring. V8 stated They should have done that after the first time and the second time wouldn't have happened. On 8/23/24 at 11:58 am, V21 Restorative Nurse stated on 8/20/24, R500 and R103 had a resident to resident altercation and both residents went to the hospital and came back and That's all I know. On 8/27/24 at 1:00 pm, V34 CNA stated on 8/20/24, during second shift R103 was walking and R500 pushed R103 down in the hallway. V34 stated she didn't see it happen but heard the staff talking about seeing R500 push R103 and stated, That's how I know. V34 CNA stated R500 and R103 went out to the local hospital and R500 was put on one-to-one monitoring when she returned from the hospital and had not been on one-to-one prior to that. On 8/23/24 at 11:35 am, V20 Transportation CNA was sitting just outside of R500's room. V20 stated V41 CNA had to leave for family emergency so (V20) was filling in to help with R500's one-to-one monitoring. V20 stated she transported R500 to a behavioral health hospital on 8/2/24 after R500 attacked the staff and was having bizarre behaviors. R500 screamed at the top of her lungs during the last hour of the ride but other than that she didn't have any behaviors. V20 stated R500 just came back here on 8/19/24 and had to be put on one-to-one a couple of days ago. The medical record for R500 documents another emergency room evaluation occurred for R500 on 8/26/24 due to aggressive physical behavior. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	The local hospital ED report for R500, dated 8/26/24, documents (R500) is a resident of (the Facility) and was apparently becoming quite aggressive with staff. Patient came flying down the hallway and pushed staff x (times) 2. She has no idea why she is in the emergency department, and has some unusual behavior at times and flaps her hands around stating that she is shaking all over. This report documents R500 is positive for agitation and behavioral problems. The Final diagnoses for R500 is documented as Behavior concern in adult and Aggressive behavior. The facility's Abuse log, dated 2024, documents one abuse allegation involving R500, dated 8/20/24 at 4:40 pm and does not include the allegation involving R134 or R84. The Immediate Jeopardy began on 8/20/24 at 12:23 pm when the facility failed to prevent, identify and investigate a potential allegation of abuse and protect residents from further abuse. V1 Administrator was notified of the Immediate Jeopardy on 8/29/24 at 11:28 am. The surveyor confirmed through interview, observation and record review that the facility took the following actions to remove the Immediate Jeopardy: 1. Investigation of both incidents were completed and reported to state survey agency and physician for R84, R103, and R500. 2. R84 was transferred to the hospital for evaluation. 3. R103 was transferred to the hospital for evaluation. No injuries were noted and R103 returned to the facility with no new orders. 4. R500 was placed on one-to-one supervision on 8/20/24. 5. R500 care plan was updated to include one-to-one supervision and again updated to include one-to-one supervision until the resident is deemed safe by psychiatry and/or nursing assessment. 6. R500 care plan was updated to include behavior monitoring Q (every) shift. 7. R84, R103, and R500 care plans have been updated to include one-to-one time with Social Services as needed to vent feelings. 8. Administrator in-serviced by Risk Management Consultant on 8/29/24 regarding Abuse Prevention Policy. 9. In-servicing training by Administrator/designee on Abuse Prevention Policy with all staff was initiated on 8/29/24. 10. In-servicing training by Administrator/designee on Abuse Prevention Policy with all staff will continue, and any remaining employees must be trained prior to reporting for work for their next scheduled shift. Employees will not be allowed to work after 11:59 pm on 8/29/24 until they have completed the in-service. 11. QAA (Quality Assessment and Assurance) team members were in-serviced on the facility's Abuse Prevention Program policy and procedure by the Administrator on 8/29/24. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hope Creek Nursing & Rehab	4343 Kennedy Drive East Moline, IL 61244

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	12. Social Services Director and/or designee will audit Trauma Screening assessments and Screening Assessments for Indicators of Aggressive and/or Harmful Behavior for all 35 residents with the potential to be affected by this alleged deficiency to ensure those assessments are current. Social Services Director/designee will ensure interventions are care planned for any residents assessed to be at risk. The audits will be completed by 11:59 pm on 8/29/24. 13. QAA team will review the Trauma Screening assessments and Screening Assessment for Indicators of Aggressive and/or Harmful Behaviors during quarterly QA (Quality Assurance) meetings with medical director and address any concerns. 14. QAA team will review the Trauma Screening assessments and Screening Assessment for Indicators of Aggressive and/or Harmful Behaviors during Morning QA meetings daily x 30 days on all new admits to assure compliance. 15. The facility will follow state and federal guidelines regarding Abuse Reporting by requiring reporting of all reports of abuse to be reported to the facility QA Committee for follow up and review. 16. In-service training by Administrator/designee on Abuse Prevention Policy with all staff will continue monthly for the next 3 months, then quarterly x 3 by the DON or Administrator. 17. Administrator will enforce the interventions of plan of removal of immediacy and assurance of continued compliance.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 30678 Based on observation, interview, and record review the facility failed to implement their abuse prevention program to protect residents from abuse for three (R84, R103, and R500) of four residents reviewed for abuse in the sample of 124. Findings include: The facility's Abuse Prevention Program, revised 3/1/21, documents Employees are required to immediately report any incident, allegation, or suspicion of potential abuse, neglect, exploitation, misappropriation of resident property, mistreatment or a crime against a resident they observe, hear about, or suspect to the Administrator. In the absence of the Administrator, reporting can be made to the DON (Director of Nursing). Upon learning of the report, the Administrator or in the absence of the Administrator, the DON shall initiate an incident investigation. All incidents, allegations or suspicion of abuse, neglect, exploitation, misappropriation of property, or a crime against a resident will be documented. Any incident or allegation involving abuse, neglect, exploitation, misappropriation of resident property, or a crime against a resident will result in an abuse investigation. Once the Administrator or in the absence of the Administrator the DON determines that there is an allegation a reasonable cause for suspecting abuse, neglect, exploitation, misappropriation of property, or a crime against a resident, the Administrator or appointed investigator will investigate the allegation and obtain a copy of any documentation relative to the incident. The Charge Nurse must complete an incident report and obtain a written, signed and dated statement from the person reporting the incident. A completed copy of the incident report and written statements from the witnesses, if any, will be provided to the Administrator (in the absence of the Administrator, the DON) within twenty-four (24) hours of the occurrence of such incident. The facility will take steps to prevent mistreatment while the investigation is underway. Residents who allegedly mistreated another resident will be immediately removed from contact with that resident during course of the investigation. The accused resident's condition shall be immediately evaluated to determine the most suitable therapy, care approaches and placement, considering his or her safety, as well as the safety of the other residents and employees of the facility. This facility will not tolerate resident abuse or mistreatment or crimes against a resident by anyone, including staff members, other residents, consultants, volunteers, and staff of other agencies, family members, legal guardians, friends, or other individuals. A facility Fall Investigation for R84, dated 8/20/24 at 12:23 pm, documents staff were in the dining room at lunch when (R500) was heard yelling on the hallway. V29 LPN sent V41 CNA to observe incident. V41 CNA witnessed R500 yelling at R84 and witnessed R84 falling backwards hitting her head on the floor. The Final Investigative Report, dated 8/20/24, documents R84 noted to be wondering per usual and was startled by R500 when she wandered near (R500's) door. R500 yelled at R84 get out of here and slammed the door. R84 startled and fell backwards onto the floor, resulting in laceration to scalp requiring three staples. Facility root cause determined to be related to peer being agitated with (R84) for wandering in or near her room and startling (R84) when (R500) yelled at her to get away and slammed her door causing (R84) to step backwards quickly and without her walker falling onto the floor. This investigation does not include any safety measures being put in place to protect R84 or other residents from R500. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A facility Fall Investigation, dated 8/20/24 at 4:40 pm, documents Resident (R103) was the receiver of physical aggression that resulted in a fall to the floor. Incident happened in the east hallway of the unit. Resident was observed on the floor laying on her left side. Resident stated that she didn't do anything. Resident stated that her left hip hurt. No injuries observed at time of incident. A facility Physical Aggression Investigation, dated 8/20/24 at 4:40 pm documents V35 LPN (Licensed Practical Nurse) heard loud screaming from R500, a Housekeeper witnessed physical aggression from (R500) to (R103) in the hallway. Victim (R103) fell to floor as a result. (R500) wanted (R103) to get away from her. On 8/28/24 at 10:45 am, the facility's Video Surveillance was reviewed with V1 Administrator and V2 DON surrounding 8/20/24 incidents for R84 at 12:23 pm and R103 at 4:40 pm, which shows R500 was not receiving any increased monitoring or one-to-one monitoring. On 8/23/24 at 11:30 am, 12:01 pm, and 12:17 pm, R84 was wandering the hallways with a wheeled walker, with bruising noted to her right cheek, and three stapled to the back of her head. On this same date at 12:19 pm, R84 wondered into R94 and R134's bedroom. On 8/27/24 at 11:45 through 12:40 pm, R84 was pacing the facility hallways. On 8/23/24 at 11:48 am through 12:38 pm, R103 was independently walking around dining room, feeding herself lunch, and talking with other residents. On 8/27/24 R103 was pacing the facility hallways. On 8/27/24 at 1:30 pm, V8 Anonymous Staff Member stated on 8/20/24, during lunch, she witnessed from approximately 15 feet away, R84 standing in front of R500's bedroom door, R500 yelling and screaming at R84, and R500 taking her hands grabbing R84 and like a bowling ball slammed R84 to the floor. V8 stated there were no new interventions put in place for increased monitoring for R500 after the incident. V8 stated on this same day around 4:35 pm R500 and R103 were at the front of the hallway and R500 grabbed R103 and threw (R103) into the hallway wall, very forcefully. After that is when they put R500 on one-to-one. They should have done that after the first time and the second time wouldn't have happened. On 8/28/24 at 10:07 am, V29 LPN (Licensed Practical Nurse) stated R500 has had some increased behaviors and has been physical with myself (V29) and possibly another resident. V29 LPN confirmed on 8/20/24 at 12:23 pm, R500 was yelling at R84 to get away from her and R84 fell to the floor. V29 LPN stated R500 was not on one-to-one before or after R84's fall. On 8/27/24 at 1:10 pm, V33 CNA stated on 8/20/24 during lunch, herself and other staff in the dining room heard R500 screaming at R84, heard a big bump, like something hit on the floor and then a door slam. V33 CNA confirmed there was no increased monitoring of R500 after the incident. On 8/27/24 at 1:00 pm, V34 CNA stated on 8/20/24, during shift report, it was reported to her that on first shift at lunch time, R84 was walking with her walker and fell and hit her head by R500's room. V34 stated R500 did not have one-to-one monitoring in place until after R500 pushed R103 in the hallway on second shift around 4:45 pm.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Respond appropriately to all alleged violations. 30678 Based on interview and record review the facility failed to identify and investigate a potential allegation of verbal and physical abuse for two (R84 and R500) of four residents reviewed for abuse in the sample of 124. Findings include: The facility's Abuse Prevention Program, revised 3/1/21, documents: It is the policy of this facility to prohibit and prevent resident abuse, neglect, exploitation, mistreatment, and misappropriation of resident property and a crime against a resident in the facility. The following Procedures shall be implemented when an employee or agent becomes aware of abuse or neglect of a resident, or of an allegation of suspected abuse or neglect of a resident by a 3rd party. Upon receiving reports of physical or sexual abuse, the Charge Nurse will immediately examine the resident. Findings of the examination must be recorded in a separate Incident Report and the resident's medical record. This report shall be made immediately, but no later than two hours after the allegation is made. The Charge Nurse must complete an incident report and endeavor to obtain a written, signed and dated statement from the person reporting the incident. A completed copy of the incident report and written statements from the witnesses, if any, will be provided to the Administrator or DON in the Administrator's absence within twenty-four (24) hours of the occurrence of such incident. When an alleged or suspected case of abuse, neglect, exploitation, or crime against a resident is reported to the facility Administrator, or DON in the Administrator's absence, will notify the following persons or agencies of such incident immediately. Any incident that involves crimes or a significant injury to a resident will be reported within 2 (two) hours of the incident. Abuse allegations involving one resident upon another resident will be reported to (the State Agency). On 8/23/24 at 11:58 am, V21 Restorative Nurse stated on 8/20/24, R500 and R84 and R500 and R103 had resident to resident altercations and R84 lost her balance and fell backwards and hit her head and had bruising from the fall. That's all I know. On 8/27/24 at 1:10 pm, V33 CNA stated on 8/20/24 during lunch, she and everyone in the dining room heard R500 screaming and heard a big bump, like something hit on the floor. Then a door slam. R84 was down by R500's room, opened up R500's door and then fell back. R500's room has an entry way so can't see her door unless your right there or closer to her room. V41 CNA said she saw R500's hands push R84 down. R84's fall was an aggressive fall. A slower fall would not have caused that to her head. On 8/27/24 at 1:30 pm, V8 Anonymous CNA stated she witnessed, wrote a statement saying R500 was yelling at R84, R500 grabbed R84 and shoved R84 to the floor. V8 stated she reported the abuse to V29 LPN, V2 DON, and V14 ADON and her statement on the incident report does not reflect what she wrote on her witness statement. On 8/27/24 at 3:15 pm, V1 Administrator stated he was not involved in the initial investigation for R84 because he was not at the facility and V2 DON completed a fall investigation for R84. V1 Administrator stated the incident was investigated as a fall and not abuse. V1 stated he is not aware of the incident being a potential abuse allegation. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 8/28/24 at 10:45 am, V2 stated R84 was startled by R500 yelled at her and slammed her door and R84 stumbled back and fell . R84 never said she was pushed. V41 CNA never said R84 was pushed until the next day, on 8/21/24. She was telling everyone the next day and I was hearing rumors that she was pushed. V2 DON stated she did tell V41 CAN to stop telling people R84 was pushed because R84 wasn't. DON confirmed the incident was not investigated as abuse because it wasn't.