

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145269	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2025
NAME OF PROVIDER OR SUPPLIER Hope Creek Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a baseline care plan within 48 hours of admission for one of 29 residents (R76) in a sample of 67. Findings include: R76 was admitted on [DATE] with diagnoses of Polyosteoarthritis, Restless Leg Syndrome, Essential Hypertension, Anemia, Osteoporosis, Depression, Fall, Spinal Stenosis and Orthopedic Aftercare and Contusion of Right Hip. post fall at home. R76's Progress Notes document on 6/3/25, R76 sustained a fall, was transferred to the hospital, was surgically treated for a left wrist fracture and returned to the facility with a left-hand brace and sling to arm, non-weight bearing to left upper extremity and pain medication. R76's medical record did not include a completed Significant Change in Condition Comprehensive Assessment/Minimum Data Set (MDS). On 6/26/25 at 1:00 PM, V15 (Care Plan and MDS Coordinator) stated a Significant Change in Condition Comprehensive Assessment/MDS had not been completed and should have been.		

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to correctly assess fall risks, develop a comprehensive care plan and implement intervention to prevent a fall with injury. This resulted in the resident sustaining a wrist fracture due to a fall because appropriate fall prevention interventions were not implemented timely for one of 29 residents (R76) in a sample of 67. Findings include: The Comprehensive Care Plans Guidelines policy dated 5/25 documents the comprehensive care plan will be developed within 7 days after the completion of the comprehensive Minimum Data Set (MDS) assessment. All Care Assessment Areas (CAAs) triggered by the MDS will be considered in developing the plan of care. The comprehensive care plan will describe, at a minimum, the following: the services that are to be furnished to attain or maintain the resident's highest practical physical, mental and psychosocial well-being; any services that would otherwise be furnished but are not provided due to the resident's exercise of his or her right to refuse treatment; the residents goals for admission, desired outcomes and preferences for future discharge; and resident specific interventions that reflect the resident's needs and preferences and align with resident's cultural identity. The Fall Prevention and Management Program policy revised 5/5/25 documents risk factors for falls include Arthritis, Thyroid Disorders, Urinary incontinence or urgency, Depression, Sleep Deprivation, Pain, Orthostatic Hypotension, Deconditioning from inactivity or acute/chronic disease/condition, Diuretics and Narcotics. Fall Risk Assessment includes history of falls, ambulation/elimination status, gait/balance, systolic blood pressure, medication use and predisposing diseases. Fall Prevention includes to identify risk factors, implement individualized approaches/interventions based upon resident risk. the Fall Prevention Strategies/interventions list may be used to identify appropriate intervention and interventions should focus on risk factors. A plan of care will be developed/updated to accurately reflect the resident's risk of falls and related prevention interventions. R76 was admitted on [DATE] with diagnoses of Polyosteoarthritis, Restless Leg Syndrome, Essential Hypertension, Anemia, Age-related Osteoporosis, Depression, Fall, Spinal Stenosis, Low Back Pain, Fibromyalgia, Lack of Coordination, Hypotension, Insomnia and Orthopedic Aftercare and Contusion of Right Hip post fall at home. R76's Minimum Data Set, dated [DATE] documents R76 had a brief interview for mental status score of 14 (little to no cognitive impairment); utilized a walker and/or wheelchair for mobility due to lower extremity impairment; required partial/moderate assistance (helper does more than half the effort) for hygiene, dressing/grooming, sit to stand, chair/bed to chair, toilet and tub/shower transfers; had occasional urinary incontinence and bowel continence; frequently experienced pain which interfered with sleep, therapy activities; rated pain at an eight (0-no pain, 10-worst pain); and was being administered an antidepressant, diuretic (medication to increase urine production) and opioid (narcotic pain medication) medication. R76's Rehabilitation Evaluation follow-up note dated 6/2/25 documents R76 was to be on Fall and Safety Precautions per facility protocol and to continue with Therapy Services due to gait/balance instability and physical deconditioning post fall at home. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R76's Fall Risk assessment dated [DATE] documents a score greater than ten indicated the resident was at high risk for falls. R76 scored an eight and was a low risk for falls. The Fall Risk Assessment documented R76 was independent with ambulation, continent of bowel and bladder, gait and balance were within normal limits and had one to two health conditions which are inaccurate assessments when compared to the MDS/Comprehensive assessment dated [DATE]. R76's Progress Notes, Change in Condition Assessment/Evaluation and the Post Fall Investigation Report documented on 6/3/25 at approximately 2:15 AM, R76 attempted to self-transfer to bathroom due to the need to have a bowel movement and an unwitnessed fall occurred. R76 complained of left wrist pain with edema. R76's x-ray report dated 6/3/25 documented a left wrist fracture which was surgically repaired on 6/4/25. R76's care plan did not include fall prevention intervention until 6/3/25. The care plan did not include goals and interventions for the following areas identified on the comprehensive assessment until 6/24/25: Active Range of Motion Restorative Nursing Program to bilateral upper and lower extremity to prevent further decline in Range of Motion; Self-Care Deficit with impaired dressing and grooming and would benefit from a Dressing/Grooming Restorative Program due to impaired strength and endurance; Self-Care Deficit with Activities of Daily Living related range of motion deficit from left wrist fracture; placed in a supervised smoking program; risk for constipation; risk for complications related to Hypotension; at risk for altered tissue perfusion related to Anemia; alteration in sleep pattern related to Insomnia; risk for renal complications due to Chronic Kidney Disease; goals and interventions for Gastric Esophageal Reflux Disease and Depression; and had an Open Reduction Internal Fixation of the Left Distal Radius (wrist) and utilized a splint. The Rehabilitation Therapy note dated 6/9/25 documents She continues on hydrocodone-acetaminophen 5-325 TID (three times daily) until 6/14. She does not know what the plan is for her wrist post fracture. She continues with PT (Physical Therapy) and OT (Occupational Therapy) as ordered. They are working on dynamic balance tasks patient requires max cues to remain NWB (non-weight bearing) to LUE (left upper extremity). On 6/25/25 at 10:05 AM, R76 stated she thought she could get up and make it to the bathroom by herself and hurt her left wrist. R76 stated she had to have her wrist surgically repaired with hardware placed and this really set me back. R76 stated staff told her that she didn't need to use the call light and could use the bathroom independently. On 6/25/25 at 11:45 AM, V16 (Licensed Practical Nurse assigned to R76 on 6/3/25) was unable to state what R76's fall risk was or which precautions were implemented prior to the fall. On 6/26/25 at 1:00 PM, V15 (Care Plan and Minimum Data Set Coordinator) stated R76's care plan was not completed until 6/24/25 and should have been. On 6/26/25 at 2:45 PM, V2 (Director of Nursing) stated she was unaware the comprehensive care plan had not been completed until 6/24/25.		