

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 10/15/2025
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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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
---	-------	-----------

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 10/15/2025
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 0689 Level of Harm - Actual harm Residents Affected - Few	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE] for therapy. R1's current care plan did not include Fall Interventions on admission. R1's Minimum Data Set (MDS) dated [DATE] documents R1 is severely cognitively impaired and is dependent on facility staff for toileting. R1's Fall Risk assessment dated [DATE] documents R1 is 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. 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, R1's 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 R1's transfer status or R1's 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</p>		