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	02/22/2026

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to identify a pressure wound prior to becoming a stage 3 for a resident at risk for pressure ulcers (R1) and failed to ensure pressure relieving interventions were implemented for 2 of 3 residents (R1, R4) reviewed for pressure ulcers in the sample of 7.The findings include:1. R1's face sheet showed she was admitted to the facility 1/30/23 with diagnoses to include hemiplegia and hemiparesis, arthritis, secondary gout, hyperlipidemia, hypothyroidism, stage 3 chronic kidney disease, depressive episodes, Parkinson's disease, and pressure ulcer of left buttock. R1's facility assessment dated [DATE] showed she had severe cognitive deficits, was dependent on staff for most cares, and was at risk for developing pressure ulcers. R1's 1/15/26 Weekly Wound Evaluation showed, . Sacrum. Pressure Injury (In-House Acquired) . Stage 3. Length: 5 cm. Width: 1.5 cm. Depth: UTD (unable to determine) . R1's care plan initiated 7/31/24 showed, [R1] has the potential and actual impairment to skin integrity of the sacrum related to fragile skin, incontinence; Pressure area to sacrum (1/15/26) . R1's care plan initiated 2/15/23 showed, [R1] is at risk for skin breakdown related to hemiplegia/hemiparesis, impaired mobility. Assess for and provide appropriate pressure relieving devices. Assess for changes in skin condition each shift. On 2/22/26 at 9:35 AM, R1 was lying in her bed. R1's tan inflatable heel protector boots were observed to be under the edge of the dresser nearby R1's bed. R1's heels were lying directly on R1's air mattress. On 2/22/26 at 12:54 PM, R1 was receiving wound care by V6 (Wound Care Nurse). V8 CNA (Certified Nursing Assistant) was assisting V6 to position R1. R1 was lying in bed during care, she was observed to be wearing blue heel protector boots on both feet. V6 said R1 does not have any wounds on her heels. V6 said there is no order for R1 to wear heel protector boots, but she feels R1 should wear heel protector boots due to her condition and that is the reason the boots are in place. The tan heel protector boots were no longer under the dresser. V6 said she brought R1 new heel protector boots because her old ones were dirty. On 2/22/26 at 1:24 PM, V12 LPN (Licensed Practical Nurse/Treatment Nurse) said R1's sacral wound was identified when a CNA was getting R1 up for the day and told me she had a wound on her bottom. V12 said it is her understanding that the nurses should be documenting a weekly skin check. The reason to do weekly assessments is to make sure people aren't developing wounds and do to add more preventative measures. We would want to know about the wound right away so if the staff see breakdown happening, we will want to address it rapidly. V12 said she doesn't believe R1 wears heel protectors. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/22/26 at 2:57, V2 DON (Director of Nursing) said, . I would prefer the wounds be identified as soon as possible to prevent them from getting worse. I would expect her to have the low air loss mattress, heel protector boots. If she is bed bound, I don't think it would hurt her to wear hell protectors or have her heels floated. The facility's policy and procedure dated 5/20/23 showed, Guidelines for Preventative Skin Care. Guideline: It is the intent of the facility to provide residents with preventative skin care. to keep them clean, comfortable, well groomed and free from pressure sores. All residents will be provided a preventative pressure reducing mattress. Further, residents will have the results of their Braden Scale scores and Weekly Skin Assessments used as an indicator as to their specific Preventative Skin Care needs. Equipment: . 4) Heels Up or specialty order therapeutic boots. Procedure: Positioning pillows and/or specialty devices may be used between two skin surfaces or to slightly elevate bony prominences/pressure areas off of the mattress. Offloading must be provided as indicated to provide pressure relief. Heels Up or specialty ordered therapeutic boots may be used to protect heels on those residents identified as being high risk for potential skin breakdown. NOTE: Should a caregiver notice any alteration in a resident's skin to include a scratch, skin tear, bruise or discolorations, redness, rash, any broken skin or any other unusual observation will be reported immediately to the Charge Nurse for assessment and appropriate follow up. 2. On 2/22/26 at 11:13 AM, V6 (Wound Care Nurse) was at R4's bedside providing wound care to an unstageable wound to his coccyx. R4 was on an air mattress that was set to firm. R4 had a pressure relief cushion in his wheelchair that was flattened and torn with the foam inside coming out. V6 confirmed the cushion was worn and stated she would replace it. V6 stated the cushion was for pressure relief. V6 was asked to check R4's mattress and she stated it was set too high; it was set on firm and should be set to his weight. V6 asked R4 if he liked his mattress hard or wanted it soft and he seemed confused by what she was asking. On 2/22/26 at 1:00 PM, V2 Director of Nursing - DON stated if a resident has a pressure ulcer they will put a low air loss mattress, have a cushion to their wheelchair, and they may have boots to offload heels. The low air loss mattresses go off the resident's weight. V2 stated the cushions for pressure relief are checked by the wound nurse The Weekly Wound Evaluation dated 2/16/26 for R4 showed an unstageable pressure injury to his sacrum; 5 cm x 2.8 cm x 0.1 cm; moderate serousanguinous drainage present with a strong odor. Education was provided on the importance of off loading, verbalized understanding. Wound location changed from right buttocks to sacrum due to wound exacerbation. Low air loss mattress ordered. The Weight Documentation dated 2/9/26 for R4 showed a weight of 197 pounds. The Care Plan dated 1/19/26 for R4 showed the resident admitted with a pressure ulcer of the right buttock related to immobility. The care plan did not show pressure ulcer preventative measures/pressure ulcer relieving devices in place.