

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 03/20/2026
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>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure fall interventions were implemented for a resident who is at a high risk for falls. This failure resulted in R1 being found in her room, laying on the floor, sustaining a comminuted right humerus fracture requiring surgical interventions. This applies to 1 of 3 residents (R1) reviewed for safety in the sample of 8. The findings include: R1's Final Incident Report shows R1 is [AGE] year-old female, cognitively impaired. On 1/17/26 at 8:00 AM, R1 was found laying on the floor next to her bed with severe complaints of right arm pain. R1 was sent to the local hospital for evaluation. R1 sustained a right humerus fracture with surgical intervention. R1's Fall Risk assessment dated [DATE] shows she is HIGH risk for falls. On 03/20/26 at 10:07 AM, R1 was residing on the memory care unit. R1 was in her room sitting in her wheelchair. R1 was wearing an immobilizer to her right arm. R1 was alert to self and forgetful. R1 said she fell at a restaurant and could not recall the details regarding the fall. R1's room did not have signs posted to call and ask for help, there were no fall mats in her room, and there were no non-skid strips in front of her bed or in her bathroom. On 3/20/26 at 11:01 AM, V6 (Agency LPN) said on 1/17/26, she was passing morning medications and the aide reported that R1 was on the floor in her room. V6 said she entered R1's room and she was lying on the floor complaining of right arm pain. She called the paramedics and R1 was sent out to the local hospital. V6 said she thinks R1 was trying to get back in bed after breakfast. R1 is alert and forgetful, is a fall risk, has a history of self-transferring, and required one person assist with transfers. On 3/20/26 at 11:15 AM, V8 (Certified Nursing Assistant-CNA) said on 1/17/26, she heard yelling down the hallway. She found R1 laying on the floor in her room. I think she was trying to self-transfer from her wheelchair to her bed. R1 was complaining of pain to her right arm. The nightstand was behind her, and it appeared R1 fell backwards. V8 said R1's room was the last room at the end of the hall. V8 said she called for assistance when she found R1 on the floor. On 3/20/26 at 11:26 AM, V9 (Former CNA) said R1 was alert and oriented, she would always self-transfer and R1 was independent with transfers. (R1) was always independent. R1 would always say she didn't need help. R1 would normally eat in the dining room and go back to her to lay down. V9 said the last time she saw R1 was about 7:45 AM, self-propelling in her wheelchair going to her room. R1 was able to self-transfer, and she did not think to ask R1 if she needed assistance. V9 said they should check the electronic health record to check if the resident is a fall risk and how they transfer. V9 said she did not know R1 needed staff assistance with transfers. On 3/20/26 at 11:42 AM, V10 (CNA) stated, I don't think R1 was a fall risk. R1 always transferred herself, she always took herself to the bathroom. R1 was safe to self-transfer, and she did not use her call light assistance. V10 said and she does not remember if R1 had any falls prior. V10 said they should check the residents electronic record for the resident's transfer status and fall interventions. On 3/20/26 at 12:57 PM, V2 (DON) said she was on a leave absence from November 2025 to February 2026. The ADON (Assistant Director of Nursing) was reviewing the falls at that time. V2 said R1 fell in her room and sustained a right humerus fracture that required surgical intervention. When R1 returned, she was placed on the memory care unit for increased supervision. R1 is confused, (continued on next page)</p>		

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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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>had a history of falls and self-transferring. R1 would forget to ask for help, she thinks she can still do things on her own and forgets her limitations. Staff should assist her with transfers and required supervision for safety. R1 was not independent for transfers and required staff assistance. Staff should check the resident's electronic health records for their transfer status. When a resident transfers to a different room their fall interventions should follow them. R1 should still have fall interventions in place. On 3/20/26 at 2:05 PM, V1 (Administrator) said even he knows R1 is a fall risk, we have been working on falls as part of our of PIP (performance improvement plan) and educating staff to look on the residents Kardex or care plan if a resident is fall risk, how the resident transfers and ensuring fall interventions are in place. R1's current care plan initiated on 2/1/24 shows she is at risk for falls related to weakness, impaired gait and balance, requires assistance for bed mobility and transfers. Interventions include cues placed in room to ask and wait for assistance, non-skid strips at bedside, non-skid strips in front of toilet, low bed, call light within reach, and apply floor mats to right side of bed. R1's hospital records dated 1/26/26 show R1 sustained a communicated (bone has broken into more than two pieces) right humerus fracture from a mechanical fall. R1's Fall Prevention and Management Program Policy dated 5/2025 states, The purpose of our Fall Prevention and Management Program is to provide our residents with an interdisciplinary approach to assess risk for falls, provide appropriate interventions to prevent falls.</p>