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	04/13/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure Physician Progress Notes and orders were maintained with a resident's record and followed promptly. The facility failed to ensure accurate and complete monitoring of a surgical site was being completed. This applies to 1 of 3 residents (R1) reviewed for quality of care in the sample of 4.The findings include:On 4/12/26 at 9:48 AM, R1 was in bed on her back with head of bed elevated slightly. R1 had a gown on and incontinence brief. R1 had a healed surgical scar to the middle outer area of her right leg. R1 had a small abrasion above the surgical site that she stated was from the hinge brace. R1 stated she had surgery and then came to the facility. R1 said she had to go back to the hospital for another procedure because she had an infection to her leg.The Progress Note dated 2/24/26 for R1 stated she was asking about her antibiotic start date. A call was placed to the surgeon's office and the nurse said there wasn't one ordered. The wound nurse removed R1's immobilizer to look at the surgical site, replaced a couple of steri-strips that had been falling off. There was minimal serous drainage and light redness present. The area was cleansed, antibiotic order obtained and processed and R1 was to follow up on 2/27/26.The Physician's Progress Note from R1's visit to his office on 2/20/26 was not in the resident's record. The note was located by V2 Director of Nurses once the surveyor requested the document on 4/12/26. The Orthopedic Physician Progress Note dated 2/20/26 for R1 showed she was doing okay; continue the knee immobilizer; remain non-weight bearing on right lower extremity; leave steri-strips in place; follow up in one week for a wound check; and cephalexin 500 mg three times per day for seven days. This order was written on 2/20/26 but not located or processed by the facility until 2/24/26.On 4/12/26 at 12:20 PM, V2 Director of Nursing - DON stated the Orthopedic Physician Progress Notes dated 2/20/26 for R1 said to continue the knee immobilizer and leave steri-strips in place, follow up in 1 week for a wound check. No other wound care orders. R1 was started on cephalexin at that visit because he thought she had a cellulitis. V2 stated the visit was on 2/20/26 and the antibiotic wasn't started until 2/24/26 because they couldn't locate the paperwork. V2 stated R1 asked out her antibiotic and they didn't know anything about it, so V4 Wound Nurse called the doctor's office and the nurse there said one wasn't ordered. The nurse then called back later and said an antibiotic was ordered. V2 stated they later located the Physician Progress Note and got it ordered.On 4/12/26 at 12:42 PM, V4 Wound Nurse stated she put a note in R1's medical record on 2/24/26 about R1, the antibiotic and what happened. V4 stated R1 came up to her and asked about her antibiotic because the orthopedic physician said she was getting one. V4 stated she called the doctor's office, and his nurse told her that R1 was not placed on an antibiotic on 2/20/26 at her appointment. The nurse did not see it in the notes for R1. V4 stated she then looked around the facility and at the nurse's desk she found the Physician's Progress Note dated 2/20/26 for R1 with the antibiotic order. V4 stated she initiated the order for the antibiotic that day (2/24/26). The doctor's office also called back and said right before R1 was leaving the doctor's office he decided to put her on an antibiotic for cellulitis. V4 stated R1 had steri-strips in place after that visit and no dressing orders.On 4/12/26 at 2:27 PM, V1 Administrator stated the only way we could fix this issue was to follow up when they return and check for the paperwork, looking for the orders. If there isn't (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	any paperwork, then we call and ask for the paperwork.The February 2026 Treatment Administration Record - TAR for R1 showed staff were monitoring a surgical site to R1's right leg. Leave surgical dressing in place until follow up unless dislodged or soiled, Notify medical doctor of any changes, signs or symptoms of infection every shift. Staff were signing off that this was being done; however, as of R1's 2/20/26 physician appointment she no longer had a dressing in place and had steri-strips. The March 2026 TAR for R1 up to 3/6/26 showed the same thing. R1's TAR's did not reflect the drainage or redness at R1's surgical site on 2/24/26. R1's medical record did not show any documentation of an infection to R1's surgical site.The hospital History & Physical/Discharge/Consult information dated 3/10/26 for R1 showed she was admitted to the hospital with purulent drainage from her surgical wound. R1 was admitted for a superficial wound infection. R1 was taken for an incision and drainage per orthopedics on 3/7/26, no deep tissue infection or abscess was found. R1 was started on antibiotics, and her cultures grew methicillin resistant staphylococcus aureus - MRSA.On 4/12/26 at 12:20 PM, V2 DON stated R1 was admitted to the hospital from her follow up orthopedic physician appointment for an incision and drainage to her surgical site. V2 stated R1 was re-admitted to the facility on [DATE] with dry dressings. V2 stated nurses are to monitor for any redness, drainage, and signs and symptoms of infection. On 4/12/26 at 12:55 PM, V2 DON stated they did not change the order on the TAR to show that R1's steri-strips along with the surgical site were being monitored. V2 acknowledged this should have been changed on the TAR.The facility's Conformance with Physician Medication Orders policy (no date) showed, all medications.shall be given only upon the written order of a physician. These medications shall be given as prescribed by the physician and at the designated time. A complete and accurate listing of current medication orders will be maintained on the resident's Physician Order Sheet.The facility's Change in Condition policy (May 2025) showed all facility staff must remain alert to changes in condition in all residents. Upon recognition of a change, appropriate nursing and medical interventions must be initiated promptly to address the residents' needs. The interdisciplinary team will ensure the change is assessed, documented, and communicated according to federal and state guidelines. All assessments, notifications, and interventions must be documented in the medical record. Include date, time, observed change, who was notified, recommendations, and outcomes.The facility's Skin Condition Monitoring policy (no date) showed it is the policy of the facility to provide proper monitoring, treatment, and documentation of any resident with skin abnormalities. Documentation of the skin abnormality must occur upon identification and at least weekly thereafter until the area is healed. Documentation of the area must include the following: size, shape, depth, odor, color, presence of granulation or necrotic tissue. Treatment and response to treatment.