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	08/31/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 32189 Based on observation and interview, the facility failed to ensure staff treated the resident with dignity and respect for one resident (R101) reviewed for resident's rights in a sample of 124. Findings include: On 08/26/24 at 10:00 AM, R101 stated she had diarrhea during the night, and no one answered R101's call light. R101 stated she had to clean herself up but made a mess on the bed and pointed at the blanket on the bed. R101 stated the staff were notified the blanket needed to be washed. On 8/26/24 at 10:00 AM, R101's bedside table was observed with a breakfast tray and a blanket on the bed was observed with a brown/diarrhea stool smear approximately 5 centimeters by 12 inches long. Multiple spots of brown/diarrhea stool were observed next to R101's bed on the floor. On 8/26/24 at 12:30 PM, R101 was observed to be lying in bed with a lunch tray on the bedside table (breakfast tray had been removed), fully clothed, covered with a blanket reading a book lying on the soiled blanket and brown spots remained on the floor. On 8/26/23 at 2:48 PM, R101 was observed in bed (lunch tray had been removed), fully clothed, covered with a blanket with eyes closed, lying on the soiled blanket and brown spots remained on the floor. On 8/26/23 at 2:50 PM, V10 (Certified Nurse Aid) was notified of R101's soiled blanket. V10 observed the blanket and stated V10 would take it off the bed immediately and get housekeeping to mop the floor.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to organize and participate in resident/family groups in the facility. 33970 Based on record review and interview the facility failed to effectively resolve grievances voiced in resident council meetings. This failure has the potential to affect all 160 residents who reside in the facility. Findings Include: Resident Council Meeting Minutes dated 10/25/23 documents concerns from residents stating the kitchen needs to be more organized to be able to serve meals on time, and there needs to be more staff in the dining room to help serve meals on time as well. The General Feedback/Grievance Form dated 10/25/23 documents Resident Council topic of concern Dietary. Detailed Description of Occurrence: kitchen to be more organized, need service to be faster, would like alternatives to spicy food. The Steps taken to investigate concern and corrective action taken areas were blank. The Resident Council Meeting Minutes dated 11/29/23 documents concerns from residents that their meal tickets that staff helps them fill out does not always match what they are serving for the meal, prefer their milk in the cartons, soups are not hot enough and council members are wondering when there will be another full time dietary manager. The General Feedback/Grievance Form dated 11/29/23 documents Resident Council topic of concern Dietary. Detailed Description of Occurrence: menu of the day and what is served is different than what is on the meal ticket, prefer milk in cartons, soup not hot enough, eating in rooms not given a choice of what to eat, full time dietary manager? The Steps taken to investigate concern and corrective action taken areas were blank. Resident Council Meeting Minutes dated 12/7/23 documents concerns from residents that they would like meal likes and dislikes to be added to their meal tickets with the new system that is being used to print tickets, requested more staff to help take orders and help serve meals in the dining room, council members suggested having managers help serve lunch in the dining room as it has been done in the past. The General Feedback/Grievance Form dated 12/27/23 documents Resident Council topic of concern Dietary. Detailed Description Occurrence: would like likes and dislikes on meal ticket, dinner time to have more staff to take orders and serve trays, have managers help serve at lunch times, dinner-not everyone getting same meal in rooms. The Steps take to investigate concern and corrective action taken areas were blank. A General Feedback/Grievance Form dated 1/31/24 documents Resident Council topic of concern Dietary. Detailed Description of Occurrence: when eating in rooms, would like to have a menu available, menus on the table are inconsistent, lunch service is not accurate of their ticket, breakfast is closing too early, dinner orders not taken and inconsistent times. The Steps taken to investigate concern and corrective action taken areas were blank. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident Council Meeting Minutes dated 2/28/24 documents concerns council members suggested having more managers in the dining room to help serve lunch. There was no correlating Grievance Form for this request. Resident Council Meeting Minutes dated 4/24/24 documents concerns from residents that they would like to be offered the chef salads and that they are sometimes given food they do not want. A General Feedback/Grievance Form dated 4/24/24 documents topic of concern Dietary. Detailed Description of Occurrence: meal of the month, chef's salad, food given that they don't want, tables need cleaned. Steps taken to investigate concern area was blank. Corrective action taken: documents Attended meeting and addressed all concerns signature on form was illegible. On 8/28/24 at 2:30 PM V15 (Activity Director) stated that grievances associated with resident council meeting minutes are written out on a grievance form and given to the applicable department head and each one should have a response in writing on the back of the form. On 8/29/24 at 8:15 AM R37 (Resident Council President) stated We bring up things in resident council, but nothing ever gets taken care of. We usually don't even hear anything in return but when we do it's oh, we talked to the staff. Well, maybe quit talking and start taking action, this is so silly. These are easy things to help us with. The Resident Room Roster dated 8/26/24 lists 160 residents currently reside in the facility.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30678 Based on observation, interview, and record review the facility failed to ensure residents were free from physical and verbal abuse and identify and investigate a potential allegation of abuse and protect resident from further abuse from R500, with a known history of verbal and physical aggression. These failures resulted in R500 verbally yelling and physically hitting R134 and shoving both R84 and R103 to the ground. R84 sustained a bleeding laceration to posterior head, facial bruising, and hospitalization requiring three staples to R84's posterior head. R103 experienced hip and knee pain, bruising, and hospital evaluation. R134 was hit in the face. These failures have the potential to affect all 35 residents residing in the facility's Dementia unit. These failures resulted in an Immediate Jeopardy. While the immediacy was removed on 8/29/24, the facility remains out of compliance at a Severity Level 2 as additional time is needed to evaluate the implementation and effectiveness of the facility's removal plan and quality assurance monitoring. Findings include: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The facility's Abuse Prevention Program policy, revised 3/1/21, documents It is the policy of this facility to prohibit and prevent resident abuse, neglect, exploitation, mistreatment, and misappropriation of resident property and a crime against a resident in the facility. This policy also documents Identification of Allegations/ Internal Reporting Requirements: Employees are required to immediately report and incident, allegation or suspicion of potential abuse, neglect, exploitation, misappropriation of resident property, mistreatment or crime against a resident they observe, hear about, or suspect to the Administrator if available or an immediate supervisor who must immediately report it to the Administrator. In the absence of the Administrator, reporting can be made to the DON (Director of Nursing). Any incident, allegation or suspicion of potential abuse, neglect, exploitation, misappropriation of resident property, mistreatment or crime against a resident is reported to a covered individual; covered individuals are notified annually of these reporting requirements. Employees without fear of retaliation may also independently report to the state survey agency any allegation of abuse, neglect, exploitation, or mistreatment of resident property, and to local law enforcement if they have a reasonable suspicion that a crime was committed. Such reports may be made without fear of retaliation. Anonymous reports will also be thoroughly investigated. Reports should be documented, and a record kept of the documentation. Upon learning of the report, the Administrator or in the absence of the Administrator, the DON shall initiate an incident investigation. Investigation: All incidents, allegation or suspicion of abuse, neglect, exploitation, misappropriation of property, or crime against a resident will be documented. Any incident or allegation involving abuse, neglect, exploitation, misappropriation of resident property, or crime against a resident will result in an abuse investigation. Once the Administrator or in the absence of the Administrator the DON determines that there is an allegation or a reasonable cause for suspecting abuse, neglect, exploitation, misappropriation of property, or a crime against a resident, the Administrator or appointed investigator will investigate the allegation and obtain a copy of any documentation relative to the incident. This policy also documents Protection of Residents: The facility will take steps to prevent mistreatment while the investigation is underway. Residents who allegedly mistreated another resident will be immediately removed from contact with that resident during course of investigation. The accused resident's condition shall be immediately evaluated to determine the most suitable therapy, care approaches and placement, considering his or her safety, as well as the safety of the other residents and employees of the facility. All personnel, residents, visitors, etc. (etcetera) are encouraged to report incidents of resident abuse, mistreatment or neglect or suspected abuse, mistreatment, or neglect, without fear of retaliation or retribution from facility or its staff. Abuse: The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm or pain or mental anguish or deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental psychosocial well-being. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. This same policy also documents Procedure: Upon receiving reports of physical or sexual abuse, the Charge Nurse will immediately examine the resident. Findings of the examination must be recorded in a separate incident report and in the resident's medical record. This report shall be made immediately, but no later than two hours after the allegation is made. If the events that cause the allegation involve abuse or resulted in serious bodily injury, or not less than 24 hours if the events that cause the allegation do not involve abuse and did not result in serious bodily injury. Crimes include but may not be limited to murder, manslaughter, rape, assault and battery, sexual abuse, theft robbery, drug diversion for personal use or gain, identify theft, and fraud and forgery. When an alleged or suspected case of abuse, neglect, exploitation, or crime against a resident is reported to the facility Administrator, the Administrator, or DON in the Administrator's absence, will notify the following persons or agencies of such incident immediately. Any incident that involves crimes or significant injury to a resident will be reported within two hours of the incident. Any incident that involves a resident death will be called to the (State Agency) immediately. Abuse allegations involving one resident upon resident upon another resident will be reported to (the States Agency). (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The Diagnosis Report for R500, documents R500 admitted to the facility on [DATE] with a diagnosis of Schizoaffective Disorder. R500 was diagnosed with Obsessive Compulsive Personality Disorder on 7/15/24 and diagnosed with Bipolar and Metabolic Encephalopathy on 7/25/23. R500 was also diagnosed with Anxiety on 8/21/24 after readmitting to the facility on [DATE] from psychological hospitalization . The facility Psychiatric service report for R500, dated 6/5/24, documents R500 with a diagnosis of Dementia. This report documents R500 with auditory hallucinations and delusions and making false accusations of staff. Psychiatric History includes multiple psychiatric hospitalization s and multiple medication changes prior to facility admission. The current Care Plan for R500 documents the following: Focus areas with goals and interventions listed: R500 has chronic health conditions, behaviors, challenges, and co-morbidities that include Schizoaffective and bipolar disorder. R500 requires the support, services and structure of the care setting and is under the care of psychiatry and receives medications and illness management through psychological services and psychosocial group programming; R500 demonstrates movement behavior that may be interpreted as wandering, pacing, or roaming the unit; R500 uses antipsychotic medications r/t (related to) behavior management; R500 displays behavioral symptoms related to Bipolar Disorder; R500 has behavior problem r/t anxiety, depression, change in mood, self-isolation, false accusations, repetitive questioning, agitation, tearful episodes, cursing, decreased socialization, delusions, hallucinations, pacing, panic, paranoia, and verbal aggression; R500 has impaired cognitive function, becomes easily confused, overwhelmed and disoriented; and R500 had chronic psychiatric illness and determined to have ineffective coping modalities that include disorganized thought processes and mood patterns, delusions, hallucinations, difficulty meeting basic physiological/self-care needs, and having reduced insight and judgement r/t Schizoaffective disorder; and R500 displays conflictual, difficult behavior with other persons with symptoms of open conflict with or repeated criticism of staff and unprovoked expressions of anger towards staff and peer. Being verbally and physically aggressive with her peers. Interventions include: Teach and remind the resident to communicate his/her feelings, including anger and frustration through means other than hitting, touching or verbally abusing another person; R500 has rapid cycling and significant shifts in mood that include mania and depression that may last for several days r/t bipolar disorder with following symptoms of hallucinations, becoming easily agitated, irritated, disturbed, having illogical thinking, and paranoid delusional thoughts about others. Goal is for R500 to seek assistance when experiencing aggressive impulses and refrain from engaging in verbal threats and loud, profane language toward others. Interventions include: Monitor/record/report to MD (medical doctor) prn (as needed) risk for harming others: increased anger, labile mood or agitation, feels threatened by others or thoughts of harming someone, possession of weapons or objects that could be used as weapons; and R500 has Behavioral Symptoms/Altercation with Roommate initiated on 4/4/24 as: R500 demonstrates behavioral distress related to: Ineffective coping mechanisms, bipolar disorder and Schizoaffective disorder. Problems are manifested by: Physically abusive behavior when agitated such as slapping or attempting to cause harm to a peer. The Behavior Monitoring Report for R500, dated 7/01/24 through 8/28/24 documents the following behaviors have been noted over the past 30 days: grabbing others, hitting others, kicking others, pushing others, physically aggressive towards others, scratching others, accusing of others, cursing at others, expressing frustration/anger at others, screaming at others, threatening others, entering other resident's rooms/personal space, disruptive sounds, repetitive motions, rummaging, agitated, anxious and restless, elopement and exit seeking, experiencing something not there, hoarding, neglecting self care, pacing, panic, refusing care, wandering and withdrawn/isolation. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The Psychiatry Note for R500, dated 4/5/24, documents On 4/4/24 (R500) became agitated at her roommate (R134) for wandering on her (R500) side of the room and going through her (R500) belongings. When R500 attempted to take her belongings back, R134 raised their arms at R500 so (R500) struck (R134). R500 was sent to the local hospital for an evaluation and returned to the facility. On 8/27/24 at 2:47 pm, V2 DON (Director of Nursing) stated she does the Fall Investigations and V1 Administrator does the Abuse Investigations and there has only been one abuse allegation involving R500 and that was with R103. R500 is very territorial about her room and space and had just been at Geriatric psychological hospital for manic behavior, not for being aggressive. V2 DON stated That is the only incident she's had. There are no others. V2 DON stated R500 went out to the psychological hospital on 8/2/24 and just readmitted back to the facility on [DATE]. On 8/20/24 R500 pushed R103 and R103 fell to the floor. V2 stated both residents went out to the local the hospital for evaluations, returned with no injuries and R500 was placed on one-to-one staff monitoring when she returned from the hospital. On 8/27/24 at 3:15 pm, V1 Administrator stated he is the Abuse Coordinator but was not involved in the incident with R84 because he was not at the facility but was involved with the altercation between R500 and R103. V1 Administrator stated V2 DON (Director of Nursing) does all the fall investigations and did R84's investigation as a fall, it was not considered abuse and he is unaware of the incident being potential abuse. On 8/23/24 at 11:40 am, R500's door was closed, and V20 Transportation CNA was sitting outside of R500's room. Upon entering R500's room noted two mattresses on the floor with bed frames standing empty. R500 was lying on one of the mattresses and R500's personal items were randomly scattered on the other mattress on the floor. R500 stated she was not feeling very good, had recently been in the hospital, has lost weight, doesn't know why, and requested a soda to drink. 1. A facility Abuse Investigation for R500 and R134, dated 4/4/24, documents V38 CNA (Certified Nursing Assistant) heard noise and went into R500 and R134's room, (R134) had two bears and a flower in her hand. (R500) went and took the bears out of (R134's) hand. (R134) got upset and raised her hands in the air. (V38) got in between the two (R134 and R500) and tried to intervene and (R500) reached around and slapped (R134). V22 RN (Registered Nurse) witness statement documents (V22 RN) was standing at the nurses' station and was trying to get there asap (as soon as possible) because (V22 RN) was hearing a commotion. When (V22) got in the room (R500) was complaining about (R134) getting into (R500's) stuff. (R134) put her hands up in the air and (R500) slapped (R134). The local hospital ED (emergency department) Physician Notes for R500, dated 4/4/24, documents R500 is from (The Facility) and staff sent her (R500) in due to having an altercation with her roommate. The Final Abuse Investigation documents the facility is unable to substantiate this allegation as well as (R500) made contact with (R134); regardless that V38 CNA and V22 RN witnessed R500 hit R134. On 8/23/24 at 12:00 pm, V22 RN stated R500 has had some bizarre behaviors, is aggressive at times and there was an incident awhile back with another resident, her old roommate before she moved and R500 has been aggressive with the staff. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	2. A facility Fall Investigation for R84, dated 8/20/24 at 12:23 pm, documented by V29 LPN (Licensed Practical Nurse) documents staff was in the dining room at lunch when someone (R500) was heard yelling on the hallway. V29 LPN asked V41 CNA to go observe the area. V41 CNA went to the hall and started to go down the hall and observed (R84) at the end of the hall. (R84) was observed falling backwards. V41 CNA was unable to assist (R84) d/t not being close enough. V41 CNA's statement is documented as: I was serving food. I heard someone yell. I went to observe the area and resident was at the end of the hall by (R500's) room. I observed the resident falling backwards and was unable to assist d/t not being close enough. The resident in the room had yelled, stepped back into her room and slammed the door. The local hospital ED (emergency department) Physician Notes for R84, dated 8/20/24, documents R84 presented to ED with a head injury. Chief complaint was an unwitnessed fall with wound to the posterior scalp and bleeding controlled at this time. CT (computed tomography) of the cervical spine and the head were completed with small left posterior scalp contusion without hemorrhage or fractures. On 8/28/24 at 10:45 am. the facility's Video Surveillance surrounding R84's on 8/20/24 at 12:23 pm incident viewed with V1 Administrator and V2 DON and shows R84 standing in R500's doorway area. R500 cannot be seen due to recession of R500's door. V41 CNA is seen walking down the hallway towards R500's door, and at approximately 15 feet from R500's door R84 is seen quickly and forcefully falling, hitting the back of her head on the floor. V41 CNA is then seen anxiously and rapidly moving in circles and about the hallway with arms flailing about. Other Staff members are then seen going down the hallway to assist. The Video Surveillance does not show R500 at the doorway due to the surrounding walls; however, there is some shadowing movement to the left upper exterior door frame area that quickly disappears while R84 is falling backwards. R84 does not appear to have stumbled backwards as the fall was so quick and forceful. R84's walker is also noted to move in the lower middle door area but does not fall over. On 8/27/24 at 1:30 pm, V8 Anonymous Staff Member stated R500 has had a lot of behaviors lately and over the past month or so and has been in and out of the hospital because of aggressive behaviors. V8 stated on 8/20/24 around 12:30 pm she heard R500 yelling and screaming and (V8) was approximately 15 feet from R500's room when R500 took both of her hands, grabbed R84 and like a bowling ball slammed R84 to the floor. She (R500) hulk smacked her (R84's) head and R84's head was gushing blood all over the floor. V8 stated she has never seen anything like that happen before, witnessed the entire incident and wrote a witness statement stating exactly what she saw and gave it to V29 LPN. V8 stated her statement was changed to reflect something other than what she saw. V8 stated V2 DON told (V8) she watched the camera, R84 had stumbled, and V2 DON needed V8 to stop telling people that R500 slammed R84 down. V8 stated she kept telling V2 DON what (V8) saw and that there was no stumbling or (V8) would have seen that. V8 stated she also told V14 ADON (Assistant Director of Nursing) what she witnessed. On 8/28/24 at 10:45 pm, V2 DON stated R84 was startled by R500 when R500 yelled and slammed her door and R84 stumbled back and fell . R84 never said she was pushed. V2 DON stated she heard rumors that were going around about R84 being pushed down the next day (8/21/24). V2 DON stated V41 CNA was telling everyone that she saw R500 push R84 down and was told to stop telling people that because the facility cameras do not show R500 pushing R84 down. When asked if the cameras show R500 not pushing R84 down or why V2 DON didn't investigate V41 CNA's allegation of abuse; regardless of when the allegation was made, V2 DON became irritated, raised her voice and stated R500 did not push R84 down, R84 stumbled and fell back. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 8/28/24 at 10:50 am, V1 Administrator stated the incident with R84 was reported to the State Agency as a fall and even if it was found to be abuse after investigating, he would not have resubmitted the incident as abuse, he would document it on the five day only. V1 also stated a abuse allegations with residents with dementia, confusion or one with a UTI (urinary tract infection) would not be considered willful abuse due to the resident not having the cognition to be willful and he would not report it as abuse. V1 Administrator confirmed the video surveillance did not show that there was or was not contact between R500 and R84 due to quality of video and positioning of camera. On 8/23/24 at 11:30 am, 12:01 pm, and 12:17 pm R84 was wandering the Dementia unit hallways with a wheeled walker and with a slow and steady gait. Bruising was noted to R84's right cheek and three staples to back of her head. On this same date at 12:18 pm, R84 wandered into another resident room. On 8/27/24 at 12:57 pm and on 8/28/24 at 10:09 am, R84 was pacing the hallways with a wheeled walker with a slow steady gait. On 8/27/24 at 1:10 pm, V33 CNA stated she and other nursing staff were in the dining room on 8/20/24 at noon assisting residents with lunch and heard R500 screaming, heard a big loud bump; like something hit on the floor, and then heard a door slam. V33 CNA stated R84 was down by R500's room, in front of R500's door and then just fell back. R500's room is at the end of the hall and the camera at beginning of hall. R500's room has an entryway so her door cannot be seen unless your closer to her room. V33 CNA stated V41 CNA told (V33) that she saw R500's hands push R84 down. V33 CNA stated R84's fall was an aggressive fall. A slower fall would not have caused that to her head. On 8/23/24 at 11:58 am, V21 Restorative Nurse stated on 8/20/24, R84 lost her balance and fell backwards, hit her head and had bruising from the fall, went to the hospital and That's all I know. On 8/27/24 at 1:00 pm, V34 CNA stated on 8/20/24, during shift change report, she was informed that on day shift R84 was walking with her walker, fell , and hit her head by R500's door, but doesn't know the details. V34 stated R500 was not on one-to-one monitoring at that time. 3. A facility Physical Abuse Investigation for R500 and R103, dated 8/20/24 at 4:40 pm, documents the Nurse heard loud screaming from around the corner in the hallway and Housekeeper in the hallway witnessed physical aggression from R500 towards R103. The victim (R103) had a fall to the floor as a result of R500's Physical Aggression. The investigation includes a statement for V39 and V40 CNA's documenting witnessing R500 yelling at R103 you stay away from me and then R500 pushing R103 to the floor. There is no witness statement from a Housekeeper included in investigation. R103 fell to the floor onto left side and complained of left hip and left knee pain. R103 and R500 were both sent to the local hospital for evaluation and treatment. The Change in Condition Evaluation for R500, dated 8/20/24 at 4:44 pm documents: R500's behavioral changes as physical and verbal aggression and a danger to self and others; Dangerous behavior as pushed peer and as a result of the physical aggression receiver of the aggression fell to the floor; Behavioral changes as resident moving furniture around and had made comment of being filthy and disgusting; and Resident has new orders to be on 1:1 supervision until further notice when she returns from ED (emergency department). (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hope Creek Nursing & Rehab	4343 Kennedy Drive East Moline, IL 61244

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The ED Physician Notes for R500, dated 8/20/24, documents R500 was recently discharged from local behavioral hospital yesterday (8/19/24), re- admitted to (the Facility) and altercation occurred (8/20/24) between R500 and another resident. The local hospital Emergency Department Provider Notes for R103, dated 8/20/24 documents the patient (R103) was in an altercation at (the Facility) on memory unit, was pushed hard and fell down and complained of left hip and left knee pain. On 8/28/24 at 10:45 am, the facility's Video Surveillance surrounding R103's 8/20/24 at 4:40 pm incident was reviewed with V1 Administrator and V2 DON and shows R103 and R500 at a table near the entrance of the hallway. R500 is seen standing facing R103 and appears to be talking to R103 and then R500 is seen quickly and forcefully grabbing R103 and shoving R103 towards the floor. R500 is then seen standing nearby while R103 is being assisted. On 8/23/24 at 11:48 am, R103 was in the dining room, standing next to a table talking to other residents. Between 11:50 am through 12:38 pm, R103 was walking independently around the dining room, sat in a stationary chair in the dining room, fed self lunch and at 12:38 pm remained sitting in the dining room. On 8/27/24 at 12:54 pm, R103 was pacing the hallways independently. On 8/30/24 at 2:30 pm, V3 Infection Preventionist assisted R103 with lowering her left pant leg. A large bruise measuring approximately 13 inches was noted to R103's left hip. V3 confirmed this was from R103's fall. On 8/27/24 at 1:30 pm, V8 Anonymous Staff Member stated on 8/20/24 around 4:35 pm she heard and witnessed R500 scream out at R103, grab R103 and throw R103 into the hallway wall, very forcefully. V8 stated after this incident R500 was put on one-to-one monitoring. V8 stated They should have done that after the first time and the second time wouldn't have happened. On 8/23/24 at 11:58 am, V21 Restorative Nurse stated on 8/20/24, R500 and R103 had a resident to resident altercation and both residents went to the hospital and came back and That's all I know. On 8/27/24 at 1:00 pm, V34 CNA stated on 8/20/24, during second shift R103 was walking and R500 pushed R103 down in the hallway. V34 stated she didn't see it happen but heard the staff talking about seeing R500 push R103 and stated, That's how I know. V34 CNA stated R500 and R103 went out to the local hospital and R500 was put on one-to-one monitoring when she returned from the hospital and had not been on one-to-one prior to that. On 8/23/24 at 11:35 am, V20 Transportation CNA was sitting just outside of R500's room. V20 stated V41 CNA had to leave for family emergency so (V20) was filling in to help with R500's one-to-one monitoring. V20 stated she transported R500 to a behavioral health hospital on 8/2/24 after R500 attacked the staff and was having bizarre behaviors. R500 screamed at the top of her lungs during the last hour of the ride but other than that she didn't have any behaviors. V20 stated R500 just came back here on 8/19/24 and had to be put on one-to-one a couple of days ago. The medical record for R500 documents another emergency room evaluation occurred for R500 on 8/26/24 due to aggressive physical behavior. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The local hospital ED report for R500, dated 8/26/24, documents (R500) is a resident of (the Facility) and was apparently becoming quite aggressive with staff. Patient came flying down the hallway and pushed staff x (times) 2. She has no idea why she is in the emergency department, and has some unusual behavior at times and flaps her hands around stating that she is shaking all over. This report documents R500 is positive for agitation and behavioral problems. The Final diagnoses for R500 is documented as Behavior concern in adult and Aggressive behavior. The facility's Abuse log, dated 2024, documents one abuse allegation involving R500, dated 8/20/24 at 4:40 pm and does not include the allegation involving R134 or R84. The Immediate Jeopardy began on 8/20/24 at 12:23 pm when the facility failed to prevent, identify and investigate a potential allegation of abuse and protect residents from further abuse. V1 Administrator was notified of the Immediate Jeopardy on 8/29/24 at 11:28 am. The surveyor confirmed through interview, observation and record review that the facility took the following actions to remove the Immediate Jeopardy: 1. Investigation of both incidents were completed and reported to state survey agency and physician for R84, R103, and R500. 2. R84 was transferred to the hospital for evaluation. 3. R103 was transferred to the hospital for evaluation. No injuries were noted and R103 returned to the facility with no new orders. 4. R500 was placed on one-to-one supervision on 8/20/24. 5. R500 care plan was updated to include one-to-one supervision and again updated to include one-to-one supervision until the resident is deemed safe by psychiatry and/or nursing assessment. 6. R500 care plan was updated to include behavior monitoring Q (every) shift. 7. R84, R103, and R500 care plans have been updated to include one-to-one time with Social Services as needed to vent feelings. 8. Administrator in-serviced by Risk Management Consultant on 8/29/24 regarding Abuse Prevention Policy. 9. In-servicing training by Administrator/designee on Abuse Prevention Policy with all staff was initiated on 8/29/24. 10. In-servicing training by Administrator/designee on Abuse Prevention Policy with all staff will continue, and any remaining employees must be trained prior to reporting for work for their next scheduled shift. Employees will not be allowed to work after 11:59 pm on 8/29/24 until they have completed the in-service. 11. QAA (Quality Assessment and Assurance) team members were in-serviced on the facility's Abuse Prevention Program policy and procedure by the Administrator on 8/29/24. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	12. Social Services Director and/or designee will audit Trauma Screening assessments and Screening Assessments for Indicators of Aggressive and/or Harmful Behavior for all 35 residents with the potential to be affected by this alleged deficiency to ensure those assessments are current. Social Services Director/designee will ensure interventions are care planned for any residents assessed to be at risk. The audits will be completed by 11:59 pm on 8/29/24. 13. QAA team will review the Trauma Screening assessments and Screening Assessment for Indicators of Aggressive and/or Harmful Behaviors during quarterly QA (Quality Assurance) meetings with medical director and address any concerns. 14. QAA team will review the Trauma Screening assessments and Screening Assessment for Indicators of Aggressive and/or Harmful Behaviors during Morning QA meetings daily x 30 days on all new admits to assure compliance. 15. The facility will follow state and federal guidelines regarding Abuse Reporting by requiring reporting of all reports of abuse to be reported to the facility QA Committee for follow up and review. 16. In-service training by Administrator/designee on Abuse Prevention Policy with all staff will continue monthly for the next 3 months, then quarterly x 3 by the DON or Administrator. 17. Administrator will enforce the interventions of plan of removal of immediacy and assurance of continued compliance.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 30678 Based on observation, interview, and record review the facility failed to implement their abuse prevention program to protect residents from abuse for three (R84, R103, and R500) of four residents reviewed for abuse in the sample of 124. Findings include: The facility's Abuse Prevention Program, revised 3/1/21, documents Employees are required to immediately report any incident, allegation, or suspicion of potential abuse, neglect, exploitation, misappropriation of resident property, mistreatment or a crime against a resident they observe, hear about, or suspect to the Administrator. In the absence of the Administrator, reporting can be made to the DON (Director of Nursing). Upon learning of the report, the Administrator or in the absence of the Administrator, the DON shall initiate an incident investigation. All incidents, allegations or suspicion of abuse, neglect, exploitation, misappropriation of property, or a crime against a resident will be documented. Any incident or allegation involving abuse, neglect, exploitation, misappropriation of resident property, or a crime against a resident will result in an abuse investigation. Once the Administrator or in the absence of the Administrator the DON determines that there is an allegation a reasonable cause for suspecting abuse, neglect, exploitation, misappropriation of property, or a crime against a resident, the Administrator or appointed investigator will investigate the allegation and obtain a copy of any documentation relative to the incident. The Charge Nurse must complete an incident report and obtain a written, signed and dated statement from the person reporting the incident. A completed copy of the incident report and written statements from the witnesses, if any, will be provided to the Administrator (in the absence of the Administrator, the DON) within twenty-four (24) hours of the occurrence of such incident. The facility will take steps to prevent mistreatment while the investigation is underway. Residents who allegedly mistreated another resident will be immediately removed from contact with that resident during course of the investigation. The accused resident's condition shall be immediately evaluated to determine the most suitable therapy, care approaches and placement, considering his or her safety, as well as the safety of the other residents and employees of the facility. This facility will not tolerate resident abuse or mistreatment or crimes against a resident by anyone, including staff members, other residents, consultants, volunteers, and staff of other agencies, family members, legal guardians, friends, or other individuals. A facility Fall Investigation for R84, dated 8/20/24 at 12:23 pm, documents staff were in the dining room at lunch when (R500) was heard yelling on the hallway. V29 LPN sent V41 CNA to observe incident. V41 CNA witnessed R500 yelling at R84 and witnessed R84 falling backwards hitting her head on the floor. The Final Investigative Report, dated 8/20/24, documents R84 noted to be wondering per usual and was startled by R500 when she wandered near (R500's) door. R500 yelled at R84 get out of here and slammed the door. R84 startled and fell backwards onto the floor, resulting in laceration to scalp requiring three staples. Facility root cause determined to be related to peer being agitated with (R84) for wandering in or near her room and startling (R84) when (R500) yelled at her to get away and slammed her door causing (R84) to step backwards quickly and without her walker falling onto the floor. This investigation does not include any safety measures being put in place to protect R84 or other residents from R500. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility Fall Investigation, dated 8/20/24 at 4:40 pm, documents Resident (R103) was the receiver of physical aggression that resulted in a fall to the floor. Incident happened in the east hallway of the unit. Resident was observed on the floor laying on her left side. Resident stated that she didn't do anything. Resident stated that her left hip hurt. No injuries observed at time of incident. A facility Physical Aggression Investigation, dated 8/20/24 at 4:40 pm documents V35 LPN (Licensed Practical Nurse) heard loud screaming from R500, a Housekeeper witnessed physical aggression from (R500) to (R103) in the hallway. Victim (R103) fell to floor as a result. (R500) wanted (R103) to get away from her. On 8/28/24 at 10:45 am, the facility's Video Surveillance was reviewed with V1 Administrator and V2 DON surrounding 8/20/24 incidents for R84 at 12:23 pm and R103 at 4:40 pm, which shows R500 was not receiving any increased monitoring or one-to-one monitoring. On 8/23/24 at 11:30 am, 12:01 pm, and 12:17 pm, R84 was wandering the hallways with a wheeled walker, with bruising noted to her right cheek, and three stapled to the back of her head. On this same date at 12:19 pm, R84 wondered into R94 and R134's bedroom. On 8/27/24 at 11:45 through 12:40 pm, R84 was pacing the facility hallways. On 8/23/24 at 11:48 am through 12:38 pm, R103 was independently walking around dining room, feeding herself lunch, and talking with other residents. On 8/27/24 R103 was pacing the facility hallways. On 8/27/24 at 1:30 pm, V8 Anonymous Staff Member stated on 8/20/24, during lunch, she witnessed from approximately 15 feet away, R84 standing in front of R500's bedroom door, R500 yelling and screaming at R84, and R500 taking her hands grabbing R84 and like a bowling ball slammed R84 to the floor. V8 stated there were no new interventions put in place for increased monitoring for R500 after the incident. V8 stated on this same day around 4:35 pm R500 and R103 were at the front of the hallway and R500 grabbed R103 and threw (R103) into the hallway wall, very forcefully. After that is when they put R500 on one-to-one. They should have done that after the first time and the second time wouldn't have happened. On 8/28/24 at 10:07 am, V29 LPN (Licensed Practical Nurse) stated R500 has had some increased behaviors and has been physical with myself (V29) and possibly another resident. V29 LPN confirmed on 8/20/24 at 12:23 pm, R500 was yelling at R84 to get away from her and R84 fell to the floor. V29 LPN stated R500 was not on one-to-one before or after R84's fall. On 8/27/24 at 1:10 pm, V33 CNA stated on 8/20/24 during lunch, herself and other staff in the dining room heard R500 screaming at R84, heard a big bump, like something hit on the floor and then a door slam. V33 CNA confirmed there was no increased monitoring of R500 after the incident. On 8/27/24 at 1:00 pm, V34 CNA stated on 8/20/24, during shift report, it was reported to her that on first shift at lunch time, R84 was walking with her walker and fell and hit her head by R500's room. V34 stated R500 did not have one-to-one monitoring in place until after R500 pushed R103 in the hallway on second shift around 4:45 pm.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 30678 Based on interview and record review the facility failed to identify and investigate a potential allegation of verbal and physical abuse for two (R84 and R500) of four residents reviewed for abuse in the sample of 124. Findings include: The facility's Abuse Prevention Program, revised 3/1/21, documents: It is the policy of this facility to prohibit and prevent resident abuse, neglect, exploitation, mistreatment, and misappropriation of resident property and a crime against a resident in the facility. The following Procedures shall be implemented when an employee or agent becomes aware of abuse or neglect of a resident, or of an allegation of suspected abuse or neglect of a resident by a 3rd party. Upon receiving reports of physical or sexual abuse, the Charge Nurse will immediately examine the resident. Findings of the examination must be recorded in a separate Incident Report and the resident's medical record. This report shall be made immediately, but no later than two hours after the allegation is made. The Charge Nurse must complete an incident report and endeavor to obtain a written, signed and dated statement from the person reporting the incident. A completed copy of the incident report and written statements from the witnesses, if any, will be provided to the Administrator or DON in the Administrator's absence within twenty-four (24) hours of the occurrence of such incident. When an alleged or suspected case of abuse, neglect, exploitation, or crime against a resident is reported to the facility Administrator, or DON in the Administrator's absence, will notify the following persons or agencies of such incident immediately. Any incident that involves crimes or a significant injury to a resident will be reported within 2 (two) hours of the incident. Abuse allegations involving one resident upon another resident will be reported to (the State Agency). On 8/23/24 at 11:58 am, V21 Restorative Nurse stated on 8/20/24, R500 and R84 and R500 and R103 had resident to resident altercations and R84 lost her balance and fell backwards and hit her head and had bruising from the fall. That's all I know. On 8/27/24 at 1:10 pm, V33 CNA stated on 8/20/24 during lunch, she and everyone in the dining room heard R500 screaming and heard a big bump, like something hit on the floor. Then a door slam. R84 was down by R500's room, opened up R500's door and then fell back. R500's room has an entry way so can't see her door unless your right there or closer to her room. V41 CNA said she saw R500's hands push R84 down. R84's fall was an aggressive fall. A slower fall would not have caused that to her head. On 8/27/24 at 1:30 pm, V8 Anonymous CNA stated she witnessed, wrote a statement saying R500 was yelling at R84, R500 grabbed R84 and shoved R84 to the floor. V8 stated she reported the abuse to V29 LPN, V2 DON, and V14 ADON and her statement on the incident report does not reflect what she wrote on her witness statement. On 8/27/24 at 3:15 pm, V1 Administrator stated he was not involved in the initial investigation for R84 because he was not at the facility and V2 DON completed a fall investigation for R84. V1 Administrator stated the incident was investigated as a fall and not abuse. V1 stated he is not aware of the incident being a potential abuse allegation. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/28/24 at 10:45 am, V2 stated R84 was startled by R500 yelled at her and slammed her door and R84 stumbled back and fell . R84 never said she was pushed. V41 CNA never said R84 was pushed until the next day, on 8/21/24. She was telling everyone the next day and I was hearing rumors that she was pushed. V2 DON stated she did tell V41 CAN to stop telling people R84 was pushed because R84 wasn't. DON confirmed the incident was not investigated as abuse because it wasn't.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 33985 Based on interview and record review the facility failed to do a Level 2 PASARR (Pre- Admission Screening and Resident Review) screen for one of two residents (R73) reviewed for PASARRs in total sample of 124. Findings Include: The facility policy, named, Resident Assessment Policy and Procedure, dated 2019, documents the following: The facility shall coordinate assessments with the preadmission screening and resident review (PASARR) program. Referring all Level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. The facility shall notify the state mental health authority or State intellectual disability, as applicable, promptly after a significant change in the mental or physical condition of a resident who has a mental disorder or intellectual disability for resident review. R73 's Medical Diagnosis List, dated 2/10/2021, documents the following diagnosis: Alcoholism, Anxiety, Depression, Disorganized Schizophrenia, and Schizoaffective Disorder-Depressive Type. R73 's Level one Form PASARR (Pre-Admission Screening and Resident Review), dated 9/11/2018, documents the following: (The Pre-Admission Screening and Resident Review) Level 1 identification Screen was reviewed and shows that a nursing facility placement is appropriate for you. The PASARR Level I screen remains valid for your stay at the nursing facility and should be transferred with you if you relocate. No further Level 1 screening is required unless you are known to have or are suspected of having a major mental illness or intellectual disability and exhibit a significant change in treatment needs. 1.) Does this individual have any of the following major mental illnesses: Major Depression, Bipolar, Psychotic Disorder, Schizophrenia, Schizoaffective Disorder. The answer is NO. R73's Diagnosis Report from the facility, dated 2/10/2021, documents the following Diagnosis: Major Depressive Disorder, Alcohol Abuse, Disorganized Schizophrenia, and Schizoaffective Disorder-Depressive Type. R73 's Admission Notes, dated 2/21/2021, documents R1's admitted was 2/10/2021. On 8/29/2024 at 8:19AM V25/Social Service Coordinator, stated, Yes, a new PASARR (Pre-Admission Screening and Resident Review) should have been done when resident was admitted to the facility. Resident has a diagnosis of Disorganized Schizophrenia, and Schizoaffective Disorder Depressive Type and R73's Level 1 did not reflect that.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 33985 Based on record review and interview the facility failed to update the care plan to reflect the removal of the tracheostomy for one of one resident (R127) reviewed for careplans in a sample of 124. Findings include: The facility policy, named Comprehensive Person-Centered Care Planning Policy and Procedure, dated 2022, documents the following: The facility will develop and implement a baseline care plan for each resident that includes instructions needed to provide effective and person-centered care. The interdisciplinary team will review and revise after each assessment both the comprehensive and quarterly review assessment. R127's Physician Order Sheets, dated 8/20/2024, documents the following: Mid neck: Cleanse. with wound cleanser, apply an antibiotic ointment and cover with band-aide as needed for discontinued trach site. R127's Care Plan dated 6/26/2024, documents the following: R127 has a tracheostomy related to impaired breathing mechanics. R127's Care Plan has not been revised to show the removal of the tracheostomy. On 8/29/2024 at 10AM V19/MDS (Minimum Data Set/Care plan Coordinator stated, I should have updated the care plan and discontinued R127's tracheostomy off of it.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. 32189 Based on observation, interview and record review, the facility failed to provide an ongoing program of activities daily to meet the resident's physical, mental, and psychosocial well-being. These failures have the potential to affect all 35 residents residing in building four on the second floor. Findings include: The facility roster, dated 8/26/24, documents 35 residents (R5, R11, R16, R20, R26, R28, R29, R33, R34, R39, R41, R46, R49, R51, R54, R57, R65, R71, R72, R75, R78, R83, R86, R90, R96, R101, R106, R109, R110, R114, R125, R126, R129, R135, R141) reside on building four on the second floor. The Quality of Life Policy and Procedure, no date, documents III. Activities A. The Facility shall provide, based on the comprehensive assessment and careplan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. 08/26/24 11:15 AM, R51stated We (R51 and R125) go outside all the time, but we can't now related to COVID. This all started on Saturday (8/23/24). 08/26/24 10:25 AM, R101stated I participate in activities sometimes but there is nothing to do now. I just watch TV (television). 08/26/24 10:40 AM, R114 stated there has not been any activities since 8/23/24 and residents are not allowed off the unit. On 8/26/24 at 11:15 AM, R125 stated I am going stir crazy. We are stuck up here and can't even leave. We could at least play Bingo or something, but we haven't had any activities since this all started (8/23/24). On 8/26/24 between 10:20 AM and 12:45 PM, 8/26/24 between 1:30 PM and 2:30 PM, 8/27/24 between 10:45 AM and 12:30 PM, 8/27/24 between 1:00 PM and 1:50 PM and 8/28/24 between 10:00 AM and 11:30 AM no group activities were observed. On 8/27/24 at 1:50 PM, V15 (Activity Director) stated We can't do activities in the activity room because the air conditioning doesn't work in there. I have activity aides doing one on ones (activities) on the COVID-19 unit (building four on the first floor). V15 stated Oh, I forgot (about building four, second floor) residents not being allowed to leave their unit. I'll have to tell V26 (Activity Aide) to go up there (building four on the second floor) and do some activities with them.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 32189 Based on interview and record review the facility failed to provide range of motion programming to residents with limitations in range of motion for two of seven residents (R57, R78) reviewed for limited range of motion in a sample of 124 residents. Findings include: 1. R57's current care plan documents I would benefit from participation in an AROM (Active Range of Motion) Restorative Nursing Program as evidenced by the following risk factors and potential contributing diagnosis: History of Cerebral Vascular Accident (lack of blood flow to the brain) with Hemiplegia or Hemiparesis both involve weakness or paralysis on one side of the body). Resident will have AROM exercises to the following extremities- left upper extremity, left lower extremity, right upper extremity, right lower extremity. Interventions: The Restorative Aide and/or Unit Aide will complete AROM Programming to the following extremities bilateral upper and lower 15 repetitions times two sets six to seven days per week. R57's Point of Care History Restorative Nursing Active Range of Motion flowsheet lacked documentation AROM was conducted as ordered: 7/30/24- 8/27/24, 19 of 29 days. On 8/29/24 at 10:25 AM, R57 stated No one has ever done any exercises or range of motion to me. 2. R78's current Careplan documents I would benefit from participation in the PROM (Passive Range of Motion) Restorative Nursing Program as evidenced by the following risk factors and potential contributing factors: - Contractures Upper and lower Extremities, - Requires Total Assistance with most ADL's (Activities of Daily Living) - General Weakness, Spastic quadriplegic (paralysis in all four extremities), cerebral palsy, contracture of muscle in multiple sites. Contractures of Lower Extremities or (Decreased ROM (Range of Motion), - Contractures of Upper Extremities or (Decreased ROM), - Decreased Strength/Endurance/Sitting Balance. R57's Point of Care History Restorative Nursing Active Range of Motion flowsheet lacked documentation PROM was conducted as ordered: 7/29/24- 8/27/24, 9 of 30 days. On 8/27/24 at 11:00 AM, R78 stated No when asked if passive range of motion has been conducted daily by staff. On 8/29/24 at 10:35 AM, R78 stated No. Not ever done. When asked if PROM had ever been done by staff.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 50627 Based on observation, interview and record review, the facility failed to ensure a residents indwelling urinary catheter drainage bag was secured in a dignity enclosure bag for one of four residents (R55) reviewed for urinary catheters in the total sample of 124. Findings include: Facility's (indwelling urinary catheter) Foley Catheter Management Policy, dated 2/28/19, documents, Policy: the facility will have a system for the management of urinary catheters. All Catheter bags are covered with privacy bags at all times. R55's Care Plan, dated 7/8/24, and 8/27/24 states R55 has 16fr, Balloon 10ml indwelling catheter due to hydronephrosis. On 8/28/24 at 10:47 AM, R55 was sitting in a wheelchair in her room. R55's indwelling urinary catheter drainage bag was attached to the underneath of her wheelchair touching the ground. The drainage was not contained in a privacy covering. On 8/29/24 at 9:56 AM, V2 (DON, Director of Nursing), confirmed that all residents who have an indwelling urinary catheter should have a privacy bag covering the urinary drainage bag and it should be kept off of the floor.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 33970 Based on observation, interview and record review the facility failed to store medications in a safe manner for three residents (R7, R5, and R124) observed during a routine medication pass in a total sample of 124. Findings Include: The facility's Storage of Medications policy dated 5/8/19 documents the purpose of the policy is to ensure that medications are stored in a safe, secure and orderly manner. Medications are stored in the containers in which they are received. On 8/27/24 at 8:10 AM V22 (Registered Nurse) opened her medication cart and pulled out a clear medicine cup full of pills with writing on the side and administered the medications to R124. V22 stated that the medicine cup was full of R124's morning medications to include: Aspirin 81 mg (milligrams), Clopidogrel 75 mg, Lisinopril 5 mg, Oxybutin 10 mg, Vitamin D 10 mg, Keflex 500 mg, Carbidopa-Levodopa 25-100mg, Ropinorole .25 mg and Triheyphenidyl hydrochloride 2 mg. Also, on 8/27/24 at 8:10 AM V22 stated that she did not normally prepare medications before she is ready to administer them. V22 stated that there were no more pre-prepared medications in her cart. Upon further inspection of V22's medication cart there was another clear medication cup with pills in it. V22 stated Oh that is (R63)'s vitamins. V22's medication cart also had another clear medication cup with writing on the side with one white pill in it. V22 stated that is (R67)'s nametidine. There were multiple other clear medication cups in the medication cart that had writing on them but did not have any pills in them. V22 stated those are just reminders for me on who is going to need medicine again on my shift. V22 repeatedly asking Is it against the rules to put the medicine back in the cart? On 8/27/24 at 9:00 AM V22 confirmed that her medication cart held all medicines for the residents who live in building one floor one. On 8/28/24 at 8:40 AM V30 (Registered Nurse) had a clear medication cup with writing on the side in the top of her medication cart. V30 stated that the cup contained R8's morning medications to include Ascorbic Acid 500 mg, Aspirin 81 mg, Ergocalciferol 1.25 mg, furosemide 40 mg, losartan potassium 25 mg, Omperazole 20 mg, protonix 40 mg, potassium chloride 20 meq (milliequivalents), proanalol 60 mg and Zinc 22 mg. On 8/28/24 at 9:05 AM V30 (Registered Nurse) confirmed that her mediation cart held all the medicines for the residents who live in building four floor one.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 33970 Based on observation, interview and record review the facility failed to store dry foods in a clean manner and failed to ensure all kitchen staff had their hair covered. These failures have the potential to affect all 160 residents who currently reside in the facility. Findings Include: The facility's Employee Health and Personal Hygiene policy dated 4/2017 documents Food service employees shall maintain good personal hygiene and free from communicable illnesses and infections while working in the facility. Hair restrains will be worn at all times. Beards should be well trimmed and covered with an appropriate hair restraint. The facility's Storage of dry foods/supplies policy dated 4/2017 documents dry foods stored in bins such as flour and sugar will be removed from the original packaging. Storage bins used will be kept clean, labeled and dated. Scoops will not be stored in the food bins. On 8/27/24 at 9:00 AM in the dry storage room in the kitchen there were four clear bins individually marked oatmeal, flour, thickener and bread crumbs. None of the bins were labeled with dates. V31 (Dietary Manager) confirmed that there were no dates on the bins and there should be. The outside of each bin appeared cloudy and dirty. The tops of the bins had an approximate 1-inch gap between the fixed lid portion and the portion of the lid flips backwards for access. V3 stated I would not consider any of those covered with that big of a gap. On 8/28/24 at 9:30 AM V32 (Cook) was moving about the kitchen area with a hair net on the crown of her head with her long mid back length hair sticking out of the back unrestrained. V32 also had some long pieces of hair out of the front of the hairnet. V32 did not respond when asked if she normally wore her hairnet in this fashion, but she did put all her hair under hairnet when questioned. The Resident Room Roster dated 8/26/24 lists 160 residents currently reside in the facility.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. 32189 Based on observation, interview, and record review, the facility failed to ensure coordinated care was implemented by failing to ensure documented hospice services rendered was included in the resident's medical record and available and accessible to the interdisciplinary team (IDT) for one of 11 residents (R71) reviewed for Hospice care Management in a total sample of 124. Findings include: The Nursing Facility Hospice, General Inpatient and Respite Care Services Agreement, dated 10/19/20, documents Hospice will develop a Plan of Care which will identify the care and services that are needed and will specifically identify which provider is responsible for performing the respective functions that have been agreed upon and included in the Plan of Care. The Plan of Care will also reflect the participation of the Hospice, the facility, and the Hospice patient and his or her family to the extent possible. A copy of the Plan of Care will be furnished to the facility upon each update. Hospice will provide representatives of the Facility with access to attend and participate in the Interdisciplinary Team conferences for the purpose of developing and evaluating the Plan of Care. Medical Records. Facility shall prepare and maintain medical records for each Hospice. R71's Facility Notification of Admission, dated 5/2/24, documents R71 was admitted to the facility for degeneration of the brain and elected hospice benefits. R71's Careplan, dated 5/4/24, has no documentation that R71 has chosen to receive Hospice Services R71's Careplan, date 8/16/24, documents I (R71) have chosen to receive Hospice services. and lacks specific Hospice responsibilities/interventions. R71 record lacked scanned Hospice documents or Progress Note entries by Hospice services or the facilities Interdisciplinary Team (IDT). On 8/28/24 at 11:07 AM, V16 (Licensed Practical Nurse) stated there are hospice binders on the floor although V16 could not find the Hospice binder or any documentation by Hospice services. On 8/28/24 at 11:50 AM, V11 (Hospice Registered Nurse and V11's Case Manager) stated I see R71 twice monthly. My Licensed Practical Nurse (Hospice LPN) brings over (to facility) the visit notes and plan of care but I think (Hospice LPN) takes the records to medical records. On 8/29/24 at 10:47 AM, V3 (Infection Preventionist/Careplan Assist) stated The Hospice records are probably in Medical Record. Why would staff need access to the Hospice's records? On 8/29/24 at 11:10 AM, V19 (Careplan Coordinator) stated I've never put those things (Hospice specific interventions) in the Careplan. I only put in (Careplan) that the resident is on hospice.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 33970 Based on observation, interview and record review, the facility failed to don PPE (Personal Protective Equipment) properly during a COVID-19 outbreak, ensure Personal Protective Equipment (PPE) was utilized throughout wound care, residents were placed in contact isolation with active wound infections and Enhanced Barrier Precautions per order, assess residents for signs and symptoms of COVID-19, initiate isolation precautions and ensure a resident's environment was kept free from cross contamination of MRSA (Methicillin- Resistant Staphylococcus Aureus) pathogen during wound care for eight of 32 residents (R55, R37, R57, R71, R101, R114, R122, R127) reviewed for Infection Control in the sample of 124 residents. These failures have the potential to affect all 160 residents who currently reside in the facility. Findings Include: 1.The Facility's Post Public Health Emergency-Standard and Guidelines policy dated 5/16/2023 documents The facility will follow CDC (Center for Disease Control) guidelines including prompt detection, triage and isolation of potentially infectious residents to prevent unnecessary exposures of COVID-19. Source Control Measures: Source control refers to the use of respirators or well-fitting face masks to cover a person's mouth and nose to prevent spread of respiratory secretions when they are breathing, talking, sneezing, or coughing. People, particularly those at high risk for severe illness, will be encouraged to wear the most protective mask they can that fits well and that they will wear consistently. The facility will allow all individuals to use a mask or respirator based on personal preference, informed by their perceived level of risk for infection based on their recent activities and their potential for developing severe disease if they are exposed. Source control options for HCP (Health Care Providers) include: A NIOSH approved particulate respirator with N95 filters or higher; a respirator approved under standards used in other countries that are similar to NIOSH approved N95 filtering face piece respirators; a barrier face covering that meets ASTM F3502-21 requirements including Workplace Performance Plus PR a well-fitting facemask. When used solely for source control any of the options listed above can be used for an entire shift unless they become soiled, damaged, or hard to breathe through. If they are used during the care of a resident for which a NIOS Approved respirator or facemask is indicated for personal protective equipment (PPE) they should be removed and discarded after the resident care encounter and new one should be donned. Source control is recommended for individuals in healthcare setting who: have suspected or confirmed SARS-CoV-2 infection or other respiratory infection; had close contact or a higher-risk exposure with someone with SARS-CoV-2 infection, for 10 days after their exposure. On 8/27/24 at 9:15 AM V3 (Licensed Practical Nurse/Infection Preventionist) provided a list of current COVID positive residents to include R3, R19, R30, R37, R47, R58, R68, R74, R87, R89, R97, R108, R119, R123, and R142. V3 stated that in building four floor one she has instructed staff to wear N95 masks at all times on the unit because that is where most of the COVID is, and it started there. V3 stated that in building one floor one she has instructed staff to wear surgical masks while on the unit because there are only a few over there. V3 stated that she has not instructed any staff that worked previously with the residents who then became positive to wear any face masks. Only the staff on the units that have COVID need to be wearing masks of any sort, if you are not on those units, you do not need to mask unless you want to. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 8/27/24 in building one floor one V22 (Registered Nurse) did not wear a mask at any time during her day shift, V14 (Registered Nurse) did not have a mask on, V21 (License Practical Nurse) did not have a mask on, V35 (Certified Nurse Aid) did not have a mask on and V34 (Certified Nurse Aid) had her surgical mask under her chin while she was walking through the dining room on the unit. 1. On 8/27/24 at 1:30 PM V35 (Certified Nurse Aid) was pushing R127 out of his room with her mask under her chin. R127 stated that V35 did not have her mask up over her nose and mouth at any time when she was toileting him. On 8/28/24 at 8:40 AM V30 (Registered Nurse) was in the hallway of building four floor one with her N95 under her chin. V30 confirmed that her N95 mask should have been covering her mouth and nose. 2. R37's Nurse's Notes dated 8/24/24 document Resident is COVID positive per rapid swab testing. On 8/29/24 R37's door had a Contact Precautions sign on the door. The sign documented that a gown, gloves, facemask and N95 mask were required for all cares. On 8/29/24 at 8:15 AM V7 (Certified Nurse Aid) transferred R37 in a sit to stand with no mask, no gowns or gloves. R37 confirmed that V7 had not had any PPE on during any of her cares. During the interview R37 repeatedly coughed and asked for a tissue and a glass of water. This cough and congestion are annoying. On 8/29/24 at 8:20 AM V7 (Certified Nurse Aid) confirmed that R37 was in Contact Isolation for COVID positive status. Stated I guess I should have had something (Personal Protective Equipment) on. 32189 The Infection Control/Isolation Guidelines policy, no date, documents Objective: To prevent unprotected exposure of residents, visitors and staff to potentially infectious microorganisms or diseases and to decrease the spread of in-house or community acquired infections. Contact Precautions- intended to prevent transmission of infectious agents which spread by direct contact with the resident (hand or skin-to-skin contact that occurs when performing resident care activities that require touching the resident) or indirect contact with an intermediate object/person (example, environmental surfaces or items in resident's environment/room). Enhanced Barrier Precautions- Intended to prevent the transmission of multi-drug resistant organisms which are spread by direct contact with the resident (hand or skin-to-skin contact that occurs when performing resident care activities that require touching the resident) or indirect contact with an intermediate object/person (example, environmental surfaces or items in resident's environment/room). Contact Precautions are used for MDRO's (Multi-drug Resistant Organisms) and Major Wound Infections. Post Contact Precaution sign on the door. Use of PPE [NAME] gown upon entry into resident's environment/room. [NAME] gloves upon entry into resident's environment/room. Enhanced Barrier Precautions are used for known infection or colonization with an MDRO. Use for the above when Contact Precautions do not apply. Post Enhanced Barrier Precaution sign on the door. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Post Public Health Emergency-Standards and Guidelines policy, dated 5/16/23, documents Source control refers to the use of respirators or well-fitting face masks to cover a person's mouth and nose to prevent spread of respiratory secretions when they are breathing, talking, sneezing, or coughing. Source control is recommended for individuals in healthcare settings who: Have suspected or confirmed SARS-COV-2 (COVID-19) infection or other respiratory infection. SARS-COV-2 Viral Testing will be performed on anyone with COVID-19 symptoms, regardless of vaccination status. The Center for Disease Control Symptoms of COVID-19, dated 6/25/24, documents The following list does not include all possible symptoms. Symptoms may change with new COVID-19 variants and can vary depending on vaccination status. Possible symptoms include: Fever or chills Cough Shortness of breath or difficulty breathing Sore throat Congestion or runny nose New loss of taste or smell Fatigue Muscle or body aches Headache Nausea or vomiting 3. On 08/26/24 at 10:40 AM, R57 was observed to be coughing upon entering room. On 8/29/24 at 10:40 AM, R57 stated R57 began coughing yesterday and felt weak. R57 stated R57 I told someone (about cough and feeling weak). I can't remember who. and stated that no COVID-19 tests have been conducted. The Progress Notes lack documentation of R57's complaints of cough and weakness, notification to V3 (Infection Preventionist) or Physician and/or COVID-19 testing. On 8/26/24 at 10:00 AM, R71's room door was observed to have no Enhanced Barrier Precaution sign posted. 4. R71's current Careplan documents I am on enhanced barrier precautions for Vancomycin-resistant enterococci (VRE), Colonization with Multi-drug Resistant Organism (MDRO). On 5/24/24, R71's Physician ordered Enhanced Barrier Precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 8/27/24 1:13 PM, V16 (Licensed Practical Nurse) looked up R71's Physician's order and stated R71 has an active order for EBP and an EBP sign should be posted on R71's door. 5. On 08/26/24 10:00 AM, R101 stated R101 had diarrhea during the night. On 8/26/24 at 10:00 AM, R101's blanket on the bed was observed with a brown/diarrhea stool smear on R101's blanket and multiple spots of brown/diarrhea stool was observed next to R101's bed on the floor. R101 room door did not have an isolation sign posted. On 8/26/23 at 2:50 PM, V10 (Certified Nurse Aid) was notified of R101's complaints of diarrhea. On 8/29/24 at 10:20 AM, R101 was observed coughing upon entering R101's room and R101's room door did not have an isolation sign posted. On 8/29/24 at 10::20 AM, R101 stated R101 developed a cough over the past few days and had another episode of diarrhea on 8/29/24. R101 denies having a COVID-19 test conducted. R101's Progress Notes dated 8/26/24 through 8/29/24 at 12:00 PM, lacked documentation of R101's diarrhea or cough and/or notification to V3 or Medical Doctor On 8/29/24 at 10:42 AM, V16 (Licensed Practical Nurse) stated V16 was unaware of R101's diarrhea and cough. V16 stated if and/or when a resident presents with signs and symptoms of COVID-19, V3 is notified. On 8/29/24 at 10:55 AM, V3 stated V3 was unaware of R101's symptoms of diarrhea and cough. 6. On 08/26/24 at 11:00 AM, R114 stated I started coughing last night. I have not felt well the past week. A wicked flu, I guess. No, I haven't had a COVID-19 test but I think I should. I know it's going around. On 8/29/24 at 10:20 AM, R114 stated I told them (staff) I didn't feel right. I've had a head cold for weeks. R114's Progress Notes, dated 8/27/24 at 2:44 PM, documents R114 complained to a surveyor that R114 has been coughing. This nurse asked him how R114 was doing R114 wants to be tested for Covid-19. Director of Nursing aware and would notify infection prevention nurse. R144's Progress Notes, dated 8/27/24 at 3:23 PM, documents R114 complaining of cough and nasal congestion. Requested to be Covid-19 tested . Covid-19 test negative. Medical Doctor notified and new orders received and noted. Resident made aware of new orders. R114's Physician's Order, dated 8/27/24, documents to administer a cough suppressant medication as needed for seven days. On 8/27/24 at 1:10 PM, V17 (Certified Nurse Aide) stated if a resident presented with signs and symptoms of COVID-19, V17 would notify the nurse on duty. On 8/27/24 at 1:13 PM, V16 stated if a resident presented with signs and symptoms of COVID-19, V16 would notify V3. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 8/29/24 at 10:55 AM, V3 stated Isolation is test based only. If testing (COVID-19) is negative, we don't initiate isolation. The Physician would be notified, and we would go by the doctor's recommendation. 38396 7. On 8/26/24 at 12:30 PM, R122 was sitting in bed in his room. R122's room contained a sign for Enhanced Barrier Precautions on the door. R122 stated he has a wound on his sacrum that requires dressing changes. R122's current Care Plan, dated 7/29/24, documents I am on enhanced barrier precautions for, wounds or skin opening requiring a dressing. Interventions: Assess or signs and symptoms of active infection and notify MD (Medical Doctor). This same Care Plan, dated 8/22/24, documents The resident has infection of the sacrum wound. Resident with osteomyelitis of the sacrum. R122's Nursing Progress Notes, dated 8/18/2024 at 8:59 PM, documents Received call from (lab services). (R122's) wound culture positive for MRSA. On 8/28/24 at 1:45 PM, V12 (Facility's Wound Doctor) applied a Personal Protective gown without tying the back and began providing R122's wound care. V12 then measured R122's sacral wound and palpated the interior of the wound with a gloved hand. V12 then picked up a bottle of wound cleaner and sprayed the sacral wound wearing the same gloves, then placed a contaminated gloved hand on the side rail of R122's bed. After wound care was completed, V12 removed the right soiled glove, picked up the bottle of wound cleaner from the contaminated field and placed the wound cleaner in her pocket. On 8/29/24 at 11:30 AM, V2 (Director of Nursing) confirmed R122's wound culture was positive for MRSA on 8/18/24 and he has remained in Enhanced Barrier Precautions (EBP). V2 stated R122 was not placed in Contact Isolation for MRSA. V2 stated The wound is contained. V2 then confirmed that during R122's wound care, touching the wound and then touching items without changing gloves and conducting hand hygiene could potentially contaminate the resident's room with the MRSA. On 8/29/24 at 11:50 AM, V3 (Licensed Practical Nurse/Infection Control Preventionist) stated she interpreted the guidance to be that R122 could be in EBP. V3 stated I didn't realize that he should be in contact isolation following the positive wound culture infection. 50627 8. On 8/28/24 at 10:47 AM, V13 (Wound Care Nurse) donned a gown and gloves. V13 removed R55's border foam dressing and gauze from R55's inner knee area. The gauze and dressing were saturated with blood and a clear drainage. R55's wound bed was red with grey and purple wound edges. V13 proceeded to perform R55's wound vac dressing change. V13 then removed her gloves and gown, washed her hands and went to her medication cart outside of R55's room. V13 started to re-enter R55's room and spoke out loud stating, I do not need to put a gown and gloves on because the wound is covered, so there is no need for a gown and gloves. V13 re-entered R55's room, without applying a gown or gloves and retrieved the label for the wound vac dressing out of the wound vac dressing change kit that was sitting on R55's bedside table. V13 then walked back to her medication cart, filled out the label outside of R55's room on her medication cart, and walked back into R55's again without applying a gown or gloves and placed the label on R55's wound vac dressing. (continued on next page)

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	08/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hope Creek Nursing & Rehab	4343 Kennedy Drive East Moline, IL 61244

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 8/28/24 at 10:47 AM, R55 was sitting in a wheelchair in her room. R55's indwelling urinary catheter drainage bag was attached to the underneath of her wheelchair touching the ground. The urinary catheter drainage tubing had white foam traveling from the bag and up the tubing, urine was dark yellow. On 8/29/24 at 10:54 AM, V3 (LPN/Infection Preventionist), stated that when placing a resident on or off enhanced barrier precautions depends on the type of infection and if the infection can be detained, then the resident does not need to be in contact precautions, only enhanced barrier precautions. 8/29/24 10:58 AM, V2 stated that when placing a resident on enhanced barrier precautions compared to contact precautions that it depends on what type of infection, such as MRSA (methicillin-resistant Staphylococcus aureus), it depends on the type of MRSA that it falls under in infections and if it can be contained. It does not matter if it is MRSA, some types of MRSA does not need to be in contact isolation, you can use enhanced barrier with some types. R55's Care Plan, dated 7/8/24, and 8/27/24 states R55 has 16fr, Balloon 10ml indwelling catheter due to hydronephrosis. The facility policy named, Hand Washing, dated 2/28/2019, documents the following: The facility requires staff to wash hands after direct resident contact for which handwashing is indicated by accepted professional practice. 9. On 8/28/2024 at 10:00AM R127 was laying in his bed with eyes closed. R127 bed was up to a 40-degree angle. R127 G-tube is in place and clamped. On 8/28/2024 at 11:30AM V37/RN (Registered Nurse) entered R127's bathroom and proceeded to wash her hands with soap and water, rinsed, then dried her hands, and applied clean gloves. V37 went to R127's bed side, explained to R127 that she was needing to flush R127's gastrostomy tube. R127 nodded yes. V37/RN proceeded by unclamping the gastrostomy tube and poured the accurate amount of water in the tube for the flush. The gastrostomy tube was kinked in multiple places and V37 attempted several times to get the kinks out by rubbing the tube with her gloved hands. The flush was completed. V37/RN began to walk towards the door with her gloves still on her hands, by the time V37 was at the doorway V37 gloves were removed, and V37 proceeded to leave the room with the dirty gloves in her hand and left the room without washing her hands. On 8/29/2024 at 8AM V3/IP/ADON (Infection Preventionist/Assistant Director of Nurses) stated, Anytime there is a procedure done on a resident and they are using gloves. The gloves need to be removed in the room and their hands need to be washed prior to leaving the room. The resident room roster, dated 8/26/2024, lists 160 residents currently residing in the facility. 33985