

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0056754		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/20/2026	
NAME OF PROVIDER OR SUPPLIER HOPE CREEK NURSING & REHAB				STREET ADDRESS, CITY, STATE, ZIP CODE 4343 KENNEDY DRIVE , EAST MOLINE, Illinois, 61244			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
S0000	Initial Comments Complaint Investigation Survey 2622419/2788048			S0000			04/07/2026
S9999	Final Observations Statement of Licensure Violations: 300.1210 b) 300.1210 c) 300.1210 d)6) Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These regulations were not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure fall interventions were implemented for a resident who is at a high risk for falls. This failure resulted in R1 being found in her room, laying on the floor, sustaining a comminuted right humerus fracture requiring surgical			S9999			04/07/2026

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 interventions. This applies to 1 of 3 residents (R1) reviewed for safety in the sample of 8. Findings include: R1's Final Incident Report shows R1 is 78-year-old female, cognitively impaired. On 1/17/26 at 8:00 AM, R1 was found laying on the floor next to her bed with severe complaints of right arm pain. R1 was sent to the local hospital for evaluation. R1 sustained a right humerus fracture with surgical intervention... R1's Fall Risk Assessment dated 10/12/25 shows she is HIGH risk for falls. On 03/20/26 at 10:07 AM, R1 was residing on the memory care unit. R1 was in her room sitting in her wheelchair. R1 was wearing an immobilizer to her right arm. R1 was alert to self and forgetful. R1 said she fell at a restaurant and could not recall the details regarding the fall. R1's room did not have signs posted to call and ask for help, there were no fall mats in her room, and there were no non-skid strips in front of her bed or in her bathroom. On 3/20/26 at 11:01 AM, V6 (Agency LPN) said on 1/17/26, she was passing morning medications and the aide reported that R1 was on the floor in her room. V6 said she entered R1's room and she was lying on the floor complaining of right arm pain. She called the paramedics and R1 was sent out to the local hospital. V6 said she thinks R1 was trying to get back in bed after breakfast. R1 is alert and forgetful, is a fall risk, has a history of self-transferring, and required one person assist with transfers. On 3/20/26 at 11:15 AM, V8 (Certified Nursing Assistant-CNA) said on 1/17/26, she heard yelling down the hallway. She found R1 laying on the floor in her room. "I think she was trying to self-transfer from her wheelchair to her bed." R1 was complaining of pain to her right arm. The nightstand was behind her, and it appeared R1 fell backwards. V8 said R1's room was the last room at the end of the hall. V8 said she called for assistance when she found R1 on the floor. On 3/20/26 at 11:26 AM, V9 (Former CNA) said R1 was alert and oriented, she would always self-transfer and R1 was independent with transfers. "(R1) was always independent." R1 would always say she didn't need help. R1 would normally eat in the dining room and go back to her to lay down. V9 said the last time she saw R1 was about 7:45 AM,			S9999			04/07/2026

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S9999	Continued from page 2 self-propelling in her wheelchair going to her room. R1 was able to self-transfer, and she did not think to ask R1 if she needed assistance. V9 said they should check the electronic health record to check if the resident is a fall risk and how they transfer. V9 said she did not know R1 needed staff assistance with transfers. On 3/20/26 at 11:42 AM, V10 (CNA) stated, "I don't think R1 was a fall risk." R1 always transferred herself, she always took herself to the bathroom. R1 was safe to self-transfer, and she did not use her call light assistance. V10 said and she does not remember if R1 had any falls prior. V10 said they should check the residents electronic record for the resident's transfer status and fall interventions. On 3/20/26 at 12:57 PM, V2 (DON) said she was on a leave absence from November 2025 to February 2026. The ADON (Assistant Director of Nursing) was reviewing the falls at that time. V2 said R1 fell in her room and sustained a right humerus fracture that required surgical intervention. When R1 returned, she was placed on the memory care unit for increased supervision. R1 is confused, had a history of falls and self-transferring. R1 would forget to ask for help, she thinks she can still do things on her own and forgets her limitations. Staff should assist her with transfers and required supervision for safety. R1 was not independent for transfers and required staff assistance. Staff should check the resident's electronic health records for their transfer status. When a resident transfers to a different room their fall interventions should follow them. R1 should still have fall interventions in place. On 3/20/26 at 2:05 PM, V1 (Administrator) said even he knows R1 is a fall risk, we have been working on falls as part of our of "PIP" (performance improvement plan) and educating staff to look on the residents Kardex or care plan if a resident is fall risk, how the resident transfers and ensuring fall interventions are in place. R1's current care plan initiated on 2/1/24 shows she is at risk for falls related to weakness, impaired gait and balance, requires assistance for bed mobility and transfers. Interventions include cues placed in room to ask and wait for assistance, non-skid strips at bedside, non-skid strips in front of toilet, low bed, call light within reach, and apply floor mats to right side of bed. R1's hospital records dated 1/26/26 show R1 sustained a communicated (bone has broken into more than two pieces) right humerus fracture from a			S9999			04/07/2026

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S9999	Continued from page 3 mechanical fall. R1's Fall Prevention and Management Program Policy dated 5/2025 states, "The purpose of our Fall Prevention and Management Program is to provide our residents with an interdisciplinary approach to assess risk for falls, provide appropriate interventions to prevent falls..." (A)			S9999			04/07/2026