STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006761	A. BUILDING: _____ B. WING _____	C 03/06/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE CREEK CARE CENTER	**4343 KENNEDY DRIVE EAST MOLINE, IL 61244**

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S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.3240a) 300.3240b) 300.3240d) 300.3240e) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. 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	S9999		

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S9999	Continued From page 1 care needs of the resident. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 of the Act) d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the Department. (Section 3-610 of the Act) e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee. (Section 3-611 of the Act) These Regulations were not met as evidenced by: Based on observation, interview and record review the facility failed to recognize and investigate vaginal bruising of unknown origin as potential abuse for one resident (R1) and failed to report immediately and investigate a resident complaint of rough treatment during peri care as potential abuse for one resident (R2). The facility failed to protect R1 and R2. The facility failed to report to IDPH for R1 and R2. R1 was admitted to	S9999		

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the hospital on 2/23/14. At that time vaginal bruising was discovered and reported to the facility. The facility did not begin an investigation until the next day, 2/24/14. R2 complained of rough treatment during peri care by a CNA to the point of making R2 cry on 2/9/14. The facility failed to immediately notify the administrator of the alleged abuse of R1 and R2. There were two of eight residents reviewed for abuse in the sample of eight. This has the potential to affect all 223 residents in the facility.

Findings include:

The Facility Data Sheet, dated 2/24/14, documents the facility had a census of 223 at the time of the survey.

1. R1's nursing notes document on 2/23/14 at 9:45 a.m. R1 was sent to the emergency room. R1's same nursing notes document at 2:00 p.m. Z1 (Emergency room nurse) "called from ER (emergency room) (R1) noted to have bruising to her inner vagina. Family aware."

R1's ER notes document on 2/23/14 at 10:15 a.m. "Bleeding and bruising around urethra. Mild swelling and ecchymosis of external genitalia." ER notes dated 2/23/14 at 1:56 p.m. document Z1 notified facility of R1's admission.

R1's ER record contained pictures taken of R1's vagina by hospital personnel. The pictures provided by the ER are dated 2/23/14 at 11:50 a.m. The first picture showed the external vagina and appeared to have a moderate amount of dried blood on the outside of the vagina. The other 3 pictures showed several small bruises, red in color in the inner labia and around the

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S9999	Continued From page 3 urethra of R1's vagina. On 2/24/14 at 11:30 a.m. R1 was in a hospital room lying in bed awake. R1's external vagina showed no abnormalities or dried blood. R1's inner labia and urethra had several small pinpoint sized red areas. On 2/24/14 at 10:45 a.m. Z1 (Emergency room nurse) stated on 2/23/14 R1's vagina had "no obvious bruising externally. R1's inside labia and clitoris had moderate bruising." On 2/24/14 at 1:00 p.m. E1 (Administrator) stated the facility had not received or investigated any allegations of suspected abuse since December 2013. E1 stated on 2/23/14 approximately 3-3:30 p.m. E6 (Nursing Supervisor) reported to E1 that the hospital had reported to the facility that R1 had been admitted to the hospital with "bruising to the genitalia." E1 stated E1 called E11(Case Manager) and asked E11 to go to the hospital the next morning (2/24/14) and check on R1. E1 stated at 8:30 a.m. on 2/24/14 E11 reported to E1 that the hospital reported the vaginal bruising to the elder abuse hotline. E1 stated around 8:30 a.m. 2/24/14 E1 called the police regarding the vaginal bruising to R1. E1 stated she did not see the vaginal bruising as potential abuse until 2/24/14 after finding out the hospital called the abuse hotline. On 2/27/14 at 12:10 p.m. E2 DON (Director of Nursing) stated E1 called on 2/23/14 at approximately 5-6:00 p.m. and reported to E2 that the emergency room had reported to the facility "potential abuse, bruising" to R1. E2 stated E2 began getting statements from staff on 2/24/14.	S9999		

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On 2/27/14 at 12:30 p.m. E11 (Case Manager) stated E1 called E11 on 2/23/14 approximately 7:30 p.m. and asked E11 to go to the hospital on 2/24/14 to check on the status of R1's "bruising or redness to R1's peri area."

On 2/27/14 at 2:13 p.m. E6 (Nursing Supervisor) stated on 2/23/14 approximately 2-2:30 p.m. E5 LPN (Licensed Practical Nurse) reported to E6 the hospital had called and reported bruising to R1's genitalia. E6 stated E6 immediately called E1 to report the bruising. E6 stated E6 was not asked by the facility until 2/27/14 to write a statement regarding R1's recent admission to the hospital and the bruising to R1's vaginal area.

2. R2's nursing notes dated 2/9/14 at 3:00 p.m. document R2 "complained of staff rushed her and too rough with cares this a.m. Rough with my legs when getting in chair and wiped my bottom too hard. She knows she was too rough because I cried at the time. You won't send her back to my room again?" This nursing note was signed by E5 LPN (Licensed Practical Nurse).

R2's most recent MDS (Minimum Data Set) dated 2/13/14 documents R2's BIMS (brief interview for mental status) score was 15/15. The facility provided a list of interviewable residents, with R2 being indicated as interviewable.

On 2/27/14 at 10:10 a.m. R2 stated "some CNA's (Certified Nursing Assistants) are rough, sometimes it causes bruising. One CNA was rough when cleaning me and I cried. I don't want her taking care of me. When CNA's are rough I have reported it to the nurse. R2 would not provide surveyor names of staff.

On 2/27/14 at 1:45 p.m. E5 LPN stated E5

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viewed the incident on 2/9/14 for R2 as potential abuse. E5 stated reporting it to E6 (Nursing Supervisor) on 2/9/14 and filling out an incident report. E5 stated the CNA in question for the alleged abuse was E12 CNA (Certified Nursing Assistant).

On 2/27/14 at 2:13 p.m. E6 (Nursing Supervisor) stated "vaguely" recalling the incident on 2/9/14 for R2. E6 stated not being aware a CNA was too rough until 2/10/14. E6 reported interviewing R2 to find out who the CNA in question of being rough was. E6 said R2 stated "it was a black CNA on night shift?" E6 stated "there are 3 black CNA's on night shift so I did not know which one it was." I did not do any interviews or investigate any further. E6 stated the incident was not reported to E1 (Administrator).

On 2/27/14 at 2:30 p.m. E1 stated the incident on 2/9/14 involving R2 was not reported to E1, E1 was unaware it occurred.

On 3/3/14 at 12:40 p.m. E1 stated interviewing of staff had not begun but "they believe it was E12". E1 confirmed E12 has continued working since becoming aware of the the incident of 2/9/14 on 2/27/14 and has not been interviewed.

On 3/3/14 at 1:10 p.m. E12 CNA stated E12 "floats to different floors a lot." E12 stated not being aware of any incidents and not being questioned regarding any incidents. E12 stated E12 has not been informed E12 can't work on any particular floor or with any particular resident.

The Facilities Resident Abuse and Neglect Prevention Protocol, dated 2/21/11, states, "any suspected abuse or neglect shall be immediately reported to the abuse coordinators. The abuse

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S9999	Continued From page 6 coordinators shall be the administrator, Director of Nursing and Director of Social services. These coordinators shall be responsible to coordinate abuse and neglect investigations within the facility... Indications of abuse or neglect may include a pattern or trend of unexplained injuries such as cuts, bruises, scratches, fractures, bleeding and burns." On 2/24/14 E1 verified IDPH had been notified the of the potential abuse occurring on 2/23/14 on 2/24/14 at 11:13 a.m. On 3/3/14 E1 verified IDPH had been notified of the potential abuse that occurred on 2/9/14 on 2/27/14 at 3:50 p.m. On 3/3/14 E1 verified E6 (Nursing Supervisor) was suspended on 2/27/14 for not reporting the potential abuse that occurred on 2/9/14. E12 was suspended on 3/3/14 for the allegation of potential abuse that occurred on 2/9/14. (A)	S9999		