PRINTED: 04/30/2024 FORM APPROVED

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
IL6006761		B. WING		C 04/05/2024			
NAME OF PROVIDER OR SUPPLIER							
HOPE CREEK NURSING & RE	HAB	NEDY DRIVE					
PREFIX (EACH DEFICIENCY	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) OMPLETE DATE		
S 000 Initial Comments	00 Initial Comments						
Complaint Survey:	Complaint Survey: 2421854/IL170639						
S9999 Final Observations		S9999					
Statement of Licens	sure Violations						
300.610a) 300.1210b) 300.3210t)							
Section 300.610 R	Section 300.610 Resident Care Policies						
procedures governifacility. The written be formulated by a Committee consisting administrator, the amedical advisory confiners of nursing and other policies shall compositive the facility and shall confiners of the written policies the facility and shall compositive the facility and shall compositive the facility and shall compositive the facility and shall confiners the facility and shall con	advisory physician or the committee, and representatives or services in the facility. The ly with the Act and this Part. It is shall be followed in operating I be reviewed at least annually documented by written, signed						
Section 300.1210 Nursing and Person	General Requirements for nal Care						
and services to atta practicable physica well-being of the re- each resident's con plan. Adequate and care and personal of	Il provide the necessary care ain or maintain the highest I, mental, and psychological sident, in accordance with aprehensive resident care I properly supervised nursing care shall be provided to each e total nursing and personal esident.						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE 04/18/24 Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	- 11	COMPI	LETED
		IL6006761	B. WING		C 04/05/2024	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
HOPE C	REEK NURSING & RE	HAB	INEDY DRIVE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 1	S9999			
	Section 300.3210 General					
	t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property.					
	These Requiremen evidenced by:	ts were NOT MET as				
	failed to develop as residents for capac activity, failed to enresidents (R1, R2) had the capacity to two cognitively impadidn't have the capacing in a sexual experiencing psychreasonable person	and record review the facility system to assess and evaluate ity to consent to sexual sure two cognitively impaired who engaged in a sexual act consent, and failed to prevent aired residents (R1, R2) who acity to consent, from al act resulting in (R1) osocial harm as any would be affected in a total dent reviewed for abuse.				
	Findings include:					
	3/1/21 documents: As part of the socia (Minimum Data Set identify residents w abuse, neglect, exp have needs and be conflict. Abuse: The willful ir confinement, intimic resulting physical h or deprivation by an caretaker, of goods	e Prevention Program dated I history evaluation and MDS) assessments, staff will ith increased vulnerability for loitation, mistreatment, or who haviors that might lead to infliction of injury, unreasonable dation, or punishment with arm or pain or mental anguish individual, including or services that are or maintain physical, mental				

Illinois Department of Public Health

FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING IL6006761 04/05/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4343 KENNEDY DRIVE HOPE CREEK NURSING & REHAB** EAST MOLINE, IL 61244 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) S9999 Continued From page 2 S9999 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. Sexual Abuse: Including, but not limited to, sexual harassment, sexual coercion, or sexual assault. Facility Assessment of Resident Capacity to Consent Sexual activity Policy (undated) documents: Purpose: To protect and ensure safety, health, and well-being of residents of (the ""Facility") who engages in sexual activity. Policy: It is the facility's policy to recognize and support each resident's right to engage in sexual activity, so long as the Facility is certain that there is consent among all parties to the sexual activity. This policy applies to all residents who are able to demonstrate consent by words and/or affirmative actions, even if the resident is non-verbal or is suffering from Dementia or some other cognitive Capacity to engage in sexual activity is defined as: I. The ability to understand information relevant to a decision to engage in sexual activity, and II. the ability to appreciate the reasonably foreseeable consequences of such a decision or lack of a decision. Capacity to consent to sexual activity has four key components: I. The ability to communicate a decision to

values.

engage in sexual activity.

II. The ability to understand a decision to engage in sexual activity, consistent with an individual's

consequences of a decision to engage in sexual

III. The ability to appreciate the potential

activity, including risks and benefits. IV. The ability to rationalize and reason the

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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						
(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) COMPLETE DATE		
S9999	Continued From page 3	S9999				
	process utilized to reach the decision to engage in sexual activity, free from undue influence or coercion.					
	Facility Incident Report dated 3/13/24 indicates on 3/13/24 at 1:00am V3, CNA (Certified Nurse Assistant) found R1 standing on the side of R2's bed with R1's penis in R2's mouth. Room Census Report indicates on 3/13/24 R1 and R2 were roommates at that time.					
	Current MDS (Minimum Data Set)/BIMS (Brief Interview for Mental Status) indicate both R1 and R2 are severely cognitively impaired and unable to give consent.					
	On 4/2/24 at 11:40am R1's spouse (V5) who visits R1 every day, stated prior to R1 becoming cognitively impaired, R1 was very cognizant of boundaries, never experimented sexually "like that" and he would have been "devastated" to have been found in that situation. V5 stated she absolutely believes R1 had no idea what he was doing or who he was doing it with. V5 stated "(R1) is no longer a reasonable person, but when he was a reasonable person, this would have never happened."					
	On 4/2/24 at 9:14am V11, R2's Family stated R2 was bisexual and would not have had any trauma related to this incident.					
	On 4/2/24 at 3:15pm V1, Administrator stated that they concluded the investigation and found the sexual act between R1 and R2 was consensual. V1 stated that the facility does have an assessment to determine ability to consent for non-cognitive impaired residents, however it was not utilized due to R1 and R2's cognitive impairments.					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6006761			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		B. WING			C 04/05/2024		
	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S NEDY DRIVE LINE, IL 612				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE E APPROPRIATE	COMPLETE DATE	
\$9999	R2's ability to consperformed prior to incident. Consensual Sexual (undated) indicates by the professional coherent and capa supporting their ow Agreement states are garding safe sexengage only with o decisional capacity relationship. On 4/2/24 at 3;21p that with (BIMS) so R2 would be able to R2 would not be abconsequences of the cognitive impairmed.	as completed to confirm R1 or ent to sexual activity was the incident or after the Il Relationship Agreement is the resident will be assessed staff to be alert, aware, ble of making decisions on choices and welfare. The residents are to be counseled practices/behavior and to ther residents who have a AND consent to the The V12, Medical Director stated ores like that, neither R1 nor to consent. V12 stated R1 and to be to understand the neir actions due to their level of nts. V12 stated the facility now to prevent this from	\$9999				