STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0047522	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERCREEK REHAB & HEALTHCARE CENTER	2220 STATE STREET , PEKIN, Illinois, 61554

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S0000	Initial Comments Complaint Investigation 2527217/2580815	S0000		08/29/2025
S9999	Final Observations Statement of Licensure Findings: 300.610a) 300.1010h) 300.1210b) 300.1210d)3) 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. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.	S9999		09/08/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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S9999	Continued from page 1 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. 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. These requirements were not met as evidenced by: Based on Interview and Record review, the facility failed to notify a resident's physician of new onset, unilateral extremity pain for a resident with severe cognitive impairment for one of three residents (R1) reviewed for injury in the sample of four. This failure resulted in R1 waiting over 24 hours to receive emergency care/ imaging for a fracture of R1's right tibia and fibula. Findings include: R1's current Care Plan, dated 8/11/25, documents R1 has diagnoses including but not limited to Alzheimer's Disease, Anxiety, Senile Degeneration, and Severe Dementia with Psychotic disturbance. This care plan documents "Resident has a behavior problem of increased confusion with anxiety related to: Alzheimer's or related dementia." R1's electronic progress note, dated 8/5/2025 at 1:26 PM and signed by V4 (Licensed Practical Nurse), documents, "Late entry: 8/3/25 (R1) was observed in	S9999		

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S9999	Continued from page 2 hallway acting per normal. Propelling herself while whimpering she "wants to go home" repeatedly. While in the dining room, this nurse attempted to administer medications and PRN (as need) ABH (Ativan, Benadryl, Haldol, anti-anxiety/ antipsychotic medicated cream) and (R1) became extremely upset and refused medications. A later reattempt to apply ABH cream with CNA (Certified Nursing Assistant) and successful. A little while later same CNA (V15) said she thought she knew what was wrong with (R1) and palpated right hip area in which (R1) winced and attempted to pull away. PRN morphine (narcotic pain medication) administered with some difficulty, however then resident rested in wheelchair at the nurse's desk for a while. Later another resident needed to use phone at the desk so when staff went to move (R1) back in her chair (R1) grabbed (her) leg at the right knee and brought towards her chest. No reported incidents to explain her pain as resident is primarily nonverbal with limited communication. Continued to monitor." On 8/22/25 at 2:45 PM, V4 (Licensed Practical Nurse) confirmed she was the nurse for R1 on 8/3/25 and stated, "I took care of (R1). On Sunday morning (8/3/25), she was tooling around and acting normal. She did not want her morning meds, sometimes she does that though. (V15 CNA) brought (R1) to the nurse's station and said I think she is in pain and when (V15) went to touch (R1's) right hip area, she winced from that. (R1) later grabbed her right knee and brought it to her center, almost like a guarding motion. Those were her only signs she displayed of pain. Neither was a normal behavior for her. I was afraid to order an X-Ray because she'd be non-compliant, she would need held and not handle that well. All of this happened just after breakfast on 8/3/25. I know (R1) was later taken to lunch and I don't think anything else was ever said. I didn't notify the DON (V2, Director of Nursing) or the MD (V7, R1's Physician)." On 8/22/25 at 3:05 PM, V15 (CNA) stated, "On 8/3/25, I was taking care of (R1) and I told the nurse (V4) when I touched (R1) on the right hip she acted like she was in pain and hurting. I know she drew her knee up at one point later too when she was in front of the nurse's station. She was displaying pain on the side. She was confused often and that day she couldn't be calmed down with music or other interventions. I could tell (R1) was more anxious and not acting her normal self." On 8/23/25 at 9:20 AM, V14 (Registered Nurse) confirmed she was R1's nurse on the evening of 8/3/25 until the morning of 8/4/25. V14 stated, "I was told in report the day before (8/3/25) that (R1) was having some pain.	S9999		

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S9999	Continued from page 3 The next morning (8/4/25) the CNA (V16) called me in the room, and we couldn't really tell what was wrong. (R1) was grabbing towards her right knee. We decided not to get her up or move her and that when dayshift comes in, they can order an x-ray. This was all before 6 AM, before we were going to change shifts. (R1) kind of guarded her right knee. That morning with (V16), she had been more resistive to care." V14 confirmed she did not notify R1's Physician (V7) or (V20, R1's Guardian). R1's nursing progress notes, dated 8/4/2025 at 11:03 AM and signed by V6 (Licensed Practical Nurse), documents R1 was refusing all pain medications and was sent to the emergency department for evaluation and imaging. On 8/23/25 at 10:33 AM, V6 (Licensed Practical Nurse) stated, "I took report on 8/4/25 (morning) and it was stated to me that (R1) was acting strange towards the end of the night shift. I assessed (R1) and when trying to assist her she recoiled and seemed fearful. I thought it could be her leg bothering her, but I wasn't sure. It was strange that (R1) wasn't allowing staff to help her. That was new behavior for her. I was not aware of anyone notifying the (V7, R1's Physician), (V20, R1's Guardian), or (V2, Director of Nursing) prior to myself, that morning." R1's Emergency Department notes, dated 8/4/25 at 2:34 PM and signed by V21 (Emergency Room doctor), documents R1 was brought to the Emergency Room for right ankle swelling and later admitted to the hospital with a right closed Tibia-Fibula fracture and Dementia. On 8/23/25 at 12:10 PM, V2 (Director of Nursing) confirmed he was notified of the situation with R1 on the date she was sent out to the hospital (8/4/25). V2 stated he was unaware she was having symptoms of pain the day prior (8/3/25). V2 confirmed when R1 was sent to the emergency room it was discovered she had a lower right leg fracture of both bones and that V7 (R1's Physician) and V20 (R1's Guardian) was not notified of the change in R1's condition until 8/4/25. The facility's Significant Condition Change and Notification policy, dated 12/2024, documents "To ensure the resident's family and or representative and medical practitioner are notified of resident changes such as: A significant change in the resident's physical, mental or psychological status; Abnormal or unusual or new complaints of pain." This policy also documents "When any of the situation exist, the licensed nurse will contact the resident's representative and their medical practitioner. The	S9999		

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S9999	Continued from page 4 medical practitioner will be contacted immediately for any emergencies regardless of the time of day. Non-emergency notifications may be made the next morning if the situation occurs on the late evening or night shift. This applies to any day of the week including holidays. If the medical practitioner cannot immediately be reached in any emergency, the medical director will be called. If the medical practitioner cannot be reached, the director of nursing or the charge nurse can make arrangements for transportation to the emergency department. Each attempt will be charted as to the time the call was made, who was spoken to, and what information was given to the medical practitioner. All significant changes will be recorded on the (facility's electronic record program) communication board in the resident record. Charting will include an assessment of the resident's current status as it relates to the change in condition." (B)	S9999		