

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145275	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/28/2024
NAME OF PROVIDER OR SUPPLIER Timbercreek Rehab & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2220 State Street Pekin, IL 61554	

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)
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33975</p> <p>Based on interview and record review the Facility failed to prevent accidents/falls with injury for one of three residents (R1) reviewed for accidents. This failure resulted in R1 requiring hospital evaluation and treatment for injuries and a decline in Activities of Daily Living (R1).</p> <p>Findings include:</p> <p>Facility Fall Prevention Policy, revised 1/10/18, documents: to provide for Resident safety and to minimize injuries related to falls, decrease falls and still honor each Resident's wishes/desires for maximum independence and mobility; all staff observe residents for safety; final risk score will be determined by the Interdisciplinary Team/IDT based on fall risk score, history of falls, medical condition which directly impacts on equilibrium and/or ambulation; unit nurse will immediately assess the Resident and provide care or treatment if needed and a fall huddle will be conducted with staff on duty to help identify circumstances of the event and appropriate interventions; unit nurse will place documentation of the circumstances of the event and appropriate interventions; report all falls during the morning Quality Assurance/QA meeting; transfer with proper number of assist and gait belt; and remind staff to allow residents to proceed at their own pace.</p> <p>Facility Mechanical Lift Policy, revised 10/30/18, documents the mechanical lift may be used to lift and move a resident with limited ability during transfer while providing safety and security for residents and nursing personnel; move resident to chair and lower resident, the guidance strap may be used to guide the resident in to a proper position while resident is being lowered; and provide resident any assistance needed prior to leaving the area.</p> <p>Facility Patient Lifts Safety Guide, undated documents: check patient's condition before using a patient lift; check patient's physical capabilities; check to see if patient can assist with transfer; check patient's weight and physical condition; use manufacturer's guidelines to make sure lift is appropriate; determine how many caregivers are required to safely lift the patient; determine number of caregivers needed; most lifts require two or more caregivers to safely operate lift and handle patient.</p> <p>Facility Resident Council Minutes, dated 3/27/24, document Residents do not like we have too many Agency staff here.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/25/24 at 2:00 pm, the Facility was unable to provide V4's (Agency Certified Nursing Assistant/CNA) in-servicing on the Facility mechanical lifts.</p> <p>1. R1's Physician Order Sheet/POS, dated 4/1/24 through 4/30/24, documents R1's diagnoses including a History of Falls, Hypertension, Congestive Heart Failure, Neuropathy, Osteoarthritis, Hyperlipidemia, Diabetes, Left Hip pain and Dependent Edema. R1's POS documents an order for pain medication (Norco one tablet every six hours), dated 4/3/24.</p> <p>R1's Skilled Progress Note, dated 3/25/24, documents R1's transfer status as a stand-up lift transfer.</p> <p>R1's Bowel and Bladder Assessment, dated 3/12/24, documents R1's functional assessment for help with mobility and help with toilet transfer as limited assistance.</p> <p>R1's Fall Risk Assessment, dated 3/12/24, documents R1 requires assistance to stand and is a high fall risk, ten points or more is a high fall risk (score of 18).</p> <p>R1's Minimum Data Set/MDS, dated [DATE], documents R1's Brief Mental Status (11/15) and R1 requiring partial/moderate assistance with Toileting and Chair to Bed Transfer and Toilet Transfer as dependent with the assistance two or more staff.</p> <p>R1's Care Plan, dated 12/13/23, documents R1 as a sit to stand transfer.</p> <p>R1's current Care Plan, documents on 4/17/24, R1's Activity of Daily Living/ADL's and Transfer status is a full mechanical lift (Hoyer) and requires two staff members.</p> <p>R1's Grievance/Complaint Report, dated 3/28/24, document concerns with not enough sit to stands.</p> <p>R1's Grievance/Complaint Report, dated 4/24/24, document concerns with CNA's (Certified Nursing Assistants) will not take people to the bathroom during meals they them they have to wait until after lunch. No method of correction was documented.</p> <p>R1's Grievance/Complaint Report, dated 4/24/24, document concerns with Second and Third Shift do not do peri-care after using the bedpan. No method of correction was documented.</p> <p>R1's Grievance/Complaint Report, dated 4/24/24, document concerns with R1 waiting thirty minutes to be taken to the bathroom, by the time they came she had gone.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>R1's local Hospital Emergency Department After Visit Summary documents R1's reason for visit as Fall and the medics state, (R1) was in the bathroom and was on a sit to stand. They were moving (R1) back to the recliner when they were not close enough to the chair. (R1) lost (R1's) footing and slipped down to the ground in what she explained as a pretzel. (R1) states (R1) did not hit head or loss of consciousness. States it was a witnessed fall. (R1) complains of back pain and leg pain. The Summary also documents R1 has pain in both knees and bilateral low back pain. The Summary reports family at bedside states (R1) was on the edge of the chair, when the seat on the sit-to-stand (lift) was released, causing (R1) to slide off the chair onto the floor with (R1's) knees tucked towards (R1's) chest. The Summary documents Radiology tests (Lumbar Spine, Right Knee, and Left Knee) were performed. Pain medication as needed for pain control and may apply ice and heat to lower back and bilateral knees for pain control.</p> <p>R1's Nursing Progress Note, dated 4/15/24, documents an incident with a transfer from a mechanical lift to a recliner. (V4/Certified Nursing Assistant/CNA) was performing a one-person mechanical lift transfer. V4 misjudged the seat of the recliner and R1 was dangling in the (mechanical lift) sling causing R1 to slip towards the floor. R1 complained of pain and was sent to the local Hospital for evaluation and treatment.</p> <p>R1's Nursing Progress Note, dated 4/15/24 at 6:30 pm, documents a CNA requested (V11/Licensed Practical Nurse/LPN) to assist with getting R1 into the recliner. R1 was dangling in the sling and V11 was able to seat R1 on the edge of the chair.</p> <p>R1's Nursing Progress Note, dated 4/15/24 at 7:00 pm, documents V6 (R1's Daughter) asked V11 (LPN) about R1's fall. V6 stated R1 told V6 R1 fell and had to be picked up off the floor. V6 stated R1 was in excruciating pain to hips and thighs, legs, knees, feet and lower back and R1 wanted to go to the hospital. R1 told V11 (LPN) R1 fell when V4 (CNA) dropped me out of the machine. V11 stated R1 was still hooked up to the sit to stand and it was not on the floor. R1 stated, it happened before V11 entered the room.</p> <p>R1's Nursing Progress Note, dated 4/15/24 at 7:05 am, documents R1's transfer to the local Hospital Emergency Department.</p> <p>R1's Nursing Progress Note, dated 4/16/24 at 1:00 am, documents R1 returned to the Facility. Pain medication administered.</p> <p>R1's Nursing Notes, dated 4/15/24 through 4/16/24, do not document an assessment of R1 for injuries or pain.</p> <p>V8's (Registered Nurse) written statement, dated 4/15/24 at 6:30 pm, documents when V8 was leaving for the day, V4 (CNA) asked for help with a transfer for R1. When V8 arrived to R1's room, R1 was sitting in a sling in the sit to stand close to the floor.</p> <p>V4's (CNA's) written statement, dated 4/15/23, documents on 4/15/24 at 6:30 pm, R1 needed to use the bathroom and then get in to R1's chair. V4 got the sit to stand and took R1 to the bathroom and as V4 was taking R1 to the chair, R1 dropped down and said R1's legs gave out. V4 immediately went and got help. The whole time R1 was still strapped in the sit to stand and R1's butt was a couple inches from the ground. The Nurse (V11) helped me get R1 in to the chair. V4's written statement does not document the assistance of two staff performing the transfer.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/25/24 at 2:00 pm, V12 (Staffing Agency) stated, We do not normally in-service our staff on mechanical lift for the Facility's, we just do basic training.</p> <p>On 4/25/24 at 2:10 pm, V2 stated, We normally leave it to the Staffing Agencies to provide training to their staff on things like mechanical lifts and transferring.</p> <p>On 4/25/24, at V12 and V2 could not provide in-service documentation for V4 (CNA) on the Facility mechanical lift usage.</p> <p>On 4/25/24 at 10:45 am V9 (CNA) stated, We got new sit to stands when the new company bought this place, but we have not been in-serviced on them yet.</p> <p>On 4/25/24 at 10:45 am, V10 (Agency CNA) stated, I have not been in-serviced on the mechanical lifts. The facility got new ones and we actually like the old lifts better.</p> <p>On 4/25/24 at 4:20 pm, V7 (R1's Daughter/Power of Attorney) stated, On the night of 4/15/24, my mom (R1) called me and was very, very upset and crying. She told me she got dropped while in the sit to stand coming back from the bathroom being put into her recliner. (V4/CNA) missed the recliner chair and mom slid out. So, I called my sister (V6) because she lives close to the Facility and is a Nurse Practitioner. She was there within ten minutes. My mom was in excruciating pain and wanted to go the hospital but at first, they would not send her because they (V11) said she did not even fall. My mom told me just one Aide was doing the sit to stand, and there actually should be two. I am worried about my mom because she does not have a tailbone and her midback is compressed, so when she said her back hurt, I was concerned more damage was done. My mom does have chronic pain, but now she has been complaining of even more pain since this happened. I asked V2 (Director of Nursing/DON) for a report and I have never gotten one. We even had a Care Plan meeting, and no one would answer my questions about what happened with transfer.</p> <p>On 4/25/24 at 4:49 pm, V6 (R1's Daughter) stated, My Sister (V7) called me to tell me Mom had called her and was in terrible pain from a fall, so I live five to ten minutes from the Facility, and I went immediately there. Mom was in horrible pain.</p> <p>On 4/25/24 at 9:40 am, R4 (R1's Roommate) stated, I was sitting right here in my recliner, and I saw everything. Little Aide (V4) did not know what she was doing. She kept messing with the buttons on the lift. (V4) did not lift (R1) up high enough to reach the seat of the recliner and (R1) went down and slid all the way to the floor and (R1's) feet were still on the sit to stand. Little girl (V4) went running out of the room yelling, Oh my gosh, help, help! Then the nurse (V11) came in and helped get (R1) back into the recliner. They were scrambling around to get her off the floor. They were saying (R1) was not on the floor but (R1) was. I could see if right from here (pointing to area straight in front of R4's recliner). R1 was screaming and crying and was in pain. Then they did not want to send her to the hospital because they were saying she was not hurt and did not actually touch the floor. (R1) was definitely hurt because you could tell she was so scared and was crying. (R1) then called her daughter (V7) and (V7) sent the other daughter (V6) up. (V6) had to ask them to send (R1) out to the hospital to be looked at. Half of the time the slings do not even work either, just a few days ago we found a bunch of pieces of the strap laying on the floor, we picked them up and they were in shreds.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/25/24 at 9:30 am, R1 stated, I was dropped on the floor during a transfer back from the bathroom. By the way, (V4/Agency Certified Nursing Assistant/CNA) was doing my transfer by herself, and there usually are two Aides helping. I was using a sit-to-stand lift and (V4) took me to the bathroom. When we got back to put me in my recliner, (V4) did not have me high enough to go onto the seat of the recliner and my butt dropped and I slid to the ground. My legs were still up on the sit to stand, and I was dangling, and my legs were bent so far up against my chest, I was like a pretzel. My Roommate (R4) was yelling really loud for the nurse to come and help me. (V4) starting yelling for help too and left the room to get help but (V4) left me dangling in the sit to stand by myself. Then (V8/Registered Nurse) came to my doorway and yelled 'Oh my God, oh my God she is on the floor' and then left and did not even offer to help me. (V8) told me was the change of shift and (V8) was leaving. So then (V11/Licensed Practical Nurse) and (V4/CNA) came and helped me into the chair. I called my daughter (V7), and she called my other Daughter (V6) who is a Nurse Practitioner and lives close, and (V6) came immediately here to help me. I was in lots of pain and hurting all over, they kept telling me they were not going to send me to the hospital because they said 'my butt did not hit the floor' so I did not need to go to the emergency room . I wanted to go to make sure nothing was hurt, so (V6) made them call 911, because they were not going to call. I got X-Rays at the hospital. Now because of this, I have been downgraded and made to be a (full mechanical lift), instead of a sit-to-stand, all because (V4) did not know how to use the sit-to-stand. They tell me the (full mechanical lift) will not fit into the bathrooms, so know I have I have to use a bedpan, and it takes them forever to get to me because I am a full lift now and they need two people. I normally have pain anyway but now my pain has been way worse because of this. They changed my pain medicine to 'Norco' but then they were out of 'Norco' and I had to go without it for an entire day, and I have been in a lot of pain because of this. They did not even offer me anything else to get rid of my pain. No one has ever talked to me about what happened or even looked at my body, so I have no idea if I have any bruising or anything.</p> <p>On 4/25/24 at 10:57 am, V8 (Registered Nurse) stated, I was the day shift nurse day and was giving report to V11 (Licensed Practical Nurse). V4 (CNA) was transferring R1 in a sit to stand back from the bathroom and missed R1's recliner, so R1 slid down towards the floor. R1 did not have another staff member with R1 to help, and us two nurses (V8 and V11) were giving report. I walked down to R1's room after V4 came down yelling for help. I did walk down to R1's room after but I did not help get her up, because my shift was over. If I were being honest, I did not see another CNA helping and I honestly cannot say if R1 did land on the floor, because I was not in there. I do know when I went to the doorway of the room, R1 was still hanging in the sit to stand sling and her bottom was just a few inches off the floor.</p> <p>On 4/25/24 at 5:04 pm, V11 (Licensed Practical Nurse) stated, I was getting shift change report from (V8/RN) and (V4 CNA) came yelling down the hallway (V4) was having problems getting (R1) in to the recliner during a sit to stand transfer after the bathroom. (V4) and I were the only two on whole side (100 Hall, 300 Hall and 400 Hall) and (V4) was my only CNA night and there was no one else to help her. When I got to (R1's) room to help, (R1) was kind of dangling from the sit to stand lift with (R1's) feet raised up high in the sit to stand. We then helped get (R1) back into the recliner by pulling on the sling and (R1's) pants and were finally able to get (R1) into the recliner. When I went in to (R1)'s room, (R1) was about three or four inches off the floor. Now (R1) is a (full mechanical lift) and uses a bed pan. Our Hoyer's do not fit in our bathrooms, so everyone is a (full mechanical lift) has to use a bed pan. We sent (R1) out to the hospital to be evaluated, per (V6's / R1's Daughter) request. I was still there when (R1) returned, but I missed the hospital orders for ice and heat or Ibuprofen to be given for pain.</p> <p>(continued on next page)</p>		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 4/25/24 at 9:30 am, V2 (Director of Nursing/DON) stated, We did not technically consider (R1) fell , so I never looked into the fall to investigate it. From what I understand, was (V4/CNA) was transferring (R1) by herself and (V4) missed the recliner. I will say (V4) should not have been transferring with a mechanical lift by herself, we usually like two people to do together. We did send (R1) out the hospital and she was sent back a few hours later with no fractures. I do know she has been in a lot of pain, but she does get a scheduled pain [NAME] (Norco).		

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<p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>33975</p> <p>Based on observation, interview and record review the Facility failed to supply Physician ordered pain medication and manage pain for one Resident (R1) of three reviewed for pain in a sample of three. This failure resulted in R1's increased level of pain and decline in Activity of Daily Living.</p> <p>Findings include:</p> <p>Facility Pain Prevention and Treatment Policy, revised 12/7/17, documents: it is the Facility policy to assess for, reduce the incidence of and the severity of pain in an effort to minimize further health problems, maximize Activity of Daily Living functioning and enhance the quality of life; assessment of pain and if appropriate, treatment in order to assure the needs of the resident who experience problems with pain are met; intervention implemented to reduce pain which may include the use of medication, medical devices or treatments, but are not limited to heat or cold or massages; and a plan based on information gathered during a resident pain assessment that identifies the resident's needs and specifies appropriate interventions to alleviate pain to the extent feasible and medically appropriate.</p> <p>Facility Conformance with Physician Medication Orders, reviewed 9/27/17, documents all medications shall be given only upon written order of a Physician; and shall be given as prescribed by the Physician and at the designated time.</p> <p>R1's Physician Order Sheet/POS, dated 4/1/24 through 4/30/24, documents R1's diagnoses including a History of Falls, Hypertension, Congestive Heart Failure, Neuropathy, Osteoarthritis, Hyperlipidemia, Diabetes, Left Hip pain and Dependent Edema. R1's POS documents an order for pain medication (Norco one tablet every six hours), dated 4/3/24.</p> <p>R1's local Hospital Emergency Department After Visit Summary documents R1's reason for visit as Fall and the medics state, (R1) was in the bathroom and was on a sit to stand. They were moving (R1) back to the recliner when they were not close enough to the chair. (R1) lost (R1's) footing and slipped down to the ground in what she explained as a pretzel. (R1) states (R1) did not hit head or loss of consciousness. States it was a witnessed fall. (R1) complains of back pain and leg pain. The Summary also documents R1 has pain in both knees and bilateral low back pain. The Summary reports family at bedside states (R1) was on the edge of the chair, when the seat on the sit-to-stand (lift) was released, causing (R1) to slide off the chair onto the floor with (R1's) knees tucked towards (R1's) chest. The Summary documents Radiology tests (Lumbar Spine, Right Knee, and Left Knee) were performed. Pain medication as needed for pain control and may apply ice and heat to lower back and bilateral knees for pain control.</p> <p>R1's Medication Administration Record/MAR, dated 4/1/24 through 4/25/24, documents pain medication Norco 5/325 milligram/mg one tab every six hours. The MAR does not document administration of pain medication (Norco) on 4/19/24, at 11:00 am, 5:00 pm or 11:00 pm. The MAR documents a note ordered again. The MAR does not document pain medication administration (Norco) for the 4/19/24 scheduled doses from 5:00 am through 11:40 pm.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>R1's Medication Administration Record and Treatment Administration Record, dated 4/1/24 through 4/25/24, does not document any additional pain management for R1 and does not document the hospital order for pain control and may apply ice and heat to lower back and bilateral knees for pain control.</p> <p>R1's Grievance/Complaint Report, dated 4/24/24, documents, Ran out of (R1's) pain medications and missed days because pharmacy did not deliver them.</p> <p>R1's Pain Assessment, dated 3/12/24, documents R1's pain presence, occasional pain frequency and effect on function and rarely over the last five days has pain limited daily activities.</p> <p>R1's current Care Plan documents: has chronic pain; anticipate the Resident's need for pain relief and respond immediately to any complaint of pain; evaluate the effectiveness of pain interventions, dosing schedules and resident satisfaction with results; monitor/report to nurse any signs or symptoms of non-verbal pain; and notify Physician if interventions are unsuccessful or if current complaint is significant from Resident's experience with pain.</p> <p>On 4/25/24 at 4:20 pm, V7 (R1's Daughter/Power of Attorney) stated, On the night of 4/15/24, my mom (R1) called me and was very, very upset and crying. She told me that she got dropped while in the sit to stand coming back from the bathroom being put into her recliner. (V4/CNA) missed the recliner chair and Mom slid out. My mom was in excruciating pain. I am worried about my mom because she does not have a tailbone and her midback is compressed, so when she said her back hurt, I was concerned that more damage was done. My Mom does have chronic pain, but now she has been complaining of even more pain since this happened. They ran out of pain medication for her and since this fall, she has now been changed to a (brand name) lift instead of a sit to stand. They told her that she now has to use a bed pan because the lift will not fit into the bathrooms. This pain has caused (R1) to have a decline in comfort.</p> <p>On 4/25/24 at 4:49 pm, V6 (R1's Daughter) stated, My Sister (V7) called me to tell me that Mom had called her right after Mom was dropped in a mechanical lift and was in terrible pain I, so I live five to ten minutes from the facility, and I went immediately there. Mom was in horrible pain. Then apparently they did not have her medication available a day or so after she came back from the hospital, so she was in terrible pain then, I am not even sure if they even offered her anything then.</p> <p>On 4/25/24 at 9:40 am, R4 (R1's Roommate) stated, I was sitting right here in my recliner, and I saw everything. Little Aide (V4) did not know what she was doing. She kept messing with the buttons on the lift. (V4) did not lift (R1) up high enough to reach the seat of the recliner and (R1) went down and slid all the way to the floor and (R1's) feet were still on the sit to stand. Little girl (V4) went running out of the room yelling, Oh my gosh, help, help! Then the nurse (V11) came in and helped get (R1) back into the recliner. They were scrambling around to get her off of the floor. They were saying that (R1) was not on the floor but (R1) was. I could see if right from here (pointing to area straight in front of R4's recliner). R1 was screaming and crying and was in pain. Then they did not want to send her to the hospital because they were saying that she was not hurt and did not actually touch the floor. (R1) was definitely hurt because you could tell that she was so scared and was crying. Ever since that fall, she has been complaining of being in more pain in her back and legs, and because of that, they now have to use that machine (mechanical lift) to move her and now she has to use a bedpan, and that hurts her butt.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145275	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/28/2024
NAME OF PROVIDER OR SUPPLIER Timbercreek Rehab & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2220 State Street Pekin, IL 61554	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/25/24 at 9:30 am, R1 stated, I was dropped on the floor by my recliner during a transfer on a sit to stand, coming back from the bathroom. When we got back to put me in my recliner, (V4) did not have me high enough to go onto the seat of the recliner and my butt dropped and I slid to the ground. My legs were still up on the sit-to-stand lift and I was dangling, and my legs were bent so far up against my chest, I was like a pretzel. My Roommate (R4) was yelling really loud for the nurse to come and help me. (V4) starting yelling for help too and left the room to get help but (V4) left me dangling in the sit to stand by myself. I called my daughter (V7), and she called my other Daughter (V6) who is a Nurse Practitioner and lives close, and (V6) came immediately here to help me. I was in lots of pain and hurting all over. I normally have pain anyway, but now my back and leg pain has been way worse because of this. They changed my pain medicine (Norco) but then they were out of it, so I had to go without it for an entire day, and I have been in a lot and lot of pain because of this. They did not even offer me anything else to get rid of my pain.</p> <p>On 4/25/24 at 11:15 am, R1 stated, I was so upset that day that I could not get any pain medication, I had to go all day without it, and I am not sure that they even tried to do anything to help me.</p> <p>On 4/25/24 at 5:03 pm, V11 (Licensed Practical Nurse) stated, I was the nurse that was on duty when (R1) went to the hospital and came back. I did not see the orders from the Hospital for ice and heat, so I did not transcribe them onto the orders.</p> <p>On 4/25/24 at 1:05 pm, V2 (Director of Nursing) stated, (R1) did experience an incident on 4/15/24 and went to the Hospital. When (R1) came back from the Hospital, (R1) had been complaining of more pain. R1's MAR and TAR (Medication or Treatment Administration Record) does not document to ice or heat for pain relief for 4/16/24 through 4/24/24, I do not think that got transcribed from the Hospital records. It does look like (R1) did not get any scheduled pain medication (Norco) either, on 4/19/24 after the 5:00 am dose and I do not see that anything else was offered. We should have offered (R1) an alternative or to at least ice/heat it when the Norco was not available. I also do not see that we notified the Physician that the medication was not here, to be able to have given something as an alternative.</p>