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 10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Timbercreek Rehab & Healthcare Center	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)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 38805 Based on interview and record review, the facility failed to assess a wound and promptly initiate treatment upon identification of pressure ulcer for one of three residents (R2) reviewed for pressure ulcer wound treatment in the sample of eleven. This failure resulted in R2's pressure ulcer worsening to Unstageable. Findings include: Facility's Decubitus Care/Pressure Area Policy Revised 1/2018 documents: 2. The pressure area will be assessed and documented on the Treatment Administration Record/TAR or the Wound Documentation Record. 3. Complete all areas of the Treatment Administration Record or Wound Documentation Record. I) Document size, stage, depth, drainage, color, odor, and treatment (upon obtaining from the physician); 4) Notify the physician for treatment orders. R2's Face Sheet documents R2's diagnoses include: Cerebral infarction, aphasia, weakness, metabolic encephalopathy, myocardial infarction type, atherosclerotic heart disease, essential hypertension, hyperlipidemia, type 2 diabetes mellitus. R2's current Care Plan documents: (R2) is at risk for impaired skin integrity including skin tears, bruising and/or pressure related to very limited mobility, inadequate nutrition, and problems with friction and shearing of skin due to needing maximum assistance for moving and changing position. R2's Braden Scale for Predicting Pressure Ulcer Risk Dated 6/22/24 documents a score of 13 (16 and less = High Risk for developing pressure ulcers). R2's Progress Note Dated 8/8/24 documents: Quality Assurance/QA team reviewed (R2's) new pressure ulcer to coccyx. Nurse reported new open pressure ulcer to coccyx on 8/4/24. On 10/2/24 at 9:10am, V7 Licensed Practical Nurse/LPN stated she was the nurse for R2 on 8/4/24 and noted R2's coccyx wound. R2's Physician Orders Dated 8/2024 has no documentation of a physician ordered treatment obtained upon identification of R2's wound on 8/4/24. R2's Treatment Administration Record/TAR did not contain documentation that wound treatments were performed on 8/4/24 or 8/5/24. (continued on next page)

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

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 10/04/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	On 10/2/24 at 9:30am, V14 Certified Nursing Assistant/CNA stated she was R2's Caregiver on 8/5/24. V14 stated that during R2's bed bath, she observed an open area on R2's coccyx. V14 stated, It was tiny, less than 0.5 cm/centimeters like a pin drop. It was open with a little redness around it. It was tiny. R2's initial Wound Assessment and Plan signed and dated 8/6/24 by V13 Wound Physician documents R2's pressure ulcer to her coccyx had an onset date of 8/4/24. The assessment documents R2's pressure ulcer was unstageable, measures 3cm x 2cm, and the wound bed contains 70 percent slough (yellow tissue). On 10/2/24 at 11:10am, V13 stated, I saw (R2's) coccyx wound on 8/6/24 when the treatment was started. The staff did not reach out to me prior to 8/6/24. V13 stated with no treatment in place, R2's pressure ulcer could worsen overnight.