

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 04/04/2025
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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>33970</p> <p>Based on observation, interview and record review the facility failed to ensure residents consumed their medications for five residents (R1, R2, R3, R5 and R7) and the facility failed to have a physician's order for medication administered for one resident (R7) of 8 residents reviewed for medication administration.</p> <p>Findings Include:</p> <p>The Facility's Medication Administration policy dated 12/16/24 documents, Drug administration shall be defined as an act in which a single dose of a prescribed drug or biological is given to a resident by an authorized person in accordance with all laws and regulations governing such acts. The complete act of administration entails removing an individual dose from a previously dispensed, properly labeled container (including a unit dose container), verifying it with the physician's orders, giving the individual dose to the proper resident, and promptly recording the time and dose given.</p> <p>The Facility's Medication Administration policy documents, Observe the resident consume the medication to insure resident swallows medication. Never leave prepared medications unattended. No medications should be left at bedside unless specifically ordered by the physician and then only in limited amounts as described by the physician.</p> <p>1. On 4/2/25 at 9:00 AM R2 was sitting up in his bed with the head of the bed up. R2 had a medicine cup full of pills on his bedside with his name written in black marker across the side. R2 stated those were his morning medicines that (V6/LPN) brought him to take.</p> <p>R2's April Medication Administration Record documents, R2's morning medicine as: Bisoprolol Fumarate 5 mg (milligrams), Finasteride 5 mg, Furosemide 20 mg, Losartan Potassium 50 mg, Phentermine HCL 37.5 mg, Tamsulosin .4 mg Bactrim DS 800-160mg, Eliquis 5 mg, and hydralazine 50 mg.</p> <p>2. On 4/2/25 at 9:05 AM R1 was sitting in her bed with the head of the bed up. R1 had a medicine cup full of pills on her bedside table that were spilled and R1 was rolling the pills towards her one by one and taking them. R1 stated she spilled her medicine, so she was rolling it towards herself and then taking it. R1 was not sure what kinds of medicines were in the cup.</p> <p>R1's April Medication Administration Record documents R1's morning medications as: Jardiance 25 mg (milligrams), Multivitamin 1 tablet, Oyster Calcium 1 tablet, Docusate Sodium 100 mg, Eliquis 5 mg, Enalapril Maleate 10 mg, Metoprolol Tartrate 50 mg and Gabapentin 600 mg.</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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. On 4/2/25 at 9:07 AM R1's roommate (R5) was taking medicine out of a medicine cup with his name written on the side. R5 confirmed that those were all his scheduled morning medicines.</p> <p>R5's April Medication Administration Record documents R5's morning medications as: Ferrous Sulfate 325 mg (milligrams), Multivitamin 1 tablet, oxybutynin 5 mg, Tamsulosin .4 mg, Zinc 3. Sulfate 220 mg, Carvedilol 3.125 mg, Cranberry Oral 450 mg, Cyclobenzaprine 10 mg, Magnesium Oxide 400 mg, Methenamine Hippurate 1 GM (Gram), Omeprazole 20 mg, Sucralfate 1 gram and Vitamin C 500 mg.</p> <p>4. On 4/2/25 at 9:20AM R3 was lying in his bed. On R3's bedside table was a medicine cup full of medicine with his name on it. R3 stated Oh right, I still need to take those. R3 did not make any move to take his medicine.</p> <p>R3's April Medication Administration Record documents his morning medications as: Calcium 600 mg(milligrams)Vitamin D 400 IU (International Units), Citalopram 40 mg, Metformin 500 mg, Aldactone 25 mg, Metoprolol 25 mg, Multivitamin 1 tablet, Omeprazole 20 mg, Pramipexole 0.25 mg (give 2 tablets), Vitamin B-12 100 mcg (micrograms), Acidophilus 1 capsule, buspirone 30 mg, cyclosporine 100 mg, Doxycycline 100 mg, Ferrous Sulfate 325 mg, Lasix 20 mg, Magnesium Oxide 400 mg and Acetaminophen 1000 mg.</p> <p>5. On 4/2/25 at 9:40 AM R7 was sitting in the main dining room with a medicine cup with her name on it. In the medicine cup were 4 gummies. Resident states she will eat them in a little bit. R7 states they are vitamins of some kind.</p> <p>R7's April Medication Administration Record did not have any documentation of a Physician's order for any type of gummy.</p> <p>On 5/2/25 at 10:00 AM V4 (Licensed Practical Nurse) stated that the gummies in R7's medication cup would have been 2 of the juice plus vegetable blend and 2 of the juice plus fruit blend vitamin/supplement. V4 confirmed there was no doctor's order for these vitamin/supplements.</p> <p>On 4/4/25 at 9:00 AM V2 (Director of Nursing) confirmed that none of these residents (R1, R2, R3, R4, R5, R6 and R7) had self-administration of medication assessments done. Those (medications) should not have been left with the residents. The nurses should have stayed until the medicine was taken.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>33970</p> <p>Based on observation, interview and record review the facility failed to properly store medications for 2 residents (R6 and R8) of seven residents reviewed for medication pass in a total sample of 8.</p> <p>Findings Include:</p> <p>The Facility's Procurement and Storage of Medication policy reviewed 12/16/24 documents, All medications, except those requiring refrigeration, shall be kept in the locked medicine room or locked medication cart.</p> <p>On 4/2/25 at 10:05 AM there were two albuterol inhalers each with over 100 doses left on R6's bedside table. The inhalers did not have any label on them with name or date dispensed. There was no one in the room.</p> <p>On 4/2/25 at 10:10 AM V5 (Licensed Practical Nurse) confirmed there were two albuterol inhalers on R6's bedside table. V5 stated R6 did not have an order for the albuterol inhaler. V5 stated, (R6) used to have an order for the inhalers. I don't know why he has some in his room, he shouldn't.</p> <p>On 4/2/25 at 10:15 AM there was a Combivent Inhaler on R8's bedside table. There was no one in the room. The inhaler had R8's name and dispensing information from the pharmacy on a label.</p> <p>R8's Medication Administration Record for April 2025 documents, Combivent Respimat Inhalation Aerosol Solution 20-100 mcg (microgram)/act (Activation). R8's Combivent was signed off for 4/2/25 at 6:00 AM.</p> <p>On 4/2/25 at 10:20 AM V5 (Licensed Practical Nurse) confirmed R8's Combivent Inhaler was at his bedside. It should not have been left in here.</p>		