

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 04/28/2025
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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32875</p> <p>Based on interview and record review, the facility failed to prevent abuse for one resident (R2) reviewed for abuse in a sample of six.</p> <p>Findings include:</p> <p>The Initial Incident Report sent to (State agency) for 4/1/25 incident between R1 and R2 documents, (R1) allegedly walked a crossed the hallway to (R2's) room and swatted at (R2) while (R2) was in bed.</p> <p>The Final Incident Report sent to (State agency) for 4/1/25 incident between R1 and R2 documents, (R2) was lying in bed yelling out, as he does sometimes when he forgets to use the call light, and resident (R1) with dementia came in (R2's) room and swatted at (R2), (R1) left .right after, then staff came in and made sure he (R2) was okay.</p> <p>On 4/23/25 at 11:59 AM, V1/Administrator stated, (R2) was in his room in bed yelling for staff and (R1) went to (R2's) room to tell (R2) hush and swatted at (R2). (R1) swatted at (R2) more than once. V1 was asked if physical contact was made and V1 stated, Yes.</p> <p>On 4/24/25 at 11:20 AM, R2 stated, I had my call light on, but staff hadn't come yet, so I was yelling for them. I was lying in bed with my back to the door. Next thing I know (R1) was beating on me. (R1) hit me several times in the arm, side of face and head. It hurt but there weren't any cuts or anything. It upset me that (R1) came in my room and that (R1) hit me.</p> <p>On 4/24/25 at 1:20 PM, V15 Licensed Practical Nurse/LPN stated, (R2) said that (R1) came to his room and hit him in the arm and side of his face.</p> <p>R1's Face Sheet documents R1 is an [AGE] year-old female admitted to the facility on [DATE] with the following, but not limited to diagnoses: Alzheimer's Disease with Late Onset, Dementia and Other Diseases Classified Elsewhere, Moderate, with Mood Disturbance, and Anxiety.</p> <p>R1's current Care Plan documents, (R1) has potential to be physically aggressive r/t (related to) Alzheimer's or other related Dementia, Anxiety.</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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R1's MDS (Minimum Data Set) Assessment, dated 4/14/25, documents R1 has a BIMs (Brief Interview for Mental Status) of 4 (severely impaired).</p> <p>R1's Nursing Note written by V15/LPN dated 4/2/25 at 12:10 AM, documents, (R1) allegedly walked into room across the hall and hit the resident (R2) that occupies that room multiple times on his right arm, shoulder and right side of his face, when writer (V15) was notified of incident by (R2) that was hit, (R1) was laying in her bed in her room, (R1) is alert with confusion per baseline.</p> <p>R1's Progress Note written by V1/Administrator dated 4/3/25 at 12:48 PM, documents, QA (Quality Assurance) met to review incident on 4/1/2025. Resident (R1) had walked across the hall into a male resident's room and proceeded to swat at (R2), then walked back to her room.</p> <p>R2's Face Sheet documents R2 is a [AGE] year-old male admitted to the facility on [DATE] with the following, but not limited to diagnoses: Hemiplegia and Hemiparesis following Cerebral Infarction Affecting Left Non-Dominant Side, Depression, and Anxiety.</p> <p>R2's MDS Assessment, dated 1/24/25, documents R2 has a BIMs of 15 (cognition intact).</p> <p>R2's Nursing Note written by V15/LPN dated 4/2/25 at 12:38 AM, documents, It was reported by CNA (Certified Nursing Assistant) (V18) that resident (R2) was yelling from his room for CNA and nurse. (V18) went to residents room and (R2) reported to (V18) that resident (R1) from across the hall came in and hit (R2) multiple times. (V18) immediately reported incident to (V15), (V15) went to (R2's) room to assess situation and (R2), (R2) stated that he was yelling out for CNA to get his urinal and (R1) from across the hall walked into his room and was yelling at (R2) to hush at the end of his bed then (R1) walked to side of (R2's) bed and slapped (R2) with open hand multiple times on (R2's) right arm, shoulder and side of his face. (R2) stated he lifted his right arm to try to block (R1) from hitting him, then (R1) walked back to her room.</p> <p>R2's Progress Note written by V1/Administrator dated 4/3/25 at 12:53 PM, documents, QA met to review incident from 4/1. (R2) was lying in bed yelling out as he does sometimes, and a female resident (R1) with dementia came in and swatted at (R2).</p> <p>The Incident Investigation form written by V1/Administrator interviewing V15/LPN dated 4/2/25 documents, (V15) said (R1) went over to (R2's) room and swatted at (R2).</p> <p>The Incident Investigation form written by V1/Administrator interviewing R2 dated 4/2/25 documents, (R2) states that a small little woman came into his room while he was in bed. (R2) said he told her (R1) to leave, and she (R1) then looked at him and started swatting at him (R2). He (R2) then yelled for the staff. They came and removed her (R1).</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Abuse, Prevention and Prohibition policy Dated 3/2025 documents Statement of Intent: Each resident has the right to be free from abuse, corporal punishment, and involuntary seclusion. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff or other agencies serving the resident, family members or legal guardians, friends, or other individuals. Policy: This facility prohibits mistreatment, neglect, or abuse of residents. This also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. This presumes that all instances of abuse, even those residents in a coma, can cause physical harm, pain, or mental anguish. The facility also prohibits misappropriation of resident property. The residents must not be subjected to abuse by anyone. The facility will educate all employees upon hire and at least annually of the definitions of the Abuse Prevention and Prohibition Policy including definitions pertaining to abuse and neglect. Annually, the Administrator will conduct local law enforcement to review the requirements for reporting to law enforcement. Protection: Resident-to-Resident Altercations: Resident to Resident abuse includes the term willful. The word willful means that the individual's action was deliberate (not inadvertent or accidental), regardless of whether the individual intended to inflict injury or harm. An example of a deliberate (willful) action would be a cognitively impaired resident who strikes out at a resident with his/her reach, as opposed to a resident with a neurological disease who has involuntary movements (e.g. (example), muscle spasms, twitching, jerking, writhing movements) and his/her body movements impact a resident who is nearby.</p>		