STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145275	A. Building B. Wing	07/16/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect a resident (R2) from physical abuse by another resident (R1), reviewed for abuse, in a sample of seven.Based on interview and record review, the facility failed to protect a resident (R2) from physical abuse by another resident (R1), reviewed for abuse, in a sample of seven.FINDINGS INCLUDE:The facility policy, Abuse, Prevention and Prohibition Policy, dated 03/2025 directs staff, 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 of other agencies serving the resident, family members or legal guardians, friends or other individuals.R1's facility form admission Record, documents that R1 was admitted to the facility on [DATE] with the following diagnoses, Schizophrenia, Mood Disorder, Anxiety, Depression, Schizoaffective Disorder and Mild Intellectual Disabilities. R1's current Care Plan, dated 3/12/24 includes the following Focus Areas, (R1) has the potential to be physically aggressive related to Mood Disorder, Schizophrenia; (R1) has the potential to be verbally aggressive related to Mood Disorder, Schizophrenia.The facility form, Allegation of Abuse, dated 5/30/25 at 2:30 P.M. and completed by V2/Director of Nurses documents, (R1) was in the hallway near the front lobby screaming at another resident (R2). (R1) struck (R2) with a closed fist to the face. Both residents separated and brought to separate rooms to discuss the incident. Neither resident was injured during this incident. (R1) quickly apologized. POA (Power of Attorney) and DR (Doctor) notified. Both residents separated and debriefed on incident. (V1) notified to complete investigation. (R1) was informed that he would have to be referred to other facilities if he is unable to keep his hands to himself or stop calling staff and residents vulgar names. (R1) apologized and apologized to (R2) and staff. (R1) was given ideas for better outlets of frustration.On 7/15/25 at 10:30 A.M., V2/Director of Nurse verified he was present when (R1) hit (R2) with a closed fist to (R2)'s face. At that time V2 stated that R1 has a history of being verbally and physically aggressive to staff and residents.

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