

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 08/25/2025
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)
F 0580 Level of Harm - Actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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

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F 0580 Level of Harm - Actual harm Residents Affected - Few	<p>Based on Interview and Record review, the facility failed to notify a resident's physician of new onset, unilateral extremity pain for a resident with severe cognitive impairment for one of three residents (R1) reviewed for injury in the sample of four. This failure resulted in R1 waiting over 24 hours to receive emergency care/ imaging for a fracture of R1's right tibia and fibula. Findings include: R1's current Care Plan, dated 8/11/25, documents R1 has diagnoses including but not limited to Alzheimer's Disease, Anxiety, Senile Degeneration, and Severe Dementia with Psychotic disturbance. This care plan documents Resident has a behavior problem of increased confusion with anxiety related to: Alzheimer's or related dementia. R1's electronic progress note, dated 8/5/2025 at 1:26 PM and signed by V4 (Licensed Practical Nurse), documents, Late entry: 8/3/25 (R1) was observed in hallway acting per normal. Propelling herself while whimpering she wants to go home repeatedly. While in the dining room, this nurse attempted to administer medications and PRN (as need) ABH (Ativan, Benadryl, Haldol, anti-anxiety/ antipsychotic medicated cream) and (R1) became extremely upset and refused medications. A later reattempt to apply ABH cream with CNA (Certified Nursing Assistant) and successful. A little while later same CNA (V15) said she thought she knew what was wrong with (R1) and palpated right hip area in which (R1) winced and attempted to pull away. PRN morphine (narcotic pain medication) administered with some difficulty, however then resident rested in wheelchair at the nurse's desk for a while. Later another resident needed to use phone at the desk so when staff went to move (R1) back in her chair (R1) grabbed (her) leg at the right knee and brought towards her chest. No reported incidents to explain her pain as resident is primarily nonverbal with limited communication. Continued to monitor. On 8/22/25 at 2:45 PM, V4 (Licensed Practical Nurse) confirmed she was the nurse for R1 on 8/3/25 and stated, I took care of (R1). On Sunday morning (8/3/25), she was tooling around and acting normal. She did not want her morning meds, sometimes she does that though. (V15 CNA) brought (R1) to the nurse's station and said I think she is in pain and when (V15) went to touch (R1's) right hip area, she winced from that. (R1) later grabbed her right knee and brought it to her center, almost like a guarding motion. Those were her only signs she displayed of pain. Neither was a normal behavior for her. I was afraid to order an X-Ray because she'd be non-compliant, she would need held and not handle that well. All of this happened just after breakfast on 8/3/25. I know (R1) was later taken to lunch and I don't think anything else was ever said. I didn't notify the DON (V2, Director of Nursing) or the MD (V7, R1's Physician). On 8/22/25 at 3:05 PM, V15 (CNA) stated, On 8/3/25, I was taking care of (R1) and I told the nurse (V4) when I touched (R1) on the right hip she acted like she was in pain and hurting. I know she drew her knee up at one point later too when she was in front of the nurse's station. She was displaying pain on the side. She was confused often and that day she couldn't be calmed down with music or other interventions. I could tell (R1) was more anxious and not acting her normal self. On 8/23/25 at 9:20 AM, V14 (Registered Nurse) confirmed she was R1's nurse on the evening of 8/3/25 until the morning of 8/4/25. V14 stated, I was told in report the day before (8/3/25) that (R1) was having some pain. The next morning (8/4/25) the CNA (V16) called me in the room, and we couldn't really tell what was wrong. (R1) was grabbing towards her right knee. We decided not to get her up or move her and that when dayshift comes in, they can order an x-ray. This was all before 6 AM, before we were going to change shifts. (R1) kind of guarded her right knee. That morning with (V16), she had been more resistive to care. V14 confirmed she did not notify R1's Physician (V7) or (V20, R1's Guardian). R1's nursing progress notes, dated 8/4/2025 at 11:03 AM and signed by V6 (Licensed Practical Nurse), documents R1 was refusing all pain medications and was sent to the emergency department for evaluation and imaging. On 8/23/25 at 10:33 AM, V6 (Licensed Practical Nurse) stated, I took report on 8/4/25 (morning) and it was stated to me that (R1) was acting strange towards the end of the night shift. I assessed (R1) and when trying to assist her she recoiled and seemed fearful. I thought it could be her leg bothering her, but I wasn't sure. It was strange that (R1) wasn't allowing staff to help her. That was new behavior for her. I was not aware of anyone notifying the (V7, R1's Physician), (V20, R1's Guardian), or (V2, Director of Nursing) prior to myself, that morning. R1's Emergency Department notes, dated 8/4/25 at 2:34 PM and signed by V21 (emergency room doctor), documents R1 was brought to the emergency room for right ankle swelling and later admitted to the hospital with a right closed Tibia-Fibula fracture and Dementia. On 8/23/25 at 12:10 PM, V2 (Director of Nursing) confirmed he was notified of the situation with R1 on the date she was sent out to the hospital (8/4/25). V2 stated he was unaware she was having symptoms of pain the day prior (8/3/25). V2 confirmed when R1 was sent to the emergency room it was discovered she had a</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>(continued on next page)</p>

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview and record review, the facility failed to assess and document a resident's pain and administer pain medication to a resident with severe cognitive impairment, who was later diagnosed with right lower leg fractures for one of three residents (R1) reviewed for accidents in the sample of four. Findings include: R1's current Care Plan, dated 8/11/25, documents R1 has diagnoses including but not limited to Alzheimer's Disease, Anxiety, Senile Degeneration, and Severe Dementia with Psychotic disturbance. This care plan documents Resident has a behavior problem of increased confusion with anxiety related to: Alzheimer's or related dementia. R1's Treatment Administration Record (TAR), dated 8/1/25-8/22/25, documents R1 has an order for Pain monitoring every shift, every day and night shift. Start Date, 3/10/2025. This record does not document dayshift pain monitoring was assessed on 8/2/25 or 8/3/25. This same TAR documents on the evening of 8/3/25, R1's pain was assessed to be a 7/10, severe pain. R1's Medication Administration Record (MAR), dated 8/1/25-8/22/25, documents R1 has an order for Morphine Sulfate (Concentrate) Oral Solution 20 Milligrams/Milliliter (ml) (Liquid Narcotic pain medication). Give 0.25 ml by mouth every two hours as needed for Pain or Air Hunger. Start Date, 3/06/2025. This same MAR does not document any other medications for pain were in place on 8/3/25 and does not document any pain medication was administered to R1 on 8/3/25. On 8/22/25 at 2:45 PM, V4 (Licensed Practical Nurse) confirmed being R1's nurse on the dayshift of 8/3/25. V4 stated, V15 (Certified Nursing Assistant, CNA) brought (R1) to the nurse's station (on 8/3/25) and said, I think she is in pain and when the CNA went to touch (R1's) right hip area, she winced from that. (R1) later grabbed her right knee and brought it to her center, almost like a guarding motion. Those were her only signs she displayed of pain. Neither was a normal behavior for her. I maybe charted Morphine administration in the progress notes; I am not sure if it was charted in the MAR or not. All of this happened just after breakfast on 8/3/25. On 8/23/25 at 9:20 AM, V14 (Registered Nurse) confirmed she was R1's nurse on the evening of 8/3/25 until the morning of 8/4/25. V14 stated, I was told in report the day before (8/3/25) that R1 was having some pain. The next morning the CNA (V16) called me in (R1's room) and we couldn't really tell what was wrong. (R1) was grabbing towards her knee. We decided not to get her up or move her and when dayshift comes in, they can order an x-ray when the place opens. This was before 6 am, just before we were going to change shifts. She kind of guarded her right knee. That morning with (V16), she had been more resistive to care. I think I was able to squirt some Morphine in her mouth for pain. I am not sure if it was charted on the MAR. Sometimes we chart on the MAR or chart in the narcotic sign out book. R1's Nursing Progress notes do not contain any pain assessments, progress notes or pain medication administrations for R1 on 8/3/25. R1's Emergency Department notes, dated 8/4/25 at 2:34 PM and signed by V21 (emergency room doctor), documents R1 was brought to the emergency room for right ankle swelling and later admitted to the hospital with a right closed Tibia-Fibula fracture and Dementia. On 8/23/25 at 12:10 PM, V2 (Director of Nursing) confirmed he was notified of the situation with R1 on the date she was sent out to the hospital (8/4/25). V2 stated he was unaware she was having symptoms of pain the day prior (8/3/25). V2 confirmed when R1 was sent to the emergency room it was discovered she had a lower right leg fracture of both bones. V2 stated if the Morphine was being administered it should be charted on the Medication Administration Record to show it was given. On 8/25/25 at 2:00 PM, V1 (Administrator) stated that V1 and V2 have searched for the Morphine sign out sheet for R1's narcotic pain medication from 8/1/25-8/22/25 and they are not able to find it. V1 confirmed there is no way to determine if R1 was properly assessed and given pain medication on 8/3/25 because it is not charted in R1's medical record. The facility's Pain Management policy, dated 2/2025, documents Effective pain management can remove the adverse psychological and physiological effects of unrelieved pain. Optimal management of the resident experiencing pain enhances the healing and promotes both physical and psychological wellness. It is the responsibility of all clinical staff to assess and periodically reassess the resident for pain and relief from pain. Expressions of pain may be verbal or nonverbal and are subjective to the resident including but not limited to: negative verbalizations and vocalizations (groaning, crying, whimpering, screaming), behavior such as resisting care, distressed pacing, irritability, depressed mood or decreased participation in usual physical and/or social activities. If the resident has been identified with pain, the resident will undergo reassessment of pain at least once per shift and before and after every pain control mechanism employed by the resident's care providers. Pain control mechanisms include but are not limited to: Medications administered for the control or relief of pain. Medications administered for the</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>(continued on next page)</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Based on Observation, Interview and Record Review, the facility failed to ensure that direct resident care staffing was adequate to meet the needs of residents in the facility. This failure has the potential to affect all 83 residents residing in the facility. Findings include: The facility's Resident Roster dated 8/22/25 and provided by V1 (Administrator), documents there are 83 residents residing in the facility. The facility's (undated) Resident Acuity spreadsheet provided by V1 (Administrator) on 8/25/25, documents the facility has 75 residents who require some level of staff assistance with Activities of Daily Living. Of those 75 residents, 27 of them require moderate assistance and 36 require total dependence on staff. This spreadsheet also documents 40 residents have behavioral mental health needs, 14 of which display aggression. R3's Grievance/ Complaint form, dated 8/4/25 and signed by V1 (Administrator), documents, This resident came to the SSD (Social Services Director, V5) to talk about the staffing. The resident is happy with staff but is unhappy with the cuts/ shortages. (R3) is worried about prolonged waits to be helped and get medications. R3's current Care Plan, dated 10/11/24, documents R1 has diagnoses including but not limited to Congestive Heart Failure, Chronic Kidney Disease, and Restless Legs Syndrome. This care plan documents R1 has a plan of Actual / At Risk and/or Potential for complications with deficits with ADL's (Activities of Daily Living) related to current medical/physical status. Has medications and diagnoses that can/may affect ADL's. This same plan of care documents R3 requires limited assistance of one staff member for transferring, toileting, locomotion, and dressing. On 8/22/25 at 2:05 PM, R3 was sitting in a recliner chair in her room. R3 stated she does not feel like the facility has enough staff to care for the residents. R3 stated, This morning, they had an emergency, and my morning medications did not get to me until lunchtime. I know it is because the nurses are just busy, and they have a lot to do. The CNAs (Certified Nursing Assistants) are busy too. I wait a long time when I do push my call light. If I need help to the use the restroom, I may wait 30-45 minutes before someone comes in to help. They just don't have enough staff working to get to everyone. R3 confirmed she requires a wheelchair to get around the facility and she has a history of falling. R4's current Care Plan, dated 8/5/24, documents R4 has diagnoses including but not limited to Heart Failure, Hemiplegia affecting right side, Epilepsy, Spastic Hemiplegia affecting left side, Chronic Kidney Disease, Joint Stiffness, Muscle Weakness, Difficulty Walking, Chronic Pain, Lack of Coordination and Abnormal Posture. This care plan documents R4 has a plan of (R4) is at risk for falls related to a history of falls, spastic hemiplegia affecting left side, decrease muscle coordination, use of assistive device, dependent on staff to stand. This care plan documents R4 requires extensive assistance of two staff for transfers and bed mobility. On 8/22/25 at 1:30 PM, R4 was sitting in the hallway outside of his room in a wheelchair. At this time R4 stated he has been waiting 45 minutes to get into bed and use the urinal. R4 stated, Staff are busy, they are not just sitting around. I know it's the end of lunch time, but I can't use the toilet because I require a (mechanical lift) to transfer so I need to get to bed and use a urinal. They need two staff to transfer me and so I must wait too long because there isn't enough of them. On 8/22/25 at 1:40 PM, V12 (Licensed Practical Nurse) stated staffing has been a challenge at times. V12 stated I am a nurse for 32 residents today in my area. I have several residents who require (mechanical lifts), two residents on dialysis and so they have decreased strength levels on several day of the week, I have another resident with a gastrostomy tube. We are not staffed based on the needs of these residents. I believe we have around 19 residents who have CHF (Congestive Heart Failure) and they need daily weights. It's a lot for two nursing assistants to keep up with. On 8/22/25 at 3:05 PM, V15 (Certified Nursing Assistant) stated, Staffing depends on the day. We have a resident (R1) on 15-minute watch right now. I have around 22 residents in my hall. Of those I have five to six (mechanical lifts) and that requires two staff members for every transfer. It can be very difficult to keep up with everything. On 8/23/25 at 10:33 AM, V6 (Licensed Practical Nurse) stated, We did just have some staffing cuts which makes it difficult at times to get things accomplished. Treatments and charting are things that often can't be caught up on. Especially charting. For example, that day (8/4/25) I had two residents transfer out to the hospital and it put me behind on everything else. It's hard to give safe resident care when you don't have enough staff in the building. The residents will often complain of longer wait times and that staff morale has decreased. On 8/22/25 at 3:20 PM, V2 (Director of Nursing) confirmed the facility is hearing more resident complaints on not having enough staff. V2 stated, Residents have complained to me about the staffing cuts that were made. We also have increased our census so we are getting more residents and more behaviors/care needs and we are scaling back on staff. It is noticeable to residents and of course staff feel it</p>		