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	03/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Timbercreek Rehab and Health Care Center	2220 State Street Pekin, IL 61554

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure baseboard heaters were maintained in a safe manner and failed to implement an effective system to monitor heater surface temperatures and resident room arrangements, including bed placement, to prevent burn hazards and potential fire risks. These deficient practices resulted in R1 becoming entrapped between the bed and a baseboard heater, sustaining painful partial-thickness burns with blistering to the left upper arm, left forearm, and left hand that required emergency room treatment. These deficient practices had the potential to affect all 87 residents residing in the facility.These failures resulted in Immediate Jeopardy.While the immediacy was removed on 3/25/26, the facility remains out of compliance at a severity Level II as additional time is needed to evaluate the implementation and effectiveness of their removal plan and Quality Assurance monitoring.These requirements were not met as evidenced by:Based on observation, interview, and record review the facility failed to ensure baseboard heaters were maintained in a safe manner and failed to implement an effective system to monitor heater surface temperatures and resident room arrangements, including bed placement, to prevent burn hazards and potential fire risks. These deficient practices resulted in R1 becoming entrapped between the bed and a baseboard heater, sustaining painful partial-thickness burns with blistering to the left upper arm, left forearm, and left hand that required emergency room treatment. These deficient practices had the potential to affect all 87 residents residing in the facility.These failures resulted in Immediate Jeopardy.While the immediacy was removed on 3/25/26, the facility remains out of compliance at a severity Level II as additional time is needed to evaluate the implementation and effectiveness of their removal plan and Quality Assurance monitoring.Findings include:The facility's Midnight Census Report dated 3/24/26 document 87 residents reside within the facility.The facility's Maintenance Director's Job Description, undated, documents, Position Description: Responsible for supervising and coordinating the activities of the maintenance department to ensure environmental center compliance in accordance of Federal, State, and Local ordinances, regulations and building codes. Ensures center is maintained in a sanitary, attractive, and orderly condition, in good repair, free from hazards such as those caused by electrical, plumbing, ventilation, heating, and cooling systems.On 3/24/25 from 4:08 PM to 5:00 PM a facility tour was conducted in the presence of V8 (Maintenance Director). During the tour, V8 utilized an infrared thermometer to measure the surface temperatures of baseboard heaters located in resident rooms. It was observed that all resident rooms were equipped with six-foot baseboard heaters installed beneath the windows. In rooms occupied by R6 and R7, the baseboard heater surface temperature measured 172 F. A stuffed animal pillow was observed resting directly on top of the heater in R6 and R7's room, and a bag was positioned immediately adjacent to the heater. In rooms occupied by R4 and R5, the baseboard heater surface temperature measured 168 F. A window curtain was observed hanging down and draping on top of the heater. In rooms occupied by R2 and R3, the baseboard heater surface temperature measured 163 F. The thermostat was missing from the unit. At the time of observation, R2 was lying in bed with the right side of the bed positioned directly against the heater. R2, who is hard of hearing, had their right (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	hand and arm within reach of the heater and stated, The heater gets very hot. In rooms occupied by R1 and R8, both residents were observed lying in bed. The baseboard heaters in these rooms were also missing thermostats. In the room occupied by R9, the resident was lying in bed. The baseboard heater surface temperature measured 160 F. The surveyor attempted to touch the surface of the heater and determined it was too hot to safely touch.R2's MDS dated [DATE] documents R2 is moderately cognitively impairedR2's current Care Plan does not include measures to keep R2 at a safe distance from the baseboard heating element or to protect R2 from burns.On 3/24/26 at 5:00 PM V8 confirmed that the facility did not maintain the manufacturer's operating and preventative maintenance instructions for the baseboard heaters. This included the parts list with component descriptions and the air-balance report. A complete set of these documents was not available on-site.On 3/24/26 at 5:00 PM V8 stated he had not previously monitored or documented the surface temperatures of baseboard heaters or heater covers and was not aware of any established process for doing so. V8 further stated that following an incident in which R1 sustained a burn on 3/21/26 from a baseboard heater, he conducted a visual inspection of all heaters on 3/22/26 to identify units requiring repair or replacement. However, V8 reported that he had only measured the surface temperature of four heaters since that time and confirmed that no formal process has been implemented for routine temperature monitoring.On 3/24/26 at 5:15 PM V1 (Administrator-In-Training) verified all curtains and personal items, and all residents should be positioned within a safe distance of approximately 12 inches from the baseboard heaters to prevent burns and fire hazards. V1 also verified the facility does not have the manufacturer's operating and preventative maintenance instructions for the baseboard heaters.R1's admission Record documents R1 is a [AGE] year-old admitted to the facility on [DATE] with diagnoses of Hemiplegia, Convulsions, Respiratory Failure, Type II Diabetes Mellitus with Diabetic Hemiplegia, Chronic Kidney Disease Stage III, Depression, and Dementia with Anxiety.R1's MDS (Minimum Data Set) assessment dated [DATE] documents R1 is cognitively severely impaired and is dependent or requires extensive assistance of staff for all ADLs (Activities of Daily Living).R1's Progress Notes dated 3/16/26 at 11:54 AM through 3/20/26 4:55 PM documents R1 receives hospice care, had no signs and symptoms of pain, and received morphine as needed to control pain.R1's Progress Notes dated 3/21/26 at 2:57 AM document and signed by V3 (LPN/Licensed Practical Nurse) document, This writer was notified by (V6/Certified Nursing Assistant/CNA) that (R1) had a burn to his arm. Both nurses went to assess immediately. (R1) was in his bed and the bed was pulled away from the wall where it had been before the burn was noticed. (R1) noted to have red blistered areas to his left lateral pinky up to his wrist and large red area that appears to have blistered and popped to his forearm, from wrist to his elbow. 911 called immediately by this writer. The other nurse administered PRN (as needed) pain medication at this time that 911 was called.R1's Hospital emergency room Notes dated 3/21/26 documents, Chief Complaint: Burn. (R1) arrives from (the facility) via AMT (Advanced Medical Transport). (R1) rolled over in bed and was found with his left arm on a baseboard heater. Significant burnt to left forearm. Caught hand and arm on radiator at nursing home prior to visit. Developed two areas of partial thickness burns with blistering left upper arm and left forearm and ulnar aspect of the hand with blistering present. Burn specialist states to debride thin blisters, if we can leave tense thick blisters intact, bacitracin, and xeroform gauze with kerlix (rolled gauze) overlying the wound. Follow-up Tuesday afternoon at the burn clinic.R1's Progress Notes dated 3/21/26 at 8:44 AM document R1 returned to the facility with wound care orders.R1's Progress Notes dated 3/22/26 at 2:48 AM and signed by V3 documents, (R1) given PRN pain mediation before starting treatment. (R1) did not tolerate the treatment well. (R1) was pulling his arm away from us and crying out in pain. The wound starts at the distal part of (R1's) pinky finger and goes up his arm and stops right below (R1's) shoulder. There are no signs and symptoms of infection at this time. Temp (Temperature) 98.8 (F/Fahrenheit). Pain medications given after treatment was done. No measurements obtained with this dressing change due to (R1's) pain level and not able to cooperate.R1's Progress Note dated 3/24/26 and signed by V6 (Nurse Practitioner) (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	documents, Reason for visit: New skin and wound consult on (R1). (R1) seen today for reports of a burn to (R1's) left arm. Upon exam, (R1) has new second degree burns to his left arm extending from his left lateral hand to behind his left upper arm. Per staff reports, (R1) was in his wheelchair and parked by a heater and obtained the burns. The burn on the lateral side of (R1's) hand is presenting as a large, fluid-filled blister. Remining burns up to the back side of his left upper arm are partial thickness wounds with dermal tissue expose. Wound Assessment: Location left arm. Etiology burn-second degree. Partial Thickness. Size 30 cm (centimeters) by 10 cm by 0.1 cm. Calculated area is 300 sq. (square) cm. Exudate (drainage) light amount of serosanguineous (pale red). Wound pain at rest FLACC (Face, Legs, Activity, Cry, Consolably) Scale four (indicating moderate pain.) Treatment cleanse with wound cleanser, apply xeroform (petrolatum based dressing) to base of wound, secure with kerlix (rolled gauze), and change three times per week and as needed (PRN).R1's emergency room Photographs taken on 3/21/26 show R1's left arm had large partial thickness burns from the top of the outer aspect of the left arm, extending down to the lower outer aspect of the left arm and left hand/fingers. This photographs show a fluid filled golf-ball sized blister to R1's top outer arm.On 3/24/26 at 4:45 PM R1 was lying in a low bed, sleeping. R1 could not be aroused at this time. R1's left arm was wrapped in rolled gauze from the top of his arm down to the tip of his fingers. On 3/24/26 at 4:00 PM V7 (Coroner) stated, I got a call from hospice that (R1) was receiving hospice services, actively dying, and did not have money or a power of attorney to take care of R1's body after R1 passes away. The hospice worker informed me that (R1) was sent to the emergency room for severe burns to his left arm that was caused by the facility's baseboard heater. I went to the emergency room to see (R1) and spoke to a burn pathologist about the burns. Since (R1) was hospice and actively dying, the hospital chose to send (R1) back to the facility with treatments for the burns. (R1) is non-verbal and could not have yelled for help when being burned. That is neglectful of the facility to have allowed (R1) to get burned to that extreme.On 3/24/26 at 6:00 PM V6 (CNA) stated, Around 12:00 AM on 3/21/26 I went into change (R1). I could not get (R1) turned because his arm was stuck between the bed and the baseboard heater. I moved (R1's) bed out and when I did, I saw (R1) had a huge burn up and down his left arm. I immediately got the nurse (V3). I am not sure how long (R1) was lying with his arm trapped between the bed and heater.On 3/24/26 at 6:30 PM V3 (LPN) stated, (V6) had come and got me right after 12:00 AM on 3/21/26 and told me (R1's) arm was burned by the baseboard heater. I immediately went in to assess (R1) and sent (R1) to the emergency room. I have had to do (R1's) treatment to the burns on his left arm since he has returned from the hospital. (R1) yells out and cries in pain whenever I do the treatments. I feel awful for (R1).The Immediate Jeopardy started on 3/21/26 when the facility failed to ensure baseboard heaters were maintained in a safe manner and failed to implement an effective system to monitor heater surface temperatures and resident room arrangements, including bed placement, to prevent burn hazards and potential fire risks and R1 became entrapped between the bed and a baseboard heater, sustaining painful partial-thickness burns with blistering to the left upper arm, left forearm, and left hand that required emergency room treatment.On 3/25/26 at 2:10 PM V1 (Administrator-In-Training), V9 (Vice President of Operations), and V10 (Regional Reimbursement Specialist) were notified of the Immediate Jeopardy.On 3/27/26 this surveyor confirmed through observation, interview, and record review that the facility took the following actions to remove the Immediate Jeopardy:1. During tour of the facility on 3/27/26 from 9:30 AM through 10:45 AM all residents and their beds were positioned at a safe distance from the baseboard heaters.2. On 3/25/26 V11 (MDS Coordinator) and V12 (MDS Coordinator) obtained surface temperatures of all baseboard heaters in all resident rooms. All baseboard heaters were verified to be at operating temperatures below 140 degrees F.3. On 3/25/26 V1 and V8 obtained manufacturer guidelines for baseboard heaters to ensure safe operation and compliance with recommended safety standards.4. On 3/25/26 V1 educated V8 to ensure baseboard heaters do not exceed a temperature of 140 degrees F or above and was directed to routinely monitor and document temperatures to ensure ongoing compliance. 5. On 3/25/26 V1 educated all department (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	heads to ensure resident beds were never lowered or pushed against baseboard heaters when in use and a visual guide was implemented and posted to demonstrate the appropriate safe distance between beds and heaters to ensure consistent compliance.6. On 3/25/26 V13 (Assistant Director of Nursing) educated all licensed nurses to ensure resident beds were never lowered or pushed against baseboard heaters when in use. 7. On 3/25/26 V14 (CNA Supervisor) and V15 (CNA Supervisor) educated all CNAs and unlicensed staff to ensure resident beds were never lowered or pushed against baseboard heaters when in use.8.On 3/25/26 V1 implemented a process to ensure all room assignments were appropriate for the number of residents in each room, to allow for safe placement away from environmental hazards, including baseboard heaters.9.On 3/25/26 V1, V2, V13, V14, and V15 conducted a facility-wide audit to identify any additional risks related to heater placement and bed positioning and all concerns were immediately corrected and resident care plans were updated accordingly.10. On 3/25/26, through 3/27/26 V1 and V8 have conducted twice daily environmental temperature rounds to ensure baseboard heater temperatures are 140 degrees F or below. These daily temperatures will continue twice daily for five days a week, and then weekly for four weeks.Completion Date: 3/25/26

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct mandatory training, for all staff, on the facility?s Quality Assurance and Performance Improvement Program. Based on record review and interview the facility failed to provide QAPI (Quality Assurance and Performance Improvement) training to all employees. This failure has the potential to affect all 87 residents residing within the facility.Findings include:The facility's Midnight Census Report dated 3/24/26 document 87 residents reside within the facility.The facility's Annual In-Service Schedule does not include in-servicing regarding QAPI.The facility's Staff In-Services and Computer Based Training dated 3/1/25 through 3/28/26 were reviewed and did not include QAPI training.On 3/28/26 at 9:50 AM V1 (Administrator In Training) verified facility staff have not received QAPI training.