

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/09/2026
NAME OF PROVIDER OR SUPPLIER Timbercreek Rehab and Health Care 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on interview and record review the facility failed to respond to resident call lights in a timely manner for five of ten residents (R4, R5, R8, R9 and R10) reviewed for call light response in a sample of 13. Findings include: R4's current Care Plan documents, R4 requires assistance from one member of staff for activities of daily living. R5's current Care Plan documents, R5 requires assistance from one member of staff for activities of daily living. R9's current Care Plan documents R9 is a Right Above the Knee Amputation requiring assistance from one member of staff for activities of daily living and R9 is a fall risk requiring the call light to be positioned for easy access when in room. R10's current Care Plan documents, R10 requires assistance from one member of staff for activities of daily living and R10 is a fall risk requiring the call light be positioned for easy access when in room. On 7/7/26 at 11:37 am, R4 (alert and oriented) stated, They do not do great answering call lights. Yesterday, it took them well over half an hour to help me. I had eye surgery a few days ago, and every time I get anesthesia it takes me a few days to feel normal. I rang my bell yesterday because I needed them to push me in the wheelchair to get to the dining room, because it is so far away, and it took forever for them to get to me. On 7/7/26 at 11:19 am, R5 (alert and oriented) stated, The staff do the best they can, but they just do not have enough. It usually takes them within a half an hour to answer my light, unless it is mealtime, then it takes way longer than a half an hour. On 7/7/26 at 1:42 pm, R9 (alert and oriented) stated, I have been here for about a month, and I do not even have a working call light to call for help, and it has not worked since I got here. I have told people about it also and no one has ever looked at it. On 7/7/26 at 1:24 pm, R10 (alert and oriented) stated, After I ring my bell, sometimes it takes them quite some time to get to me and it takes a long time. On 7/7/26 at 1:48 pm, V19 (Certified Nursing Assistant/CNA) stated, I do not think (R9) ever uses his call light, he gets up on his own. On 7/8/26 at 8:36 am, V16 (Ombudsman) stated, The last Resident Council meeting was held on 6/24/26, lasted two and a half hours, and they still complained about call lights taking too long. It is an ongoing issue. On 7/7/26 at 1:53 pm, V2 (Director of Nursing) entered R9's room and pressed the button to activate R9's call light. R9's call light was lying on the floor and would not sound or light up. V2 stated, I am going to get (V18/Maintenance Director) to look at it. I expect the call lights to be answered promptly. On 7/7/26 at 2:06 pm, V18 (Maintenance Director) stated, There was a split call light button, with two cords on it. I fixed (R9's) call light and it is working now. The Facility Call Light Policy and Procedure, dated 7/2025, documents: promote resident safety in the community; call lights will be answered in a timely and efficient manner once engaged by a Resident; and call lights shall be left within Resident reach when the Resident is in their room. The Facility Resident Rights for People in Long-Term Care Facilities, dated 11/2018, documents: facility must treat you with dignity and respect and must care for you in a manner promotes your quality of life; and must not be abused or neglected (physically, verbally or mentally); and must provide services to keep your physical and (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 145275	If continuation sheet Page 1 of 3

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	mental health at their highest practical levels. The Facility Certified Nursing Assistant Job Description, undated, documents: answers call light promptly; and answering Resident call lights and requests. The Facility Resident Council Minutes (4/23/26) document issues with call lights. The Facility Resident Council Minutes (6/24/26) document issues with call lights.		

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. Based on observation, interview and record review the facility failed to provide hydration services (fresh water) for three of ten residents (R5, R9 and R10) reviewed for hydration in a sample of 13. Findings include: The Facility Resident Council Minutes (4/23/26) document issues with ice water. The Facility Resident Council Minutes (5/27/26) document issues with ice water not passed at times and only certain staff will do it. The Facility Resident Council Minutes (6/24/26) document issues with ice water continues to be a problem. The Facility Grievance Form, dated 5/25/26, documents, ice water is only passed by certain (Certified Nursing Assistants) and that staff was educated on passing of ice water and frequently passing water. The Facility Grievance Form, dated 5/27/26, documents, water stations are not getting fresh water in them daily and the Facility is to assess the water stations. R5's current Care Plan documents that R5 is at risk for complications with hydration and R5 should be allowed to drink as desired/accepted/tolerated. R9's current Care Plan documents R9 is at risk for complications with hydration and that R9 should be allowed to drink as desired/accepted/tolerated. R10's current Care Plan documents R10 is at risk for complications with impaired skin integrity and hydration, and that R10 should be allowed to drink as desired/accepted/tolerated. On 7/7/26 at 11:19 am, R5 (alert and oriented) did not have water in R5's water pitcher (that was sitting on R5's bedside table. R5 stated, The staff do the best they can, but they just do not have enough. I have not gotten any fresh water today. On 7/8/26 at 9:23 am R5's water pitcher was approximately a fourth full (with no ice) and R5 stated, I still have the same water as yesterday, they have not gotten to me yet. On 7/7/26 at 1:42 pm, R9 (alert and oriented) did not have fresh water at bedside. R9 stated, They do not do a very good job getting me fresh water, it is hit and miss. I have not gotten any fresh water today yet. I do not even have a working call light to call for help. On 7/8/26 at 10:03 am, R9, had no ice water at bedside and stated, They have not brought me any ice water yet today. On 7/7/26 at 1:24 pm, R10 (alert and oriented) did not have any water at bedside and stated, I do not get fresh ice water every day. On 7/8/26 at 10:50 am, V13 (Certified Nursing Assistant/CNA) stated, We are supposed to pass fresh water every shift and extra if someone requests more. We usually pass it in our slow time, like after morning get-ups/breakfast time and lunch. Some CNA's have different routines, and I am not sure if it always gets done. On 7/8/26 at 8:36 am, V16 (Ombudsman) stated, The last Resident Council meeting that was held on 6/24/26, lasted two and a half hours. The Residents has so many complaints that hydration stations were taken away, and I did not see any when I was there either. They had so many complaints about not getting fresh water. They also complained that between mealtimes, they cannot even get iced tea or juice. The Facility Resident Rights for People in Long-Term Care Facilities, dated 11/2018, documents: facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life; and must not be abused or neglected (physically, verbally or mentally); and must provide services to keep your physical and mental health at their highest practical levels. The Facility Certified Nursing Assistant Job Description, undated, documents to provide hydration to all residents.		