

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

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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 07/22/2026
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 0825 Level of Harm - Actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure physician-ordered rehabilitation services were implemented and monitored for one (R1) of three residents reviewed for rehabilitation services in the sample list of five. This failure resulted in R1 not receiving ordered rehabilitation services from admission through the time of survey, placing R1 at risk for avoidable functional decline and causing R1 to express fear, anxiety and depression. Findings include: R1's census record documents R1 admitted to the facility on [DATE]. R1's Medical Diagnosis list documents R1 was admitted to the facility following a left lower extremity fracture requiring surgery and has diagnoses including Cellulitis of the left lower limb, Type 2 Diabetes Mellitus, Morbid Obesity, Chronic Venous Insufficiency, Chronic Diastolic Heart failure, Osteoporosis, Muscle Disorder, and Complex Regional Pain Syndrome of the left lower extremity. R1's Minimum Data Set (MDS), dated [DATE], documents R1 is cognitively intact and requires extensive assistance/dependence with toileting, showering, and transfers. On 7/20/26 at 11:15 AM, R1 was seated in a motorized wheelchair with blankets positioned around the chair. Five undated occlusive dressings were observed on R1's left lower extremity. On 7/20/26 at 11:20 AM, R1 stated she was admitted to the facility for physical therapy following surgery for a fractured left leg but has never received therapy since admission. R1 stated she continued to experience weakness and recurrent infections in R1's left leg. R1 stated she had expected to receive therapy to improve her strength and mobility but had not been evaluated or treated. R1 stated she remained dependent upon staff for transfers and mobility. R1 further stated she feels fearful of possibly losing her leg and anxiety and depression about not regaining function in her leg and being able to return home because she is not getting the therapy she needs to improve. On 7/20/26 at 1:00 PM, V15 (Therapy Director) stated R1 had not received therapy services since admission. V15 stated an occupational therapy evaluation had been completed on 4/28/26 and a request for payor authorization was emailed to V16 (Business Office Manager), and a subsequent request for prior insurance authorization for therapy for R1 was submitted on 6/8/26 because R1 would benefit from physical and occupational therapy. V15 stated no authorization had been received and no additional communication regarding the request had occurred. R1's electronic medical record revealed no evidence physical or occupational therapy services had been initiated. R1's record also contained no documentation of a restorative nursing program or other interventions implemented to maintain or improve R1's functional abilities while awaiting therapy authorization. On 7/21/26 at 9:30AM, V1 (Administrator) and V16 (Business Office Manager) stated a prior authorization request had been sent to the corporate office at the end of June; however, no response had been received. Both V1 and V6 acknowledged the facility had not followed up regarding the authorization request. V1 confirmed this request should have been followed up on. On 7/21/26 at 11:00 AM, V11 (R1's Physician) stated he wrote admission orders for Physical and Occupational Therapy because R1 was (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 0825 Level of Harm - Actual harm Residents Affected - Few	alert, oriented, and capable of participating in rehabilitation to improve strength, prevent decline in activities of daily living, and promote healing of R1's left leg wounds. V11 stated he was unaware therapy services had not been initiated and reported the facility requested therapy orders again on the day of survey. The facility's Therapy Services Agreement, dated 8/2/24, documents the facility operates a licensed skilled nursing facility that furnishes nursing care to residents requiring therapy services and contracts with a therapy provider to furnish Physical Therapy, Occupational, and Speech Therapy services in accordance with federal and state regulations and facility policies. The agreement further required therapists to participate in interdisciplinary conferences, coordinate resident care, and outlined the facility's responsibility to provide payer source information and obtain required authorizations to facilitate timely initiation of therapy services.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident with impaired skin integrity received ongoing wound assessment, physician oversight, implementation of ordered treatment, and care planning for one (R5) of three residents reviewed for skin integrity in the sample list of five. Findings include: R5's Medical Diagnosis List documents R5 has diagnoses including Lymphedema, not elsewhere classified, Irritant contact dermatitis due to friction or contact with other specified body fluids, Obesity, unspecified, Cellulitis of left lower limb, Complete paraplegia, Neuromuscular dysfunction of bladder, Neurogenic bowel, not elsewhere classified, and Colostomy complication, unspecified. R5's Minimum Data Set (MDS), dated [DATE], documents R5 is cognitively intact and dependent on staff for all activities of daily living. R5's Physician orders dated 6/29/26 documents for staff to cleanse the posterior scrotum and left hip with wound cleanser, apply collagen particles mixed with zinc oxide, cover with an absorbent (ABD) dressing every night shift and as needed. R5's Braden assessment dated [DATE] documents R5 is at Moderate Risk for Skin Impairment. R5's care plan documents R5 has impaired skin integrity related to Hoyer transfers, catheter and ostomy devices, and documents irritant contact dermatitis to the posterior scrotum. R5's care plan had not been comprehensively revised to reflect R5's current wound status, progression, and treatment needs. On 7/21/26 at 9:50 AM, V6, V7, and V8 (Certified Nursing Assistant/CNA) transferred R5 from his motorized wheelchair to bed. Observation revealed a suprapubic catheter with brown drainage noted on the gauze surrounding the insertion site. No dressing was present over the scrotal/coccyx area despite physician orders requiring absorbent (ABD) dressing. Two new open areas, each approximately the size of a quarter, were observed between R5's legs. After being notified, V14 (Registered Nurse) assessed the wounds and stated there were definitely two open areas and that the current treatment was not going to help. V14 stated she would notify the physician for new orders. During care, R6 stated the dressing changes had been moved to night shift and that many of the nurses were not completing the dressing changes. On 7/21/26 at 9:30 AM, V2 (Director of Nursing) stated the facility had experienced problems with its wound program and confirmed R5 should have been receiving weekly skin assessments with documented wound measurements. V2 stated she is not surprised treatments are not being completed daily. R5's Skin Issues Progress Notes documents a Progress Note dated 6/29/26 identified a house-acquired moisture-associated skin damage (MASD) to R5's scrotum, with the wound site documented as the right/left thigh. R5's wound measurements were documented as length 0.85 centimeters (cm), width 0.78 cm, depth 0 cm, with an area of 0.56 cm². R5's Treatment orders included collagen particles, zinc, and an ABD dressing to be applied daily. R5's Skin Issues Progress Note dated 7/7/26 documents an increase in wound size, with measurements of length 1.48 cm, width 1.57 cm, depth 0 cm, and an area of 1.99 cm². The assessment also documented heavy saturation of the dressing; however, the same treatment regimen was continued. There is no documentation of physician notification of the wound changes. R5's Skin Issues Progress Notes dated 7/13/26 and 7/17/26 did not include wound measurements or a description of the wound status. On 7/21/26 at 11:30 AM, V13 (Nurse Practitioner) for V11 (R5's Physician), stated V11's office had not received any communication from the facility regarding the R5's thigh or scrotal wound from 6/29/26 through 7/21/26. V13 further stated that R5 was evaluated by the nurse practitioner on 7/1/26, but the facility did not report any skin concerns during that visit. Additionally, V13 stated that the wound treatment order entered by the facility on 6/29/26 was not issued by the physician or nurse practitioner. The facility's Skin Identification, Evaluation, and (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Monitoring Policy dated 2/2026 documents This policy establishes guidelines for the assessment, treatment, documentation, and monitoring of wounds and skin alterations to ensure residents receive timely and appropriate care. Nursing staff are responsible for completing wound assessments, documenting wound appearance and measurements when applicable, evaluating dressings, completing weekly re-evaluations, following health care provider treatment orders, and updating care plans with appropriate interventions. When a new wound is identified, staff will initiate protective measures, notify the provider, resident/resident representative, wound care nurse, and Director of Nursing as appropriate, while ensuring all findings, treatments, notifications, and education are documented in the medical record. The facility will provide ongoing oversight through education, audits, and QAPI monitoring to promote compliance and support wound healing and prevention.		