

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 07/30/2026
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 0689 Level of Harm - Actual harm Residents Affected - Few	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 provide continuous observation for two of two residents (R4, R8) that are at high risk for falls and require continuous monitoring, in a sample of 10. These failures resulted in R4 having an unwitnessed fall which required R4 to be transferred to the hospital emergency room for evaluation and was diagnosed with Acute Cystitis with Hematuria, Urinary Tract Infection, Post Traumatic Contusion, Edema of Left Frontal Scalp (Hematoma) and Left Hip Pain. The following days, R4 was reported to be lethargic, had slurred speech, was leaning left, hallucinating, required more assistance with activities of daily living and went on hospice on 7/17/26, 6 days post fall. Findings include: The Skilled Fall Policy dated 5/25 documents the purpose of the Fall Program is to develop, implement, observe and evaluate an interdisciplinary approach and manage strategies and interventions that foster resident independence and quality of life. Each resident in the community who experiences a fall will be treated and assessed to adequately treat any current injuries and comprehensively assessed to determine causal effects of the fall to develop intervention to prevent further falls. After each fall, an occurrence report will be completed, root cause will be determined and interventions will be implemented. The Resident Monitoring- One to One form documents staff must maintain residents in line of sight, keep residents close enough so residents can't be out of sight and must not leave the residents. Relief of staff members must take place while residents are still in view. Document using codes at least hourly. 1. R4 was admitted on [DATE] with diagnoses of Chronic Obstructive Pulmonary Disease, Anxiety Disorder, Vascular Dementia, Peripheral Vascular Disease, Persistent Mood Disorder and Cerebral Ataxia. R4's Minimum Data Set, dated [DATE] section C Brief Interview for Mental Status documents a score of 4, severely cognitively impaired. R4's Fall Risk dated 6/16/26 was scored at a 30 (high risk for falls) and on 7/11/26 a 34 (high risk for falls). R4's Care Plan documents on 5/26/26, R4 was moved closer to the nurse's station and one-to-one observation was initiated. R4's Resident Monitoring One-to-One tracking forms dated 7/1/26 through 7/26/26 lacked hourly monitoring 9 of 26 days. The monitoring form dated 7/11/26 noted R4 was checked by V12 (Certified Nurse Aide from a sister facility) at 1:00 AM. R4's Progress Notes documents R4 had multiple falls (1/22/26, 2/4/26, 4/20/26, 5/25/26 x2 (fracture of orbital socket with laceration) and 7/11/26). R4 has combative and aggressive behaviors such as hitting staff and threatening to kill others. R4 sustained a fall on 7/11/26 at 2:30 AM and was found bleeding on her bathroom floor. R4 was transported to the hospital for evaluation and treatment and returned to the facility on 7/11/26 at 6:33 AM. The Progress Notes document R4 sustained multiple traumatic injuries following the fall (7/11/26) including forehead laceration, forehead bruising, skin tears to right upper arm, left anterior leg and right lateral lower leg, left arm pain and left hip pain with tenderness to palpation, as well as treated for a Urinary Tract Infection with (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
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F 0689 Level of Harm - Actual harm Residents Affected - Few	Hematuria (blood in urine) from Cystitis. R4's Power of Attorney declined further workup and on 7/17/26 elected hospice benefits. R4's Hospital Emergency Department record dated 7/11/26 documents R4 sustained a left forehead hematoma, contusion and edema of left frontal scalp, and was diagnosed and treated for Acute Cystitis with Hematuria and Urinary Tract Infection. The Interdisciplinary Team meeting note dated 7/13/26 documents V9 (Certified Nurse Aide) who was providing one-to-one cares with R4, left R4's room to go get V8 (Registered Nurse) because she needed to do rounds on her hallway. V9 asked V11 (Certified Nurse Aide) to go to R4's room to do one-to-one observation, V11 found R4 on bathroom floor with blood coming from her forehead. V8's (Registered Nurse) witness statement dated 7/12/26 at 12:03 PM documents on 7/10/26 at approximately 11:00 PM, V8 (Registered Nurse) observed R4 up walking around in her room without supervision. V8 then went to find V9 (Certified Nurse Aide), leaving R4 unsupervised walking around her room. On 7/28/26 at 1:00 PM, V8 (Registered Nurse) confirmed her witness statement and that R4 was seen walking around her room unsupervised and V8 left R4 alone to find V9 on 7/10/26 at 11:00 PM. On 7/29/26 at 9:14 AM, V9 (Certified Nurse Aide) stated she was the CNA assigned to R4 when R4 fell on 7/11/26. V9 stated the nurse was supposed to relieve V9 but never came back. V9 asked V11 (Certified Nurse Aide) to watch R4 while V9 went to find the nurse but V11 was finishing with another resident's cares. On 7/29/26 at 12:43 PM, V11 (Certified Nurse Aide) stated that just within minutes of V9 exiting R4's room, V11 went into R4's room and found R4 on the bathroom floor bleeding from her head. R4's record lacked documentation of post fall monitoring/assessments including pain, neurological checks and vital signs or monitoring for signs and symptoms of sepsis related to diagnosed Urinary Tract Infection. As of 7/14/26, the last pulse was taken on 7/7/26, respiratory rate and temperature on 5/11/26. On 7/29/26 at 2:00 PM, V1 (Administrator) and V2 (Director of Nursing) stated the facility did not have a post fall (witnessed/unwitnessed fall, if injury was sustained or if resident hit their head) monitoring policy. When asked what the protocol was and what the nurses were expected/taught to do post fall, V2 was unable to answer the question. V1 and V2 were unable to provide any educational materials which were utilized to teach/guide staff post fall protocols. V2 agreed one-to-one observations were not documented hourly between 7/1/26 and 7/26/26. V1 and V2 agreed R4 was left alone twice during the shift, once by V8 (Registered Nurse) on 7/10/26 at 11:00 PM and again by V9 (Certified Nurse Aide) on 7/11/26 approximately between 2:20 PM and 2:30 PM. 2. R8 was admitted on [DATE] with diagnoses of Psychotic Disorder with Delusions, Schizoaffective Disorder, depression, Fracture of Vertebrae, Dementia, Anxiety Disorder and Cerebral Ataxia. R8's Fall Risk dated 3/25/26 was scored at a 30 (high risk for falls). R8's Care Plan dated 7/6/26 documents R8 requires one-to-one observation due to behavioral problems and aggression towards others, as well as fall risks. R8's Progress Note dated 7/15/26 documents R8 has been on one-to-one observations since 6/21/26. Due to R8 not getting out of bed at night, one-to-one is discontinued at night and will continue during the day. R8's Resident Monitoring One-to-One tracking forms dated 7/7/26 through 7/14/26 lacked hourly monitoring 6 of 8 days. It was unable to be determined what time of the day the night one-to-to observations were to be stopped. Between 7/15/26 and 7/20/26, one-to-one observations were stopped at various times, the earliest being 4:00 PM and the latest at 7:00 PM. The Daily Assignment Sheets dated 7/15/26 through 7/20/26 and 7/22/26 through 7/27/26 have a Certified Nurse Aide assigned to be the one-to-one sitter during the 6:00 PM to 6:00 AM shift. On 7/29/26 at 2:00 PM, V2 (Director of Nursing) stated she didn't know when R8 required one-to-one observations but agrees the tracking forms demonstrated gaps in the observations.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review the facility failed to document a discharge summary and/or a recapitulation of stay for one resident (R1) of three residents reviewed for discharge. R1's Medical Record documents that he was admitted to the facility with diagnosis to include but not limited to Anemia post hemorrhage, Chronic Obstructive Pulmonary Disease and Congestive Heart Failure. R1's Medical Record contain a Release of Responsibility form dated 6/26/26 and signed by R1. The form documents R1 was educated to wait to see the doctor for discharge orders and R1 did not want to. R1's Medical Record does not contain any other documentation regarding R1's discharge against medical advice. On 7/28/26 R1 stated that no one discussed discharge instructions, safety or any other information before he left the facility. (V7/Social Services Director) had me sign a piece of paper so they (facility) wasn't responsible for me leaving and then I left. I didn't get any medications or supplies or instructions of any kind. On 7/28/26 V1 (Administrator) confirmed R1's Medical Record did not contain documentation regarding his condition upon discharge. All discharged charts should follow the Discharge Policy, whether it is AMA or not. The Facility's Discharge Summary and Plan policy dated 8/2025 documents The Discharge Plan, Instructions and Summary provides a recapitulation or summary of the resident's stay. Discharge, Plan, Instructions, and Summary: a. Social Services Director or Social Service Designee will open the Discharge Plan, Instructions and Recapitulation of Stay at the time the discharge is scheduled. b. The IDT (Interdisciplinary Team) will be notified when the assessment is open and incomplete sections will be discussed in the morning meeting. c. Social Service Director or Designee will complete sections A, B, D, H. d. Nursing will complete sections C and E; Wound nurse will ensure skin and treatments are recorded. e. Dietary will complete section F. f. Activities will complete section G. g. Social Services Director of Social Services Designee will ensure all sections are complete and the document is signed and locked. The Facility's Discharge Summary and Plan policy dated 8/2025 documents Discharge Education: a. Nurse will review discharge instructions and mediations with resident/resident representative. Copy of Disposition of Medication form will be given to resident/resident representative and a copy scanned into the record. b. Social Services Director or designee will include the Discharge Plan, Instructions, and summary in the Discharge Packet. Nurse will document discharge note in the progress notes section of the resident record. Discharge note will include-skin assessment, who they discharge with, where they are discharging to, what belongings were sent with them and other pertinent information.		