Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING IL6007330 10/05/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **2220 STATE STREET** TIMBERCREEK REHAB & HEALTHCARE CENT **PEKIN, IL 61554** SUMMARY STATEMENT OF DEFICIENCIES (X4)ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) **initial Comments** S 000 Annual Licensure and Certification Survey S9999 Final Observations S9999 Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) 300.1220b)3) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal Attachment A care needs of the resident. Statement of Licensure Violations d) Pursuant to subsection (a), general nursing

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | | |
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| | | DDRESS, CITY, STATE, ZIP CODE | | 10/05/2022 | | | |
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| S9999 | Continued From page 1 | | S9999 | | | Đ. | |
| | care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: | | | | | | |
| 0 | assure that the resi as free of accident nursing personnel s | ecautions shall be taken to dents' environment remains hazards as possible. All shall evaluate residents to see eceives adequate supervision prevent accidents. | | e e e | w y | 6, | |
| | Section 300.1220 S Services | Supervision of Nursing | | | | | |
| | b) The DON shall s nursing services of | upervise and oversee the the facility, including: | | N. | × | | |
| | each resident based comprehensive ass and goals to be account and personal care a representing other s activities, dietary, and are ordered by the part the preparation of the plan shall be in writing | essment, individual needs complished, physician's orders, and nursing needs. Personnel, services such as nursing, and such other modalities as obysician, shall be involved in ne resident care plan. The ang and shall be reviewed and with the care needed as | | | €: | | |
| | These requirements by: | s were not met as evidenced | | | | M4 (E) | |
| 4-1 | review, the facility faresidents fall, failed analysis and failed treduce the risk of fu | on, interview, and record alled to evaluate each to conduct root cause o implement interventions to ture falls for one of three ewed for falls in the sample of | 254 | | SS S | | |

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ B. WING IL6007330 10/05/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2220 STATE STREET **TIMBER CREEK REHAB & HEALTHCARE CENT PEKIN, IL 61554** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 2 S9999 33. This failure resulted in R38 falling on 7/19/22 and receiving a trimalleolar fracture of the right ankle. Findings include: The facility's Fall Prevention policy, dated 11/10/18, documents, "Policy: to provide for resident safety and to minimize injuries related to falls: decrease falls and still honor each resident's wishes/desires for maximum independence and mobility. Immediately after any resident fall the unit nurse will assess the resident and provide any care or treatment needed for the resident. A fall huddle will be conducted with staff on duty to help identify circumstances of the event and appropriate interventions. The unit nurse will place documentation of the circumstances of a fall in the nurses notes or on an AIM for Wellness form along with any new intervention deemed to be appropriate at the time. The unit nurse will also place any new intervention on the CNA (Certified Nursing Assistant) assignment worksheet. Report all falls during the morning Quality Assurance meetings Monday through Friday. All falls will be discussed in the Morning Quality Assurance meeting and any new interventions will be written on the care plan." On 10/02/22 at 09:59 AM, R38 was alert sitting up in bed. R38 stated she was on a motorized wheel chair and stood in the bathroom by herself when she lost her balance and slid down the wall. R38 stated she wasn't supposed to transfer herself but no staff were available. R38 uncovered her right leg to show she had a splint from her foot up to the top of her calf that was covered with an ace bandage. R38 stated she ended up breaking her ankle when she fell.

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right ankle pain. X-ray completed at hospital

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