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 ______	C 08/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERCREEK REHAB & HEALTHCARE CENTER	2220 STATE STREET PEKIN, IL 61554

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint 1624444/IL87553 - F157, F224, F273, F275, F278, F280, F309, F314, F354, F407, F425 cited Complaint 1624488/IL87600 - F157, F224, F273, F275, F278, F280, F309, F314, F354, F425 cited Complaint 1624558/IL87677 - F278 cited A Partial Extended Survey was conducted. This survey resulted in Immediate Jeopardies cited at F224 and F314 which were not abated at the time of exit.	F 000		
F 157 SS=G	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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.

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 _____	C 08/22/2016

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TIMBERCREEK REHAB & HEALTHCARE CENTER	**2220 STATE STREET PEKIN, IL 61554**

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F 157	Continued From page 1	F 157		

or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:
Based on interview, and record review the facility failed to notify the physician of R1's initial development and decline of a pressure ulcer, R1 not receiving a physician prescribed pressure ulcer treatment, and R1 failing to receive speech, occupational, and physical therapy as ordered by the physician. The facility also failed to notify the facility's Dietician of R1's pressure ulcer. These failures had the potential to affect one of three residents (R1) reviewed for notification of change in the sample of seven and resulted in R1 not receiving care and services to prevent R1's pressure ulcer from deteriorating to a stage four pressure ulcer. R1 currently is hospitalized, intubated, sedated for several surgical debridements of the pressure ulcer, and has required a colostomy and a supra-pubic catheter due to the wound progression.

Findings include:

The facility's Notification for Change in Resident Condition or Status policy dated 7-1-12 documents, "The facility and/or facility staff shall promptly notify appropriate individuals (i.e.,

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 ______	C 08/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERCREEK REHAB & HEALTHCARE CENTER	**2220 STATE STREET PEKIN, IL 61554**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 2	F 157		

Administrator, DON/Director of Nursing, Physician, Guardian, Healthcare Power of Attorney, etc,) of changes in the resident's medical/mental condition and/or status. The nurse supervisor/charge nurse will notify the resident's attending physician or on-call physician when there has been a significant change in the resident's physical, emotional, and the onset of pressure ulcers or stasis ulcers .... Notifications will be made within twenty four hours of a change occurring in the resident's medical/mental condition or status."

The facility's Pressure Ulcer-Nutritional Intervention policy dated 7/2010 documents, "Residents admitted or identified with stage two, three, or four pressure ulcers are referred to the dietician in a telephone consultation to review nutritional needs."
The Facility's Medication Administration policy dated 10/2007 documents, "If a medication is not available for a resident, call the pharmacy and notify the physician when the drug is expected to be available."
A Shower/Abnormal Skin Report dated 7/13/16, completed by E8 (Certified Nurse Aide/CNA) and signed by E9 (Licensed Practical Nurse) documents R1 has an "open area" to the coccyx area.
R1's Medical Record dated 7/13/16 through 7/17/16, does not document any assessment, treatment, or monitoring of R1's open area documented on the Shower/Abnormal Skin Report dated 7/13/16.
R1's Wound Progress Notes dated 7/19/16, 7/26/16, and 8/2/16 and signed by Z1 (Advanced Practice Nurse) documents weekly deterioration of R1's sacral wound to the point of requiring hospitalization and surgical debridement on

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 ______	C 08/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERCREEK REHAB & HEALTHCARE CENTER	**2220 STATE STREET PEKIN, IL 61554**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 3 8/3/16. A Progress Note Details (Wound Report), completed by Z1 (Advanced Practice Nurse) dated 7/19/16 at 9:39 a.m., documents "(R1) new treatment order to apply medihoney until Santyl (wound debriding ointment) becomes available, then use Santyl to wound bed daily and cover with border dressing daily." A Fax Transmittal Form dated 8/2/16 (sent by E7-Wound Nurse), documents "(R1) was supposed to be on Santyl 3 weeks ago and was not approved by insurance." A Progress Note Details (Wound Report), completed by Z1 (Advanced Practice Nurse) on 8/2/16, "At the time orders were written, Santyl was not available Staff was informed to use Medihoney until Santyl became available. Today I was informed that Santyl was not approved by (R1's) insurance, therefore (R1) did not benefit from Santyl. Today on evaluation the wound needed to be debrided....." R1's Dietary Progress Notes from 7-13-16 to 8-3-16 do not include any Dietician notes or assessments. A Hospital Discharge Summary dated 7/1/16 documents, "(R1) will require ongoing therapies including physical therapy, occupational therapy, and speech therapy for swallow, language, and cognition." R1's Admission Physician Orders dated 7/1/16 and signed by E4 (R1's Primary Physician) documents, "Physical Therapy (PT), Occupational Therapy (OT) and Speech Therapy to evaluate." R1's Therapy Record from 7-1-16 to 8-3-16, does not include R1 receiving any therapy services.	F 157		

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 ______	C 08/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERCREEK REHAB & HEALTHCARE CENTER	2220 STATE STREET PEKIN, IL 61554

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F 157	Continued From page 4	F 157		

On 8/9/16 at 2:30 p.m., Z9 (Physical Therapist/Therapy Program Director) stated R1 did not receive any therapy while in the facility (7/1/16-8/3/16). Z9 stated "I'm not able to do anything until approval is received by the facility. The facility did not get it approved by the corporation."

On 8/9/16 at 12:05 p.m., E7 (Wound Nurse) stated "On 7/19/16 (Z1/Advanced Practice Nurse) ordered medihoney until Santyl came in. That day I ordered Santyl from the (Pharmacy). A week later I came in to work and there was a request (from Insurance) for more information for the use of Santyl. I provided that information to the insurance. Then the next week (E7 came to work) the (Santyl) still wasn't here (7/26/16). The next week (8/2/16) the Santyl was still not here and I lost my temper. I only work 12 hours per week and the floor nurses should have addressed Santyl not being obtained. If the Santyl would have been used (on R1's pressure ulcer) the pressure ulcer probably wouldn't have progressed to the point of requiring surgical debridement... Medihoney does not work as good as Santyl."

On 8-9-16 at 11:00 a.m., Z2 (Pharmacist) stated, "The pharmacy received an order for (R1's) Santyl on July 20th, 2016. The Santyl was not covered by insurance. We let the facility know we needed a prior authorization from the physician, but never received one. The facility should have called the physician to get a prior authorization or to let the physician know the Santyl was not covered."

On 8-10-16 at 1:35 p.m., Z6 (Wound Physician) stated, "The facility should have called me or

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 ______	C 08/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERCREEK REHAB & HEALTHCARE CENTER	**2220 STATE STREET PEKIN, IL 61554**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 5	F 157		

(Z1/Advanced Practical Nurse) when the wound worsened . When the coccyx wound was found on (R1) on 7-13-16, a physician should have been notified and an treatment order obtained."

On 8-11-16 at 8:50 a.m., E3 (Assistant Director of Nursing) stated, "When the open area was found on (R1's) coccyx on 7-13-16 the physician should have been notified about the area and a treatment order obtained....We would also report to the dietician for additional nutritional interventions. I would have expected the nurse to notify the primary physician about the wound worsening and the resident's overall condition. I would also expect the physician to be notified when physical, occupational, and speech therapy was not given as ordered."

On 8/10/16 at 10:17 a.m., Z1 (Advanced Practice Nurse) stated, "I was not aware that Santyl was not being used on (R1's) sacral wound like I had ordered on 7/19/16. No one asked me to fill out a form for the insurance company." Z1 stated that if Santyl had been used as ordered the Santyl would have "most definitely" help stop the wound progression. Z1 stated "The sacral wound wouldn't have been as far gone. By the time I observed the wound on 8/2/16 it was too deep and I was concerned with bone involvement. I couldn't believe how the wound had declined from the week before. I was not notified in between my visits of the decline in the wound. I had (R1) referred to a vascular surgeon for surgical debridement because it was not appropriate for me to debride the wound in the nursing home setting. Someone (at the facility) should have jumped on (R1's wound decline) much sooner. (R1's) dressing was supposed to be done daily so the nurses should have identified the decline of

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 ______	C 08/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERCREEK REHAB & HEALTHCARE CENTER	2220 STATE STREET PEKIN, IL 61554

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F 157	Continued From page 6 (R1's) wound and notified a physician immediately." On 8/9/16 at 2:45 p.m., Z4 (R1's primary physician) stated, "I would have wanted to know about (R1's) wound decline. I would have looked at his labs, nutritional status, and the medical side of (R1's) health. (R1) had Physical Therapy, Occupational Therapy, and Speech Therapy ordered on admission 7/1/16. I was not aware that (R1) was not receiving any type of therapy. I did not give orders to discontinue any of (R1's) therapy. The prescreening of a resident prior to admission is to determine if the facility can meet the residents needs. If the facility admits them then the Admission Orders need to be followed." On 8-11-16 at 11:00 a.m., E14 (Dietician) stated, "I was never notified of (R1's) wounds...I have never done an assessment on (R1)..."	F 157		
F 224 SS=J	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility neglected to follow their policy/wound protocol by neglecting to provide wound treatments as ordered, neglecting to	F 224		

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F 224	Continued From page 7	F 224		

initially assess a pressure ulcer and notify the physician, neglecting to notify the physician of changes in condition for a worsening wound, and neglecting to provide nutritional interventions for a pressure ulcer for one of three residents (R1) reviewed for provision of nursing care in the sample of seven. This failure resulted in R1's pressure ulcer deteriorating to a stage four and R1 requiring hospitalization for surgical debridement. R1 continues to be hospitalized in a sedated state, intubated and with a colostomy and suprapubic catheter as a result of the extensive wound damage.

These failures resulted in an Immediate Jeopardy.

Findings include:

Facility Abuse Prevention Program Policy dated 11/11/11, states "This facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, corporal punishment, and involuntary seclusion. This facility therefore prohibits mistreatment, neglect or abuse of its residents, and has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of mistreatment, neglect or abuse of our residents....Neglect is the failure to provide, or willful withholding of, adequate medical care, mental health treatment, psychiatric rehabilitation, personal care, or assistance with activities of daily living that is necessary to avoid physical harm, mental anguish, or mental illness of a resident."

A Facility Physician Order Sheet dated 7/1/16,

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 ______	C 08/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERCREEK REHAB & HEALTHCARE CENTER	**2220 STATE STREET** **PEKIN, IL 61554**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 224	Continued From page 8 documents R1 is a 46 year old that was admitted on 7/1/16 with diagnoses which include, Acute Bilateral Watershed Infarction (Stroke), Obesity, Left Hemiparesis, Left Carotid Stenosis, Hypertension, Diabetes Mellitus, and Dysphasia. A Facility Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 7/14/16, documents R1 requires total assistance of two staff for transfers and bed mobility, is unable to ambulate, is incontinent of bowel and bladder, and has limited range of motion in bilateral upper and lower extremities. The MDS with the ARD of 7/14/16, also documents R1 scored a 13 out of 15 on the Brief Interview for Mental Status, indicating R1 is cognitively intact. A Nursing Admission Assessment dated 7/1/16, documents R1 does not have any pressure ulcers present on admission. A Shower/Abnormal Skin Report dated 7/13/16 completed by E9 (Licensed Practical Nurse), documents R1 had an open area on the sacral area. R1's Medical Record dated 7/13/16 through 7/17/16, does not document any assessment, treatment or monitoring of R1's open area at the sacral area. On 8/10/16 at 10:21 a.m., E8 (Certified Nurse Aide) verified that R1 was totally dependent for cares and that E8 identified a small open area on R1's coccyx and reported such to E9 on 7/13/16. On 8/10/16 at 12:05 p.m., E9 (Licensed Practical Nurse) stated E9 was R1's Nurse on 7/13/16. E9 stated "I signed the shower sheet that (E8-Certified Nurse Aide) gave me indicating (R1) had an open area on the coccyx area. Sometimes I'm handed a stack of shower sheets and I sign one, flip to the next sheet, sign it and flip to the next sheet. I did not assess (R1's) wound or notify anyone. I missed it and I take responsibility for that." E9 verified that the Charge Nurse was	F 224		

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 ______	C 08/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERCREEK REHAB & HEALTHCARE CENTER	2220 STATE STREET PEKIN, IL 61554

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 224	Continued From page 9 not notified so that an assessment could be completed per policy. On 08/11/16 at 9:35a.m. E12 (Licensed Practical Nurse) stated, "I was one of (R1's) primary nurses. I do not recall a treatment being ordered at that time." R1's clinical record documents that orders for R1's pressure ulcer were not received until 07/18/16. R1's Nurse Progress Notes dated 7/18/16 at 11:00 p.m., states "(Certified Nurse Aide) notified this Nurse (E11-Licensed Practical Nurse) of open area on mid coccyx. Area measuring nine centimeters (cm) by four cm shear skin. Denies pain at this time. (Treatment) order in place. (Z4-R1's primary physician), (Z3-Power of Attorney), Administrator (E1) notified." R1's Nurse Progress Notes dated 7/19/16 at 10:30 a.m., document a new physician order was obtained to have a "Wound Doctor" evaluate R1's wound. Facility Skin Condition Monitoring policy dated 11/1/12, states "Upon notification of a skin lesion, wound, stasis ulcer, or other skin abnormality, the Charge Nurse will assess and document findings. The Charge Nurse will then implement the following policy: a. Notify the physician and obtain treatment order if needed. Documentation of the skin abnormality must occur upon identification and at least weekly thereafter until the area is healed. Documentation of the area must include the following: a. Characteristic 1. Size 2. Shape 3. Depth 4. Color 5. Presence of granulation tissue or necrotic tissue. b. Treatment and response to treatment. c. Prevention techniques." On 8/9/16 at 12:05 p.m., E7 (Wound Nurse) stated "(R1) was high risk for skin breakdown according to (R1's) admission Braden Scale on 7/1/16. I took care of (R1's) wounds. (R1's)	F 224		

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 ______	C 08/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERCREEK REHAB & HEALTHCARE CENTER	**2220 STATE STREET PEKIN, IL 61554**

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F 224	Continued From page 10 wound on the sacral area was unstageable from first identifying it. On 7/19/16 (Z1) ordered medihoney until Santyl came in. That day I ordered Santyl from the (Pharmacy). A week later I came in to work and there was a request (from Insurance) for more information for the use of Santyl. I provided that information to the insurance. Then the next week (E7 came to work) the (Santyl) still wasn't here (7/26/16). The next week (8/2/16) the Santyl was still not here and I lost my temper. I only work 12 hours per week and the floor nurses should have addressed Santyl not being obtained. If the Santyl would have been used (on R1's pressure ulcer) the pressure ulcer probably wouldn't have progressed to the point of requiring surgical debridement. The wound worsened over the three week period. I notified (Z1) on 8/2/16. When (Z1) observed (R1's) wound (on 8/2/16) he said 'oh s***, oh s***, oh s***,' because it looked so bad. (R1) was paralyzed and should have been turned at least every two hours and put on a low air loss mattress. (R1) probably wasn't being turned every two hours. (Z1) was concerned that the Santyl had not been used and (R1's) wound had gotten worse. In all honestly I feel like (R1) was neglected. I am upset over this. Medihoney does not work as good as Santyl." On 8/16/16 at 9:35 a.m., E16 (Licensed Practical Nurse) stated "I took care of (R1) approximately five nights a week. (R1) had a pressure ulcer on coccyx area that started out as purple/red color, not open. When I came to work about five days later (the coccyx) wound was open and dark purple. I know the Santyl that was ordered didn't come in when originally ordered and I don't know why it didn't come. I worked night shift. The (Certified Nurse Aides) were able to turn (R1). (R1) was cooperative. I know pillows were used	F 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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TIMBERCREEK REHAB & HEALTHCARE CENTER	**2220 STATE STREET PEKIN, IL 61554**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 224	Continued From page 11	F 224		

to position (R1) but (R1) would smash the pillows down. We did not attempt anything else other than the pillows as far as I know."
A Medication Administration Policy dated 7/3/13, states "If the medication is not available for a resident, call the pharmacy and notify the physician when the drug is expected to be available."
On 8/10/16 at 10:17 a.m., Z1 (Advanced Practice Wound Nurse) stated Z1 started treating R1 on 7/19/16. Z1 stated R1's sacral wound was a pressure ulcer. Z1 stated R1 laid on his back all the time and had a hard time moving due to recent stroke. "I was not aware that Santyl was not being used on (R1's) sacral wound like I had ordered on 7/19/16. No one asked me to fill out a form for the insurance company." Z1 stated that if Santyl had been used as ordered the Santyl would have "most definitely" helped stop the wound progression. Z1 stated "the sacral wound wouldn't have been as far gone. By the time I observed the wound on 8/2/16 it was too deep and I was concerned with bone involvement. I couldn't believe how the wound had declined from the week before. "

R1's Wound Progress Notes dated 7/19/16, 7/26/16, and 8/2/16 documents weekly deterioration of R1's sacral wound to the point of requiring hospitalization and surgical debridement on 8/3/16.
On 08/10/16 at 10:17 a.m. Z1 stated "I was not notified in between my visits of the decline in the wound. I had (R1) referred to a vascular surgeon for surgical debridement because it was not appropriate for me to debride the wound in the nursing home setting. Someone (at the facility) should have jumped on (R1's wound decline) much sooner. (R1's) dressing was supposed to

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 ______	C 08/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERCREEK REHAB & HEALTHCARE CENTER	2220 STATE STREET PEKIN, IL 61554

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F 224	Continued From page 12	F 224		

be done daily so the nurses should have identified the decline of (R1's) wound and notified a physician immediately."

On 8/11/16 at 8:50 a.m., E3 (Assistant Director of Nursing) stated "The open area was found on 7/13/16 on (R1) which would have been a stage two at minimum or could have been a stage three according to the depth. When the area was found the nurse should have measured and assessed the area, informed the physician about the area and obtained a treatment. We would have looked at a Braden Score and depending on weight and mobility follow the dietary policy to report to the Dietician and implement additional nutritional interventions. If the Santyl did not come in I would expect the (Director of Nursing) and (Assistant Director of Nursing) and management to be notified. I would also let the wound physician know. I would expect the nurse to notify the physician about the wound and wound worsening and the residents overall condition..."
On 8/9/16 at 2:45 p.m., Z4 (R1's primary physician) stated the facility has had a lot of staff turnover and "has had issues with wound care not being consistent. I would have wanted to know about (R1's) wound decline. I would have looked at the labs, nutritional status and the medical side of (R1's) health."
A Notification for Change in Resident Condition or Status dated 7/1/12, states "The nurse supervisor/charge nurse will notify the resident's attending physician or on-call physician when there has been...a significant change in the resident's physical/emotional/mental conditions."
On 8/10/16 at 1:50 p.m., E13 (Dietary Manager) verified that she was not aware of R1's pressure ulcer until after R1 went to the hospital on 8/3/16. E13 stated, I would have notified the (Registered

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 ______	C 08/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERCREEK REHAB & HEALTHCARE CENTER	**2220 STATE STREET** **PEKIN, IL 61554**

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F 224	Continued From page 13 Dietician)." E13 stated no nutritional interventions were implemented for R1. E13 stated the Registered Dietician had not assessed R1 since he was admitted on 7/1/16. E13 stated "the (Registered Dietician) was here in the middle of July and didn't see (R1). My mistake, somehow I missed putting him on the (Registered Dietician's) list." On 8/11/16 at 11:00 a.m., E14 (Registered Dietician) stated "I was never notified of (R1's) pressure ulcer. I have never done a dietary assessment on (R1). If I was notified I would have started a bridge plan such as ordering a supplement or maybe revising the diet. I also may have added protein or a multivitamin. I would also monitor labs such as Hemoglobin A1C and an Albumin to check for protein needs." Facility Pressure Ulcers-Nutritional Intervention policy dated 7/2010, states "It is the policy of (the facility) that nutritional interventions shall be utilized as one of the means of treatment to improve the healing process in residents with pressure ulcers and for the prevention of new pressure ulcers. 1. Food Service Manager will be notified by nursing staff if a resident is admitted with or acquired pressure skin breakdown at the facility. 2. Residents with pressure ulcers will have a program of increased protein, calories, vitamins, minerals and fluids developed by the dietician and ordered by the resident's physician. 3. Incorporate the additional nutrients into the meal or snack pattern of the resident's diet according to intake. 4. Nourishments will vary depending on the stage of the pressure ulcer and on the potential intake of the resident...6. Residents admitted or identified with stage II, III, or IV pressure ulcers are referred to the dietician in a telephone consultation to review nutritional needs...8. Residents on modified diets will have a	F 224		

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 ______	C 08/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERCREEK REHAB & HEALTHCARE CENTER	2220 STATE STREET PEKIN, IL 61554

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F 224	Continued From page 14 supplement regimen determined by the dietician and ordered by the physician." On 8-10-16 at 10:30 a.m., R1 was lying in a bed on the right side in the ICU (Intensive Care Unit). R1 was intubated and sedated. R1 had a colostomy and a supra-pubic catheter. Z8 (Certified Wound Nurse) provided pressure ulcer care to R1. Z8 removed multiple four by four dressings saturated in pinkish/yellow drainage from R1's stage four sacral pressure ulcer. Z8 then obtained R1's sacral pressure ulcer size measuring at approximately 33 cm (centimeters) long by 9.5 cm wide by 9 cm deep. R1's Sacral Pressure Ulcer extended from R1's sacral region, around both sides of R1's anus, and into the scrotum. The Pressure Ulcer was beefy red with large amounts of yellowish/pinkish drainage, and had an approximate four cm round necrotic area over R1's tail bone. On 8-10-16 at 12:15 p.m., Z5 (Surgeon) stated, "(R1's) sacral wound was the worst pressure wound I have ever seen. It was nine centimeters (cm) deep. Worst case of neglect I have seen. Pure nursing home neglect. There is no reason (R1) should have developed this wound in a month or two time. It (pressure wound) was definitely caused by pressure. They (nursing facility) could not have provided pressure relief. (R1) should not be in this condition when (R1) is only in his forties. I did the first coccyx wound debridement at the hospital, and after removing the necrosis (dead tissue) the wound was a stage four that had tunneled around the rectum into the scrotum. (R1's) wound now has caused (R1) to be intubated and sedated, and (R1) required a colostomy and supra-pubic catheter. (R1) was also septic. (R1) is going to require several more debridements of the wound."	F 224		

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 ______	C 08/22/2016

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TIMBERCREEK REHAB & HEALTHCARE CENTER	**2220 STATE STREET PEKIN, IL 61554**

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F 224	Continued From page 15 On 8-10-16 at 10:15 a.m., Z7 (Certified Wound Care Nurse) stated, "I was present for (R1's) first coccyx wound debridement (8/4/16). Hard eschar (dead tissue) covered (R1's) coccyx/sacral area. The eschar was debrided from the wound and the wound was a stage four pressure ulcer. Had pressure been resolved it (pressure ulcer) could have been prevented." On 8-10-16 at 9:00 a.m., Z3 (R1's Family Member) stated, "at home (R1) was able to move around until he had a Stroke. The only reason he needed nursing home care was to receive rehabilitation. The doctor thought he could make a full recovery with therapy. Every time I visited (R1) at the facility he was on his back. (R1) is going to be devastated when he wakes up at the hospital and sees that he has all of them tubes and problems." The Immediate Jeopardy was identified on 8-18-16 at 2:15 p.m. to have begun on 7/13/16 when E8 (Certified Nurse Aide) identified an open area to R1's sacral area and the facility Neglected to act upon treating the area. E1 (Administrator) and E3 (Assistant Director of Nursing) were notified of the Immediate Jeopardy on 8-18-16 at 2:30 p.m. The immediacy was not removed at the time of the exit.	F 224		
F 273 SS=D	483.20(b)(2)(i) COMPREHENSIVE ASSESSMENT 14 DAYS AFTER ADMIT A facility must conduct a comprehensive assessment of a resident within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the	F 273		

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 ______	C 08/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERCREEK REHAB & HEALTHCARE CENTER	2220 STATE STREET PEKIN, IL 61554

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 273	Continued From page 16 facility following a temporary absence for hospitalization or for therapeutic leave.) This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to complete an Admission Minimum Data Set (MDS) and Care Area Assessment in the required timeframe for one of seven residents (R1) reviewed for pressure ulcers in the sample of seven. Findings include: The CMS's (Centers for Medicare and Medicaid Services) RAI (Resident Assessment Instrument) Version 3.0 Manual dated October 2015, documents an Admission Comprehensive Minimum Data Set assessment and Care Area Assessments must be completed no later than the fourteenth calendar day of the resident's admission (Resident's admission date plus thirteen calendar days). R1's Physician Order Sheets dated 7/2016, document R1 was admitted to the facility on 7/1/16. R1's Admission MDS with an Assessment Reference Date (ARD) of 7/14/16, Section A0310, documents the "Type of Assessment" as an Admission Assessment. R1's Admission MDS with an ARD of 7/14/16, documents Section Z0500 "Signature of (Registered Nurse) Assessment Coordinator Verified Assessment Completion" on 7/22/16. R1's Admission MDS with an ARD of 7/14/16,	F 273		

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 ______	C 08/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERCREEK REHAB & HEALTHCARE CENTER	2220 STATE STREET PEKIN, IL 61554

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F 273	Continued From page 17 Section A. CAA Care Area Assessment Summary documents R1's CAA's were not completed until 7/22/16 at 1:58 p.m. On 8/9/16 at 11:12 a.m., E4 (Care Plan Coordinator) stated "I have thirteen days from admission to complete an admission MDS and CAA's. E4 verified that R1's MDS with the ARD of 7/14/16 was not signed as completed until 7/22/16.	F 273		
F 275 SS=D	483.20(b)(2)(iii) COMPREHENSIVE ASSESS AT LEAST EVERY 12 MONTHS A facility must conduct a comprehensive assessment of a resident not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to complete an annual Minimum Data Set (MDS) within the RAI (Resident Assessment Instrument) Manual's required time frame for one of seven residents (R3) reviewed for MDS comprehensive assessments in the sample of seven. Findings include: The CMS's (Centers for Medicare and Medicaid Services) RAI Version 3.0 Manual dated October 2015, documents, "An annual comprehensive MDS is to have an ARD (Assessment Reference Date) no later than the ARD of previous OBRA (Omnibus Budget Reconciliation Act) comprehensive assessment plus 366 calendar days."	F 275		

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 ______	C 08/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERCREEK REHAB & HEALTHCARE CENTER	**2220 STATE STREET PEKIN, IL 61554**

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F 275	Continued From page 18	F 275		

The Facility's Comprehensive Assessment/Care Planning undated policy documents, "The MDS and care plan shall be re-evaluated according to the following schedule at least every 12 months, within 14 days of determination of a significant change in the resident's status, and every three months."

R3's Resident History MDS Transmittal Record documents R3 has not received an annual comprehensive MDS assessment since 7-15-15.

On 8-17-16 at 11:00 a.m., E19 (Regional Director of Operations) stated, "(R3's) annual (MDS) should have been done 7-10-16, but (E4/Care Plan Coordinator) coded the last MDS on 7-23-16 as a quarterly.... (R3's) last comprehensive annual MDS assessment was done on 7-15-15."

On 8-18-16 at 9:40 a.m., E4 (Care Plan Coordinator) verified that R3 should have had an annual MDS completed sometime between 4-14-16 and 7-23-16. E4 confirmed that R3 has not had an annual MDS completed since 7-15-15.

F 278 SS=D — 483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED — F 278

The assessment must accurately reflect the resident's status.

A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

A registered nurse must sign and certify that the assessment is completed.

F 278 | F 278

Continued From page 19

Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to accurately assess three of seven residents (R1, R3, R4) reviewed for Minimum Data Set (MDS) Assessments in the sample of seven.

Findings include:

The CMS's (Centers for Medicare and Medicaid Services) RAI (Resident Assessment Instrument) Version 3.0 Manual dated October 2015, documents, "Coding instructions: Code '0' (no) if the resident did not have a pressure ulcer in the seven day look back period. Code '1' (yes) if the resident had any pressure ulcer (stage 1, 2, 3, 4, or unstageable) in the seven day look back period. If this is not the first assessment...the

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 ______	C 08/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERCREEK REHAB & HEALTHCARE CENTER	**2220 STATE STREET PEKIN, IL 61554**

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F 278	Continued From page 20	F 278		

review period is from the day after the Assessment Reference Date (ARD) of the last Minimum Data Set (MDS) assessment to the ARD of the current assessment; review nursing home incident reports, fall logs and medical record; and Code '1', (yes) if the resident has fallen since the last assessment."

1. R1's Nursing Admission Assessment dated 7/1/16, documents R1 does not have pressure ulcers present on admission.
R1's Nurse Progress Notes dated 7/18/16 at 11:00 p.m., states "Certified Nurse Aide (Unknown) notified this Nurse (E11-Licensed Practical Nurse) of open area on mid coccyx. Area measuring nine centimeters (cm) by four cm shear skin. "
R1's Admission Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 7/14/16, documents on Section M0210 " Unhealed Pressure Ulcer(s)" that R1 has one or more unhealed pressure ulcer(s) at Stage I or higher. R1's MDS Assessment with an ARD of 7/14/16, documents on Section M0300 " Current Number of Unhealed Pressure Ulcers at Each Stage " that R1 has one " Unstageable-Non removable dressing (known but not stageable due to non-removable dressing/device) " and that the pressure ulcer was present on admission.

On 8/9/16 at 11:12 a.m., E4 (Care Plan Coordinator) verified that R1's pressure ulcer was not documented in R1's medical record until 7/18/16 and should not have been reflected on R1's MDS with an ARD of 7/14/16. E4 stated "I don't recall where I got the (pressure ulcer) information that (R1's) pressure ulcer was present on admission."

F 278 Continued From page 21 F 278

2. R3's Progress Notes dated 7-12-16 and signed by Z1 (Advanced Practice Nurse), documents all of R3's pressure ulcers to the buttock and coccyx have resolved (healed). R3's Treatment Administration Records dated 7-12-16 through 7-23-16, document all of R3's pressure ulcers have resolved. R3's MDS Section M Skin Conditions dated 7-23-16, documents R3 has one unhealed stage three pressure ulcer.

On 8-9-16 at 10:50 a.m., E4 (Care Plan Coordinator) stated, "According to (Z1's/Advanced Practice Nurse) progress notes dated 7-12-16, all of (R3's) wounds were healed on 7-12-16. (R3's) MDS Section M Pressure Ulcers should have documented 'yes' under healed pressure ulcers and had coded a '0' instead of '1' for the number of stage three pressure ulcers (R3). It was not coded right." E4 also verified that the facility uses the RAI Manual for instructions on coding the MDS.

3. R4's Situation Background Assessment and Recommendation (SBAR), dated 4/22/16, documents R4 had a fall on 4/22/16.
R4's MDS dated 5/31/16 does not document R4's 4/22/16 fall on the Health Conditions Section J1800 of the 5/31/16 MDS.
On 8/17/16, E2 (Director of Nursing/DON) stated, "The 4/22/16 fall should have been coded on (R4's) MDS dated 5/31/16."

F 280 SS=D 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP F 280

The resident has the right, unless adjudged

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 ______	C 08/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERCREEK REHAB & HEALTHCARE CENTER	2220 STATE STREET PEKIN, IL 61554

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 22	F 280		

incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review the facility failed to revise a comprehensive pressure ulcer care plan for one of three residents (R3) reviewed for pressure ulcers in the sample of seven.

Findings include:

On 8-9-16 at 11:20 a.m., E5 (Certified Nursing Assistant/CNA) and E6 (CNA) provided incontinence care to R3. During these cares, R3's buttocks and coccyx had no reddened or pressure areas noted.

R3's current Pressure Ulcer Care plan

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 ______	C 08/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERCREEK REHAB & HEALTHCARE CENTER	2220 STATE STREET PEKIN, IL 61554

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 23 documents, "Pressure Wound to coccyx, left buttocks, and right buttocks monitor and treat as followed and see Treatment Administration Record for detailed descriptions of wounds and daily treatments." On 8-9-16 at 10:50 a.m., E4 (Minimum Data Set Coordinator) stated, "(R3) currently does not have any pressure wounds. I was never told that (R3's) wounds were healed, so (R3's) care plan was never updated. The care plan still states that (R3) has pressure ulcers."	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to obtain and follow a physician ordered treatment for one of three residents (R1) reviewed for high risk of developing pressure ulcers in the sample of seven. Findings include: R1's Physician Order Sheet dated 7-1-16 (R1's Admission)to 8-3-16 (R1's Discharge to the hospital) documents, " (skin fold dressing)...apply externally bid (twice daily).."	F 309		

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 ______	C 08/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERCREEK REHAB & HEALTHCARE CENTER	**2220 STATE STREET PEKIN, IL 61554**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 309 — Continued From page 24 — F 309

R1's Treatment Administration Records (TARs) dated 7-1-16 to 8-3-16 documents, " topically to affected areas 6-2 (6 am to 2 pm shift) and 2-10 (2 pm to 10 pm shift)." These TARs from 7-1-16 to 8-3-16 indicate R1 did not receive the treatment as ordered.

On 8-11-16 at 9:10 a.m., E12 (Licensed Practical Nurse) stated, "I was one of (R1's) primary nurses. We (the facility) did not have the (skin fold dressing) that was ordered by the physician, so that treatment was never applied to (R1's) gluteal folds for gaulding..."

On 8-17-16 at 9:50 a.m., E7 (Wound Nurse) stated, "We (the facility) do no have the (skin fold dressing) in the facility. It takes away moisture from the groin. I noticed (R1) had an order for it but I never tried to order it. We (the facility) should have notified the doctor to get other options in place of the (skin fold dressing). (R1) never received the treatment as ordered. I never assessed (R1's) other skin areas so I am not sure where the (skin fold dressing) was supposed to be used on (R1). The order to use it (skin fold dressing) was given to the facility on admission. "

F 314 SS=J — 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES — F 314

Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and

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 ______	C 08/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERCREEK REHAB & HEALTHCARE CENTER	2220 STATE STREET PEKIN, IL 61554

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 25	F 314		

prevent new sores from developing.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to prevent a facility acquired pressure ulcer from deteriorating and failed to provide pressure ulcer treatments as ordered by the physician for one of three residents (R1) reviewed for pressure ulcers in the sample of seven. These failures resulted in R1's pressure ulcer deteriorating to a stage IV pressure ulcer resulting in R1 requiring hospitalization for surgical debridement of the wound. As a result, R1 required intubation, sedation, colostomy and a suprapubic catheter placement due to the extensive area of wound involvement. R1 continues to be hospitalized in a sedated state, unable to communicate.

These failures resulted in an Immediate Jeopardy.
Findings include:

The facility Pressure Ulcer Prevention Guidelines Policy dated 11/2012, states "To provide adequate interventions for the prevention of pressure ulcers for residents who are identified as HIGH or MODERATE risk for skin breakdown as determined by the Braden Scale...The nurse will complete a skin assessment on all residents upon admission then weekly for four weeks...The following guidelines will be implemented for any resident assessed at a Moderate or High skin risk: Turn and reposition every two hours (Turning and positioning may be more often than every two hours for high risk, if indicated), Range of Motion (Range of Motion as indicated by the resident's

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 ______	C 08/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERCREEK REHAB & HEALTHCARE CENTER	2220 STATE STREET PEKIN, IL 61554

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 26 need and/or assessment. Specify approaches on the Care Plan), Special Mattress (Specify type of mattress on the Care Plan), Positioning Devices (as needed-Devices while in chair or in bed as needed to maintain turning. Specify on Care Plan), Incontinence Care (May include lotions, barrier creams), Daily Skin Checks for High Risk (Follow protocol for coding skin condition), Weekly Skin Checks (Observe and measure weekly)...Nutritional Supplement (High Risk), Care Plan Entry. Any resident scoring High or Moderate risk for skin breakdown will be noted on the Treatment sheet and signed off by the nurse. In addition, a brief weekly narrative will be completed describing the resident's skin condition on the back of the treatment sheet." The facility Skin Condition Monitoring policy dated 11/1/12, states "Upon notification of a skin lesion, wound, stasis ulcer, or other skin abnormality, the Charge Nurse will assess and document findings. The Charge Nurse will then implement the following policy: a. Notify the physician and obtain treatment order if needed...Documentation of the skin abnormality must occur upon identification and at least weekly thereafter until the area is healed. Documentation of the area must include the following: a. Characteristic 1. Size 2. Shape 3. Depth 4. Color 5. Presence of granulation tissue or necrotic tissue. b. Treatment and response to treatment. c. Prevention techniques." The facility Pressure Ulcers-Nutritional Intervention policy dated 7/2010, states "It is the policy of (the facility) that nutritional interventions shall be utilized as one of the means of treatment to improve the healing process in residents with pressure ulcers and for the prevention of new pressure ulcers. 1. Food Service Manager will be	F 314		

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 ______	C 08/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERCREEK REHAB & HEALTHCARE CENTER	2220 STATE STREET PEKIN, IL 61554

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 27	F 314		

notified by nursing staff if a resident is admitted with or acquired pressure skin breakdown at the facility. 2. Residents with pressure ulcers will have a program of increased protein, calories, vitamins, minerals and fluids developed by the dietician and ordered by the resident's physician. 3. Incorporate the additional nutrients into the meal or snack pattern of the resident's diet according to intake. 4. Nourishments will vary depending on the stage of the pressure ulcer and on the potential intake of the resident...6. Residents admitted or identified with stage II, III, or IV pressure ulcers are referred to the dietician in a telephone consultation to review nutritional needs...8. Residents on modified diets will have a supplement regimen determined by the dietician and ordered by the physician."

A Facility Physician Order Sheet dated 7/1/16, documents R1 is a 46 year old that was admitted on 7/1/16 with diagnoses which include, Acute Bilateral Watershed Infarction (Stroke), Obesity, Left Hemiparesis, Left Carotid Stenosis, Hypertension, Diabetes Mellitus, and Dysphasia.

A Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 7/14/16, documents R1 required total assistance of two staff for transfers and bed mobility, is unable to ambulate, is incontinent of bowel and bladder, and has limited range of motion in bilateral upper and lower extremities. The MDS with the ARD of 7/14/16, also documents R1 scored a 13 out of 15 on the Brief Interview for Mental Status, indicating R1 was cognitively intact and R1 was verbal and able to make needs known.

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 ______	C 08/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERCREEK REHAB & HEALTHCARE CENTER	2220 STATE STREET PEKIN, IL 61554

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 28 A Nursing Admission Assessment dated 7/1/16, documents R1 did not have any pressure ulcers present on admission. R1's initial Care Plan dated 7/1/16, documents R1 is at risk for skin breakdown per Braden Risk Assessment with interventions which include: skin check weekly by nurse; incontinent care and barrier cream after incontinence as needed; report any new skin concerns to the doctor for treatment and follow up; prevent skin areas from prolonged contact, use pillows for positioning, float heels, assist to turn and reposition at least every two hours and as needed. R1's Braden Scales for Predicting Pressure Ulcer Risk dated 7/1/16 and 7/7/16, document R1 is at High Risk for developing pressure ulcers. R1's medical record does not document the completion of the Braden Scale for the next two weeks (7/14/16 and 7/21/16) as facility policy indicates. On 8/9/16 at 12:05 p.m., E7 (Wound Nurse) verified R1's Braden Scales for the weeks of 7/14/16 and 7/21/16 were not completed. R1's Medical Record dated 7/1/16 through 7/17/16, does not document R1 received daily skin checks or weekly skin narratives, as facility policy indicates for high risk residents. R1's Medical Record dated 7/1/16-7/17/16, does not document R1 received weekly skin checks by nurse as R1's care plan indicates. A Shower/Abnormal Skin Report dated 7/6/16, documents R1 has no skin breakdown. A Shower/Abnormal Skin Report dated 7/13/16,	F 314		

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 ______	C 08/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERCREEK REHAB & HEALTHCARE CENTER	2220 STATE STREET PEKIN, IL 61554

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 29	F 314		

Continued From page 29

completed by E8 (Certified Nurse Aide/CNA), documents R1 has an "open area" to the coccyx area. The Shower/Abnormal Skin Report dated 7/13/16 was signed by E8 and E9 (Licensed Practical Nurse/LPN) on 7/13/16.

On 8/10/16 at 10:21 a.m., E8 (Certified Nurse Aide) stated E8 frequently cared for R1. E8 stated R1 required total dependence for cares. E8 stated E8 identified a small open area on the "top of (R1's) tailbone. It was smaller than the tip of my finger and red in color. I reported it to (E9-Licensed Practical Nurse). (E9) stated 'I'll pass it on.' I found it on second shift at approximately 3:00 p.m. I did not see a dressing to the wound anytime soon. I reported it everyday. (The Nurses) finally got him a special mattress (low air loss mattress) and a dressing to (R1's) wound. Prior to the special mattress (R1) had a regular facility mattress."

On 8/10/16 at 12:05 p.m., E9 (Licensed Practical Nurse) stated E9 was R1's Nurse on 7/13/16. E9 stated "I signed the shower sheet that (E8-Certified Nurse Aide) gave me indicating (R1) had an open area on the coccyx area. Sometimes I'm handed a stack of shower sheets and I sign one, flip to the next sheet, sign it and flip to the next sheet. I did not assess (R1's) wound or notify anyone. I missed it and I take responsibility for that."

R1's Medical Record dated 7/13/16 through 7/17/16, does not document any assessment, treatment, or monitoring of R1's open area documented on the Shower/Abnormal Skin Report dated 7/13/16.

On 8/16/16 at 9:35 a.m., E16 (Licensed Practical

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 ______	C 08/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERCREEK REHAB & HEALTHCARE CENTER	**2220 STATE STREET** **PEKIN, IL 61554**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 30	F 314		

Nurse) stated "I took care of (R1) approximately five nights a week. (R1) had a pressure ulcer on coccyx area that started out as purple/red color, not open. When I came to work about five days later (the coccyx) wound was open and dark purple." I know the Santyl that was ordered didn't come in when originally ordered and I don't know why it didn't come. I worked night shift. The (Certified Nurse Aides) were able to turn (R1). (R1) was cooperative. I know pillows were used to position (R1) but (R1) would smash the pillows down. We did not attempt anything else other than the pillows as far as I know."

On 8-11-16 at 9:10 a.m., E12 (Licensed Practical Nurse) stated, "I was one of (R1's) primary nurses....I saw the wound as a blister on (R1's) coccyx. I do not recall a treatment being ordered at that time."

On 8-11-16 at 8:50 a.m., E3 (Assistant Director of Nursing) stated, "The open area that was found on (R1) on 7-13-16 would have been a stage two pressure ulcer at minimal, but possibly a stage three pressure ulcer according to depth. When the area was found on (R1) the nurse should have assessed and measured the area and obtained a treatment. We should have looked at the Braden score... We would have looked at off loading the pressure and obtained a pressure reducing mattress."

R1's Nurse Progress Notes dated 7/18/16 at 11:00 p.m., states "Certified Nurse Aide (Unknown) notified this Nurse (E11-Licensed Practical Nurse) of open area on mid coccyx. Area measuring nine centimeters (cm) by four cm shear skin. Denies pain at this time. (Treatment) order in place. (Z4-R1's primary physician),

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 ______	C 08/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERCREEK REHAB & HEALTHCARE CENTER	**2220 STATE STREET PEKIN, IL 61554**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 31 (Z3-Power of Attorney), Administrator (E1) notified." R1's Nurse Progress Notes dated 7/19/16 at 10:30 a.m., document a new physician order was obtained to have a "Wound Doctor" evaluate R1's wound. A Progress Note Details (Wound Report), completed by Z1 (Advanced Practice Nurse) dated 7/19/16 at 9:39 a.m., documents "(R1) has (history) of hemiparesis; associated signs and symptoms: decrease sensation, decrease mobility." The Progress Note continues to document, R1 has an unhealed "Medial Sacral" chronic Unstageable Pressure Injury obscured full-thickness skin and tissue loss pressure ulcer. The Progress Note documents the measurement of the Medial Sacral wound to be "9 cm length by 4 cm width, with an area of 36 square cm. There was no drainage noted. The patient reports a wound pain of level (two). Wound bed is 1-25% adherent, yellow slough." Z1 also documented a new treatment order to apply "Medihoney until Santyl (wound debriding ointment) becomes available, then use Santyl to wound bed daily and cover with border dressing daily." On 7/19/16, Z1 also ordered R1 to receive a pressure redistribution mattress (low air loss mattress). On 8/16/16 at 8:50 a.m., Z1 (Advanced Practice Wound Nurse) stated "when I documented 'chronic pressure ulcer' I meant that (R1) had to have had the sacral pressure ulcer for a week prior to me seeing it. I called Z4 (R1's primary physician) on Wednesday (8/3/16) because (R1) had not been sent to the hospital for surgical debridement like I had ordered on 8/2/16. When I called (Z4) he told me 'I told them to send him to the hospital yesterday'...the facility should have acted on (R1's sacral wound) sooner. It had to	F 314		

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 ______	C 08/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERCREEK REHAB & HEALTHCARE CENTER	**2220 STATE STREET PEKIN, IL 61554**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 32	F 314		

be bad and they did not act upon it. When I ordered a pressure redistribution mattress that meant something different than (R1) already had on his bed. (E7-Wound Nurse) knows that when I order it."

A Treatment Administration Record (TAR) dated 7/20/16, documents "pressure redistribution mattress". The TAR on day shift from 7/20/16 through 7/26/16, documents E11 (Licensed Practical Nurse) circled E11's initials indicating the pressure redistribution mattress was not available on those dates.

On 8/16/16 at 12:13 p.m., E11 verified that E11 circled her initials on R1's TAR dated 7/20/16 through 7/26/16 because R1's pressure redistribution mattress was not obtained. E11 stated "(R1) still had his old mattress on his bed so I wasn't going to sign it off that the new mattress was in place."

A Manufacturer pamphlet (date unknown), for the mattress originally on R1's bed (Panacea Mattress), states "may be appropriate through Stage II wounds. Mattress wound Stage ratings are general usage guidelines. Resident-specific assessment could alter your particular usage of these mattresses."

On 8/17/16 at 9:15 a.m., Z14 (Mattress Supplier Account Manager) stated "I spoke to a product manager regarding the Panacea original mattress (original mattress on R1's bed). If a pressure ulcer progresses past a stage II we would suggest a powered or a air mattress such as a Panacea convertible or a Panacea Air Advanced (Low Air Loss Mattress).

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 ______	C 08/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERCREEK REHAB & HEALTHCARE CENTER	2220 STATE STREET PEKIN, IL 61554

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 33	F 314		

On 8/16/16 at 2:50 p.m., E2 (Director of Nursing) stated "According to the manufacturer's guidelines the Panacea Mattress should be used for residents with pressure ulcers through a Stage II. When a pressure ulcer advances past a Stage II then a different mattress should be used. I would need to look at the facility policy for any other recommendations."

An Equipment Delivery Invoice dated 7/27/16, documents R1's low air loss mattress was not ordered until 7/26/16 at 5:19 p.m. (despite order written on 7/19/16) and was not delivered to R1 until 7/27/16.

On 8/9/16 at 12:05 p.m., E7 (Wound Nurse) stated "(R1) was high risk for skin breakdown according to (R1's) admission Braden Scale on 7/1/16. I took care of (R1's) wounds. (R1's) wound on the sacral area was unstageable from first identifying it. On 7/19/16 (Z1) ordered medihoney until Santyl came in. That day I ordered Santyl from the (Pharmacy). A week later I came in to work and there was a request (from Insurance) for more information for the use of Santyl. I provided that information to the insurance. Then the next week (E7 came to work) the (Santyl) still wasn't here (7/26/16). The next week (8/2/16) the Santyl was still not here and I lost my temper. I only work 12 hours per week and the floor nurses should have addressed Santyl not being obtained. If the Santyl would have been used (on R1's pressure ulcer) the pressure ulcer probably wouldn't have progressed to the point of requiring surgical debridement. The wound worsened over the three week period. I notified (Z1) on 8/2/16. When (Z1) observed (R1's) wound (on 8/2/16) he said 'oh sh**, oh sh**, oh sh**', because it looked so bad. (R1)

F 314

Continued From page 34

was paralyzed and should have been turned at least every two hours and put on a low air loss mattress. The air mattress did not arrive until 7/27/16 because it was not ordered until 7/26/16. I don't know why the nurses did not order it. (Z1) was concerned that the Santyl had not been used and (R1's) wound had gotten worse. In all honesty I feel like (R1) was neglected. I am upset over this. Medihoney does not work as good as Santyl."

On 8-10-16 at 1:35 p.m., Z6 (Facility Wound Specialist Physician) stated, "The facility is responsible to obtain the Santyl (Wound Debriding Ointment). I would have expected this treatment to be obtained within 24 hours. It should have been obtained. The facility should have informed me, or Z1 (Z6's Advanced Practice Nurse) when (R1's) wound worsened. I was not informed. I usually leave wound issues up to (Z1). When (R1's) coccyx wound was found on 7-13-16, a physician should have been notified and a treatment should have been obtained."

On 8/16/16 at 9:35 a.m., E16 (Licensed Practical Nurse) stated I know the Santyl that was ordered didn't come in when originally ordered and I don't know why it didn't come. I worked night shift. The (Certified Nurse Aides) were able to turn (R1). (R1) was cooperative. I know pillows were used to position (R1) but (R1) would smash the pillows down (due to his weight of 299 pounds). We did not attempt anything else other than the pillows as far as I know.

On 8/16/16 at 10:15 a.m., E1 (Administrator) stated "no one reported to me that (R1) would not turn and reposition. No one reported to me that

F 314

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 ______	C 08/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERCREEK REHAB & HEALTHCARE CENTER	2220 STATE STREET PEKIN, IL 61554

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 35	F 314		

the positioning devices (pillows) were not working for (R1). If (R1) refuses to turn and reposition, it should be documented...We would discuss (R1) refusing to turn and reposition at morning meeting. It was never discussed at morning meeting. Morning meeting includes all the nursing supervisors. It was never discussed at morning meeting because the nurses or (Certified Nurse Aides-CNAs) never reported it to any manager or myself. I would hope the nurse or CNAs would have reported it so we could have discussed additional interventions."

A Progress Note Details (Wound Report), completed by Z1 on 7/26/16, documents R1's Medial Sacral wound (Wound #1) measurements are "10.5 cm length by 8 cm width, with an area of 84 (square) cm. No sinus tract has been noted. No undermining has been noted. There is no drainage noted. The patient reports a wound pain of level (two). Wound bed is 51-75% adherent, yellow slough, 1-25% granulation....Periwound does not exhibit signs or symptoms of infection...Wound #2 (New Wound) Left Inferior Buttock is an acute skin tear and has received a status of Not Healed. Initial wound encounter measurements are 1.5 cm length by 0.6 cm width, with an are of 0.9 (square) cm. A sinus tract has been noted at (midnight position). No undermining has been noted. There is a small amount of drainage noted...Cleanse wound #1 (Medial Sacral) with Saline, protect periwound with Skin Protectant, Apply Santyl to wound bed, cover wound with Barrier Island Dressing, Change daily and (as needed) for soiling and/or saturation; Cleanse wound #2 with cleanser, protect with skin prep, Apply Hydrocolloid to wound bed, change every 72 hours and (as needed) for soiling and/or saturation...Sacral area

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 ______	C 08/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERCREEK REHAB & HEALTHCARE CENTER	**2220 STATE STREET PEKIN, IL 61554**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 36	F 314		

slow to heal, contributing factors are obesity, (history) of stroke, incontinence, generalized weakness. Plan to continue with low air loss mattress. Heel Offload, keep skin dry, keep turning patient, will follow up in one week."

R1's Medical Record dated 7/19/16 through 7/26/16, does not document any information regarding the Acute Skin Tear to R1's left inferior buttock area, noted by Z1 on 7/26/16.

On 8/9/16 at 12:05 p.m., E7 (Wound Nurse) stated R1's skin tear to the left inferior buttock was not identified until Z1 was assessing R1's sacral pressure ulcer on 7/26/16. E7 stated R1 has daily treatment orders and should be getting daily skin checks according to the facility policy.

A Progress Note Details (Wound Report), completed by Z1 on 8/2/16, documents "Wound #1 (Medial Sacral) has a status of Not Healed. Subsequent wound encounter measurements are 10.5 cm length and 6.5 cm width with an area of 68 (square) cm. No sinus tract has been noted. No undermining noted...Wound bed is 76-100% moist, yellow slough...Periwound skin does not exhibit signs and symptoms of infection...Consulted (Surgical) services for deep debridement of Wound #1 and Wound #2...This wound (#1 Medial Sacral) was first seen on 7/19/16, on that initial visit Santyl was ordered for the treatment of slough in the wound bed. At the time orders were written, Santyl was not available. Staff was informed to use Medihoney until Santyl became available. Today I (Z1) was informed that Santyl was not approved by (R1's) insurance, therefore (R1) did not benefit from Santyl. Today on evaluation the wound needed to be debrided. On a closer look (R1) has a tunnel

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 ______	C 08/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERCREEK REHAB & HEALTHCARE CENTER	**2220 STATE STREET PEKIN, IL 61554**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 37	F 314		

ulceration with slough near the anus area. (R1) is also receiving Coumadin (Anticoagulant). In light of all that I felt that (R1) may be better served if the wounds are debrided by surgical service. Given the extent of debridement, location of areas that needs to be debrided and the fact that (R1) is on Coumadin, I felt the (Nursing Home) setting is not the appropriate place for any kind of debridement for (R1). (E7-Wound Nurse) notified (Z4-R1's Primary Physician). Keep (R1) off his back. Turn (R1) every two hours to the right and left side, (R1) will need Santyl post debridement. Will (follow up) with (E7) in one or two days regarding surgical consult."

A Fax Transmittal Form dated 8/2/16 (sent by E7-Wound Nurse), documents Z4 was notified of Z1's request for a surgical consult for R1's sacral pressure ulcer. E7 also documented "(R1) was supposed to be on Santyl 3 weeks ago and was not approved by insurance."

On 8/10/16 at 10:17 a.m., Z1 (Advanced Practice Wound Nurse) stated Z1 started treating R1 on 7/19/16. Z1 stated R1's sacral wound was a pressure ulcer. Z1 stated R1 laid on his back all the time and had a hard time moving due to recent stroke. "I was not aware that Santyl was not being used on (R1's) sacral wound like I had ordered on 7/19/16. No one asked me to fill out a form for the insurance company." Z1 stated that if Santyl had been used as ordered the Santyl would have "most definitely" help stop the wound progression. Z1 stated "the sacral wound wouldn't have been as far gone. By the time I observed the wound on 8/2/16 it was too deep and I was concerned with bone involvement. I couldn't believe how the wound had declined from the week before. I was not notified in between my

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 ______	C 08/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERCREEK REHAB & HEALTHCARE CENTER	**2220 STATE STREET PEKIN, IL 61554**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 38 visits of the decline in the wound. I had (R1) referred to a vascular surgeon for surgical debridement because it was not appropriate for me to debride the wound in the nursing home setting. Someone (at the facility) should have jumped on (R1's wound decline) much sooner. (R1's) dressing was supposed to be done daily so the nurses should have identified the decline of (R1's) wound and notified a physician immediately." On 8/9/16 at 2:45 p.m., Z4 (R1's primary physician) stated the facility has had a lot of staff turnover and "has had issues with wound care not being consistent. I would have wanted to know about (R1's) wound decline. I was not notified. I would have looked at his labs, nutritional status and the medical side of (R1's) health." On 8/10/16 at 1:50 p.m., E13 (Dietary Manager) stated "I was not aware of (R1's) pressure ulcer until late last week after (R1) was discharged (to the hospital). I would have notified the (Registered Dietician)." E13 stated no nutritional interventions were implemented for R1. E13 stated the Registered Dietician had not assessed R1 since he was admitted on 7/1/16. E13 stated "the (Registered Dietician) was here in the middle of July and didn't see (R1). My mistake, somehow I missed putting him on the (Registered Dietician's) list." An SBAR (Situation Background Assessment Recommendation) Communication Form dated 8/3/16 at 3:00 p.m., documents Z4 (R1's Primary Physician) was notified of R1's worsening pressure ulcer. The SBAR documents "Wound appears infected, discolored, infected...(R1) sent to (Hospital) for consult/wound debridement	F 314		

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 ______	C 08/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERCREEK REHAB & HEALTHCARE CENTER	**2220 STATE STREET PEKIN, IL 61554**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 39	F 314		

surgically per (Z4 and Z1's) request."

An Ambulance Transport Narrative dated 8/3/16 at 4:37 p.m., documents "(The facility nurse) related that (R1) has a stage IV decubitus ulcer on (R1's) coccyx which (R1's) physician wants checked in the Emergency Department for possible surgical consult. (R1) is non verbal but will acknowledge with nods and shakes of his head."

An Emergency Department (ED) Progress Note dated 8/3/16, documents R1 "Presents to the ED for a wound evaluation to his buttocks. (R1) has a history of left paralysis from (Cerebral Vascular Accident) and history of decubitus ulcers. Nursing Home is concerned about a worsening wound to his buttocks, low grade fever, decreased (blood pressure) and elevated pulse."

On 8/15/16 at 4:00 p.m., Z12 (Emergency Department Physician), stated "(R1) was in bad shape when he came into the Emergency Department. (R1's) blood pressure was low and the sacral pressure ulcer looked bad. When I documented (R1) had a history of decubitus ulcers, I meant that he had this wound while at the nursing home. I would have no way of knowing if (R1) had prior decubitus ulcers. Basically it means the decubitus ulcer was there when (R1) came through the Emergency Department doors."

A Hospital Progress Note dated 8/4/16, documents R1 was brought to the Emergency Department (ED) on 8/3/16 with signs and symptoms of sepsis. R1 was found to be Hypotensive in the ED. R1 was given "Three liters of (Normal Saline) and admitted to ICU as

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 ______	C 08/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERCREEK REHAB & HEALTHCARE CENTER	2220 STATE STREET PEKIN, IL 61554

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 40	F 314		

(R1) was still hypotensive...Source of Sepsis is the decubitus wound which looks bad. Surgery called to debride the wound."

An Intensive Care Unit (ICU) Progress Note dated 8/3/16, stated R1 was "admitted to the ICU for septic shock, decubitus wounds, diarrhea, and (Acute Renal Failure)...consult for possible (Acute Coronary Syndrome) and elevated troponin." (Troponin is a lab test primarily used to help diagnose a heart attack)

R1's Debridement of Decubitus Ulcer Operative Note dated 8-5-16 and signed by Z5 (Surgeon) documents, "We (surgical staff) started with the sacral wound. A combination of sharp and cautery excisional debridements were used to remove dead tissue deep to the muscle. An extensive amount of necrosis was noted. The tissue has a very bad smell, almost smelled like stool. Some pus was also noted.....The necrotic tissue was very close and may be involving part of the anal sphincter. Attention was turned the area of skin necrosis posterior to the scrotum. A combination of sharp and cautery excisional debridements were used to remove dead tissue....Necrotic tissue was so deep in the middle of the wound and extends to likely involving the scrotum. Not safe to continue with more debridement, as we are getting closer to the scrotum and possibly the posterior part of the penis."

On 8-10-16 at 10:15 a.m., Z7 (Hospital Certified Wound Care Nurse) stated, "I was present for (R1's) first coccyx wound debridement (8/4/16). Hard eschar (dead tissue) covered (R1's) coccyx/sacral area. The eschar was debrided

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 ______	C 08/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERCREEK REHAB & HEALTHCARE CENTER	**2220 STATE STREET PEKIN, IL 61554**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 41	F 314		

from the wound and the wound was a stage four pressure ulcer. Had pressure been resolved it (pressure ulcer) could have been prevented."

On 8-10-16 at 12:15 p.m., Z5 (Surgeon) stated, "(R1's) sacral wound was the worst pressure wound I have ever saw. It was nine centimeters (cm) deep. Worst case of neglect I have saw. Pure nursing home neglect. There is no reason (R1) should have developed this wound in a month or two time. It (pressure wound) was definitely caused by pressure. They (nursing facility) could not have provided pressure relief. (R1) should not be in this condition when (R1) is only in his forties. I did the first coccyx wound debridement at the hospital, and after removing the necrosis (dead tissue) the wound was a stage four that had tunneled around the rectum into the scrotum. (R1's) wound now has caused (R1) to be intubated and sedated, and (R1) required a colostomy and supra-pubic catheter. (R1) was also septic. (R1) is going to require several more debridements of the wound."

On 8-10-16 at 10:30 a.m., R1 was lying in a bed on the right side in the ICU (Hospital Intensive Care Unit). R1 was intubated and sedated. R1 had a colostomy and a supra-pubic catheter. Z8 (Certified Wound Nurse) provided pressure ulcer care to R1. Z8 removed multiple four by four dressings saturated in pinkish/yellow drainage from R1's stage four sacral pressure ulcer. Z8 then obtained R1's sacral pressure ulcer size measuring approximately 33 cm (centimeters) long by 9.5 cm wide by 9 cm deep. R1's Sacral Pressure Ulcer extended from R1's sacral region, around both sides of R1's anus, and into the scrotum. The Pressure Ulcer was beefy red with large amounts of yellowish/pinkish drainage, and

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 ________	C 08/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERCREEK REHAB & HEALTHCARE CENTER	2220 STATE STREET PEKIN, IL 61554

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 42 had an approximate four cm round necrotic area over R1's tail bone. On 8-10-16 at 9:00 a.m., Z3 (R1's Family Member) stated, "Every time I visited (R1) at the facility he was on his back. (R1) is going to be devastated when he wakes up at the hospital and sees that he has all of them tubes and problems." The Immediate Jeopardy was identified on 8-18-16 at 2:15 p.m. to have begun on 7-13-16 when E8 (Certified Nurse Aide) identified an open area to R1's sacral area and the facility failed to act upon treating the area. E1 (Administrator) and E3 (Assistant Director of Nursing) were notified of the Immediate Jeopardy on 8-18-16 at 2:30 p.m. The immediacy was not removed at the time of the exit.	F 314		
F 354 SS=F	483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.	F 354		

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 ______	C **08/22/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERCREEK REHAB & HEALTHCARE CENTER	**2220 STATE STREET PEKIN, IL 61554**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 354	Continued From page 43 This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to have a Registered Nurse provide direct care on 8-20-16. This failure had the potential to affect all 115 residents in the facility. Findings include: According to the facility's 8-20-16 Labor Analysis Report, 8-20-16 Nursing Schedules, and August 20th, 2016 calendar, the facility did not have any direct care Registered Nurses scheduled for 8-20-16. On 8-22-16 at 2:00 p.m., E1 (Administrator) verified that on 8-20-16 the facility did not have any Registered Nurses scheduled to provide direct care. The Facility Data Sheet dated 8-9-16 and signed by E1, documents 115 residents reside in the facility.	F 354		
F 407 SS=D	483.45(b) REHAB SVCS - PHYSICIAN ORDER/QUALIFIED PERSON Specialized rehabilitative services must be provided under the written order of a physician by qualified personnel. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide physician ordered therapy for one of four residents (R1) reviewed for therapy	F 407		

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 ______	C 08/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERCREEK REHAB & HEALTHCARE CENTER	**2220 STATE STREET PEKIN, IL 61554**

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F 407	Continued From page 44 services in the sample of seven. Findings include: A Rehabilitative Care and Services Policy (date unknown), states "It is the policy (of the facility) to provide Specialized Rehabilitative Services as ordered by the resident attending physician. Specialized Rehabilitative Services include, but are not limited to: Physical Therapy, Speech Therapy, and Occupational Therapy. When the physician has written an order consultation with a therapist, the Director of Nursing shall contact the proper therapy discipline consultant to see the resident." The Facility Inquiry/Referral Form completed by E10 (Facility's Hospital Liason) dated 6/29/16, documents R1 would require Physical and Occupational Therapy. On 8/10/16 at 1:10 p.m., E10 verfied that E10 did R1's prescreening for nursing home placement on 6/29/16 (at the hospital). E10 stated R1's physician recommended skilled nursing home placement for continued physical and occupational therapy. On 8/16/16 at 12:55 p.m., E1 (Administrator) verified R1 was prescreened prior to admission on 7/1/16. E1 verified E1was aware that R1 needed skilled therapy and accepted R1 to the facility. A Hospital Discharge Summary dated 7/1/16, documents, "(R1) will require ongoing therapies including physical therapy, occupational therapy, and speech therapy for swallow, language, and cognition."	F 407		

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 ______	C 08/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERCREEK REHAB & HEALTHCARE CENTER	2220 STATE STREET PEKIN, IL 61554

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 407	Continued From page 45	F 407		

R1's Admission Physician Orders dated 7/1/16, documents "PT (Physical Therapy), OT (Occupational Therapy) and ST (Speech Therapy) to (evaluate)".

R1's Medical Record dated 7/1/16 through 8/3/16, does not document any therapy was provided for R1.

On 8/11/16 at 9:10 a.m., E12 (Licensed Practical Nurse) stated "I was one of (R1's) primary nurses. (R1) did not receive therapy because of his insurance. I asked therapy, E1 (Administrator), and E15 (Business Office Manager) why (R1) wasn't getting therapy and was told (R1's) insurance would not cover it."

An Email dated 7/12/16 at 11:24 a.m., documents E18 (Business Office Manager) requested approval from E17 (Corporate Finance) for R1's Skilled Therapy per R1's Admission Orders. An Email dated 7/12/16 at 11:26 a.m., documents E17 replied to E18 with the following: "(R1) needs to request charity therapy or set up restorative."

On 8/16/16 at 11:45 a.m., E18 verified E18 has no further documentation regarding R1's therapy until 7/28/16.

An Email dated 7/28/16 at 9:32 a.m., documents E18 again requested approval for R1's therapy. An Email dated 7/28/16 at 9:34 a.m., E17 replied to E18 with the following: "(R1) denied rehab care to direct bill (insurance company)."

On 8/9/16 at 2:30 p.m., Z9 (Physical Therapist/Therapy Program Director) stated R1 did not receive any therapy while in the facility

F 407 Continued From page 46 F 407

(7/1/16-8/3/16). Z9 stated "I'm not able to do anything until approval is received by the facility. The facility did not get it approved by the corporation. I finally realized that my company can direct bill (R1's insurance) and I started those procedures on 7/28/16. (R1) was discharged to the hospital before I received approval."

On 8/9/16 at 2:45 p.m., Z4 (R1's Primary Physician) stated R1 had Physical Therapy, Occupational Therapy, and Speech Therapy ordered on admission 7/1/16. Z4 stated he was not aware that R1 was not receiving any type of therapy. Z4 stated the prescreening of a resident prior to admission is to determine if the facility can meet the resident's needs. If the facility admits them then the Admission Orders need to be followed. Z4 stated "I do not recall giving any order to discontinue (R1's) therapies. I would have had to have a better reason than insurance not paying. I would have expected that therapy had assessed (R1) and a valid reason was given for not giving (R1) therapy."

On 8/10/16 at 10:21 a.m., E8 (Certified Nurse Aide) stated R1 required total assistance with care due to a recent Stroke and Paralysis. E8 stated "I took care of (R1) a lot and tried to work on getting him stronger. At some point I reported R1's need for speech therapy because (R1) hated the pureed diet and would tell me 'I just want regular food.'"

On 8/9/16 at 9:45 a.m., Z11 (Hospital Social Worker) stated "when (R1) was discharged from the hospital on 7/1/16 he was on a pureed diet with the goal to receive Speech Therapy and upgrade (R1's) diet as tolerated." Z11 stated R1 was admitted to the hospital from the facility on

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 ______	C 08/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERCREEK REHAB & HEALTHCARE CENTER	**2220 STATE STREET** **PEKIN, IL 61554**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 407	Continued From page 47 8/3/16 and R1 was still on a pureed diet because he had not received any therapies. Z11 stated hospital records prior to R1's admission to the facility on 7/1/16, documented that R1 needed therapy and speech therapy to work on upgrading R1's pureed diet with thickened liquids.	F 407		
F 425 SS=G	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to obtain a physician ordered medication for one of three residents (R1) reviewed for pressure ulcers in the sample of seven. This failure resulted in R1's sacral pressure ulcer to	F 425		

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 ______	C 08/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERCREEK REHAB & HEALTHCARE CENTER	**2220 STATE STREET PEKIN, IL 61554**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 48	F 425		

deteriorate to a Stage IV and required surgical debridement.

Findings include:

A Medication Administration Policy dated 7/3/13, states "If the medication is not available for a resident, call the pharmacy and notify the physician when the drug is expected to be available."

A Progress Note Details (Wound Report), completed by Z1 (Advanced Practice Nurse) dated 7/19/16 at 9:39 a.m., documents "R1 has an unhealed "Medial Sacral" chronic Unstageable Pressure Injury obscured full-thickness skin and tissue loss pressure ulcer. The Progress Note documents the measurement of the Medial Sacral wound to be "9 cm length by 4 cm width, with an area of 36 square cm. There was no drainage noted. The patient reports a wound pain of level (two). Wound bed is 1-25% adherent, yellow slough." Z1 also documented a new treatment order to apply "Medihoney until Santyl (wound debriding ointment) becomes available, then use Santyl to wound bed daily and cover with border dressing daily."

A Progress Note Details (Wound Report), completed by Z1 on 7/26/16, documents R1's Medial Sacral wound (Wound #1)measurements are "10.5 cm length by 8 cm width, with an area of 84 (square) cm. No sinus tract has been noted. No undermining has been noted. There is no drainage noted. The patient reports a wound pain of level (two). Wound bed is 51-75% adherent, yellow slough, 1-25% granulation....Periwound does not exhibit signs or symptoms of infection...Cleanse wound #1

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 ______	C 08/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERCREEK REHAB & HEALTHCARE CENTER	**2220 STATE STREET PEKIN, IL 61554**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 49 (Medial Sacral) with Saline, protect periwound with Skin Protectant, Apply Santyl to wound bed, cover wound with Barrier Island Dressing, Change daily and (as needed) for soiling and/or saturation..." A Progress Note Details (Wound Report), completed by Z1 on 8/2/16, documents "Wound #1 (Medial Sacral) has a status of Not Healed. Subsequent wound encounter measurements are 10.5 cm length and 6.5 cm width with an area of 68 (square) cm. No sinus tract has been noted. No undermining noted...Wound bed is 76-100% moist, yellow slough...Periwound skin does not exhibit signs and symptoms of infection...Consulted (Surgical) services for deep debridement of Wound #1 and Wound #2...This wound (#1 Medial Sacral) was first seen on 7/19/16, on that initial visit Santyl was ordered for the treatment of slough in the wound bed. At the time orders were written, Santyl was not available. Staff was informed to use Medihoney until Santyl became available. Today I (Z1) was informed that Santyl was not approved by (R1's) insurance, therefore (R1) did not benefit from Santyl. Today on evaluation the wound needed to be debrided. On a closer look (R1) has a tunnel ulceration with slough near the anus area. (R1) is also receiving Coumadin (Anticoagulant). In light of all that I felt that (R1) may be better served if the wounds are debrided by surgical service. Given the extent of debridement, location of areas that needs to be debrided and the fact that (R1) is on Coumadin, I felt the (Nursing Home) setting is not the appropriate place for any kind of debridement for (R1)..." On 8/9/16 at 12:05 p.m., E7 (Wound Nurse) stated "On 7/19/16 (Z1) ordered medihoney until	F 425		

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 ______	C 08/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERCREEK REHAB & HEALTHCARE CENTER	2220 STATE STREET PEKIN, IL 61554

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F 425	Continued From page 50	F 425		

Santyl came in. That day I ordered Santyl from the (Pharmacy). A week later I came in to work and there was a request (from Insurance) for more information for the use of Santyl. I provided that information to the insurance. Then the next week (E7 came to work) the (Santyl) still wasn't here (7/26/16). The next week (8/2/16) the Santyl was still not here and I lost my temper. I only work 12 hours per week and the floor nurses should have addressed Santyl not being obtained. If the Santyl would have been used (on R1's pressure ulcer) the pressure ulcer probably wouldn't have progressed to the point of requiring surgical debridement. The wound worsened over the three week period...(Z1) was concerned that the Santyl had not been used and (R1's) wound had gotten worse...Medihoney does not work as good as Santyl."

On 8/10/16 at 10:17 a.m., Z1 (Advanced Practice Wound Nurse) stated Z1 started treating R1 on 7/19/16. Z1 stated R1's sacral wound was a pressure ulcer. Z1 stated R1 laid on his back all the time and had a hard time moving due to recent stroke. "I was not aware that Santyl was not being used on (R1's) sacral wound like I had ordered on 7/19/16. No one asked me to fill out a form for the insurance company." Z1 stated that if Santyl had been used as ordered the Santyl would have "most definitely" helped stop the wound progression. Z1 stated "the sacral wound wouldn't have been as far gone. By the time I observed the wound on 8/2/16 it was too deep and I was concerned with bone involvement. I couldn't believe how the wound had declined from the week before. ..I had (R1) referred to a vascular surgeon for surgical debridement because it was not appropriate for me to debride

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 ______	C 08/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERCREEK REHAB & HEALTHCARE CENTER	2220 STATE STREET PEKIN, IL 61554

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F 425	Continued From page 51 the wound in the nursing home setting. Someone (at the facility) should have jumped on (R1's wound decline) much sooner..." On 8-10-16 at 1:35 p.m., Z6 (Facility Wound Specialist Physician) stated, "The facility is responsible to obtain the Santyl (Wound Debriding Ointment). I would have expected this treatment to be obtained within 24 hours."	F 425		