| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **145275** | A. BUILDING _____ B. WING _____ | **09/10/2020** |

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) |
|---|---|
| F 0885<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Many | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record reviews, staff interview, and review of the facility policy, the facility failed to inform all residents, family, or their representatives by 5:00 PM the next calendar day following the occurrence of a confirmed infection of COVID-19. This affected all 72 residents who resided in the facility and their families, when two residents tested positive for COVID-19. Findings include: 1. Review of R1's medical record indicated the resident tested positive for COVID-19 infection on 09/01/20. The record also indicated the resident's family and physician had been notified of the infection. There was no evidence the facility had informed each resident, family or representatives of the development of a COVID-19 infection in the facility by 5:00 PM on 09/02/20. 2. Review of R2's medical record indicated the resident was discharged from the hospital on [DATE] at 11:30 AM. At 12:00 PM the hospital called the facility and informed them that R2 had tested positive for COVID-19. The record indicated the resident's family had been notified of the infection. There was no evidence the facility had informed each resident, family or their representative of the development of a COVID-19 infection in the facility by 5:00 PM on 09/06/20. Interview with the Regional Director of Clinical on 09/10/20 at 3:15 PM, indicated they do not inform all the residents, families, or representatives when one resident develops the COVID-19 infection. She also stated the facility does not have a policy regarding notification of reporting to all the residents, family, or their representatives in the facility by 5:00 PM the next calendar day following the occurrence of a confirmed infection of COVID-19. Review of the facility's COVID-19 Control Measures, revised on 08/26/20, indicated there was additional references in the Control Measures Policy regarding, Reporting Requirements. The policy stated to refer to CMS (Centers for Medicare & Medicaid Services) and CDC (Centers for Disease Control) for the reporting requirements of Suspected or Confirmed Cased of COVID-19, staff and/or residents. |

| 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.