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 _____	07/28/2020

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 0686 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to implement Physician ordered skin integrity interventions and treatments for two of two residents (R2 and R3) reviewed for pressure ulcers in a sample of five. Findings include: Facility Preventative Skin Care Policy, revised 1/2018, documents: It is the facility policy to provide skin care through repositioning and careful washing, rinsing, drying and observation of the resident's skin condition to keep them clean, comfortable, well groomed, and free from pressure ulcers; staff on every shift and as necessary will provide skin care; after thorough cleansing of the skin, lotion or other approved skin protectant is to be applied and observation of any reddened areas will be reported to the Charge Nurse; and a thin layer of body lotion/skin protectant may be applied as a protective barrier to areas exposed to incontinence. Facility Pressure Sore Prevention Guidelines Policy, revised 1/2018, documents: It is the facility's policy 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 Policy documents the following guidelines will be implemented for any resident assessed at a Moderate or High Risk as follows: turn and position every two hours, Range of Motion, Incontinence Care, Daily Skin Checks, Weekly Skin Checks, Nutritional Supplement and Care Plan Entry. The Facility Decubitis Care/Pressure Area Policy, revised 1/2018, documents: It is the policy of this facility to ensure a proper treatment program has been instituted and is being closely monitored to promote the healing of any pressure ulcer; the pressure ulcer will be assessed and documented on the Treatment Administration Record/TAR or Wound Documentation Record. 1. R3's Admission skin assessment dated [DATE], documents bilateral redness of the buttocks. R3's Physician order [REDACTED]. Change three times a day. R3's TAR dated 6/1/20 through 6/30/20 does not document treatments on 6/22/20, 6/24/20, 6/25/20, 6/29/20 between 2:00 PM and 10:00 PM and 6/25/20 and 6/29/20 between 6:00 am and 2:00 PM. R3's TAR dated 7/1/20 through 7/30/20 does not document treatments on 7/8/20 through 7/12/20 and 7/16/20 between 2:00pm and 10:00 PM, 7/9/20 and 7/21/20 between 6:00 am and 2:00 PM, and 7/9/20 between 10:00 PM and 6:00 am. R3's Weekly Wound Tracking dated 7/14/20 documents a stage four pressure ulcer on R3's coccyx measuring 3.5 centimeter (CM) long by 4.0 cm wide by 1.0 cm deep. R3's Wound Evaluation and Management Summary by V3 (Wound Doctor), dated 7/21/20 documents a stage four pressure ulcer on R3's coccyx measuring 5.0 cm long by 4.0 cm wide and 1.0 cm deep with [MEDICAL CONDITION] (an infection in the wound). V3's notes document the coccyx wound has deteriorated requiring surgical excsional debridement to remove necrotic tissue. R3's Physician order [REDACTED]. Diagnosis: [REDACTED]. On 7/28/20 at 10:47 am, V5 (Licensed Practical Nurse/LPN) stated per V4 (Physician) that not changing the wound dressing and cleaning it as ordered by V3 (Wound Doctor) can definitely be what lead to R3's infection and deterioration of the coccyx wound. On 7/24/20, at 11:19 am, V2 (Director of Nursing/DON) stated, Nursing treatments and medications are supposed to be documented in the MAR (Medication Administration Record) and TAR (Treatment Administration Record), not normally the nurses notes. Even Agency nurses know to document in the MAR and TAR and the same with wound and catheter. There is no other place for it to be documented. V2 stated, As a nurse, you know if it is not documented then it was not done. V2 verified that R3's skin breakdown prevention interventions were not completed as ordered and as a result R3 acquired a pressure ulcer. 2. R2's Admission Skin Assessment, dated 4/18/20, documents that R2 has cracking/flaking bilateral feet and has excoriation in the groin area. R2's Admission Skin Assessment does not document any skin issues with R2's left posterior heel. R2's, Physician order [REDACTED]. R2's Physician order [REDACTED]. R2's Treatment Administration Record/TAR, dated 4/18/20 through 4/20/20 documents a daily treatment for [REDACTED]. R2's TAR does not document the Physician ordered cleansing of the groin/peri-area with cleanser (Therawox) and the cream ([MEDICATION NAME]) twice a day on 4/19/20, 4/20/20, 4/23/20, 4/24/20, 4/25/20, 4/26/20, 4/27/20 and 4/29/20. R2's TAR does not document the physician ordered heel boots on at all times while in bed for 6:00 am to 6:00 pm shift for 4/19/20, 4/20/20, 4/23/20, 4/24/20, 4/26/20, 4/27/20 and 4/29/20. R2's TAR does not document the heel boots on at all times while in bed for 6:00 pm to 6:00 am shift for 4/23/20, 4/24/20, 4/25/20 and 4/27/20. R2's TAR, does not document daily skin checks on the 6:00 am to 6:00 pm shift on 5/4/20, 5/12/20, 5/17/20, 5/19/20, 5/21/20, 5/22/20, 5/25/20, 5/26/20, 5/27/20, 5/28/20, 5/29/20, 5/30/20 or 5/31/20. R2's TAR, dated 6/29/20, 6/25/20, 6/26/20 and 6/27/20 does not document R2's heel boots on at all times when in bed. R2's POS, dated 5/14/20, documents an order to apply lotion to the extremities daily for a [DIAGNOSES REDACTED]. R2's TAR, dated 5/14/20 through 5/31/20, does not document a treatment to apply the skin lotion to the extremities. R2's TAR, dated 6/3/20, 6/6/20, 6/8/20, 6/26/20, 6/27/20 or 6/28/20 does not document a treatment to apply the skin lotion to the extremities. R2's Wound Evaluation & Management Summary by V3 (Wound Doctor), dated 5/19/20 through 6/16/20 does not document any skin issues with R2's left posterior heel. R2's Nursing Documentation (A.I.M.S. for Wellness), dated 6/25/20 at 1:30 am, documents discoloration to the left heel, skin barrier (Skin Prep) to the left heel, measurements of four centimeters by four centimeters with dark discoloration to left heel, yellowish/clear drainage observed. R2's Nursing Documentation (A.I.M.S. for Wellness), dated 6/25/20, documents pain to the right heel and coccyx and that R2 was sent to the local Emergency Department for new wounds, confusion, hallucinations and signs of infection. R2's TAR, dated 6/25/20, documents a Physician order [REDACTED]. The TAR does not document a treatment on 6/20/20, 6/21/20, 6/22/20, 6/23/20 or 6/24/20. Wound Evaluation & Management, dated 6/25/20, documents that V4 (Wound Doctor) ordered a treatment to R2's left posterior heel pressure ulcer measuring 6.0 centimeters by 10 centimeters and depth not measurable, of ([MEDICATION NAME] ointment apply once daily for 30 days and Alginate Calcium apply once daily for 30 days). R2's treatment record, dated 6/25/20, 6/26/20, 6/27/20 and 6/28/20 does not document an order for [REDACTED]. V4 documents, The wound was cleansed with Normal Saline and anesthesia was achieved using topical [MEDICATION NAME]. Then with clean surgical technique, 15 blade was used to surgically excise 60 centimeters of devitalized tissue and necrotic subcutaneous fat and surrounding connective tissues were removed at a depth of 0.2 centimeters. Treatment options-risks-benefits and the possible need for subsequent additional procedures on this wound were explained on 6/25/20. Facility Weekly Wound Tracking, dated 6/25/20, documents that R2's Left Posterior Heel Pressure Ulcer is new and house acquired. On 7/24/20, at 11:19 am, V2 (Director of Nursing/DON) stated, Nursing treatments and medications are supposed to be documented in the MAR (Medication Administration Record) and TAR (Treatment Administration Record), not normally the nurses notes. Even Agency nurses know to document in the MAR and TAR and the same with wound and catheter. There is no other place for it to be documented. V2 stated, As a nurse, you know if it is not documented then it was not done. V2 verified that R2's skin breakdown prevention interventions were not completed as ordered and as a result R2 acquired a pressure ulcer.
F 0690 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

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.

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F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) Based on interview and record review the facility failed to provide indwelling urinary catheter care per physicians orders and re-insert the correct indwelling urinary catheter size during a catheter change for one (R2) of three residents reviewed for catheters in a sample of five. Findings include: Facility Foley Catheterization Policy, revised 1/02, documents, A Foley catheter is to be inserted only by order of the physician. Replacement of Foley catheters will be done as needed, or as ordered by the Physician. R2's Nursing Notes, dated 4/18/20, at 2:33 pm and 7:45 pm, document that R2 admitted to the facility on [DATE] with a indwelling urinary catheter (Foley) intact, patent and draining dark yellow clear urine. R2's Physician Order, dated 4/18/20, documents a physicians order for Foley catheter care every shift and as needed and to change the 14 French/10 milliliter/ml indwelling urinary catheter once monthly, on the second of the month and as needed, on the 6:00 pm to 6:00 am shift (night). R2' Treatment Administration Record/TAR, dated 4/18/20 through 4/28/20, does not document indwelling urinary catheter care on Day Shift for 4/23/20, 4/24/20, 4/26/20, 4/27/20 and 4/29/20. R2's TAR does not document indwelling urinary catheter care on Night Shift on 4/23/20, 4/24/20, 4/25/20 and 4/27/20. R2's TAR, dated 5/1/20 through 5/31/20, does not document indwelling urinary catheter care on Day Shift for 5/2/20, 5/3/20, 5/4/20, 5/12/20, 5/17/20, 5/21/20, 5/22/20, 5/25/20, 5/26/20, 5/27/20, 5/28/20, 5/20/20 and 5/31/20. R2's TAR does not document indwelling urinary catheter care on Night Shift for 5/7/20, 5/17/20, 5/26/20, 5/27/20 and 5/28/20. R2's TAR, dated 5/2/20, does not document the physician ordered indwelling urinary catheter change. R2's TAR, dated 5/3/20, documents that R2's catheter was changed but does not document the physician ordered 14 French catheter and documents No 14 French catheter, used 16 French. R2's Nursing Note, dated 5/4/20, at 2:30 am, documents, Foley catheter changed this shift, no14 French available, 16 French used. R2's Physician order [REDACTED]. R2's Medication Administration Record/MAR documents the first dose of administration of the antibiotic on 5/31/20. The MAR does not document administration on 5/29/20 and 5/30/20. R2's Telephone Order Sheet, dated 6/13/20, at 10:35 am, documents an order for [REDACTED]. On 7/24/20, at 11:19 am, V2 (Director of Nursing/DON) stated, Nursing treatments and medications are supposed to be documented in the MAR (Medication Administration Record) and TAR (Treatment Administration Record), not normally the nurses notes. Even Agency nurses know to document in the MAR and TAR and the same with wound and catheter. There is no other place for it to be documented. V2 stated, As a nurse, you know if it is not documented then it was not done. I am sure it did not help his urinary tract infection.
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure medical records were complete and accurate for one of three residents (R3) reviewed for documentation of treatment orders in a sample of five Findings include: On 7/23/20 at 11:00 am, V1 (Administrator) provided copies of requested medical records for R3. R3's Physician order [REDACTED]. Change three times a day. R3's Treatment Administration Record (TAR) dated 7/1/20 through 7/30/20 does not document treatments on 7/8/20 through 7/12/20 and 7/16/20 between 2:00pm and 10:00 PM, and on 7/9/20, 7/21/20 between 6:00 am and 2:00 PM, and 7/9/20 between 10:00 PM and 6:00 am. On 7/28/20 at 9:34 am, an additional copy of R3's TAR was requested from V1. On 7/28/20 at 10:43 am, V1 provided an additional copy of R3's July 2020 TAR. The additional copy provided by V1 had been altered from the original copy given on 7/23/20 at 11:am. The additional July TAR provided by V1 documents, Physician order [REDACTED]. Change three times a day. The TAR dated 7/1/20 through 7/30/20 does not document treatments on 7/8/20 between 2:00pm and 10:00pm and 7/9/20 between 10:00pm and 6:00 am. On 7/28/20, V1 was asked why the original copy of R3's TAR given on Thursday 7/23/20 documents 10 missed treatments for the coccyx wound, but the additional copy of the same TAR for R3 provided on 7/28/20 documents only two missed treatment on R3's coccyx. On 7/28/20 V1 stated The nurses that went back and reviewed the MAR's and TAR's signed where they knew they did the treatment but failed to sign out at the time treatment was completed. Facility Decubitus Care/Pressure Areas revised 1/18 documents, Complete all areas of the Treatment Administration Record or Wound documentation record. On 7/28/20 at 9:30 am, V2, DON, stated Nurses should document what they do when they do it. Basic nursing education teaches us that if it isn't documented it isn't done. V2 stated she had no idea why the holes were filled in on the second batch of TARs provided to the surveyors.