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 _____	08/14/2020

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 0660 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Plan the resident's discharge to meet the resident's goals and needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to set up home health services upon discharge for two (R1, R2) of three residents reviewed for discharges in a sample of three. Findings include: Policy Discharge Planning, dated 11/1/17, documents It is the policy of this facility to assist each individual resident to make decisions in advance of discharge about the rehabilitative, psychosocial, and health care goals of the resident. It is the intent of the facility to ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution, provider, home caregiver or resident themselves to ensure continuity of care and services. The Social Services Director shall serve as the Discharge Chairperson and will be responsible for providing multi-disciplinary participation in discharge. On 6/30/20 at 11:05am, V1 (Administrator) stated V2 (Social Services Director) is responsible for setting up all home health appointments and any medical equipment needed prior to discharge. The medical equipment is to be set up before discharge and should be ready to go before discharge and if that is not able to be done then I need to know. I would not discharge a resident unless the home health and medical equipment was set up or available. 1. Facility Admit document, no date, documents R1 was admitted [DATE]. Facility discharge document, no date, documents R1 was discharged [DATE]. R1's Social Service Notes has no documentation R1 was set up with home health services or durable medical equipment. R1's Social Service Treatment Plan, dated 4/14/20, documents under Physical Needs: Wheelchair, and under admitting [DIAGNOSES REDACTED]. R1's Minimum Data Set, dated dated [DATE], documents R1 is cognitively intact and requires extensive assistance of one for bed mobility, transfer, dressing, and did not walk in room or corridor. It also documents R1 has lower extremity impairment on one side. R1's Discharge Evaluation, dated 4/24/20, documents R1 needs assistance based on care provided in the last 7 days for bathing, dressing, grooming; moving in bed to/from lying/sitting position; history of falls in last 30 days; meal prep, shopping, medication, and financial assistance services needed. R1's physician orders, dated 4/29/20, documents Patient discharged to home with home health. On 6/30/20 at 9:50am, V2 (Social Services Director) stated I am responsible for admissions, discharges, behaviors, and to coordinate family visits. I had trouble finding a home health agency for (R1). The home health agencies refused her insurance, and I did not follow up on (R1). I know she was here for physical therapy because of a [MEDICAL CONDITION]. At that same time, V2 verified she did not follow up or try to set up home health after R1 discharged . On 6/30/20 at 10:50am, V4 (R1's Insurance Representative) stated I was assigned (R1) after she was discharged from the nursing home with no home health in place. She was discharged to her apartment complex in the lobby and she had no way to get to her upstairs apartment. I called (nursing home) and spoke to (V2 Social Services Director) and she kept telling me she was new and knew she discharged (R1) without home health or any medical equipment in place for her to get around her apartment because the insurance would not pay for her physical therapy. On 6/30/20 at 11:55am, V1 (Administrator) stated (R1) should never have been discharged and left in the lobby of her apartment building. How did she get upstairs and out of the chair in the lobby? We should have kept her until services were available especially since she was here after a [MEDICAL CONDITION]. I can't believe that was done and she was left with no way to get in her apartment. On 6/30/20 at 11:55am, V2 (Social Services Director) stated Insurance wasn't paying for (R1) so we discharged her. I couldn't find any home health agency to take her insurance, and every place I called they would not take her insurance. I did not document who I contacted. She was my first discharge and I did not know what to do. I did not ask for help from anyone to find out what to do. I knew she did not have home health set up when she was discharged . I was told the day of (R1's) discharge she was to go home with home health, so I did not have much time to get home health set up. (R1) was transported by our facility van in our wheelchair and was left in the lobby of her apartment building without a wheelchair because the wheelchair she was in was ours and the driver brought it back here (facility). (R1) had no family to contact to assist with the discharge. At that time, V2 verified R1 used a wheelchair and received physical therapy while at the facility, and there were no further social services notes. On 7/1/20 at 9:20am, R1 stated I was kicked out of the place! I was driven to my apartment complex where they left me on a bench in the lobby by the elevator. I could not get up to my apartment on the eighth floor because they even took the wheelchair! I saw a friend in the lobby and that was how I got up to my apartment. I did not have home health services set up and could not get around my apartment because I did not have a walker or wheelchair to get around after my discharge. I used the nursing homes walker and wheelchair while I was there, but I don't have those things here at home. I finished rehab and they discharged me that day. I know discharges are not to happen this way and I should have had home health set up before I got home. I was lucky I had friends to help me out, as it was I still waited a week to get home health from my insurance setting it up. 2. Facility Admit document, no date, documents R2 was admitted [DATE]. Facility Discharge document, no date, documents R2 was discharged [DATE]. R2's current medical [DIAGNOSES REDACTED]. R2's physician orders, dated 4/30/20, document Physical therapy to eval and treat. R2's physician orders, dated 5/20/20, document Discharge home with home health. R2's Discharge Summary for Resident, dated 5/20/20, documents R2 needs assist with transfers, ambulation, and activities of daily living. Physical therapy to be continued after discharge. R2's Minimum Data Set, dated dated [DATE], documents R2 requires limited assistance for bed mobility, transfer, walk in room, dressing, toilet and personal hygiene. R2's social services notes, dated 5/20/20, document Discharging today due to insurance issues. (Local home health agency) sent referral. R2's Social Service Notes has no documentation R2 was set up with home health services prior to discharge. On 6/30/20 at 11:05am, V2 (Social Services Director) stated I did not verify if (R2) had home health services set up before discharge because all I did was call for a referral. I do not know if he has home health to help him. I do not remember who I called; no I did not document who all I called, and I do not have any other information or charting other than what is in the chart. I was told to discharge (R2) that day, so I did. We do not have to provide notice if insurance cuts them off; they have to leave the nursing home. (R2) got a cut letter for insurance and he was sent home the same day. At that same time, V2 verified she did not follow up or try to set up home health after R2 discharged . On 7/1/20 at 10:30am, R2 stated I was told to go home and that was that. I do not have home health and I am not getting any physical therapy. On 7/1/20 at 10:32am, V5 (R2's family member) stated (R2) has no home health or physical therapy services set up. I was called to come get him on his discharge day and that is what I did. He was supposed to be set up with Hospice Home Health, but I have never heard anything on that.
F 0760 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to obtain and administer prescribed medications for one (R3) of three residents reviewed for medications in a sample of three. Findings include: The facilities Conformance With Physician Medication Orders Policy dated 9/27/17 documents, Policy: All medications, including cathartics, headache remedies and vitamins etc., shall be given only upon the written order of a physician. All such orders shall have the handwritten signature of the physician. (Rubber stamps are not acceptable.) These medications shall be given as prescribed by the physician and at the designated time. Procedure: 7. The residents attending physician shall be notified of medications

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 0760 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) about to be stopped so the physician may promptly renew such orders to avoid interruption of the residents' therapeutic regimen. R3's Physician order [REDACTED]. Take 1 tablet by mouth three times daily for anxiety. R3's Medication Administration Record/MAR dated 5/1/2020 through 5/31/2020 documents [MEDICATION NAME] 1 milligram, 1 tablet by mouth three times a day for anxiety and was not given from 5/25/2020 12:00PM through 5/29/2020 at 8:00PM. R3's Social Service Progress Note dated 5/27/2020 and signed by V2 (Social Service Director) documents, Took grievance from resident. Resident states that he has not gotten several medications since Saturday. Resident states he has no appetite and feels like he is going to be sick. Resident was crying while talking. Told him it will be looked into. On 6/30/2020 at 12:30 PM V1 (Administrator) stated, Yes I recall (R3's) [MEDICATION NAME] not being given. It was an issue with pharmacy. It was over a holiday weekend and had to be faxed over a few times before it was finally delivered. On 6/30/2020 at 3:40 PM R3 stated, I was out of my [MEDICATION NAME] for about five days. I get it three times a day, so that is a lot to go without. I was really feeling sick and very anxious. They kept telling me it was coming from the pharmacy, but it wouldn't be there. I finally filed a grievance and it popped up in a couple of days. I don't know what the problem was, but I need my medication.