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 _____	**09/02/2020**

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 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Reasonably accommodate the needs and preferences of each resident.** Based on observation, interview and record review, the facility failed to timely answer call lights for three of three residents (R1, R4, R6) reviewed for call lights in a sample of six. Findings include: On 9/1/20 at 9:06a.m. V6 (R1's Family) complained that R1's call light was not answered in a timely manner. V6 stated that it generally takes anywhere from 15 minutes to 45 minutes for R1's call light to be answered. R1's Social Services notes dated 5/22/20 document that R1 filed a grievance/complaint that staff were taking too long to answer R1's call light. On 8/31/20 at 10:05 a.m. R4 engaged her call light to have her incontinence brief changed. At 10:12a.m. R1 and R6, who also reside on the same hallway, engaged their call lights. The lights outside and above R4, R1, and R6's doors could be seen flashing. A call light panel was visible on the wall at the nurses' station which showed that R4, R1 and R6 had engaged their call lights. A call light alarm was also sounding at the nurses' station. Two staff members were sitting at the nurses' station within hearing and visual distance of the call lights and call light board. One of the staff members was V4 (Registered Nurse) who was R4, R1, R6's nurse. Neither staff member attempted to see what R4, R1, R6 needed. At 10:27a.m. V3 (Certified Nurse Aide) walked into R1's room to see what R1 needed. At 10:28a.m. V3 walked into R6's room to see what he needed. V3 did not answer R4's call light until 10:29a.m. which was 24 minutes after R4 first engaged it. On 8/31/20 at 10:45a.m. R3 and R4 were seated in wheelchairs in their room. R4 verified she had to wait 24 minutes for her call light to be answered. R4 stated that 24 minutes is too long to wait for staff to help her with her activities of daily living (ADLs). R4 stated that she frequently has to wait as long as 45 minutes for staff to answer her call light. R4 stated that she requires assistance to go into the bathroom and has had incontinence as a result of waiting for staff to come assist her. R3 stated that she and R4 have complained about the long call light waiting times but the facility has not addressed the issue. On 8/31/20 at 10:55a.m. V3 stated that when R4, R1 and R6 initially engaged their call lights he was on a break. V3 stated that he told his nurse, V4, when he left for break so she could answer any call lights and address residents' needs. V3 stated that sometimes it's a problem answering the call lights on a timely basis because he is usually busy caring for residents on two different hallways at the same time. On 8/31/20 at 11:30a.m. V4 verified that she was supposed to answer call lights while V3 was taking a break around 10:00a.m. V4 stated that while she was sitting at the nurses' station, she did not notice any call lights going off on her hallway. On 9/1/20 at 10:35a.m. V1 (Administrator) stated that in most facilities when residents have to wait 15 to 20 minutes for the call light to be answered it is considered excessive.
F 0585 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.** Based on interview and record review the facility failed to attempt a grievance resolution for one of three residents (R1) reviewed for grievances in a sample of six. Findings include: A Resident Grievances/Complaints policy (undated) states, All staff is required to report any, and all grievances and complaints received from Residents. The Administrator is responsible to promptly resolve complaints and grievances. This policy includes a separate form called a Grievance/Complaint Report with a space for the name of the complainant, date, and description of the grievance or complaint. This policy further states, 5. Grievance and complaint investigations shall be completed within 15 days by the investigator who shall distribute copies of the report to the Administrator and the Social Services Director. The Social Services Director shall keep complete forms on file. 6. The investigator shall notify the Resident and document the results of the investigation on the grievance/complaint form. The Social Services Director is responsible to notify the family and resident representative of the resolution. On 9/1/20 at 9:06a.m. V6 (R1's Family) stated that R1, V5 (R1's Family), and V6 have all complained to the facility about R1's call lights not being answered in a timely manner. V6 stated that the facility has not done anything to resolve that grievance. R1's Social Services note dated 5/27/20 documents that R1 filed a grievance alleging that staff do not assist R1 with activities of daily living (ADLs), staff make R1 bear weight on her leg when she isn't supposed to, and that R1 pushes the call light but no one ever answers causing R1 to be incontinent. R1's medical record does not include documentation that an effort was made to resolve her grievance. A review of Grievance/Complaint Reports dated 5/2020 through 8/2020 does not include a form containing R1's complaint/grievance. On 8/31/20 at 11:00a.m. V2 (Social Services Director) verified R1's social services notes include a note regarding R1's complaint that staff do not assist R1 with activities of daily living (ADLs), staff make R1 bear weight on her leg when she isn't supposed to, and that R1 pushes the call light but no one ever answers causing R1 to be incontinent. V2 stated there are no other records that R1's grievance/complaint was ever addressed. On 9/1/20 at 10:30a.m. V1 (Administrator) verified that R1's grievance had not been addressed. V1 stated that when residents tell a staff member about a grievance or complaint, a form is filled out and given to V1 to address. V1 stated that R1's grievance/complaint was never transcribed to a Grievance/Complaint form and given to V1 to resolve. V1 stated that if R1's complaint had been resolved or addressed a follow-up note would have been placed in R1's chart.
F 0770 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide timely, quality laboratory services/tests to meet the needs of residents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure laboratory tests were obtained as ordered by a Physician for one of three residents (R2) reviewed for laboratory testing in a sample of six. Findings include: A Laboratory Tests policy dated 9/27/17 states, Laboratory testing will be completed in collaboration with Medicare guidelines, pharmacy recommendations and Physician orders. R2's nursing assessment form (AIM for Wellness) dated 8/16/20 and documented by V11 (Licensed Practical Nurse) at 1:30a.m. documents that R2 had developed a fever, headache, and stomach pain. This form further documents that R2's Physician (V12) was notified and ordered for R2 to have blood cultures. R2's physician's orders [REDACTED]. On 9/2/20 at 12:15p.m. V1 (Administrator) verified that V11 documented on R2's AIM for Wellness form that V12 instructed her to order the laboratory test of blood cultures on 8/16/20 to assist with determining the cause of R2's fever, headache, and stomach pain. V1 stated V1 interviewed V11 who confirmed she did not implement R2's blood cultures order given to her by V12. On 9/2/20 at 1:45p.m. V12 stated when he gave V11 the telephone order to have blood cultures performed on R2, he expected those orders to be implemented.

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.