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 03/05/2015

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 Investigation 1520996/II #75247-F323 cited Complaint Investigation 1521073, IL #75335- No deficiency cited. Complaint Investigation 1521076\ IL #75341 - No deficiency cited. Complaint Investigation 1521143/ IL #75420 - No deficiency cited. A partial extended survey was conducted.	F 000		
F 323 SS=K	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to maintain the temperature of hallway heaters to prevent a thermal hazard to independently mobile residents. This failure resulted in R4 sustaining a burn with blister to the left elbow on 1/13/15. The facility also failed to develop and implement policies and procedures following R4's burn to ensure hallway heaters no longer posed a thermal hazard. These failures have the potential to affect four of five residents (R1, R3, R4, R5) on the sample reviewed for thermal hazards and 94 residents (R6-R99) on the supplemental sample.	F 323		

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

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These failures resulted in an Immediate Jeopardy. While the immediacy was removed on 3/04/15, the facility remains out of compliance at a Severity Level 2. Additional time is needed to evaluate the implementation of the policies and procedures as well as inservicing of staff to determine the effectiveness of these changes.

Findings include:

On 3/3/15 at 4:20a.m. during a tour of the facility, a wall heater located on the C100 hall across from C106 was attached to the wall approximately three feet high, at about the same height as a hand rail. The heater was hot to the touch, and the housing of the heater was loose making it accessible to anyone in the hall. A heater located across from room C103 felt even hotter than the first.

On 3/03/15 at 5:40a.m. E1 (Administrator) stated the facility had one resident who was burned by one of the hallway heaters, "...about one month ago..." R4 had received a burn after, "R4 put an arm on the heater in the hallway and got some redness from that."

An incident final investigation dated 1/14/15 states, "R4 was found to have a small blister on R4's left elbow during R4's shower...R4 has a tendency to wheel self up toward the wall heaters and laying R4's arm on it" The incident report states, "R4 often roams around the building of R4's own free will. In order to prevent reoccurrences R4 will be closely monitored by staff while in the hallways and removed from potential hazardous situations. Maintenance also checked the heaters to make sure they are functioning properly."

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A nurse's note dated 1/13/15 at 8:00p.m. states, "R4 found to have a burn with blister on left elbow during shower. Area 9cm (Centimeters) by 5cm with blister in the center...R4 has a habit of wheeling self in wheelchair up to the wall heater and laying R4's arm on it."

On 3/03/15 at 8:45a.m. E11 (Maintenance person) used an infrared-thermometer to check the temperatures of the wall heaters in the four C-wing halls and the four B-wing halls. E11 stood in front of a heater located next to room C105 then pointed the infrared-thermometer at the heater approximately two inches from the heater, which registered 141 degrees Fahrenheit. E11 verified the reading by feeling the wall with a bare hand, which felt neither hot nor cold, then measured the temperature of the wall using the infrared-thermometer which measured the wall as 79 degrees Fahrenheit. E11 then rechecked the temperature of the wall heater, which remained 141 degrees Fahrenheit. E11 measured the temperature of the wall heater located next to room C206 which measured 160-162 degrees Fahrenheit. E11 stated, "That one seems pretty hot." E11 continued measuring the temperatures of all the wall heaters in the facility. The heater across from room C106 measured 145 degrees Fahrenheit. The heater across from room B303 measured 148 degrees Fahrenheit. The heater next to the men's restroom on the B100 hall measured 143 degrees Fahrenheit. The heater next to room B405 measured 173 degrees Fahrenheit. The heater next to room B106 measured 150 degrees Fahrenheit.

On 3/03/15 12:55p.m. E5 (Dietary Manager) instructed E11 on calibrating a stem thermometer

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using a cup of ice and water in order to compare the temperature readings of the infrared-thermometer. E11 placed the stem thermometer and also a digital thermometer in a cup filled with ice and a small amount of water. E11 verified the digital thermometer read 32.3 degrees Fahrenheit, the stem thermometer read 32 degrees Fahrenheit and the infrared-thermometer read 32 degrees Fahrenheit.

The facility's Infrared-Thermometer instruction manual dated 10/2002 states, "Infrared thermometers measure the surface temperature of an object...To measure a temperature, point unit at object and pull the trigger."

On 3/03/14 at 8:35a.m. E11 stated that after R4 had been burned 1/13/15, E11 and E19 (Maintenance Director), "...checked all the C-wing hallway heaters. They were all working properly, not blowing any hotter than suppose too." E11 stated E19, "...usually wrote some sort of report about how E19 fixed something or what E19 did to repair equipment." E11 was unable to provide documentation that E11 and E19 adjusted the temperature of the wall heaters.

On 3/03/15 at 6:30a.m. R4 was self-propelling a wheelchair in the dining room. R4 was able to remember that R4 received a burn to R4's left arm on the heater, "by room 6."

On 3/03/15 at 1:10p.m. R22 stated, "The registers are warm, too warm for someone older."

On 3/03/15 at 1:25p.m. R10 stated, " I have never touched the registers because I was told by the

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CNAs (Certified Nurse Aides) and nurses not to touch them because I could get burned."

On 3/03/15 at 1:00p.m. E13 (Licensed Practical Nurse) stated, "I keep an eye on them (residents) to make sure that when people sit in front of the grill to watch out for them so they don't get burned..."

On 3/03/15 at 12:55p.m. E20 (Licensed Practical Nurse) stated, " The B400 hallway heater gets hot by where I park the med cart."

On 3/03/14 at 1:15p.m. R65 stated, "Sometimes they (staff) park the (mechanical) lift next to the heater in the hallway by my room. It gets really hot and when they bring it in the room, sometimes they have to let it cool off before they can use it," on R65.

On 3/03/15 at 1:20p.m. R5 stated, "I've noticed that some of the heaters in the hall get very warm."

On 3/04/15 9:30a.m. R69 stated, "I have touched the register before. I didn't get burned but thought it was pretty hot."

On 3/04/15 at 8:30a.m. E1 (Administrator) stated the facility had no documentation the wall heaters had been adjusted after R4's burn on 1/13/15. E1 also stated the facility was, "...periodically temping the heaters but there is no documentation for that." E1 stated, "The temperature of the heaters should be 120 degrees or less."

On 3/03/15 at 2:00p.m. E2 (Director Of Nurses) provided documentation that there were 98

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independently mobile residents in the facility at the time of the survey.

An Immediate Jeopardy was identified at approximately 1:40p.m. 3/04/15. It began on 1/13/15 when R4 sustained a burn to R4's left elbow while leaning against a wall heater in the hallway. E1 (Administrator) and E15 (Director of Business Operations) were notified of the Immediate Jeopardy on 3/04/15 at 2:00p.m.. The surveyor confirmed through interview and record review that the facility took the following actions to remove the Immedicate Jeopardy:

The facility completed a 100% audit of all wall heaters. They were continually adjusted until all temperatures were at or below 113 degrees. (Completed: March 3, 2015) at 113 degrees it would take two hours to develop a second degree burn, so it was decided that was a safe temperature threshold.

A Quality Assurance Program was put into place where all heaters will be tested daily using an infrared thermometer to ensure they remain at or below 113 degrees. (Completed: March 3, 2015) A daily tracking log will be maintained and submitted to the Administrator to monitor for discrepancies. The daily temping will be done by maintenance Monday through Friday and on Saturday and Sunday the weekend manager will be responsible for temping them. Any emergent needs will be reported to maintenance and the Administrator. Additionally, the Administrator will conduct random temperature audits and log appropriately.

The facility conducted an in-service with staff to educate them that heaters are only to be

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F 323	Continued From page 6 adjusted by the maintenance department. Staff was also educated to redirect residents from sitting in front of and/or leaning on wall heaters. Residents will be closely monitored by staff during their rounds and throughout their daily activity. The in-service was conducted by the Administrator, DON and ADON. No employee will be allowed to start their shift until they have completed the training. (Started: March 3, 2015; Projected Completion: March 5, 2015) All wall heater faces were screwed into the brick wall so that no one but maintenance can adjust the temperatures therefore removing the opportunity for any further incidents. (Completed March 4, 2015)	F 323		