STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145726	A. Building B. Wing	02/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Timber Point Healthcare Center	205 East Spring Street Camp Point, IL 62320

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to accurately assess a resident's risk of abuse and failed to adequately supervise a resident to prevent resident-to-resident physical abuse for two of three residents (R2 and R3) reviewed for abuse in the sample of four. These findings resulted in R2 and R3 physically assaulting each other and R3 experiencing pain, ongoing increased anxiety, fear, and restlessness.Findings Include:The facility's Abuse and Retaliation Policy Prevention Program Policy dated 1/2026 documents, Policy: The facility affirms the right of our resident to be free from abuse, neglect, exploitation, retaliation, misappropriation or property, deprivation of goods and services by staff, or mistreatment. The facility therefore prohibits abuse, neglect, exploitation, misappropriation or property, and mistreatment of residents. In order to do so, the facility has attempted to establish a resident-sensitive and resident-secure environment. The purpose of this policy is to ensure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation or property, deprivation of goods and services by staff, and mistreatment of residents. Abuse means any physical or mental injury, retaliation, or sexual assault inflicted upon a resident other than by accidental means. Physical Abuse is the infliction of injury on a resident that occurs other than by accidental means, and that requires medical attention. Physical abuse including hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment. Sexual abuse included, but is not limited to, sexual harassment, sexual coercion, or sexual assault including non-consensual or non-competent to consent sexual activity. Resident Assessment: As part of the resident's life history on the admission assessment, comprehensive care plan, and MDS (Minimum Data Set) assessments, staff will identify residents with increased vulnerability for abuse, neglect, exploitation, mistreatment, history of trauma or misappropriation of resident property, who have needs, triggers and behaviors that might lead to conflict. Through the care planning process, staff will identify any problems, goals, and approaches that would reduce the changes of abuse, neglect, exploitation, mistreatment, or misappropriation of resident property for these residents. Staff will continue to monitor the goals and approaches regularly and update as necessary.1.R2's MDS (Minimum Data Set) assessment dated [DATE] documents R2 was severely cognitively impaired.R2's current Face Sheet documents R2 was a [AGE] year-old admitted to the facility on [DATE] with the diagnoses of Vascular Dementia with other behavioral disturbance, Schizoaffective Disorder, and Delusional Disorder. This same Face Sheet documents R2 expired on [DATE].R2's Progress Notes dated [DATE] at 11:26 PM and signed by V3 (Registered Nurse/RN) document, This nurse heard yelling from the middle hall. Upon entering room noted (R2) wheeling out of a female resident's room (R3's). (R3) stated that (R2) allegedly crawled on top of (R3) in her bed and punched (R3) on the right side of (R3's) face three times and then (R3) punched (R2) back and (R3) pushed (R2) off of (R3). This same note documents R2 was sent to the emergency room for psychiatric treatment due to (continued on next page)

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.

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	increased agitation.R2's Hospital Emergency Department Notes dated [DATE] document, You (R2) were seen in the emergency department on [DATE] with the chief complaint of combative. EMS (Emergency Medical Services) report that (R2) allegedly hit another resident (R3) earlier today.2.R3's MDS assessment dated [DATE] documents R3 is cognitively intact and has no behaviors.R3's current Face Sheet documents R3 is a [AGE] year-old admitted to the facility on [DATE] with the diagnoses of Chronic Obstructive Pulmonary Disease, Hypertension, Generalized Anxiety Disorder, and Insomnia.R3's Progress Notes dated [DATE] at 11:38 PM and signed by V3 (RN) document, 10:00 PM (R3) states a male resident (R2) allegedly crawled on top of (R3) and punched (R3) three times to the right side of (R3's) face. (R3) assessed for injuries with no injuries noted. No redness noted to face. (R3) asked if she feels safe to stay in her room and she states she does feel safe. (R3) assured that we (facility staff) would shut her door and monitor the hallway. No complaints of pain or distress noted. Bed in low position with call light in reach. Will continue to monitor.R3's Physician's Progress Notes dated [DATE] and signed by V10 (Psychiatric Advanced Practical Nurse/APN) document, APN met with (R3) to discuss recent increase in anxiety symptoms. Today (R3) describes a triggering event in which another resident (R2) entered (R3's) room, confused, and attempted to climb on (R3's) bed. This triggered fear and anxiety in (R3). Describes thoughts that (R3) may have caused or contributed to this (happening). (R3) interested in therapy to further process. Continued leg bouncing and describes feeling restless.R3's Physician's Progress Notes dated [DATE] and signed by V10 document, APN met with (R3) to discuss recent increase in anxiety concerns. Last visit increased Prozac dosage. Discussed increase in Hydroxyzine. Today (R3) reports continued concerns with anxiety and worry. Reports feeling recent incident of other resident (R2) coming in (R3's) room and trying to get on (R3's) bed was somehow her fault. Discuss plans to further process this with therapist.R3's Physician's Orders dated [DATE] and signed by V10 (APN) document, Increase Prozac from 10 mg (milligrams) to 20 mg daily. Change Hydroxyzine 50 mg BID (twice daily) PRN (as needed) to BID scheduled.R3's Physician's Orders dated [DATE] and signed by V10 document, Change Hydroxyzine 50 mg BID to 25 mg TID (three times daily).R3's current Care Plan documents R3 has episodes of anxiety. This same Care Plan does not address R3's allegations of abuse or any interventions to address or protect R3 from R2 after R3 made allegations of resident-to-resident (R2 to R3) abuse on [DATE].R3's Abuse Risk Review dated [DATE] and signed by V8 (Social Service Director) documents R3 has not experienced or made allegations of any type of abuse (including resident-to-resident altercations) since the last review dated [DATE], therefore no further care plan recommendations were needed.On [DATE] at 9:30 AM R3 was lying in bed. R3 stated, A few months ago, (R2) kept trying to have a relationship with me and I was not interested. (R2) lived in the room next to me. One time (R2) came up to me in the hallway and tried to touch my breasts. I blocked (R2) from touching my breasts. I told the staff. I cannot recall who I reported this too. It was too long ago. (R2) would always follow me around in the hallways and I would have to tell (R2) Leave me alone! I am not a whore! I did not want any kind of relationship with (R2). One night ([DATE]) I had dozed off asleep and woke up to (R2) rubbing my stomach. (R2) had his knees on my bed (left side of the bed) and was leaning over me. I yelled for help and yelled at (R2) to, Get the h**l off of me and get out of my room! (R2) started punching me in the head. It hurt my head. I drew my fist back and hit (R2). When I hit (R2) it knocked (R2) backwards and (R2) got back into (R2's) wheelchair. I was stunned and traumatized. I felt like (R2) was going to try and sexually attack me. Since then, I have been afraid and scared of men. I sleep in my shorts and a jacket every night, so I do not expose myself and have had to start seeing a therapist to help me cope with what (R2) did to me. How would you feel if a man came into your room during the night and you were woken up to that? I was so (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	scared.On [DATE] at 11:25 AM R4 was sitting in a wheelchair in her room. R4 stated, On ([DATE]) I was lying in bed and was woke up to (R3) yelling of help and no one came to help (R3). I saw (R2) crawling on top of (R3) in bed. (R3) was trying to get (R2) off of her. I saw (R3) hitting (R2) and (R2) finally got off (R2) and got back into his wheelchair. (R3) told me that (R2) hit her on the head. (R2) had tried to come into our room several nights before this. I was scared of (R2) and did not want (R2) to do anything to me. I told (V1/Administrator) everything that (R2) did to (R3) that night.On [DATE] at 12:30 PM V8 (Social Service Director) stated, I completed (R3's) abuse risk review on [DATE] and it is inaccurate. When I completed the abuse risk I did not know that (R3) had made an allegation of abuse on [DATE]. At this time V8 confirmed R3's care plan has not been updated with interventions to address R3's abuse allegations or with interventions to protect R3 from further abuse or address R3's increase in anxiety or fear.On [DATE] at 2:00 PM V10 (Psychiatric APN) stated I have been seeing (R3) monthly. (R3) was really upset and anxious about (R2) coming into her room. (R3) kept feeling like she was dressing wrong and giving (R2) the wrong impression. I told (R3) it was not her fault. I have had to increase (R3's) medications to try and treat (R3's) anxiety from this.On [DATE] at 8:20 PM V3 (RN) stated, On the night of [DATE] I heard (R3) screaming for help. I went to (R3's) room and (R2) was in his wheelchair in (R2's) room. (R3) told me (R2) got in bed with her and (R2) hit (R3) in the head. (R3) stated she hit (R3) back. (R2) was showing signs of increased mania that night and should not have been in (R3's) room. (R2) was capable of transferring himself from his wheelchair into (R3's) bed. (R3) would have no reason to lie. I sent (R2) to the emergency room immediately for treatment. It was not safe to leave (R2) in the building with the behaviors (R2) was having. I immediately called (V1/Administrator) and told (V1) that (R3) reported that (R2) got in bed with (R3) and hit (R3) in the head, and (R3) hit (R2) back.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on record review and interview, the facility failed to thoroughly investigate an allegation of resident-to-resident physical abuse for two of three residents (R2 and R3) reviewed for abuse in the sample of four.Findings include:The facility's Abuse and Retaliation Policy Prevention Program Policy dated 1/2026 documents, Internal Investigation: Any incident or allegation involving abuse, neglect, exploitation, retaliation, mistreatment, or misappropriation or resident property will result in an investigation. Investigation Procedures: The appointed investigation will, at a minimum, attempt to interview the person who reported the incident, anyone likely to have direct knowledge of the incident, and the resident, if interviewable. Any written statements that have been submitted will be reviewed, along with any pertinent medical record or other documents.R2's Progress Notes dated 1/2/26 at 11:26 PM and signed by V3 (Registered Nurse/RN) document, This nurse heard yelling from the middle hall. Upon entering room noted (R2) wheeling out of a female resident's room (R3's). (R3) stated that (R2) allegedly crawled on top of (R3) in her bed and punched (R3) on the right side of (R3's) face three times and then (R3) punched (R2) back and (R3) pushed (R2) off of (R3). This same note documents R2 was sent to the emergency room for psychiatric treatment due to increased agitation.R2's Hospital Emergency Department Notes dated 1/2/26 document, You (R2) were seen in the emergency department on 1/3/26 with the chief complaint of combative. EMS (Emergency Medical Services) report that (R2) allegedly hit another resident (R3) earlier today.R3's Progress Notes dated 1/2/26 at 11:38 PM and signed by V3 (RN) document, 10:00 PM (R3) states a male resident (R2) allegedly crawled on top of (R3) and punched (R3) three times to the right side of (R3's) face. (R3) assessed for injuries with no injuries noted. No redness noted to face. (R3) asked if she feels safe to stay in her room and she states she does feel safe. (R3) assured that we (facility staff) would shut her door and monitor the hallway. No complaints of pain or distress noted. Bed in low position with call light in reach. Will continue to monitor.R2 and R3's Abuse Investigations and Witness Statements dated 1/2/26 through 1/6/26 and signed by V1 (Administrator) only include two statements obtained from R4 and V3 (RN) and does not include documentation of R2 crawling on top of R3 and hitting R3, or R2 hitting R3 back.On 2/14/26 at 11:00 AM V1 (Administrator) stated, I am sorry. I did not know (R2) hit (R3) and (R3) hit (R2) back (on 1/2/26). I only have interviews from (V3) and (R4/R3's Roommate). I did not interview anyone else regarding the incident and did not know (V3) had charted that (R2) and (R3) had hit each other. At this time V1 verified the abuse investigation should have been more thorough and should have included more statements from other staff working and other residents. V1 also verified her abuse investigation did not identify that R2 and R3 had hit each other.On 2/14/26 at 8:20 PM V3 (RN) stated, I reported to (V1) immediately on 1/2/26 that (R3) reported (R2) was on top of (R3) in bed and hit (R3) in the head. I also reported that (R3) hit (R2) back.