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	06/03/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on interview, and record review the facility failed to resolve several repeated grievances for eight of eight residents (R5, R14, R23, R30, R31, R47, R50, R58) reviewed for grievances in a sample of 44. Finding Include: The facility's grievance policy dated/revised 1/2025, documents, To provide a process to assist residents, their representatives such as other interested family members or other resident advocates in filing grievances or complaints when such requests are made. Consistent with 483.12(c)(1), by anyone furnishing services on behalf of the provider, all alleged violations involving neglect, abuse, including injuries of unknown source and/or misappropriation of resident property will be immediately reported to the administrator of the provider as required by state law. Written grievance decisions will include the date the grievance was received, a summary statement of the resident grievance, steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the residents concern(s), a statement as to whether the grievance as confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, the date the written decision was issued. R5's grievance form dated 12/19/2024, documents R5 filed a grievance of missing clothing items. R14's grievance form dated 1/13/2025, documents R14 filed a grievance of missing clothing items. R23's grievance forms dated 8/20/2024 and 12/19/2024 document R23 filed grievances of missing clothing items. R30's grievance form dated 5/27/2025, documents R30 filed a grievance of missing clothing items. R31's grievance forms dated 8/20/2024, and 12/19/2024, documents R31 filed grievances of missing clothing items. R47's grievance form dated 8/20/2025, documents R47 filed a grievance of missing clothing items. R50's grievance form dated 1/24/2025, documents R50 filed a grievance of missing clothing items. R58's grievance form dated 12/19/2024, documents R58 filed a grievance of missing clothing items. (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

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	06/03/2025

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Resident Council Grievance form dated 6/18/2024, documents continuing issue of missing clothing items. On 6/2/2025 at 10:02 AM during resident council meeting R5, R14, R23, R30, R31, R47, R50, and R58 stated they have made numerous grievances of their clothes missing and their clothes have never been found or resolved. On 6/3/2025 at 11:00 AM, V1 (Administrator) confirmed missing laundry is an ongoing issue.

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	145726	A. Building B. Wing	06/03/2025

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to develop a plan of care to address advanced directives for one of two residents (R44) reviewed for advanced directives in the sample of 44. Findings include: The facility's Advanced Directive and Advanced Care Planning/POLST (Physician Orders for Life Sustaining Treatment) Guideline dated [DATE] documents Purpose: It is the practice of the facility to establish, implement and maintain written guidelines for advanced directives and advanced care planning/POLST. The resident has the right and the facility will assist the resident to formulate an advance directive at their option. Procedure: G. During the quarterly RAI (Resident Assessment Instrument) process and with any significant changes of condition, facility staff will a. Identify, clarify, and review the existing care instructions and whether the resident wishes to change or continue instructions from the advance directive. e. Changes to the resident choices for advanced directives will be documented, included in the resident plan of care, State specific documents will be updated as necessary, physician orders will be obtained to reflect new choices as applicable, and all items will be communicated to staff providing resident care. Advance Care Planning A. In order for a resident to exercise his or her right to make informed choices about care and treatment in preparation for a time when the resident may not be able to make decisions, designated personnel and/or physician will assist with defining and clarifying medical issues and presenting the information regarding relevant health care issues to the resident or his/her legal representative, in a language that the resident can understand, as appropriate. B. The interdisciplinary team will identify, clarify, and review, as part of the comprehensive care planning process, the existing care instructions along with resident's goals wishes as the resident's medical condition changes. R44's IDPH (Illinois Department of Public Health) Uniform Practitioner Order for Life-Sustaining Treatment (POLST) Form dated 4-9-24 and signed by V12 (R44's) Power of Attorney documents, No CPR: Do Not Attempt Resuscitation (DNR). Comfort-Focused Treatment. R44's Current Care Plan does not include a plan of care to address R44's advanced directives. On [DATE] at 1:48 PM V11 (Care Plan Coordinator) stated, (R44) does not have a current Advanced Directives Care Plan.

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	145726	A. Building B. Wing	06/03/2025

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. Based on observation, interview, and record review the facility failed to protect the resident's right to be free from misappropriation of intravenous medication for one of one resident (R319) reviewed for misappropriation of medications out of a sample list of 44. Findings include: The Abuse Prevention Policy undated documents This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation of 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 assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff and mistreatment of residents. Misappropriation of Resident Property means the deliberate misplacement, exploitation, or wrongful temporary, or permanent use of a resident's belongings or money without the resident's consent. Misappropriation of a resident's property means the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings or money without the resident's consent. R64's Nurse Progress Notes dated 5/26/25 at 1:15 PM, document V23 (Registered Nurse) received an order to infuse a one-liter bag of normal saline intravenously at maximum flow. V23 further documents that V23 inserted a 22-gauge intravenous needle in R64's left forearm and infused one liter of normal saline by gravity tubing at maximum flow. On 06/01/25 at 11:01 AM, in R64s room an intravenous pole with an empty one liter bag of Normal Saline that was hanging from the pole and dated 1/7/25 with (R319's) name on the printed pharmacy label. On 6/1/25 at 11:05 AM, R64 stated R64 received intravenous fluids sometime last week and that bag hanging was the fluids V23 (Registered Nurse) infused. On 06/01/25 at 11:25 AM, V2 (Director of Nursing) stated R64 was given the intravenous fluids last week. V23 called V2 and made V2 aware that V23 hung a bag of fluids that was in the medication storage room that had belonged to a former resident (R319). V2 stated V2 told V23 to remove (R319's) name off the bag. V2 stated V2 was not aware the date on the intravenous bag was 1/7/25 or that the bag was still in R64's room. V2 stated V23 should have used a bag of normal saline from the facility medication back up supply. On 06/03/25 at 8:03 AM, V23 stated that V23 was struggling to remove the bag of fluids from the medication storage unit. V23 stated there were extra bags of fluids in the medication storage room so V23 grabbed one and infused an extra bag of normal saline instead. V23 stated V23 was aware the bag V23 infused in R64 belonged to a former resident R319.

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	145726	A. Building B. Wing	06/03/2025

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to issue a bed hold notice for two of two residents (R25 and R28) reviewed for hospitalization in the sample of 44. Findings include: The facility's Bed Hold and readmission policy dated November 2016 documents Standards: 1. Residents, or their designated representative, shall be informed of this policy at the time of admission and at the time of transfer to a hospital, or for therapeutic leave which extends beyond 24 hours. The facility provides written notification at the time of transfer as included in the designated state form. The notice to the resident or the representative will specify the facility's policy, the duration of the state bed hold policy and the reserve bed payment policy. 2 In the event of an emergency hospitalization the resident or their representative shall be notified by telephone or in person of this policy, within 24 hours, and asked to provide the facility with their decision. The staff member making the call or explaining the policy may accept verbal determination as to whether the resident desires bed hold or having their name placed on their reservations/waiting list and shall document same in the medical record and end the progress notes. Follow up written confirmation may be required. 1. R25's Census Record and Progress Notes documents R25 was sent to the hospital and admitted for 24-hour observation from 12/20/24 through 12/21/24. R25's Electronic Health Record does not include evidence of R25 receiving a bed hold notice upon transfer to the hospital on [DATE]. On 06/01/25 at 10:05 AM R25 stated, I went to the hospital in December 2024 for chest pain. I did not get a bed hold notice when I was sent for chest pain. On 06/02/25 at 10:20 AM V1 (Administrator) stated R25's medical record does not include evidence of a bed hold being given to R25 when R25 was transferred to the hospital on [DATE]. 2. R28's Face Sheet documents R28 was admitted to the facility on [DATE] with diagnoses which included Type 2 Diabetes Mellitus with Diabetic Neuropathy, Dementia, Chronic Kidney Disease (Stage 3), and Malignant Neoplasm of Uterus. R28's Nursing Note dated 4/17/25 at 3:05 PM documents R28 was sent to the ER/emergency room for treatment of constipation. R28's Electronic Health Record does not include evidence of R28 receiving a bed hold notice upon transfer to the hospital on 4/17/25. R28's emergency room Summary dated 4/17/25 documents that R28 was seen in the ER on [DATE] for constipation. (continued on next page)

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	145726	A. Building B. Wing	06/03/2025

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/2/25 at 2:20 PM V1/Administrator stated that R28 was sent to the ER on [DATE] and there was not a bed hold done for R28. On 6/3/25 at 8:25 AM, V25/Registered Nurse stated that a bed hold should be given to the resident when they are sent to ER.

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	145726	A. Building B. Wing	06/03/2025

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to accurately code a MDS (Minimum Data Set) Assessment for one of 17 residents (R44) reviewed for MDS accuracy in the sample of 44. Findings include: The facility's Comprehensive Assessment/MDS Policy undated documents Policy: It is the policy of this facility to perform a comprehensive, accurate, standardized, reproducible assessment of each residence status following admission, quarterly thereafter and annually in order to obtain information vital to the development of the resident's plan of care. In addition to facility approved departmental assessment forms, the assessment shall be summarized using a standardized federally and state approved uniform data set. Standards: 11. All assigned disciplines shall participate in the completion of the MDS assessment form and shall verify accuracy and completion of each respective section by indicating the letter of the section, adding their signature and dating. The scope of each discipline's assessment is defined by professional practice or industry guidelines. R44's Physician's Orders dated 04/11/2025 document, Admit to hospice. R44's MDS assessment dated [DATE] Section O Special Treatments, Procedures, and Programs documents R44 does not receive any special treatment, procedures, and programs, including hospice. On 06/02/25 at 10:42 AM V11 (MDS Coordinator) stated R44's MDS assessment dated [DATE] is inaccurately coded and I should have marked that R44 receives hospice services.

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	145726	A. Building B. Wing	06/03/2025

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to refer a resident to the PASRR (Preadmission Screening and Resident Review) State Agency to obtain a Level II PASRR after being diagnosed with a Mental Illness for one of one resident (R31) reviewed for Mental Illness in the sample of 44. Findings Include: The Pre-admission Screening and Resident review (PASRR) policy, undated documents It is the policy of this facility to 1. Comply with Federal, State and the appointed screening agency Maximus, in standards addressing the PASRR assessment/screening process. 2. Request full and complete PASRR materials (Level 1 and 2) from each referral source prior to or soon following admission. Procedure: 1. A facility representative shall request the complete screening from the referral source. 2. A copy of all the materials received will be placed in the residence business file and the EMR (electronic medical record) at the discretion of administration. R31's admission Record documents that R31 was admitted to the facility on [DATE] with the following, but not limited to, diagnoses: Depression Disorder. On 2/1/21 R31 was diagnosed with Bipolar II Disorder. R31's current Physician Orders documents R31 has an order for Quetiapine (Antipsychotic medication) 300 mg (milligrams) two tablets by mouth at bedtime for Bipolar II Disorder. R31's Medical Record reviewed 6/1/25 does not include evidence of the facility obtaining R31's PASRR Level II after being diagnosed with Bipolar II Disorder on 2/1/21. On 6/2/25 at 2:07 PM, V27/Social Service Director stated that R31 did not have a PASRR II It was never requested. V27 verified that R31 got the diagnosis of being Bipolar on 2/1/21 and that is when the PASRR II should have been done.

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	145726	A. Building B. Wing	06/03/2025

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure the fingernails were kept trimmed for two of 17 residents (R29 and R37) reviewed for ADL (Activities of Daily Living) Assistance in the sample of 44. Findings include: The facility's Nail Care Guidelines dated 2/23 documents Guidelines: Nail care includes routine cleaning and regular trimming. Proper nail care can aid in the prevention of skin problems around the nail bed. Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin. 1. R29's MDS (Minimum Data Set) assessment dated [DATE] documents R29 requires substantial/maximal assistance of staff for personal hygiene. R29's Shower Sheets dated 03/01/25 through 06/02/25 document R29's fingernails have not been trimmed during this timeframe. On 06/01/25 at 9:54 AM R29 was lying in bed. All of R29's fingernails were long, jagged, and extended past her fingertips. R29 stated she cannot remember the last time her nails were clipped. R29 stated she would like them clipped. 2. R37's MDS assessment dated [DATE] documents R37 is severely cognitively impaired and requires touching assistance of staff for personal hygiene. R37's Shower Sheets dated 04/16/25 through 06/02/25 document R37's fingernails have not been trimmed during this timeframe. On 06/01/25 at 9:43 AM R37 was lying in bed. All of R37's fingernails were long, jagged, and extended past his fingertips. R37 stated he would like his fingernails cleaned and trimmed. On 06/03/2025 at 9:10 AM V2 (Director of Nursing) stated, All residents' nails should be trimmed short and clean. All residents should get their nails cleaned and trimmed if needed with all showers. If the residents are diabetic, then the nurse would need to trim the nails.

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	06/03/2025

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

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to follow the Advanced Directive for one of two residents (R65) reviewed for Advanced Directive in the sample of 44. Findings include: The Advanced Directive and Advanced Care Planning/POLST (Physician Orders for Life Sustaining Treatment) Guideline dated [DATE] documents Purpose: It is the practice of the facility to establish, implement and maintain written guidelines for advanced directives and advanced care planning/POLST. The resident has the right and the facility will assist the resident to formulate an advance directive at their option. Procedure: G. During the quarterly RAI (Resident Assessment Instrument) process and with any significant changes of condition, facility staff will a. Identify, clarify, and review the existing care instructions and whether the resident wishes to change or continue instructions from the advance directive. e. Changes to the resident choices for advanced directives will be documented, included in the resident plan of care, State specific documents will be updated as necessary, physician orders will be obtained to reflect new choices as applicable, and all items will be communicated to staff providing resident care. Advance Care Planning A. In order for a resident to exercise his or her right to make informed choices about care and treatment in preparation for a time when the resident may not be able to make decisions, designated personnel and/or physician will assist with defining and clarifying medical issues and presenting the information regarding relevant health care issues to the resident or his/her legal representative, in a language that the resident can understand, as appropriate. B. The interdisciplinary team will identify, clarify, and review, as part of the comprehensive care planning process, the existing care instructions along with resident's goals wishes as the resident's medical condition changes. R65's Medical Record documents that R65 was admitted to the facility on [DATE] with the following, but not limited to diagnoses: End Stage Renal Disease, Chronic Pulmonary Edema, Dependence on Renal Dialysis, Atherosclerotic Heart Disease of Native Coronary Artery without Angina Pectoris, Heart Failure, Emphysema, and Malignant Neoplasm of Upper-inner Quadrant. The Medical record also documents that R65 passed away on [DATE]. The IDPH (Illinois Department of Public Health) UNIFORM PRACTITIONER ORDER FOR LIFE-SUSTAINING TREATMENT (POLST) FORM dated [DATE] documents that R65 requested NO CPR (Cardiopulmonary Resuscitation): Do Not Attempt Resuscitation (DNAR). R65's Nursing Note written by V22/Registered Nurse dated [DATE] at 11:02 PM, documents At 10 PM this nurse (V22) entered the room to give (R65) her HS (bedtime) meds (medications) and put on (R65's) Bipap (Bilevel Positive Airway Pressure machine). (R65) was lying in bed on her right side, HOB (Head of Bed) was elevated and o2 (oxygen) was on. (R65) was unresponsive with no pulse and no respiration. Had CNA call 911 while this nurse ran to check DNR (Do Not Resuscitate) status and grab the crash cart. CPR (Cardiopulmonary Resuscitation) was initiated until code status was confirmed. 911 also arrived and confirmed code status. Ambulance left with copy of POLST and face sheet. The CPR (Cardiopulmonary Resuscitation) Checklist dated [DATE] documents that R65 was given CPR by V21/Certified Nursing Assistant/CNA. (continued on next page)

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	06/03/2025

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

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 11:32 AM, V21/CNA stated that she was working the evening shift and heard V22/RN yell that R65 was not breathing. V21 went to R65's room and started doing compressions. V22 returned to the room and told V21 to stop the CPR that R65 was a DNR. V21 also stated I didn't know that I needed to know the code status before I started CPR. There needs to be a better way to know someone's status.

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	145726	A. Building B. Wing	06/03/2025

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

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F 0686 Level of Harm - 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 observation, interview, and record review the facility failed to update the care plan with pressure relieving interventions, implement pressure relieving interventions to prevent facility acquired pressure ulcers, conduct routine skin checks, and perform Braden Scale Assessments (Pressure Risk Assessments) quarterly as directed by the facility's policy for three of five residents (R4, R10, and R32) reviewed for pressure ulcers in the sample of 44. These failures resulted in R4 developing two facility acquired painful stage two pressure ulcers to R4's buttocks, R32 developing a facility acquired unstageable deep tissue pressure injury to R32's right heel that continues to worsen, and R10 developing a facility acquired painful unstageable pressure ulcer to R10's right heel that required surgical debridement (removing of damaged tissue). Findings include: (continued on next page)

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	06/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0686 Level of Harm - Actual harm Residents Affected - Few	The facility's Measurement of Alterations in Skin Integrity policy dated [DATE] documents Policy: 1. At first observation of any skin condition, the charge nurse or treatment nurse is responsible to measure and/or describe skin condition in the clinical record. 2. All measurements will be recorded in centimeters. All wounds/ulcers (i.e. (example) pressure, arterial, diabetic, venous) will be measured weekly and results recorded in a clinical record. Wound Assessment: 2. Pressure Injuries: A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, comorbidities and condition of the soft tissue. Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis. Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions). Stage 3 Pressure Injury: Full-thickness skin loss. Full-thickness loss of skin, in which adipose fat is visible in the ulcer and granulation tissue epibole (rolled wound edges) are often present. Sloth and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss. Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If sloth or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. (example) dry, adherent, and intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed. Deep Tissue Pressure Injury (DTPI): Persistent non-blanchable deep red, maroon, or purple discoloration. Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood-filled blister. Pain and temperature change often precedes skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent or tissue injury or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness, pressure injury (Unstageable Stage 3 or Stage 4). Do not use (DTPI) (Deep Tissue Pressure Injury) to describe vascular, traumatic, neuropathic, or dermatologic conditions. (continued on next page)

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	06/03/2025

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

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(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 - Actual harm Residents Affected - Few	The facility's Prevention of Pressure Wounds policy dated [DATE] documents Purpose: The purpose of this procedure is to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors. Preparation: 1. Review the resident's care plan to assess for any special needs of the resident. 2. See policy and procedure for specific task, such as bathing, incontinent care, and repositioning. General Guidelines: 1. Pressure injuries are usually formed when a resident remains in the same position for an extended period of time causing increased pressure or a decrease of circulation (blood flow) to that area and subsequent destruction of tissue. 2. The most common site of a pressure injury is where the bone is near the surface of the body including the back of the head around the ears, elbows, shoulders blades, backbone, hips, knees, heels, ankles, and toes. 3. Pressure can also come from splints, casts, badges, and wrinkles in the bed linen. If pressure injuries are not treated when discovered, they quickly get larger, become very painful for the resident, and often time become infected. 4. Pressure injuries are often made worse by continual pressure, heat, moisture, irritating substances on the resident's skin (i.e. (example), perspiration, feces, urine, wound discharge, soap residue, etc. (et cetera) decline in nutrition and hydration status, acute illness and/or decline in the resident's physical and/or mental condition. 5. Once a pressure injury develops, it can be extremely difficult to heal. Pressure injuries are a serious skin condition for the resident. 6. The facility should have a system/procedure to assure assessments are timely and appropriate and changes in condition are recognized, evaluated, reported to the practitioner, physician, and family, and addressed. Interventions and Preventive Measures: General Preventive Measures 1. Identify risk factors for pressure injury development. 2. For a person in bed: a. Change position at least every two hours or more frequently if needed; b. Determine if resident needs a special mattress; c. If a special mattress is needed, use one that contains foam, air, as indicated; 13. Protect bony prominence's as needed. Residents with Risk Factors - Bed-fast 1. Change position at least every two hours and more frequently as needed. 2. Use a special mattress that meets clinical condition. 5. Unless resident has both sacral and ischial pressure injuries, avoid placing directly on the greater trochanter for more than momentary placement. Resident with Risk Factors -Chair-fast 2. Residents who are able to cooperate and understand should be taught to shift weight every 15 minutes while sitting in a chair. Equipment and Supplies 1. Tools for assessing skin and pressure injury risk: a. Braden Risk Assessment Form. The facility's Braden Pressure Ulcer Risk Assessment Tool dated [DATE] documents The Braden scale is recognized by the AHCPR (Agency for Healthcare Research and Quality) as being an appropriate clinical tool for determining Pressure ulcer risk because of the amount of clinical research supporting its reliability and validity. The Braden Scale has 6 (six) subscales: sensor, perception, moisture, activity, mobility, nutrition, and friction/shear. Form Completion Instructions: 1. This form should be completed for every new admission, weekly for the first month, at least quarterly, and with any significant change in condition. 7. Use the scale listed on the top of the page to determine the resident's Risk Level. A score of 19 or above indicates no risk. A score of 18 or less indicates risk of pressure ulcer development. 9. Review the subscales scores in each category to determine appropriate individualized interventions to be implemented where needed. These individualized interventions should be part of the plan of care. 1.) R10's current Physician's Order Report dated [DATE] through [DATE] documents R10 is an [AGE] year-old with the diagnoses of a history of a right femur fracture with closed reduction, Type II Diabetes Mellitus, Transient Cerebral Ischemic Attack, Hyperlipidemia, and Lack of Coordination. (continued on next page)

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	06/03/2025

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R10's MDS (Minimum Data Set) assessment dated [DATE] documents required substantial/maximum assistance of staff for rolling left and right and transfers, was at risk for developing pressure ulcers, and currently had no pressure ulcers at that time. R10's MDS assessment dated [DATE] documents R10 is severely cognitively impaired, requires substantial/maximum assistance of staff for rolling left and right and transfers. This same MDS documents R10 is at risk for developing pressure ulcers and currently has an unstageable pressure ulcer that was facility acquired. R10's Electronic Health Record dated [DATE] through [DATE] does not document that R10 receives routine skin checks. R10's Braden Scale assessment dated [DATE] documents R10 had a score of 15, indicating R10 was at a mild risk of developing a pressure ulcer. This same assessment documents R10's mobility was very limited. R10's Braden Scale assessment dated [DATE] documents R10 had a score of 16, indicating R10 was at a mild risk of developing a pressure ulcer. This same assessment documents R10's mobility was slightly limited. R10's Electronic Health Record does not include any further Braden Scale Assessment since [DATE]. R10's Pressure Ulcer assessment dated [DATE] documents, Date Pressure Ulcer Observed: [DATE]. Length 3.5 cm (centimeters) by width 2.0 cm by depth 0.5 cm. Moderate serosanguinous (pale red to pink, thin, and watery) exudate (drainage). Stage: Unstageable-slough (dead tissue) and or eschar (layer of dead tissue). R10's Progress Notes dated [DATE] documents, Pressure ulcer noted to right heel. R10's current Care Plan does not include any pressure relieving interventions until [DATE], once R10 already developed a pressure ulcer to the right heel. R10's Wound Center Progress Notes dated 5-28-25 and signed by V20 (Advanced Practice Nurse) documents, History of Present Illness: [DATE]: Has heel boots, however at nursing home, not been consistently applied. [DATE]: Follow/up for right heel pressure injury. (R10) has not had foam heel lift boot on during the day, only at night. Bilateral heel lift boots. (R10) still complains of pain. Discussed the importance of off-loading. [DATE]: Follow/up for right heel pressure injury. Slough debrided today. Wound Assessment: Right heel is a chronic stage three pressure injury pressure ulcer acquired on [DATE] and has received a status of not healed. [DATE] subsequent wound encounter measurements are 2.5 cm (centimeters) length by 0.7 cm width, by 0.1 cm depth. There is a moderate amount of sero-sanguineous drainage noted. 1-25% (percent) slough, 51-75% eschar. The peri-wound skin exhibited edema. (R10) to wear heel lift boots at all times even when in the wheelchair during the day. Start betadine (anti-septic solution) paint to the area. Continue with heel lift boots. On [DATE] from 9:30 AM to 10:15 AM R10 was sitting in her wheelchair with her heels in padded boots. These boots did not have a pressure off-loading cavity to the heels, therefore pressure was not being relieved to either of R10's heels. (continued on next page)

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	145726	A. Building B. Wing	06/03/2025

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 10:00 AM V7 (Registered Nurse/RN) provided a treatment of betadine solution to R10's right heel pressure ulcer. R10's right pressure ulcer was dark purple in color and approximately 2.5 cm long by 0.6 cm wide with an unmeasurable depth. On [DATE] at 10:15 AM V7 (RN) stated, (R10's) wound to the right heel was caused by pressure. (R10) did not wear any kind of pressure relieving boots and did not have her heel off-loaded while in bed prior to development of the pressure ulcer. On [DATE] V2 (Director of Nursing/DON) stated, Braden Scale Assessments are supposed to be performed quarterly and with a significant change in status. (R10) has not had a Braden Scale Assessment completed since [DATE]. (R10) was due to have a Braden Scale Assessment done on [DATE]. Either I or (V11/MDS Coordinator) were responsible for completing (R10's) Braden Scale Assessment in April. On [DATE] at 11:20 AM V20 (Wound Clinic Advanced Practice Registered Nurse) stated, (R10's) wound to the right heel was caused by pressure. (R10) should have had her heels off-loaded and pressure relieving interventions implemented prior to (R10) developing the pressure ulcer to the right heel. That would have help to prevent (R10) from developing a pressure ulcer to the right heel. (R10's) pressure relieving boots should have had a hole cutout in the heel to prevent pressure. Regular padded boots would not relieve pressure and (R10) would need her heels always off-loaded if the boots did not have a heel cutout. (R10) does have pain to the right heel pressure ulcer. I had to surgically debride (R10's) right heel wound on [DATE]. (R10) should always have someone doing weekly skin checks while at the facility. On [DATE] at 11:30 AM V2 (DON) stated, I looked back in (R10's) medical record and (R10) has not been receiving skin checks since [DATE]. Somehow this was missed. If (R10) was receiving skin checks prior to [DATE] the pressure ulcer would have been found before it was found as bad as it was. When the pressure ulcer to (R10's) right heel was found it was unstageable and very big. (R10) did not have any care planned pressure relieving interventions prior to the development of (R10's) pressure ulcer to the right heel. 2.) On [DATE] at 8:49 AM, R4 was laying supine in R4's bed. R4 stated that R4 has a wound on her coccyx. R4 stated the staff don't put a bandage on the area, but they clean it when she is changed. R4 further stated R4's bottom hurts all the time. R4's mattress was a standard foam mattress. On [DATE] at 9:40 AM, V17 (Certified Nursing Assistant), V18 (Certified Nursing Assistant), and V19 (Certified Nursing Assistant) provided perineal care to R4 in R4's bed. V17 cleaned barrier cream off R4's coccyx and there were two small open areas each comparable in size to a pea at the top of each side of R4's buttocks. V17 confirmed R4 was not on a pressure relieving air mattress. V17, V18, and V19 stated they were unsure of how long R4's coccyx had openings. R4's current care plan documents R4 is at risk for developing pressure ulcers related to decreased mobility, incontinence, and morbid obesity. This same care plan documents R4 requires extensive assistance for mobility and transfers with a mechanical lift. R4's Braden assessment dated [DATE], documents R4 has mild risk for skin impairment. R4's current care plan documents R4 is to have a pressure relieving mattress on R4's bed. (continued on next page)

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	145726	A. Building B. Wing	06/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0686 Level of Harm - Actual harm Residents Affected - Few	R4's Physician order dated [DATE] documents R4's bed is to have a pressure relieving mattress. On [DATE] at 10:00 AM, V23 (Registered Nurse) stated V23 was not aware R4 had open areas on R4's buttocks. On [DATE] at 10:05 AM, R4's electronic medical chart does not contain documentation of any pressure areas on R4's buttock. R4's Nurse progress note dated [DATE] by V2 (Director of Nursing) documents R4 has two stage two pressure ulcers on R4's coccyx and wound nurse will evaluate. 3.) R32's Nurse Progress Note dated [DATE] at 11:13 AM, documents R32 received a shower and R32's heels on R32's feet were soft and boggy and R32 seemed like R32 had pain when heels were touched. R32's right heel appears to have a deep tissue injury (DTI). R32 was placed in heel boots for protection and comfort. Staff educated on ensuring repositioning every two hours and offloading heels. R32's MDS dated [DATE] documents R32 is severely cognitively impaired. R32's MDS documents R32 is dependent on staff for all ADLs. R32's Braden assessment dated [DATE] documents R49 is at high risk for skin alterations. R32's current care plan documents R32 is at risk for skin alterations related to dementia, poor safety awareness, and fragile skin. R32's current care plan does not contain pressure relieving interventions to prevent pressure ulcers. R32's Wound Note dated [DATE] documents to apply zero pressure heel boots while in bed with a wedge cushion and skin prep (preparation) twice daily. R32's Wound Note dated [DATE] documents R32 has an unstageable pressure ulcer to the right heel measuring 2.5 cm x 4 cm that continues to worsen. This note documents R32's pressure ulcer was found [DATE] and the area was pale and soft. R32's pressure ulcer on [DATE] was dark red in color and unblanchable. R32 has orders for skin prep to heels twice daily, heel protectors while in bed, and turn and reposition while in bed every two hours. R32 is unable to communicate her needs due to cognitive decline secondary to dementia. R32 is non ambulatory. R32's Nurse Progress Note dated [DATE] documents R32's left heel has a 3.5 cm x 2.0 cm intact wound that was black in color and was irregular shaped. Skin prep as ordered, and heel protectors are in place. On [DATE] at 9:30 AM, R3 was sitting in R32's high back wheelchair with socks on R32's feet. R32's heels were touching the floor of the dining room with no pressure relieving interventions in place, including heel protector boots as ordered. On [DATE] at 11:41 PM, R32 's right heel was open to air and R32's heel had a large dark brown/black pressure ulcer covering the right heel. R32 was lying in bed with bilateral heels on a foam mattress. R32 did not have an air mattress and did not have heel protector boots on as ordered. (continued on next page)

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	145726	A. Building B. Wing	06/03/2025

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 2:21 PM, V26 (Nurse Practitioner) stated R32's right heel continues to worsen and V26 states it's because pressure is not being relieved to the heel as V26 directed the staff to do. V26 further stated whether it's when R32 is sitting up in R32's chair or in bed and the boots are not being applied correctly, the continued pressure to R32's heel is still an issue that would cause R32's right heel pressure ulcer to worsen.

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	145726	A. Building B. Wing	06/03/2025

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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** Based on observation, interview, and record review the facility failed to ensure an indwelling urinary catheter bag was secured and off the floor for one (R64) of two residents reviewed for catheters in the sample list of 44. Findings include: The Urinary Catheter Care policy dated September 2005 documents The purpose of this procedure is to prevent infection of the resident's urinary tract. General Guidelines: 11. Be sure the catheter tubing and drainage bag are kept off the floor. R64's current Physician Orders document R64 was admitted to the facility on [DATE] with a 16 F (French) indwelling (urinary) catheter for urinary retention. On 06/01/25 at 11:02 AM, R64 was laying supine in bed with R64's indwelling urinary catheter bag laying on the floor next to R64's bed. On 06/03/25 at 10:00 AM, V5 (Licensed Practical Nurse) stated indwelling urinary catheter bags should be secured to the side of the bed and below the bladder. V5 further stated a urinary catheter bag should never be on the floor.

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	145726	A. Building B. Wing	06/03/2025

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure oxygen tubing was changed weekly as ordered and dated for five of five residents (R5, R12, R13, R38, and R39) reviewed for oxygen in the sample of 44. Findings include: The facility's Respiratory Therapy Prevention of Infection policy dated 8/2008 documents The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment, including ventilators, among residents and staff. Steps in the Procedure - Infection Control Considerations Related to Oxygen Administration 7. Change the oxygen cannula and tubing every seven (7) days, or as needed. 8. Keep the oxygen cannula and tubing used PRN (as needed) in a plastic bag when not in use. Documentation - The following information should be recorded in the resident's medical record: 1. The date and time the respirator therapy was performed. 1.) R38's current Physician Order Report documents, 04/22/25 Oxygen: Change tubing and mask weekly and PRN (as needed). R38's Treatment Administration Records (TARs) dated 06/01/25 through 06/02/25 document, Oxygen: Change tubing and mask weekly and as needed on Sundays. These same TARs document R38's oxygen tubing was not changed on Sunday (06/01/25). On 06/01/25 at 10:29 AM R38 was lying in bed with oxygen on at two liters via nasal cannula. R38's nasal cannula and oxygen tubing were not labeled with a date. 2.) R5's Medical Record documents that R5 was admitted to the facility on [DATE] with diagnoses which included Emphysema and Acute and Chronic Respiratory Failure with Hypoxia. R5's Physicians Orders printed 6/3/25, documents Oxygen at four liters continuous. Order date 11/18/24. Change oxygen tubing weekly and as needed (label) once a day on Sunday night. Order date 5/16/24. R5's Treatment Flowsheet dated 6/1/25 - 6/30/25 documents to change oxygen tubing weekly and as needed (label) once a day on Sunday night. It was not signed as being done on Sunday 6/1/25. On 6/01/25 at 9:52 AM R5 was sitting in a chair in her room wearing oxygen by nasal cannula. The tubing was dated 5/11/25. R5 stated that the oxygen tubing has not been changed in a while. R5 removed the nasal cannula from her nose and stated, This nose piece is dirty and gummed up. 3.) R12's Medical Record documents that R12 was admitted to the facility on [DATE] with diagnoses which included Chronic Obstructive Pulmonary Disease. R12's Physicians Orders printed 6/3/25, documents Oxygen at two liters as needed. Order date 12/18/23. Change oxygen tubing and clean filters weekly on Sundays. Order date 5/1/24. (continued on next page)

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	145726	A. Building B. Wing	06/03/2025

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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/1/25 at 10:00 AM, R12 was wearing oxygen lying in bed resting. R12's oxygen tubing was not labeled with the date or initials. R12 stated that she does not know when the tubing was last changed but it is not changed weekly. 4.) On 06/01/25 at 9:59 AM, R39's oxygen tubing was connected to the oxygen concentrator in R39's room. R39's oxygen tubing was not labeled with the date. 5.) On 6/1/25 at 10:02 AM, R13's oxygen tubing was connected to the oxygen concentrator in R13's room. R13's oxygen tubing was not labeled with the date. On 6/2/25 at 10:00 AM, V23 (Registered Nurse) stated all oxygen tubing should be dated. On 06/2/25 at 11:58 AM V2 (Director of Nursing) stated, All oxygen tubing should be labeled with the date changed and should be changed every week on Sundays.

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	145726	A. Building B. Wing	06/03/2025

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Timber Point Healthcare Center	205 East Spring Street Camp Point, IL 62320

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review the facility failed monitor and record cool down temperatures for prepared meats, label opened food items in the refrigerators, label opened dry foods, and failed to use correct dish machine sanitizing test strips. These failures have the potential to affect all 69 residents residing in the facility. Findings include: The facility's CMS (Centers for Medicare and Medicaid Services) Form 671 dated 6-1-25 and signed by V1 (Administrator) documents 69 residents currently reside within the facility. The facility's two stage cool down process policy (not dated), documents, Potentially hazardous foods will be cooled properly to prevent food borne illness. Foods will be cooled to proper temperatures. The time and temperature of food cooling will be documented at two- and four-hour intervals. The facility's labeling and dating food policy (not dated), documents, Prepared and packaged foods will be labeled and rotated to decrease the risk of food borne illnesses, provide the highest quality of product for the residents and minimize waste. Bagged or boxed food once removed from original package will be placed in an ingredient bin that is labeled with the common name of the food, date the item is placed, use by date: mark with the date or day or number of days from opened date. Use by date will be based either from manufacturers use by date first or recommended maximum storage period. The facility's dishwashing procedure policy (not dated), documents, To prevent food borne illness, all dish wares will be cleaned in the dish machine. For temperature sanitizing machines attach a 160 EF (EfferSan sanitizing test strip) to a clean, dry, cool plate; weave a 10-degree Fahrenheit test strip in the tines of a fork; or run through the wash/rinse cycle a maximum reading thermometer to determine if the sanitizing water reaches 180 degrees Fahrenheit. On 6/2/2025 at 9:00 AM, on one of the facility's kitchen counters there was a bag of opened hot dog buns with no date opened with the top folded over. V15 (Dietary Manager) confirmed these should have been sealed and dated. On 6/2/2025 at 9:00 AM, the facility's refrigerator located in the back of the kitchen contained several opened undated foods such as liquid eggs, onion, shredded cheese, and an open bottle of soda not belonging to a resident. V15 confirmed these items should have been dated and the soda should not have been in the refrigerator. On 6/2/2025 at 9:10 AM, V15 removed quaternary test strips to use in the sanitizing machine, placed strip on a small white plate, placed the plate on a dish washing rack, then placed a clear plastic cup on top of test strip and ran this through a cycle in the sanitizing machine. On 6/2/2025 at 9:15 AM, V15 confirmed she did not know what test strips to use on the sanitizing machine and she did not have the correct test strips. V15 confirmed this dishwasher needs 160 EF sanitizer test strips to accurately measure the dish machine for sanitizer levels and the facility does not have the correct test strips to test the dish machine. (continued on next page)

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	06/03/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 6/2/2025 at 9:30 AM, V16 (Kitchen Cook) stated she was cooking a pork loin for 5/3/2025. V15 confirmed kitchen staff were not using a cool down log for meals cooked ahead of time.

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	06/03/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on interview and record review the facility failed to track infections of individuals who enter or live in the facility per CMS (Central Management Services) requirement. This failure had the potential to affect all 69 residents residing in the facility. Findings Include: The facility's CMS (Centers for Medicare and Medicaid Services) Form 671 dated 6-1-25 and signed by V1 (Administrator) documents 69 residents currently reside within the facility. The facility's Infection Prevention and Control Manual Infection Prevention and Control Program (not dated) documents, A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to regulatory requirements and following accepted national standards. A system of surveillance that is designed to identify possible communicable diseases or infections before they can spread to other persons in the facility. When and to whom possible incidents of communicable disease or infections should be reported to. On 6/3/2025 at 1:30 PM, V2 (Director of Nursing/DON) confirmed they had no tracking of infections currently or in the past for residents or employees.

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	06/03/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on interview and record review the facility failed to designate or hire a full-time infection preventionist per CMS (Central Management Services) requirement. This failure had the potential to affect all 69 residents residing in the facility. Findings Include: The facility's CMS (Centers for Medicare and Medicaid Services) Form 671 dated 6-1-25 and signed by V1 (Administrator) documents 69 residents currently reside within the facility. The facility's Infection Prevention and Control Manual Infection Prevention and Control Program (not dated) documents, The facility will designate one or more individual(s) as the infection preventionist(s)(IP)(s) who is responsible for the facility's IPCP (infection prevention control program). The infection preventionist will have primary professional training in nursing, medical technology, microbiology, epidemiology, or another related field. Is qualified by education, training, experience, or certification, works at least part time at the facility, has completed specialized training in infection prevention and control. The facility IP will also be a member of the facility's quarterly assessment and assurance committee and report to the committee on the IPCP on a regular basis. On 6-1-25 at 11:08 AM V1 (Administrator) stated, We (the facility) terminated (V6/Prior Infection Preventionist) on 2-13-25. (V4) is working on the Infection Preventionist Training but has not completed the training yet. The facility has not had a full-time Infection Preventionist since 2-13-25.

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	06/03/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on record review and interview the facility failed to ensure all Certified Nursing Assistants received 12 hours of annual in-service training. This failure has the potential to affect all 69 residents residing within the facility. Findings Include: The facility's CMS (Centers for Medicare and Medicaid Services) Form 671 dated 6-1-25 and signed by V1 (Administrator) documents 69 residents currently reside within the facility. All CNA (Certified Nursing Assistant) trainings from 1/1/2024 through 6/2/2025 were reviewed and no CNAs received 12 hours of required annual in-service training. On 6/3/2025 at 1:30 PM, V2 (DON/Director of Nursing) confirmed all CNAs currently employed at the facility have not received 12 hours of annual in-service training required.