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	06/16/2026

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** A.Based on observation, interview, and record review the facility failed to ensure the medication storage rooms were kept clean and in good repair. These failures have the potential to affect all 67 residents residing in the facility.B. Based on observation, interview, and record review the facility failed to ensure opened multi-dose injectable medications were labeled with the date when opened and a multi-dose insulin pen was disposed of after the expiration date and ensure medications were stored in their original packaging until administered for three of five residents (R6, R37 and R61) reviewed for storage and labeling of medications in a sample of 33. Findings include: A. The facility's CMS (Centers for Medicare and Medicaid Services) Form 671 dated [DATE] and signed by V1 (Administrator), documents 67 residents reside within the facility. The facility's Medication Room Cleaning Policy dated 6/26 documents, To maintain a clean, safe, and sanitary medication room that supports infection prevention, medication integrity, and resident safety. The medication room shall be kept clean, organized, and free of clutter at all times. Cleaning shall be performed routinely and documented according to facility procedures. Procedure: Clean and disinfect medication preparation surfaces daily and when visibly soiled. Clean sinks, handles, counters, and other high-touch surfaces daily. Sweep and mop floors daily using an approved disinfectant. Clean shelves, medication carts, and the medication refrigerator weekly or as needed. Staff shall documented completion of required cleaning tasks on the medication room cleaning log. On [DATE] at 9:27 AM the south medication room sink faucet was covered in a thick white and brown crusty substance. The south medication room floor had scattered debris. V5 (RN/Registered Nurse) stated, The facility has two medication rooms that store all the residents' medications. I am not sure when the south medication room was last cleaned. V5 verified the sink faucet was covered in a thick white and brown crusty substance and the floor had scattered debris. On [DATE] at 10:30 AM the north medication room sink was covered in a thick white crusty substance. Two bottom cabinets were missing the doors and resident medications were stored within this cabinet. Inside this cabinet was a buildup of cobwebs, dust, and dirt. V4 (RN) stated, This medication room needs cleaned. On [DATE] at 9:00 AM V22 (Housekeeper) stated, I was not aware that housekeeping was supposed to clean the medication rooms until today. We (housekeepers) never had a cleaning log for the medication rooms until today. (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	B. The facility's Storage of Medications dated [DATE], documents Storage of Medications. Policy: Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only by licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. C. All medications dispensed by the pharmacy are stored in the container with the pharmacy label. Expiration Dating: B. Drugs dispensed in the manufacturer's original container will be labeled with the manufacturer's expiration date. E. When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated. 1. The nurse shall place a date opened sticker on the medication and enter the date opened and the new date of expiration (Note: the best stickers to affix contain both a date opened and expirations notation line). The expiration date of the vial or container will be 30 days unless the manufacturer recommends another date or regulations/guidelines require different dating. The facility's Insulin Storage Recommendations, undated, documents Cartridges/pens/prefilled syringes: Humalog Pen: opened-room temperature-28 days. Lantus Pen: opened- room temperature- 28 days. On [DATE] at 9:25 AM V4/RN (Registered Nurse) opened the top drawer to North medication cart. In this drawer two clear medication cups were observed with loose pills. On the outside of one of the clear medication cups it was labeled Tramadol 50mg (milligrams) and Tylenol 650mg with three loose pills in the clear medication cup. On the second clear medication cup it had labeled Calcium 500mg and Hydroxyzine 25mg. V4 stated she had prepared R61's Tramadol 50mg and Tylenol 650 mg and R61 refused the medication, so V4 stuck the clear container with the loose pills in the medication carts top drawer. V4 then stated she had popped out R37's Calcium 500mg and Hydroxyzine 25 mg ahead of time and that the pills were not due to be given until 1:00 PM. V4 verified she should not have pre-popped R37's 1:00 PM medications and the pills should have remained in their original packaging until it was time to give R37's medication. V4 also verified 61's medications should have been double locked (due to the tramadol being a narcotic) and in the medications original packaging or destroyed if R61 refused her medications. On top of V4's medication cart was a container of resident's insulin injector pens. R6's Insulin Lispro 100units/ml was opened, 1/4 full, and dated [DATE]. R6's Lantus 100units/ml was opened, ¾ full, and undated. V4 verified R6 insulin lispro was expired a few days ago and should have been discarded and R6's Lantus should have been labeled and dated when it was opened and was not. On [DATE] at 2:20 PM, V2/Director of Nursing stated that when a resident refuses medication, the nurse must wait a short period and try again. Continued refusal requires immediate disposal of the medication instead of storing it loosely in the medication cart. Furthermore, pre-popping medications are entirely unacceptable. V2 stated, Nurses are also required to use the insulin dating guide to maintain accurate expiration dates and dispose of expired insulin correctly.

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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 to ensure food service sanitation and infection control practices were maintained by failing to label opened food items stored in refrigerators and dry storage racks with the date an item was opened, ensuring staff wore hair restraints while working in the kitchen, and failing to maintain proper chlorine sanitizer levels in the dishwashing machine. These failures have the potential to affect all 66 residents residing in the facility. Findings Include:The facility's Labeling and Dating Foods policy, no date, documents, Policy, prepared and packaged foods will be labeled and rotated to decrease the risk of food-borne illnesses, provide the highest quality product for the residents, and minimize waste. Refrigerator Stores, foods prepared on the premises to be held cold will be labeled with the date of preparation and time as required for cooling purposes. Potentially hazardous foods that contain a Sell by date, Use by date, or Expiration date, such as cottage cheese, milk, soft cheese, non-cured deli meats, egg products will be labelled with the date it is opened and with a discard date of Best Used By or Expiration Date or Use by Date or recommended maximum storage whichever is first. Commercially processed foods that have been prepared and packaged by a food processing place will be labeled with the date it is opened. This will be discarded by the 3rd day or by the Best Used By date. Many bulk condiments are shelf-stable if unopened and should be refrigerated after opening. When refrigerated, label with the date it is opened and with a discard date of Best Used By date or recommended maximum storage, whichever is first.The facility's Personal Hygiene policy, not dated, documents, Policy, all food handlers will report to work in uniform and practice good hygiene. Purpose: to reduce the risk of food-borne illness and Food Handler hazards. Procedure, 4. Hairnets, bonnets, or other hair-coverings must be worn at all times in the kitchen. The hair-covering must completely cover the hair.The facility's Dishwashing Procedure policy, not dated, documents, Policy, to prevent food-borne illness, all dishware will be cleaned in the dish machine. Policy specifications, 2, check chemicals to determine an adequate supply. If not, replace. Before dishes are washed, the sanitation temperature or level of chemical sanitizer in the dish machine should be tested with the correct test strip. For chemical sanitizing machines, dip the appropriate chemical sanitizer test strip in the water on the train board nearest to the opening at the clean end of the dish machine. Dip for 1 second only. The test strip should turn the appropriate color to indicate 50 ppm (parts per million) for chlorine. If the test strip does not turn the correct color, the above procedure should be repeated. If the test strip does not turn the appropriate color on the second attempt, the dish machine should be evaluated for proper functioning before the dishes are washed.The facility's CMS (Centers for Medicare and Medicaid Services) Form 671 dated 6/14/26 and signed by V1 (Administrator), documents 67 residents reside within the facility.On 6/14/2026 at 9:30 AM, during the kitchen tour, upon entering the kitchen, V8 (Dietary Dish Washer) and V9 (Cook) did not have hairnets on. During kitchen tour one of the kitchen refrigerators had 3 small saran wrapped packages of yellow square cheese opened and not dated, 1 bag of mozzarella cheese opened and not dated, 2 packs of bologna opened and not dated, a large square of butter opened and not dated, a container of liquid egg thawing and not labeled or dated, and a condiment squeeze container containing a purple substance not labeled or dated.On 6/14/2026 at 9:45 AM, V8 (Dietary Dish Washer) tested the facility's high-temp dish washer using Chlorine Test Paper after the wash cycle. Test strip read 10ppm (parts per million).On 6/14/2026 at 10:00 AM, V7 (Dietary Manager) confirmed all items in the fridge should always have a label and an open date. V7 also confirmed dish washer chlorine test strip should be at 50ppm.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a call light was in reach for four of 17 residents (R8, R48, R50, R71) reviewed for call lights in a sample of 33. Findings include:The facility's Answering Call Light Policy, dated 8/2008, documents The purpose of this procedure is to respond to the resident's requests and needs. 5. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident. 1. R8's Care Plan, dated 3/30/26, documents (R8) requires assistance of 1-2 staff with ADLs (Activities of Daily Living) related to (R8's) diagnosis of sepsis, increased weakness, decreased mobility, lack of coordination, and abnormal gait and mobility. (R8's) level of function fluctuates throughout the day due to recent Urinary Tract Infection and Sepsis. Fluctuating cognitive function impacting (R8's) level of function and staff assistance needed to [NAME] her ADL/functional ability needs. On 6/14/26 at 10:00 AM, R8 was lying in her bed. R8's call light was observed out of R8's reach clipped to R8's privacy curtain. R8 stated, I like it when my call light is within reach just in case I need something. On 6/14/26 at 10:15 AM, V11/CNA (Certified Nursing Assistant) verified at this time R8's call light was clipped to R8's privacy curtain on the left side of R8's bed and R8 was unable to reach the call light. V11 stated she was unsure why it was clipped to the privacy curtain and stated it should be next to R8 within R8's reach. 2. R50's Care Plan, dated 6/2/25 documents (R50) requires supervision to substantial assist of 1-2 staff with her ADLs related to her diagnosis of COPD (Chronic Obstructive Pulmonary Disease), Cerebral Infarction, Cognitive Communication Deficit, Depression, Insomnia, Hemiplegia Left Side, PVD (Peripheral Vascular Disease), Respiratory Failure, Hypertension, Heart Disease, History of Falls, GERD (Gastro-Esophageal Reflux Disease), Schizophrenia, OSA (Obstructive Sleep Apnea), Psoriasis, Atherosclerotic Heard Disease. Fluctuating cognitive function and behaviors issues such as refusing cares at times impacts (R50's) level of function and staff assistance needed to meet (R50's) ADL needs. On 6/14/26 at 9:55 AM, R50 was lying in bed. R50's call light was lying on the right side of R50's bed on the floor out of R50's reach. R50 stated the staff always try to clip the call light to R50's bed, but it will not stay clipped to R50's bed because the call light is too heavy. R50 stated, they (facility staff) have tried to fix it, but it's not fixed yet. I would like the call light next to me. On 6/14/26 at 10:15 AM, V11/CNA verified R50's call light was on the floor. V11 stated they got new clips for the call lights and if they put the clip on the call light wrong, the call light will still fall from the bed because it will not stay clipped on the bed. V11 verified all resident call lights should be within reach. 3. R71's Care Plan, dated 5/15/26, documents (R71) has impaired ability to complete ADLs independently related to recent hospitalization for pneumonia, and candidal stomatitis. (R71) requires assistance of 2 staff for all ADLs. On 6/14/26 at 10:09 AM, R71 was sitting in his recliner in his room. R71's call light was lying on R71's (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bed behind R71's recliner out of R71's reach. R71 stated he would like his call light in reach because he cannot get up on his own. R71 stated they leave his call light out of reach a lot. On 6/14/26 at 10:17AM V11/CNA verified R71's call light was on the bed behind R71's recliner and out of R71's reach. V11 stated, (R71) should not be left without a call light within reach as (R71) requires assistance to transfer and with (R71's) care. 4. R48's computerized Medical Record documents that R48 is an [AGE] year-old that was admitted to the facility on [DATE] with diagnoses which included Cervical Disorder at C4-C5 Level with Myelopathy, Vascular Dementia, Epilepsy, Dysphagia, and Difficulty in Walking. R48's MDS (Minimum Data Set) assessment dated [DATE] documents that R48 requires substantial assistance for toileting, hygiene, bed mobility, and partial assist for transfers. R48's Care Plan, dated 5/18/26, documents that R48 is at risk for falls. The same Care Plan documents Keep call light within reach. On 6/14/26 at 9:43 AM, R48 was lying in her bed. R48's call light was on the floor out of R48's reach. R48 stated, I do use my call light, but I don't know where it is. On 6/14/26 at 9:45 AM, V28 Registered Nurse/RN verified at this time R48's call light was on the floor and R48 was unable to reach the call light. V28 stated the call light should be within reach of V28 at all times.

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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. Based on record review and interview, the facility failed to accurately code the MDS (Minimum Data Set) Assessments for three of 17 residents (R3, R44, and R50) reviewed for MDS Accuracy in the sample of 33. 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. The CMS's (Center's for Medicaid and Medicare) RAI Version 3.0 Manual dated 10/25 documents, Coding Instructions: Code 1, yes if PASARR (Pre-admission Screening and Resident Review) Level II screening determined that the resident has a serious mental illness and/or ID/DD (Intellectual Disability/Developmental Disability) or related condition. 1.R44's PASARR Level II Outcome dated 6/20/25 documents, You meet PASARR inclusion criteria for Serious Mental Illness with the diagnoses of Schizoaffective Disorder, Posttraumatic and Stress Disorder. Your day-to-day life has been impacted by your illness. R44's MDS (Minimum Data Set) Assessments Section A1500 Preadmission Screening and Resident Reviews dated 11/21/25 and 2/19/26 are coded as R44 is not considered by the state level II PASARR process to have a serious mental illness and/or intellectual disability or a related condition. On 6/15/26 at 10:30 AM V23 (MDS Coordinator) verified R44's MDS Section A1500 Assessments dated 11/21/25 and 2/19/26 were inaccurately coded and should have been coded as R44 does have a serious mental illness according to R44's state level II PASARR dated 6/20/25. 2. R50's PASARR Level II Outcome dated 6/23/25 documents, You meet PASARR inclusion criteria for Serious Mental Illness with the diagnoses of Schizoaffective Disorder. Your day-to-day life has been impacted by your illness. R50's MDS Assessments Section A1500 Preadmission Screening and Resident Reviews dated 3/3/26 are coded as R50 is not considered by the state level II PASARR process to have a serious mental illness and/or intellectual disability or a related condition. On 6/15/26 at 10:30 AM V23 (MDS Coordinator) verified R50's MDS Section A1500 Assessments dated 3/3/26 were inaccurately coded and should have been coded as R50 does have a serious mental illness according to R50's state level II PASARR dated 6/23/25. 3. R3's state level PASARR level II dated 6/13/2026 documents R3 has Depression and Schizophrenia. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's MDS Assessments Section A1500 Preadmission Screening and Resident Reviews dated 9/2/25 and 6/13/26 are coded as R3 is not considered by the state level II PASARR process to have a serious mental illness and/or intellectual disability or a related condition. On 6/15/26 at 11:34 AM V23 (MDS Coordinator) verified R3's MDS Section A1500 Assessments dated 9/2/2025 and 12/11/2025 were inaccurately coded and should have been coded as R3 does have a serious mental illness according to R3's state level II PASARR dated 6/13/2025.

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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. Based on observation, interview, and record review the facility failed to ensure residents' fingernails were kept clean and trimmed for two of 17 residents (R28 and R71) reviewed for ADLs (Activities of Daily Living) in the sample of 33.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.R71's MDS (Minimum Data Set) Assessment, dated 5/21/26, documents R71 requires substantial/maximal assistance for personal hygiene. R71's current Care Plan documents R71 requires staff assist with R71's ADL's including bathing, dressing, grooming, transfers, and mobility as required. On 6/14/2026 at 10:09 AM, R71 was sitting in his recliner. All R71's fingernails were long, jagged, with dark brown matter underneath the nails. R71 stated he wants his fingernails trimmed and cleaned and the staff have not done it since R71 was admitted to the facility. On 6/14/36 at 10:17AM, V11/CNA (Certified Nursing Assistant) verified R71's nails were long, jagged, and had black matter under all fingernails and needed cleaned and clipped. V11 stated fingernails should be trimmed and clean with at least each shower and as needed, but if the resident is diabetic, V11 does not believe they can trim anyone's fingernails. R28's MDS (Minimum Data Set) dated 3/13/26 documents R28 is dependent on staff for personal hygiene. R28's current Care Plan documents R28 is dependent on staff for personal hygiene. On 6/14/2026 at 9:52 AM all R28's fingernails were long, jagged, and had brown debris underneath. R28 stated, My fingernails haven't been clipped in a couple of weeks. On 6/14/26 at 10:40 AM V6 (CNA/Certified Nursing Assistant) stated, We only clip the residents' fingernails whenever they ask. V6 confirmed R28's fingernails were long, jagged, and dirty and needed to be clipped.

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F 0686 Level of Harm - Minimal harm or potential for 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 interview and record review the facility failed to identify a pressure ulcer, failed to document physician notification and treatment orders, and failed to document a pressure ulcer assessment for one of two residents (R69) reviewed for pressure ulcers in the sample of 33. Findings include:The Pressure/Skin Breakdown policy dated 1/2026 documents 2. The nurse shall assess and document/report the following: a. Full assessment of skin condition including but not limited to location, stage or partial/full thickness, length, width and depth, presence of exudates or necrotic tissue. 7. The physician will authorize pertinent orders related to wound treatments, including pressure redistribution surfaces, wound cleansing and debridement approaches, dressings (occlusive, absorptive, etc. (Etcetera), and application of topical agents. R69's computerized Medical Record documents that R69 is a [AGE] year-old that was admitted to the facility on [DATE] with diagnoses which included Fibromyalgia, Diabetes Mellitus, Morbid Obesity, Major Depressive Disorder, and Venous Insufficiency.R69's Wound Report created 6/15/26 at 12:36 PM, documents that R69 has a Pressure Ulcer to her Right Buttock Gluteal Fold that was identified on 6/14/26 at 12:36 PM. The wound measures 1 cm (centimeter) x (by) 1 cm x 0.2 cm.R69's MDS (Minimum Data Set) assessment dated [DATE] documents a BIMS (Brief Interview for Mental Status) of 15, indicating (cognitive intact) and R69 requires substantial assistance and partial assistance for transfers.R69's Care Plan documents that R69 is at risk for developing pressure ulcers. The intervention is to do a skin check weekly, provide incontinent care as needed, and report any signs of skin breakdown. R69's Physician Orders printed on 6/15/26 documents an order was added for Enhanced Barrier Precautions (EBP) to start on 6/14/26 however there was no treatment for R69's pressure ulcer.The Treatment Administration Record (TAR) for 6/1/26-6/30/26 printed on 6/15/26 at 12:40 PM, does not document a treatment order for R69's pressure ulcer.On 6/14/2026 at 10:02 AM, R69 stated that she has a wound on her buttock that is not being treated. R69 also stated that she has been trying to treat it herself for a couple of weeks. On 6/14/26 at 12:25 PM, V3/Wound Nurse stated that R69 does have a wound that is a stage two and measures 1 cm x 1 cm x 0.2 cm. The wound is on R69's Right Gluteal Fold. V3 also stated that the facility was not aware that V3 had a wound prior to this surveyor asking V3 to do a skin check on R69.On 6/15/26 at 1:00 PM, V3/Wound Nurse stated that she did not enter the order to the TAR for R69's pressure ulcer until today (6/15/26). V3 also stated that she did not document the pressure ulcer assessment or doctor notification in R69's medical record until 6/15/26.On 6/15/26 at 2:10 PM, V18/Regional Director of Operations stated that V3/Wound Nurse did not follow the facility policy and procedure for pressure ulcers by not documenting a wound assessment immediately, documenting physician notification, or documenting an order to treat R69's wound.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, interview, and record review, the facility failed to ensure restorative services were provided for two (R4, R7) of two residents reviewed for range of motion in a sample of 33.Findings Include:The facility's Rehabilitative Nursing Care policy dated/revised April 2007 documents, policy statement, rehabilitative nursing care is provided for each resident admitted . Policy interpretation and implementation, 4. Rehabilitative nursing care is provided to residents who require it. Such a program includes but is not limited to: f. assisting residents with their routine range of motion exercises. 5, through the resident care plan, the goals of rehabilitative nursing care are reinforced in the Activities Program, Therapy Services, etc.On 6/14/2026 at 11:00 AM, R4 was in bed resting, dressed, and pleasant. R4 stated he never has any staff member coming in and helping him with range of motion or any exercises in bed for his arms or legs. R4 stated he would like to have someone do this, he feels his joints would feel better and not be sore and cramped.R4's Care Plan dated 6/16/2026 documents, R4 requires an active range of motion to upper extremities related to his diagnosis of osteoarthritis and diabetic neuropathy and requires a restorative AROM (active range of motion) program. This same document also states, Bed Mobility, R4 is limited in ability to move independently in the bed related to decreased mobility and weakness and requires a restorative bed mobility program.R4's last three months of Point of Care Restorative Nursing charting documents 39 occurrences where R4 was not provided ROM (range of motion) as per R4's plan of care.On 6/16/2026 at 1:00 PM, R7 was in bed, resting, watching television, and waiting to go to his dialysis treatment at another facility. R7 stated that no staff has done any range of motion exercises with him since he was admitted to the facility. R7 stated he would like someone to help him do a range of motion exercises to help his joints not get contracted due to his conditions and lack of strength to move like he used to.R7's Care Plan dated 6/16/2026 documents, R7 requires an active range of motion to upper extremities to upper extremities related to the diagnosis of paraplegia and requires a restorative AROM (active range of motion) program. This same document states, R7 is limited in functional status regarding the ability to transfer and dress self-related paraplegia status. R7 will perform 3 sets of 10 reps of AROM to upper extremities 6-7 days/week through next review.R7's last three months of Point of Care Restorative Nursing charting documents 48 occurrences where R7 was not provided ROM (range of motion) as directed in R7's plan of care. On 6/16/2026 at 1:00 PM, V23 (Medical Data Set Coordinator) provided R3 and R7's Point of Care Restorative Nursing charting documents and stated: boy, the Certified Nursing Assistants are really shining. V23 stated R4 and R7's restoratives should have been done as directed by R4 and R7's care plan.

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	06/16/2026

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to follow physician orders when administering insulin for one of five residents (R6) reviewed for significant medication errors in a sample of 33.Findings include:The facility's Preventing and Detecting Adverse Consequences and Medication Errors, dated, [DATE], documents Procedures C. Facility staff monitor the resident for possible medication-related adverse consequences, including mental status and level of consciousness, when the following conditions occur: 1) A clinically significant change in condition/status. 2. Addition or discontinuation of medications and/or non-pharmacologic interventions. 6. Medication error, example: wrong or expired medication. D. When any of the above occurs, the prescriber and/or staff rule out medication as a cause and document it in the resident's clinic record. 1) A review of medications potential causes of permanent significant change that requires a Significant Change of Status MDS (Minimum Data Set) Assessment should be performed within the required 14-day observation period. F. In the event of a significant medication-related error or adverse consequence, immediate action is taken, as necessary, to protect the residents' safety and welfare. Significant is defined as: 1. Requiring medication discontinuation or dose modification. G. The attending physician is notified promptly of any significant error or adverse consequence. H. The physician's orders are implemented, and the resident is monitored closely for 24 to 72 hours or as directed. J. The following information is documented in an incident report and in the resident's clinical record: 8. Factual description of the error or adverse consequence. 9. Name of physician and time notified. 10. Physician's subsequent orders. 11. Resident's condition for 24 to 72 hours as directed.R6's Face Sheet documents R6 is a [AGE] year-old female who admitted to the facility on [DATE] with the following, but not limited to, diagnoses: Heart Failure, Post-Traumatic Stress Disorder, Acute Kidney Failure, Type Two Diabetes Mellitus with Diabetic Neuropathy, Anxiety Disorder, and Depression.R6's Physician Orders documents a physician order for insulin lispro 100units/ml (milliliter) administer per sliding scale before meals and at bedtime with a start date of [DATE] and a discontinued date of [DATE].R6's Referral Form dated [DATE] and signed by V30/R6's Physician documents Discontinue Sliding Scale Insulin. Change Accu-Check to twice a day. Call if sugar is above 250.R6's MAR (Medication Administration Record), dated [DATE]st through [DATE]th, 2026, documents R6 received insulin lispro 100units/ml per sliding scale 12 times after the physician order was discontinued on [DATE].On [DATE] at 11:24 AM, V4/Registered Nurse checked R6's blood glucose level, which was 181 mg (milligrams)/dL (deciliter). V4 stated, (R6) receives insulin lispro per sliding scale, so based on (R6's) sliding scale, (R6) would need 5 units of lispro insulin. V4 then prepared and administered R6's insulin lispro into R6's right lower abdominal quadrant.On [DATE] at 9:32 AM, V2/Director of Nursing verified R6's insulin lispro was given 12 times after the order was discontinued on [DATE]. V2 stated, I would say it is a significant medication error because the medication was insulin, and it was given when it wasn't ordered.

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	145726	A. Building B. Wing	06/16/2026

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. Based on record review and interview the facility failed to provide physical therapy and occupational therapy services as ordered by the physician for two of two residents (R1 and R9) reviewed for therapy services in the sample of 33.Findings include:The facility's Specialized Rehabilitation Services policy dated 2/20/26 documents, It is the policy of this facility to provide specialized and supportive rehabilitative services either directly, or through arrangements with services provider. Services shall be provided in accordance with the assessment results, the written comprehensive plan of care, and in accordance with physician's orders. Rehabilitative services shall be provided to all residents whose physician has determined a need and the resident or their legal representative consents to the service. A qualified therapist shall evaluate the resident and develop a plan of care which includes the amount, frequency, and duration within three days of the physician's order. The qualified therapist will assess the resident and develop a plan of care including the type, amount, frequency and duration of treatment and measurement of progress no later than one working day of the physician's order. The therapist will provide the attending physician assessment results and obtain specific treatment orders prior to initiating service.1.R1's Progress Notes dated 5/26/26 at 4:59 AM and signed by V5 (Registered Nurse) documents, (V27/Physician) and students here today. Physical Therapy (PT) for declines ADLs (Activities of Daily Living).R1's Physician's Order dated 5/26/26 documents, Physical Therapy-declined ADLs.R1's Electronic Health Record does not include evidence of a Physical Therapy evaluation or treatment as ordered on 5/26/26.On 6/15/26 at 10:55 AM V25 (Occupational Therapist) stated, (R1) has not received a Physical Therapy evaluation or treatment for an ADL decline. We (therapy department) were not aware of (R1) having an order for PT until today.2.R9's Wound Assessment and Plan Treatment Order dated 5/26/26, 6/2/26, and 6/11/26 and signed by V24 (Advance Practice Registered Nurse/APRN) documents, Recommend PT/OT (Physical Therapy/Occupational Therapy) for offloading needs and appropriately fitted (pressure-relieving) cushion. Follow-up again this week.R9's Electronic Health Record does not include evidence of a PT/OT consult for offloading needs and a pressure-relieving cushion as ordered since 5/26/26.On 6/15/26 at 11:00 AM V26/Physical Therapist verified R9 has not had a Physical or Occupational Consultation done regarding offloading needs or evaluation of a pressure-relieving cushion. V26 stated, I was not aware (R9) had an order for a PT/OT consult for offloading or a pressure relieving cushion.On 6/15/26 at 11:10 AM V24 (APRN) stated, I have been asking for PT/OT to consult with (R9) for offloading needs and a properly fitting wheelchair cushion for around two weeks. I was not aware that it has not been done.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview, and record review the facility failed to ensure the daily resident census and direct care staff posting was posted in an area accessible to residents and visitors. This failure has the potential to affect all 67 residents residing in the facility.Findings include:The facility's CMS (Centers for Medicare and Medicaid Services) Form 671 dated 6/14/26 and signed by V1 (Administrator), documents 67 residents reside within the facility.The facility's Posting Direct Care Daily Staffing Numbers policy dated 08/08 documents, Our facility will post on a daily status for each shift, the number of nursing personnel responsible for providing direct care to residents. At the beginning of each shift facility shall post the nurse staffing data as required by state and federal regulations. The information should be clean and readable format. The information should be posted in a prominent place accessible to residents and visitors. Shit staffing information shall be recorded on the form provided by the facility's Administrator for each shift. The information recorded on the from shall include the name of the facility, the date for which the information is posted, the resident census at the beginning of the shift for which the information is posted, twenty-four hour shift schedule operated by the facility, the shift for which the information is posted, type and category of nursing staff working during that shift for each category and type of nursing staff, total number of license and non-licensed nursing staff working for the posted shift.On 6/14/26 at 10:30 AM a tour was done of the facility. During this tour the direct care staffing report was posted in the front lobby behind glass doors in a cabinet on the wall. The direct care staffing report was dated 6/9/26 through 6/15/26. This report did not document the census or direct care staffing hours for 6/10/26, 6/11/26, 6/12/26, 6/13/26, or 6/14/26.On 6/14/26 at 10:35 AM V1 (Administrator) verified the direct care staffing report including the direct care staffing and census was not posted within the facility from 6/10/26 through 6/14/26. V1 stated, I usually post the direct care staffing report and forgot.