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 _____	08/20/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBER POINT HEALTHCARE CENTER	205 EAST SPRING STREET CAMP POINT, IL 62320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 497	Continued From page 81 This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews, the facility failed to do annual performance reviews on all CNAs (Certified Nurse Aides) in order to determine needs/weakness to base the 12 hours of required inservice training and failed to include caring for the cognitively impaired in that training. Ten of these 19 CNAs employed have been working over one year at the facility. Findings include: On 8/6/10 at 2:30 pm E2 (DON/Director of Nursing) was asked to provide the CNA 12 hour training for the past year. E2 stated, "I do that. I can get it for you." At 12:00 pm on 8/11/10 E1 (Administrator) was informed that E2 had been requested to provide the CNA 12 hour training on 8/6/10 and had not provided it as of this time. E1 stated, "I am the one that takes care of that. I will get it." At 3:00 pm 8/11/10 E1 presented signature sheets with topics and dates. E1 stated, "This is what I have." E1 was asked to provide the substance of the training. E1 replied, "It is just our policies. I can pull them all if you want me to." At 4:30 pm on 8/11/10 E1 stated, "Here is a list of all the CNAs. I have checked off each CNA to see the number of inservices they attended since the last survey. This is all I have. I just got this information together for the first time. I dated it 7/30/10 because that is just after last years survey. I just did this today." The form had only names and talleys. There was no evidence of what they were trained in or that the training had been evaluated.	F 497		

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 _____	08/20/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBER POINT HEALTHCARE CENTER	205 EAST SPRING STREET CAMP POINT, IL 62320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 497	Continued From page 82 "This is what I have. I can put the dates on it as to when they were hired if you want."	F 497		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 300.1210b)1)2) 300.1630f) 300.2430a) 300.2430b)1) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 1) Medications including oral, rectal, hypodermic, intravenous and intramuscular shall be properly administered. 2) All treatments and procedures shall be administered as ordered by the physician. Section 300.1630 Administration of Medication f) Nurses' stations shall be equipped as per	F9999		

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 _____	08/20/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBER POINT HEALTHCARE CENTER	205 EAST SPRING STREET CAMP POINT, IL 62320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 83 Sections 300.2860 or 300.3060 and shall have all necessary items readily available for the proper administration of medications. Section 300.2430 Sterilization of Equipment and Supplies a) Every facility shall follow an acceptable plan to provide for sterile equipment and supplies, such as needles, syringes, catheters, and dressing. b) Every facility shall sanitize bed pans, urinals, wash basins, emesis basins, enema equipment, and similar patient care utensils as follows: 1) Individual bed pans, urinals, wash basins, and similar equipment shall be washed and rinsed after each use, and be sanitized at least weekly. If individual equipment is not provided, the equipment shall be washed, rinsed, and sanitized after each use. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These Regulations were not met as evidenced by: A. Based on observation, record review, and interview, the facility failed to assure accurate manufacturer information was available to guide staff in the use of blood glucose monitoring units. The facility failed to utilize the correct blood glucose monitoring test strips for the blood glucose monitoring units and to follow the manufacturer's instructions for calibration and coding of blood glucose monitoring units for	F9999		

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 _____	08/20/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBER POINT HEALTHCARE CENTER	205 EAST SPRING STREET CAMP POINT, IL 62320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 84 evaluation of diabetic residents' blood sugars. This has the potential to cause inaccuracy of assessments of blood sugars and therefore potentially alter the pharmaceutical treatment the diabetic residents receive or do not receive based on potentially inaccurate assessments. This practice has the potential to affect all 22 diabetic residents, 8 on the sample of 15, and 14 off the sample, R3, R8, R9, R10, R11, R13, R14, R18 R19, R23, R29, R33, R34, R35, R36, R37, R38, R39, R40 R41, R42 and R43. B) In addition, the facility failed to obtain and follow manufacturers's specifications for cleaning and disinfecting blood glucose meters used for multiple residents. Residents using the blood glucose monitors include two especially immuno-compromised residents who were post surgical residents (R3) and (R19) This practice affected 10 of 10 residents who use blood glucose meters in a sample of 15 (R3, R8, R9, R11, R13, R18, R19, R29, R33, and R37) and 12 residents (R10, R14, R23, R34, R35, R36, R38, R39, R40, R41, R42, and R43) in the supplemental sample. Findings include: A) On 8/04/10 at 5:10 p.m., E13 (RN/Registered Nurse) was using a blood glucose monitoring unit with "no code" test strips to perform glucose monitoring testing for R38 and R39. E13 (RN) stated, "These strips are so nice. Now that we have these we don't have to code the (blood glucose monitoring unit) machine anymore." On 8/05/10 E2 (DON/Director of Nursing) provided a 56 page manual from the manufacturer of the blood glucose monitoring	F9999		

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 _____	08/20/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBER POINT HEALTHCARE CENTER	205 EAST SPRING STREET CAMP POINT, IL 62320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 85 units. The manual was not the correct manual for the blood glucose monitoring units currently in use at the facility. E2 (DON) indicated the facility was currently using two blood glucose monitoring units (each the same model) and this manual was all the information she had from the manufacturer. Pages 10 through 30 of the manual provided by E2 (DON) indicates the manual is for a blood glucose monitoring unit that requires calibration and coded blood glucose testing strips. On 8/05/10 at 11:35 a.m., Z1 (Blood Glucose Monitoring Unit-(Brand Name) Customer Service Representative) stated the blood glucose monitoring unit in the manual the facility had provided does not operate with a "no code" test strip, but requires a coded test strip and calibration. When given the model number from the back of the blood glucose monitoring units the facility is using, Z1 (Customer Service Representative) stated that the units the facility are using are not the blood glucose monitoring unit in the manual the facility provided. Z1 (Customer Service Representative), when given the model number from the back of the units, stated, "It's not manufactured anymore, but it is a coded machine (requires coded test strips and calibration) and takes strips that need to be coded." On 8/05/10 at 12:00 p.m., E2 (DON/Director of Nursing) was checking the medical supply room at the north nurses station and the south medication room for the facility's supply of blood glucose monitoring test strips. A total of 3 full boxes of blood glucose testing strips were found and all were the "no code" blood glucose monitoring test strips. E2 (DON) indicated this	F9999		

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 _____	08/20/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBER POINT HEALTHCARE CENTER	205 EAST SPRING STREET CAMP POINT, IL 62320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 86 was her total supply of blood glucose test strips for the facility. On 8/06/10 at 12:15 p.m., when asked how long the no code test strips have been used with blood glucose monitoring units that require coded strips, E2 (DON) stated, "This is the only information I can get on the auto (no code) strips as far as invoices. This is all there is." E2 (DON) submitted an invoice that indicates from 2/01/10 through 7/21/10 a total of 108 boxes of "no code" test strips were ordered to be used with the blood glucose monitoring units. On 8/05/10 at 12:20 p.m., Z2 (Director of Quality and Regulatory Issues for - brand name - blood glucose monitoring unit) verified the manual the facility supplied for review was not the manual for the blood glucose monitoring units being used by the facility. On 8/05/10 at 1:05 p.m., Z2 (Brand name-Director of Quality and Regulatory Issues) stated, "The (model in the manual presented by the facility) takes coded (test) strips." Regarding the blood glucose monitoring unit actually in use at the facility, Z2 stated, "I couldn't tell you if it affects the accuracy for certain because of the pre-calibration of the (test) strip to the meter. There's no way to tell. The (correct test) strips are still available for purchase for (the blood glucose monitoring unit the facility has been using)." On 8/5/10 at 2:30 p.m., Z2 (Brand name-Director of Quality and Regulatory Issue) stated, "We checked the warehouse and the (the blood glucose monitoring unit the facility is using) is an old product. It takes coded (test) strips and the strips are still available for purchase."	F9999		

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 _____	08/20/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBER POINT HEALTHCARE CENTER	205 EAST SPRING STREET CAMP POINT, IL 62320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 87 The current (brand name - model number) manufacturer blood glucose monitoring product manual available on the (brand name) Internet site states on page 5 "The (brand name glucose monitoring unit), test strips, and control solutions have been designed, tested, and proven to work together as a system to produce accurate blood glucose test results. Use only (brand name) control solutions, and use only the proper (brand name) test strips ...." On page 14 the manual states: "...Important Test Strip Information: Each model of the (brand name glucose monitoring unit) uses its own (brand name) test strips ...." On 8/05/10 at 4:18 p.m., when discussing the use of glucose monitoring test strips that do not require coding being used in glucose monitoring units that require coding, E3 (Medical Director) stated, "We look at potential for harm. You have a valid point. We need to develop a new and very intensive program." On 8/11/10 at 4:18 p.m., Z3 (Physician) stated, "I was not aware of this. No one told me. We do confer the A1C (laboratory blood test for approximating blood glucose levels over a period of time) with the routine sugars (blood glucose monitoring). The A1Cs have matched pretty well so far. Of course the A1C's a plasma (blood sample) ...There's always a potential for anyone at anytime. Sugars can be fine one minute but not the next. The (blood glucose monitors) can be off (in accuracy) roughly 10 to 15 percent anyway." On 8/10/10 at 10:45 a.m., E2 (DON) provided a list of diabetic residents that receive insulin injections at least daily. This list shows a total of 13 resident receive insulin injections routinely	F9999		

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 _____	08/20/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBER POINT HEALTHCARE CENTER	205 EAST SPRING STREET CAMP POINT, IL 62320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 88 (R8, R10, R11, R13, R14, R18, R23, R35, R36, R37 R40, R42, and R43). E2 (DON) stated there are no residents currently receiving sliding scale insulin based on blood glucose monitoring test results. On 8/10/10 E2 (DON) also provided a list of resident who receive routine blood glucose monitoring tests. The list shows there are a total 22 residents who receive blood glucose monitoring testing (R3, R8, R9, R10, R11, R13, R14, R18 R19, R23, R29, R33, R34, R35, R36, R37, R38, R39, R40 R41, R42, and R43). E2 (DON) indicated 3 residents have fluctuating blood glucose monitoring test results. E2 (DON) stated: R18 is a "very brittle" diabetic who has low blood sugars occasionally, R36 has trouble with blood sugars being low, and R43's blood sugars vary up and down but has been hyperglycemic. The blood glucose testing schedule for each resident is as follows: R3 - weekly before each meal and at bedtime (total of 4 times weekly) R8 - twice weekly before each meal and at bedtime (total of 8 times weekly) R9 - weekly before each meal and at bedtime (total of 4 times weekly) R10 - every other day before each meal and at bedtime (total of 12 times or 16 times on alternating weeks) R11 - fasting (in morning) and at bedtime Monday-Wednesday-Friday (total of 6 times weekly) R13 - twice daily (total of 14 times weekly) R14 - twice weekly before each meal and at bedtime (total of 8 times weekly) R18 - twice weekly before each meal and at bedtime (total of 8 times weekly) R19 - weekly before each meal and at bedtime	F9999		

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 _____	08/20/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBER POINT HEALTHCARE CENTER	205 EAST SPRING STREET CAMP POINT, IL 62320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 89 (total of 4 times weekly) R23 - twice weekly before each meal and at bedtime (total of 8 times weekly) R29 - weekly before each meal and at bedtime (total of 4 times weekly) R33 - weekly before each meal and at bedtime (total of 4 times weekly) R34 - weekly before each meal and at bedtime (total of 4 times weekly) R35 - twice weekly before each meal and at bedtime (total of 8 times weekly) R36 - twice weekly before each meal and at bedtime (total of 8 times weekly) R37 - twice weekly before each meal and at bedtime (total of 8 times weekly) R38 - before each meal and at bedtime Monday-Wednesday-Friday (total of 12 times weekly) R39 - twice daily (total of 14 times weekly) R40 - twice weekly before each meal and at bedtime (total of 8 times weekly) R41 - weekly before each meal and at bedtime (total of 4 times weekly) R42 - twice weekly before each meal and at bedtime (total of 8 times weekly) R43 - every morning (total of 7 times weekly) The 22 diabetics receive a total of at least 165 blood glucose monitoring tests on a weekly basis. B) Information provided, at the time of the entrance conference on 8/3/10 and on the CMS (Centers for Medicare and Medicaid)-672 Resident Census and Condition, indicate that 62 residents resided in the facility at the time of the survey. Of these 62 residents, 22 residents had blood glucose monitoring done with two blood glucose monitors, made by the same	F9999		

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 _____	08/20/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBER POINT HEALTHCARE CENTER	205 EAST SPRING STREET CAMP POINT, IL 62320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 90 manufacturer, that were used for multiple residents. R3 was identified as being treated for a post surgical abdominal wall Hernia repair complicated with Methicillin Resistant Staph Aureus Infection. R19 was receiving treatment for a recent surgical excision of a Squamous Cell Carcinoma on the forehead. The current Centers for Disease Control guidelines for RECOMMENDED INFECTION-CONTROL AND SAFE INJECTIONS PRACTICES TO PREVENT PATIENT-TO-PATIENT TRANSMISSION OF BLOOD BORNE PATHOGENS, include: Environmental surfaces such as (blood glucose meter) should be decontaminated regularly and anytime contamination with blood or body fluids occurs or is suspected. (Blood glucose meter) should be assigned to individual patients. If a (blood glucose meter) that has been used for one patient must be reused for another patient, the device must be cleaned and disinfected. Maintain supplies and equipment such as fingerstick devices and (blood glucose meter) within individual patient rooms if possible. Do not carry supplies and medications in pockets. Because of possible inadvertent contamination, unused supplies and medications taken to a patient's bedside during fingerstick monitoring or insulin administration should not be used for another patient. 1) On 8/4/10 at 4:10 pm, E13 (RN/Registered Nurse) removed a blood glucose meter from the top drawer of the medication cart. The meter did not appear to have been covered or contained in any packaging or anything but the drawer. The	F9999		

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 _____	08/20/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBER POINT HEALTHCARE CENTER	205 EAST SPRING STREET CAMP POINT, IL 62320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 91 meter was not cleaned or sanitized at this time. E13 then entered R9's room with the meter. E13 applied gloves and placed a glucose monitor test strip into the glucose machine, cleaned R9's left first finger with a pre-packaged alcohol wipe (70% Isopropyl Alcohol) and pricked R9's finger with a single use lancet and touched the blood to the glucose monitor test strip. E13 (RN) then removed her gloves and entered R9's adjoining bathroom which R9 shares with another resident, R52. E13 sat the glucose meter down on the bathroom sink and proceeded to wash her hands. E13 picked up the meter with her ungloved hand and then wiped it using a wet wash cloth. E13 stated, "Our policy says to wipe it (the blood glucose meter) with just a moist wash cloth. Nothing really touches the machine." E13 was asked how she cleaned it before she used it. E13 stated, "I didn't. I assumed the last person to use it did." E13 laid the used moist wash cloth that she had wiped the meter with on the top of the medication cart. E13 was then asked if she had other blood glucose tests to perform and any other wash cloths. E13 stated, "No, I don't have any more. I'll throw that cloth in the soiled utility when I get down the hall to the soiled utility. I will get other wash cloths then." 2. On 8-4-10 at 5:10 pm, E13 (RN/Registered Nurse) completed a blood glucose test using R39's right index finger. After the test, E13 laid the glucose monitoring machine on top of the medication cart with the blood strip still in the machine. E13 then put the monitoring machine under her arm while washing her hands. Next, E13 used a moistened washcloth to wipe down the glucose monitoring machine. E13 stated "That's how the manufacturer suggest to clean the machine."	F9999		

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 _____	08/20/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBER POINT HEALTHCARE CENTER	205 EAST SPRING STREET CAMP POINT, IL 62320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 92 E13 proceeded to use the same machine to complete R38's glucose monitoring test. After the test, E13 wiped the machine with the same moistened cloth she used to wipe down the machine after use on R39. E2 (DON/Director of Nursing/Infectionist) stated on 8/4/10 at 5:36 pm, "We only have two (blood glucose meters) that we are using. They are duplicate machines (meters) from the same manufacturer. There is one on each med cart. We use the same machine on all the residents that use that med cart and the other cart has its own machine for the other end. The policy for disinfecting them is in the manual that came with them. I will have to find it." On 8/5/10 at 11:15 am, E2 (DON/Infectionist) provided a photo copy of a blood glucose monitoring manual. The manual was from the same manufacturer of the facility's meters but the picture of the meter on the manual was not the same meter as the facility was using. E2 stated, "That is the only manual that we have. We do not have a policy that is just for (blood glucose meters)." At 11:23 am on 8/5/10, E2 was shown and given a copy of the current "Centers for Disease Control guidelines for RECOMMENDED INFECTION-CONTROL AND SAFE INJECTIONS PRACTICES TO PREVENT PATIENT-TO-PATIENT TRANSMISSION OF BLOOD BORNE PATHOGENS" which includes instructions that the meters must be cleaned and disinfected. E13 (RN/Registered Nurse) was with E2 at the time and said, "We've been doing (glucose checks) for years and we have never cleaned the machine."	F9999		

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 _____	08/20/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBER POINT HEALTHCARE CENTER	205 EAST SPRING STREET CAMP POINT, IL 62320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 93 At 12:20PM on 8/5/10, E1 (Administrator) asked where the regulation stated that the (blood glucose meter) had to be cleaned a certain way. E1 was told where he could find it in the State Operations Manual. E1 explained that he did not have that manual. E1 was told how to look up the downloadable manual on the government web site. E1 inquired, "Why do we have to clean them between residents when the hospital doesn't do that?" E1 was asked if he had the current standards of practice and if he was aware that E2 had been shown and given that information. E1 stated that he had been told and stated that he knew the paramedics didn't clean there machines. E3 (facility Medical Director) stated at 4:18 pm on 8/5/10, "Yes, I heard about the facility not cleaning the (blood glucose meters) before and after residents. But of course it is only the lancets that touch the resident. I have called the hospital epidemiologist and he said that it has not been a standard of practice to disinfect them between use. I am on the board with those people at the hospital and they never mentioned it." E3 made note that they looked at the antibiogram and she did not feel that their residents were at any risk. E3 was asked if she was aware there were two post surgical immuno-compromised residents, one of which was in isolation for MRSA (Methicillin Resistant Staph Aureus) of the wound. E3 was made aware of other infection control concerns observed during the survey as documented below and E3 was asked if she had considered the potential risk. E3 responded, "You have made a valid point. We need to develop a new and very intense infection control program." Z1 (Customer Service Representative for the	F9999		

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 _____	08/20/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBER POINT HEALTHCARE CENTER	205 EAST SPRING STREET CAMP POINT, IL 62320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 94 Blood Glucose Meter manufacturer) reported on 8/5/10 at 11:45am, "That manual is not for the machine that you have given me the serial number for. We don't even manufacture the machine that you have described. That machine is not recommended for use for more than one person because of possible blood exposure to other patients." On 8/5/10 at 9:50 am E12 (LPN/Licensed Practical Nurse) stated regarding how to sanitize/clean the blood glucose meter, "I use a damp cloth, no alcohol, and wipe down the machine (blood glucose meter)." At 9:55 am on 8/5/10, E24 (LPN) indicated that she uses a 2X2 gauze with warm water to gently wash the meter before and after she uses it. E12 stated, "I don't wash between residents unless they touch the machine. Then I wash it." (A) 300.615b) 300.615d) Section 300.615 Determination of Need Screening and Request for Resident Criminal History Record Information b) All persons seeking admission to a nursing facility must be screened to determine the need for nursing facility services prior to being admitted, regardless of income, assets, or funding source. (Section 2-201.5(a) of the Act) A screening assessment is not required provided	F9999		

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 _____	08/20/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBER POINT HEALTHCARE CENTER	205 EAST SPRING STREET CAMP POINT, IL 62320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 95 one of the conditions in Section 140.642(c) of the rules of the Department of Healthcare and Family Services titled Medical Payment (89 Ill. Adm. Code 140.642(c)) is met. d) Screening shall be administered through procedures established by administrative rule by the agency responsible for screening. (Section 2-201.5(a) of the Act) The Illinois Department on Aging is responsible for the screening required in subsection (b) of this Section for individuals 60 years of age or older who are not developmentally disabled or do not have a severe mental illness. The Illinois Department of Human Services is responsible for the screening required in subsection (b) of this Section for all individuals 18 through 59 years of age and for individuals 60 years of age or older who are developmentally disabled or have a severe mental illness. The Illinois Department of Healthcare and Family Services or its designee is responsible for the screening required in subsection (c) of this section. These requirements are not met as evidenced by: Based on interview and record review, the facility failed to have the Illinois Department of Human Services complete prescreening for three of three residents identified with severe mental illness in a sample of 15. Findings include: 1. R11's Interagency Certification of Screening Results states the date of screening as 3/5/10. The screening was certified by the Department on Aging. The OBRA-1 (Omnibus Budget	F9999		

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 _____	08/20/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBER POINT HEALTHCARE CENTER	205 EAST SPRING STREET CAMP POINT, IL 62320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 96 Reconciliation Act) Initial Screen states there is a reasonable basis to suspect a mental illness and list the diagnoses of Schizoaffective Disorder. Part IV of the screen states R11 will be referred to a MH PAS (Mental Health Pre-Admission Screen) organizations for additional screening. There is no additional pre-screening found for R11. 2. R30's Interagency Certification of Screening Results shows the date of screening as 9-23-09. The screening was certified by the Department on Aging. The OBRA -1 Initial Screen shows a MH Pass organization screened R30 and referred R30 to the Department of Aging. There is no screening information found from the Department of Human Services. 3. R33's Interagency Certification of Screening Results show the date of screening as 7-13-10. The screening was certified by the Department on Aging. The OBRA-1 Initial Screen shows there is a reasonable basis to suspect a mental illness and list the diagnoses of Schizophrenia. The form states R33 was referred to another agency but there is no further documentation of any additional screening. On 8-11-10 at 10:00 am, E16, Psychiatric Rehab Service Coordinator stated she did not have any additional information as to why appropriate screening was not completed. (B) 300.4030 a) Section 300.4030 Individualized Treatment Plan	F9999		

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 _____	08/20/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBER POINT HEALTHCARE CENTER	205 EAST SPRING STREET CAMP POINT, IL 62320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 97 for Residents with Serious Mental Illness Residing in Facilities Subject to Subpart S a) On admission, information received from the admission source (e.g., resident, family, preadmission screening (PAS) agent) shall be used to develop an interim treatment plan. In developing an individual's interim treatment plan (IITP), the facility shall review the PAS/MH assessments and "Notice of Determination" and consider the use of this information in developing the interim treatment plan. The IITP shall focus on those behaviors and needs requiring attention prior to development of the individualized treatment plan (ITP). Each IITP shall be based on physician's orders and shall include diagnosis, allergies and other pertinent medical information. The following information shall also be considered, as appropriate, to allow for the identification and provision of appropriate services until a final plan is developed: 1) Known risk factors (e.g., wandering, safety issues, aggressive behavior, suicide, self-mutilation, possible victimization by others); 2) Observable resident medical/psychiatric conditions that may require additional immediate assessment or consultation; 3) Therapeutic involvement that might be of interest to the resident, be recommended based on referral information, aid in orientation or provide meaningful data for further professional assessment; and 4) Other known factors having an impact on the resident's condition (e.g., family involvement, social interaction patterns, cooperation with treatment planning). k) The resident's treating psychiatrist shall review and approve the resident's treatment plan as developed by the IDT. The date of this review	F9999		

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 _____	08/20/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBER POINT HEALTHCARE CENTER	205 EAST SPRING STREET CAMP POINT, IL 62320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 98 and approval shall be entered on the resident's treatment plan and be signed by the attending psychiatrist. These requirements are not met as evidenced by: Based on interview and record review, the facility failed to complete an interim treatment plan and have the treating psychiatrist review and approve the plan of care for three of the three SMI (Serious Mental Illness) residents, R11, R30, R33 in a total sample of 15. Findings include: 1. Review of R11, R30 and R33's record shows no interim treatment plan. On 8-11-10 at 10:00 am, E16, Psychiatric Rehab Service Coordinator stated interim treatment plans were not developed for any of the SMI residents. 2. R11, R30 and R33's treatment plans do not contain documentation of a review and approval by the treating psychiatrist. On 8-11-10 at 10:00 am, E16 Psychiatric Rehab Service Coordinator stated they all have a psychiatrist they see but no one is in charge of actually reviewing and approving the plan of care. (B) 300.4060a) 300.4060b)	F9999		

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 _____	08/20/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBER POINT HEALTHCARE CENTER	205 EAST SPRING STREET CAMP POINT, IL 62320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 99 Section 300.4060 Discharge Plans for Residents with Serious Mental Illness Residing in Facilities Subject to Subpart S a) As part of the ITP, a discharge plan shall be considered by the interdisciplinary team as a component of the individual's comprehensive program plan. This plan shall address the reduction of symptoms and the acquisition of behaviors and prioritized skill deficits that inhibit the individual from moving to a more independent environment. b) Within one year prior to a planned discharge, preparation shall address: 1) Identification and linkage to proposed community providers; 2) Self-directed initiation and compliance with mental health services while in the facility; 3) Use of community mental health services; 4) Assistance with locating and securing housing; and 5) Assistance with identification, application and securing financial resources. These requirements are not met as evidenced by: Based on interview and record review, the facility failed to develop a discharge plan for three of the three SMI (Serious Mental Illness) residents, R11, R30, R33 in a total sample of 15. Findings include: R11, R30 and R33's records do not contain any discharge plans. On 8-11-10 at 10:00 am, E16 Psychiatric Rehab	F9999		