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 _____	04/02/2013

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 441	Continued From page 38 policies, E16 stated, "We use that (pre-moistened towels with 1:10 dilution of bleach and detergent). I don't wash them (hands) from the rooms unless I touch something without gloves on. Then I use (pre-moistened towels with 1:10 dilution of bleach and detergent). I used them now because I touched the phone. I use that cause it has bleach in it."	F 441		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS: 300.1210b) 300.3240a)b)e) Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall 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 resident care plan. 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. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence,	F9999		

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F9999	Continued From page 39	F9999		

that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee.

These REQUIREMENTS are NOT MET as Evidenced by:

Based on observation, interview and record review, the facility failed to prevent the mistreatment and abuse of a resident by staff, failed to establish a resident sensitive environment, failed to identify resident behaviors as potential risk factors for abuse, failed to ensure all staff were knowledgeable on appropriate approaches to redirect resident behavior, and failed to follow Operational Policies and Procedures regarding abuse, for one of six (R21) residents reviewed for abuse, in a sample of 15.

The facility also failed to ensure staff reported mistreatment and abuse of a resident by staff and failed to follow Operational Policies and Procedures regarding abuse, for one of six (R21) residents reviewed for abuse, in a sample of 15 and failed to ensure staff intervened during the mistreatment and abuse of a resident and failed to follow Operational Policies and Procedures regarding resident protection from abuse, for one of six (R21) residents reviewed for abuse, in a sample of 15.

Findings include:

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F9999	Continued From page 40	F9999		

On 3/26/13 at 1:57 p.m., E4 (Certified Nursing Assistant) and E5 (Certified Nursing Assistant) were preparing to transfer R21 from the wheelchair to the bed for incontinence care. R21 repeatedly stated she did not want to lay down in bed and that she preferred to remain upright in the wheelchair. E4 instructed R21 that they would be laying her down in the bed for a few minutes, and that R21 could get back up in the wheelchair when they were finished with incontinence care. R21 continued to state, "No, I don't want to lay down" and "leave me alone." At that point, E4 and E5 each hooked their arms underneath R21's axilla, lifted R21 up out of the wheelchair. E4 grabbed the elastic waistband of R21's pants with her left hand and pulled upwards on R21's pants as they lifted R21 up out of the wheelchair and into the bed. R21's feet barely touched the floor and R21 did not bear any weight during the transfer. Throughout the transfer, R21 repeatedly stated "leave me alone" and "stop it." E4 and E5 proceeded to situate R21 in the bed and E4 started to pull down R21's pants. R21 began to squirm in the bed and E5 used her hands to hold R21's forearms against her chest in an attempt to keep her still. R21 repeatedly yelled throughout the incontinence care, "stop it", "you're hurting me" and "why do you do that." E5 did not speak to R21, attempt to redirect or calm R21 throughout the incontinence care and continued to hold R21's arms close to her chest for several minutes, until R21 was turned to the right side. E4 did not attempt to calm or redirect R21, did not stop the incontinence care and repeatedly wiped R21's buttocks and perineum vigorously. E4 stated, to R21, "I don't want to do this anymore than you want it done." Once positioned to the right side, R21 continued to yell,

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"you're hurting me...STOP." At that point, E4 stated to R21, in a stern voice, "HEY!" E6 (Certified Nursing Assistant) then entered the room, with additional incontinence supplies and was present throughout the remainder of incontinence care. As E4 began applying protective cream to R21's buttocks, R21 cried out, "please stop!" and E4 yelled back at R21, "No, you stop!" Upon completion of incontinence care, R21 was left in her bed and was not returned to her wheelchair, as previously requested.

On 3/26/13 at 2:15 p.m., upon the completion of incontinence care, E4 stated "nothing will redirect her (R21). Sometimes, if you leave and come back, (R21) will respond better, but it depends on her mood."

On 3/26/13 at 3:10 p.m., E1 (Administrator/Abuse Coordinator) was notified of the 1:57 p.m. incident with R21, E4, E5 and E6. E1 stated nothing had been reported by staff present in the room during the incident, as potential abuse or mistreatment. E1 immediately began an investigation in to the incident.

Attempts to call E4 and E5 for interviews were unsuccessful.

A Physician's Order Sheet dated 3/01/13, documents R21 has the diagnoses of Profound Dementia. A Minimum Data Set dated 1/11/13, indicates R21 has significant cognitive impairment. A Plan of Care dated 1/14/13, documents R21 has an "Altered Thought Process" and "Depression", but does not indicate R21 has any aggressive behaviors. The 1/14/13

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Plan of Care, under "Altered Thought Process", instructs staff to "reorient/redirect, speak slowly/clearly, allow time to respond, explain procedures."

On 3/27/13 at 10:40 a.m., E7 (Licensed Practical Nurse) stated R21's aggressive behaviors and resistance to care have gotten worse over the last two months.

On 3/27/13 at 12:42 p.m., E3 (Assistant Director of Nursing) stated it is known that R21 can often be resistive to cares, be verbally aggressive and strike out. E3 stated R21's Plan of Care should identify specific approaches for staff to utilize when R21 is being aggressive or resistive to cares.

On 3/27/13 at 9:35 a.m., E8 (Psycho/Social Rehabilitation Coordinator) stated "when notified of a resident's behaviors or resistance to care", he will "assist in developing appropriate care plan interventions" related to those specific behaviors. E8 stated he was "unaware" R21 was verbally/physically resistive to cares, as it was not communicated to him by staff.

On 4/01/13 at 12:14 p.m., Z3 (Spouse), who was present outside the door of R21's room on 3/26/13 at 1:57 p.m., stated he could hear R21 yelling. Z3 stated R21 "often gets like that" and it's "upsetting" for him to hear R21 yell over and over that way.

The facility policy, titled "Abuse Prevention Program", documents "This facility prohibits mistreatment, neglect or abuse of its residents by:...orienting and training employees on how to

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F9999	Continued From page 43 deal with stress and difficult situations, and how to recognize and report occurrences of mistreatment, neglect, and abuse; establishing an environment that promotes resident sensitivity, resident security and prevention of mistreatment..." and immediately protecting residents involved in identified reports of possible abuse..." The facility policy, titled "Abuse Prevention Program", documents "Employees are required to report any incident, allegation or suspicion of potential abuse, neglect or misappropriation of property to the administrator or an immediate supervisor, who must then immediately report it to the administrator." The "Abuse Prevention Program" policy, further documents abuse as "the willful infliction of injury, unreasonable confinement, intimidation or punishment with the resulting physical harm, pain, or mental anguish" and verbal abuse as "the use of oral, written, or gestured language that willfully included disparaging and derogatory terms to residents...." (A)	F9999		