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 _____	C 09/22/2016

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 000	INITIAL COMMENTS Original investigation of IRI of 9/2/16/ IL88740	F 000		
F 223 SS=D	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to prevent one of three residents reviewed for abuse (R1) in a sample of three from being physically and verbally abused. Findings include: Facility Occurrence Resolution notes that on 9/2/16 E4 (Certified Nurse's Aide CNA) reported to the nurse (E7) that E4 had witnessed E5 (CNA) holding R1's wrists down during care and holding her hand over R1's mouth. E4 then witnessed E5 hold a soiled brief up to R1's face and was yelling at R1. R1 is cognitively impaired and has frequent behavioral issues such as hitting and yelling. R1 stated, "She put shit in my mouth". There was no sign of the resident (R1) having feces in his mouth. E5 admitted holding her hand across his mouth and holding his wrists down. E5 was immediately terminated from her	F 223		

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
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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 223	Continued From page 1 position with the facility and a police report was made by E1 (Administrator). On 9/22/16 at 10:32 A.M. E4 stated that on 9/2/16 the following occurred: E4 was in R1's room with E5 providing incontinent care. R1 was agitated and E5 was holding R1's wrist down and putting her hand over R1's mouth. E5 then took R1's soiled briefs and held them up to R1's face. E5 ended up leaving the room at this time. R1 stated to E4 that E5 had put "shit" in his mouth. E4 stated that she went to get E6 (CNA) to sit with R1 while E5 went to report the abuse to a supervisor. On 9/22/16 at 11:19 A.M. E2 (Director of Nursing) stated that after she was told of the incident, E2 and other department heads waited for E5 to come back from break. E2 then interviewed E5. E5 admitted to holding down R1's wrist and covering R1's mouth with her hand. E2 stated she terminated E5 at that time.	F 223		