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 07/21/2006

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 225	Continued From page 15 hospitalized or alternative arrangements can be made.) The following monitoring tools will be implemented to assure that measures described above are effective and ongoing: 6. The facility administrator, DON and other member of the IDT as assigned hold weekly Accident/Incident meetings. All incidents are reviewed to assure that any and all possible occurrences of abuse have been addressed in accordance with the facility's Abuse and Neglect policy (i.e. was staff response timely and appropriate? Were the resident(s) representative (s) and physician (s) notified in a timely manner? Was the accused abuser immediately removed from the premises? Was a thorough and exhaustive investigation completed? Etc.) Noted areas of non-compliance are, and will be immediately addressed and additional employee training/discipline will be provided as warranted. 7. the Facility administrator and assigned designee will complete random employee questioning during regular rounds regarding the facility's Abuse and Neglect policy. Employees will be queried as to their understanding and knowledge of Abuse and Neglect and evaluated for appropriate response. Questioning will specifically target effective identification of abuse; when to report allegations of abuse and how to immediately secure the resident environment (i.e. immediate employee suspension or removal of accused abuser from premises.) Noted problems will be immediately addressed via one -to-one counseling and additional staff training. This Quality Monitoring program will begin July 20, 2006.	F 225		

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F9999	FINAL OBSERVATIONS Licensure Violations 300.1210a) 300.3240a)b)e) 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. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) 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. (Section 3-610 of the Act) e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, 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. (Section 3-611 of the Act)	F9999		

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F9999	Continued From page 17 These requirements were not met as evidenced by: Based on observation, interview and record review, the facility failed to report suspected abuse to the abuse coordinator as soon as possible after the incident occurred in 2 of 2 cases (R5 and R10), failed to start an investigation into the incident until the morning after the incident occurred, and failed to protect other residents from potential abuse by allowing the staff member to finish her shift once an allegation of abuse was made. Findings include: The facility's Incident Report Form-IDPH (Illinois Dept. of Public Health) Notification states the following. On 7-9-06 at 5:45 p.m., an "alert, confused female resident was allegedly pushed into her (ambulation device) during a transfer from the dining room chair to the (ambulation device) and CNA (Certified Nursing Assistant) allegedly cursed at this resident and also a confused male resident." The Administrator's, E1's, summary of the investigation into the incident states "On 7-9-06 at approximately 5:45 p.m. while staff was cleaning up the South dining room from the evening meal, two CNAs and one resident state the following occurred: "(R5) was being transferred from her dining room chair into her (ambulation device) by (E12, CNA) ...the two staff members witnessed (E12) take (R5) by the arm to transfer her, while she was resisting (which is normal for this resident) (E12) placed her elbow into the resident's chest which forced her to sit in the (ambulation device.) Further (E12), per the	F9999		

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F9999	Continued From page 18	F9999		

two staff members and the resident witness, stated 'sit the f..k down.' ...(E12) went to another resident, (R10) and took a glass from him that belonged to his table mate-he was attempting to drink from the glass and (E12) said to (R10) ' get the hell out of the dining room.' (E12) has been relieved of her duties at this facility based on the witness statements and interviews by administration."

On 7-17-06 at 11:15 a.m., E1, Administrator and abuse coordinator, stated E8 reported the incident of 7-9-06 to the nurse on duty at the time it happened but the nurse, E4, did not report the incident to her until the next day. E1 stated E12 was not relieved of her duty pending investigation until the morning of 7-10-06. E12 completed her shift, working about four more hours on the floor taking care of residents the evening of 7-9-06. E 1 initiated an investigation 7-10-06 upon learning of the allegations and found through interview, two CNA witnesses and one resident who overheard the incident, that the allegation of abuse was founded and E12 was terminated. E1 stated she also interviewed all staff working the evening of 7-9-06 to see if there were any other instances of abuse or mistreatment since E12 had not been relieved of duty as soon as the allegation was made and finished out her shift. E 1 verified that E4 should have reported the alleged incident of abuse to her as soon as she received it and E12 should have been removed from duty immediately pending the investigation.

On 7-17-06 at 12:00 p.m., E4, Licensed Practical Nurse (LPN), related the following: On 7-9-06 about 5:45 p.m., E8, CNA, came to E4 and stated E12, CNA, took R5 and slammed her back in the (ambulation device) and told her to "shut the hell

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F9999	Continued From page 19	F9999		

up." E4 stated she should have called the administrator but there had been some animosity between the staff and she "wasn't sure" whether to call then or not. E4 decided to come in the next morning and reported the incident to the administrator the morning of 7-10-06. E4 stated she had been in-serviced recently on abuse procedures but stated " it was my mistake, I just didn't tell her till the next day."

During interview on 7-18-06 at 1:55 p.m., E8, CNA, was interviewed. E8 stated on 7-9-06 after supper about 5:30 p.m., she saw E12, CNA, transfer R5 from her dining room chair into her (ambulation device) by putting her elbow into R5's chest and pushing her while telling her to "sit down and shut up." E12 then approached R10, who was in a wheelchair and has a history of drinking other resident's drinks, and yelled at him (unsure what she said) and shoved him in his wheelchair out of the dining room. E8 stated she went directly to the nurse on duty, E4, Licensed Practical Nurse (LPN), and reported the incidents .

The facility's investigation contains a witness statement from E6, another CNA, as follows: E6 states on 7-9-06 she was in the south dining room feeding another resident when she witnessed E12, CNA, grab R5 under the arm and slam her into her (ambulation device) with her forearm while cursing at the resident. E12 then approached R10 who was drinking another resident's drink. E12 told R10 "no." R10 then told E12 "no" back, and then E12 stated to R10, " come the F... on." This witnessed abuse statement was verified with E6 during interview on 7-18-06 at 10:30 a.m.

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F9999	Continued From page 20 The facility's investigation also includes a statement by R11 who relates she did not see E 12 "doing anything to a resident but did hear her swearing at resident. Couldn't remember what she said but it wasn't very nice." During interview on 7-17-06 at 12:00 p.m., E4, Licensed Practical (LPN), related the following: On 7-9-06 about 5:45 p.m., E8, CNA came to E4 and stated E12, CNA, took R5 and slammed her back in the (ambulation device) and told her to " shut the hell up." E4 stated she should have called the administrator but there had been some animosity between the staff and she "wasn't sure" whether to call then or not. E4 decided to come in the next morning and reported the incident to the administrator the morning of 7-10-06. E4 stated she had been in-serviced recently on abuse procedures but stated "it was my mistake, I just didn't tell her till the next day." During interview on 7-17-06 at 11:15 a.m., E1, Administrator and abuse coordinator stated E8 reported the incident of 7-9-06 to the nurse on duty at the time it happened but the nurse, E4, did not report the incident to her until the next day . E1 stated E12 was not relieved of her duty pending investigation until the morning of 7-10-06 . E12 completed her shift, working about four more hours on the floor taking care of residents the evening of 7-9-06. E1 conducted an investigation and found through interview, two CNA witnesses and one resident who overheard the incident, that the allegation of abuse was founded and E12 was terminated. E1 stated she also interviewed all staff working the evening of 7 -9-06 to see if there were any other instances of abuse or mistreatment since E12 had not been relieved of duty as soon as the allegation was	F9999		

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F9999	Continued From page 21 made and finished out her shift. E1 verified that E4 should have reported the alleged incident of abuse to her as soon as she received it and E12 should have been immediately removed from duty pending the investigation. The facility ' s Abuse Prevention Program Facility Policy states " ...The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of mistreatment, neglect or abuse of our residents. This will be done by: ...orienting and training employees on how to deal with stress and difficult situations, and how to recognize and report occurrences of mistreatment, neglect and abuse; immediately protecting residents involved in identified reports of possible abuse... Supervisors shall immediately inform the administrator or designee of all reports of potential mistreatment." Under Protection of Residents the policy states: " Employees of this facility who have been accused of mistreatment will be removed from resident contact immediately until the results of the investigation have been reviewed by the administrator or designee. Employees accused of possible mistreatment shall not complete the shift as a direct care provider to residents." (A)	F9999		