AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED		
				06/2	06/25/2015	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE	• • • •	
IMBER I	POINT HEALTHCARE	- CENTER				
		САМР РО	DINT, IL 6232			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
S9999	Final Observations		S9999			
	Statement of Licen	sure Violations				
	Screening and Req History Record Info e) In addition to the 2-201.5(a) of the Ad shall, within 24 hou resident, request a check pursuant to t Information Act for admission to the fa check was initiated Hospital Licensing J be based on the rea and other identifiers Department of Stat of the Act) This REQUIREMEN Based on interview failed to provide pro checks within 24 hou R31, R32, R33, and sample reviewed for Findings include: On 6-24-15 at 11:00 provided e-mail cor R33, and R34 docu background checks E1 stated, "My norr checks prior to adm (R30, R31, R32, R3 checks were done y admission dates." R30's medical reco to the facility on 5-2 check inquiry indica was initiated on 5-2	screening required by Section et and this Section, a facility rs after admission of a criminal history background he Uniform Conviction all persons 18 or older seeking cility, unless a background by a hospital pursuant to the Act. Background checks shall sident's name, date of birth, s as required by the e Police. (Section 2-201.5(b) NT is not met as evidenced by: and record review the facility oof of initiation of background burs for five residents (R30, d R34) on the supplemental or background checks. D a.m., E1 (Administrator) offirmations on R30, R31, R32, menting when inquiries for a were submitted and received. nal procedure is to run the nission(I) have no proof 83, and R34's) background within 24 hours of the rd indicates R30 was admitted t2-15, and R30's background ates the background check				
	ment of Public Health	DER/SUPPLIER REPRESENTATIVE'S SIG		TITLE		(X6) DATE
JUNAIURI	DINECTORS OR PROVIL	DENSOFFLIER REFRESENTATIVES SIC		IIILE		07/17/1

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		E SURVEY PLETED
		IL6003750	B. WING			25/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
IMBER	POINT HEALTHCARI	E CENTER	T SPRING STF OINT, IL 62320			
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S9999	Continued From pa	age 1	S9999			
	check inquiry indica 5-27-15. R32's medical reco to the facility on 4-1 check inquiry was of 4-13-15. R33's medical reco to the facility on 5-1 check inquiry docu on 5-5-15. R34's medical reco admitted to the fac background check initiated on 5-27-15. The facility's Identifi and Procedure, dat "Conduct a Crimina Within 24 hours of name-based Unifor (UCIA) criminal his on name, date of b required by the Dep	21-15, and R31's background ates it was initiated on ord indicates R32 was admitted 11-15, and R32's background documented as initiated on ord indicates R33 was admitted 1-15, and R33's background ments the check was initiated ord documents R34 was ility on 5-21-15, and R34's inquiry was documented as 5. fied Offender Facility Policy ted 2011, documents, al History Background Check: admission, request a rm Conviction Information Act tory background check based irth and other identifiers partment of State Police for ng admission to the facility."				
	steps necessary to while the results of check or a fingerpr while the results of fingerprint-based c the Identified Offen Recommendation i	be responsible for taking all ensure the safety of residents a name-based background int-based check are pending; a request for a waiver of a heck are pending; and/or while der Report and s pending. evaluate care plans at least				

AND PLAN OF CORRECTION				(X3) DATE SURVEY COMPLETED	
		- B. WING		06/	25/2015
		ADDRESS. CITY. S	TATE. ZIP CODE		23/2013
	205 FA				
	CAMP F	POINT, IL 6232	0		
ACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO	TION SHOULD BE	(X5) COMPLET DATE
ued From pa	age 2	S9999			
ent such rev re plan if nec tion. The fac uously evalua r making any cessary to er EQUIREMEI on interview ration the fac al History An ler and failed ors or revise of an Identi nt (R27) revise sample of fift gs include: cility's Identif dure, dated 2 s if the Resid tiately compl tment of Pub ation Form a m Conviction secheck for ation was su nation from t um, the facilit nois State Po gation within uling an on-s nt and the Ac current elect as admitted for current MDS 5, document	tiew. The facility shall modify ressary in response to this illity remains responsible for ating the identified offender of changes in the care plan that near the safety of residents. NT was not met as evidenced of, record review, and illity failed to obtain a (CHAR) alysis Report for an Identified to identify inappropriate onew interventions on the plan fied Offender for one of one ewed for Identified Offenders een. fied Offender Policy and 2011 documents, "Reporting dent is an Identified Offender: ete and submit the Illinois lic Health, Identified Offender and submit the Illinois lic Health offender and submit the Illinois in the information for the UCIA of confirmation that all the binited correctlyafter the he Identified Offender and an Information for the the bitted correctlyafter the he Identified Offender and three business days ite facility interview with the diministrator." ronic record documents that to the facility on 11-25-13. (Minimum Data Set), dated s that R27 has a BIMS (Brief				
	ROR SUPPLIER HEALTHCARE SUMMARY STA ACH DEFICIENC GULATORY OR L nued From particle to the idention to the idention the and failed to the idention the and failed to an interview vation the fact to an interview to an interview vation the fact to an interview vation from to ta and the fact to an	IDENTIFICATION NUMBER: IL6003750 A OR SUPPLIER STREET / 205 EAS CAMP F HEALTHCARE CENTER 205 EAS CAMP F SUMMARY STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST BE PRECEDED BY FULL GULATORY OR LSC IDENTIFYING INFORMATION) Jued From page 2 ic to the identified offense and shall nent such review. The facility shall modify re plan if necessary in response to this tition. The facility remains responsible for uously evaluating the identified offender r making any changes in the care plan that cessary to ensure the safety of residents. IEQUIREMENT was not met as evidenced I on interview, record review, and vation the facility failed to obtain a (CHAR) ial History Analysis Report for an Identified der and failed to identify inappropriate iors or revise new interventions on the plan e of an Identified Offender for one of one nt (R27) reviewed for Identified Offenders sample of fifteen. gs include: cility's Identified Offender Policy and dure, dated 2011 documents, "Reporting s if the Resident is an Identified Offender: diately complete and submit the Illinois tment of Public Health, Identified Offender: ation Form along with a copy of the UCIA rm Conviction Information Act) nsecheck for confirmation that all the ation was submitted correctlyafter the nation from the Identified Offender am, the facility will receive a phone call from nois State Police Division of Internal igation within three business days uling an on-site facility interview with the nt and the Administrator." current MDS (Minimum Data Set), dated 5, documents that R27 has a BIMS (Brief ew Mental Status) score of five (severe ive impairment).	IDENTIFICATION NUMBER: A. BUILDING: IL6003750 B. WING A OR SUPPLIER STREET ADDRESS, CITY, S' SUMMARY STATEMENT OF DEFICIENCIES 205 EAST SPRING STE SUMMARY STATEMENT OF DEFICIENCIES ID ACH DEFICIENCY MUST BE PRECEDED BY FULL ID GUE AFTORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG S9999 Ic to the identified offense and shall ID neud From page 2 S9999 ic to the identified offense and shall ID neutry evaluating the identified offender IT r making any changes in the care plan that cessary to ensure the safety of residents. IEQUIREMENT was not met as evidenced IO ior interview, record review, and ration the facility failed to obtain a (CHAR) ial History Analysis Report for an Identified Identified Offenders sample of fifteen. gs include: cillty's Identified Offender Folicy and Idure, dated 2011 documents, "Reporting s if the Resident is an Identified Offender: Identified Offender ation form along with a copy of the UCIA Immodify rm Conviction Information Act) secheck for confirmation that all the <	HECTION IDENTIFICATION NUMBER: A. BUILDING: IL6003750 B. WING SOR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 205 EAST SPRING STREET CAMP POINT, IL 62320 SUMMARY STATEMENT OF DEFICIENCIES ID ACH DEFICIENCY MUST BE PRECEDED BY FULL ID GAULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG S9999 Ured From page 2 S9999 ic to the identified offense and shall rent such review. The facility shall modify re plan if necessary in response to this tition. The facility remains responsible for oucusely evaluating the identified offender r making any changes in the care plan that cessary to ensure the safety of residents. IEQUIREMENT was not met as evidenced on interview, record review, and vation the facility failed to obtain a (CHAR) all History Analysis Report for an Identified g include: cility's Identified Offender Policy and dure, dated 2011 documents, "Reporting s if the Resident is an Identified Offender: ation Form along with a copy of the UCIA m Conviction Information Act)	VECTION IDENTIFICATION NUMBER: A. BUILDING: COM IL6003750 B. WING 06/ A OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE HEALTHCARE CENTER 205 EAST SPRING STREET CAMP POINT, IL 62320 SUMMARY STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST BE PRECEEDED BY FULL SULATORY OR LSC IDENTIFICATION INFORMATION) PROVIDER'S FLAN OF CORRECTIVE ACTION SHOLD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY WILT BE PRECEEDED BY FULL SULATORY OR LSC IDENTIFICATION STATEMENT (OR DEFICIENCY) ued From page 2 S9999 ic to the identified offense and shall tent such review. The facility shall modify re plan if necessary in response to this iton. The facility remains responsible for uously evaluating the identified offender r making any changes in the care plan that cessary to ensure the sastely of residents. EEQUIREMENT was not met as evidenced Ion interview, record review, and ration the facility failed to obtain a (CHAR) all History Analysis Report for an Identified offender for one of one nt (R27) reviewed for Identified Offenders sample of fifteen. gs include: State Policy Deficience for no for an Identified Offender for is if the Resident is an Identified Offender tiaton Form along with a copy of the UCIA rm Conviction Information Act) rsscheck for confirmation that all the ation mas submitted Orrectlyafter the nation rom submitted correctlyafter the nation rom submitted corecorectlyafter the na

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED		
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		IL6003750			06/	25/2015
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S ⁻ T SPRING STF			
TIMBER	POINT HEALTHCARE	- CENTER	OINT, IL 6232			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT		
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S9999	Continued From pa	ige 3	S9999			
	found guilty of Crim Battery. On 6-23-15, E1 pro Offender Informatic CHAR report. On 6-23-15 at 9:32 stated, "(I) do not h Identified Offender to the State Police and did not follow u On 6-24-15 at 9:40 R27's wheelchair in room and up the ha R27's ldentified Off 6-15-15, document Offender, assessed Department of Pub Plan Coordinator) s risk by reading the services. I assumed A progress note for documents, "(R35) (R35)CNA's (Cer reported (R27) occ outside of (R35's) r notified immediately dated 5-28-15, doc on the way he spok today, (R27) stated room and play hous (R36) stated to the doesn't come in to (R27) will touch me touching other peop and the proper way R27's Identified Off 6-15-15, does not a	a.m., R27 was propelling independently out of R27's allway of the facility. render care plan, dated s, "(R27) is an Identified d as low risk by IDPH (Illinois lic Health)" E3 (CPC/Care stated, "I got the information of progress notes of social d (R27) was at low risk." R27, dated 1-28-15, stated that (R27) flirts with tified Nursing Assistants) asionally is observed sitting oom(E2 Director of Nursing) y." Additional progress note, uments, "(R27) was redirected to (R36) in the dining room to (R36), 'Lets go to (R36's) se.' As (R36) was leaving CNA and nurse, 'I hope (R27) my room because I am afraid e.' (R27) was redirected about on to speak to another resident.' render plan of care, dated address any inappropriate nterventions regarding R27's				

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		B. WING		06/	25/2015	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
IMBER	POINT HEALTHCAR	- CENTER	T SPRING STF OINT, IL 6232			
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	On 6-25-15 at 10:10 a.m., E2 (DON/Director of Nursing) stated, "(R27) has made sexually inappropriate comments that staff has to redirect (R27)new interventions should be put in to place on the care plan to prevent these behaviors." (B)					
	b) The facility shall serious incident or Section, "serious" r that causes physica c) The facility shall, Regional Office wit reportable incident incident or acciden resident, the facility law enforcement pur notify the Regional purposes of this Se Office by phone on Department repres phone that the requ Office by phone ha unable to contact th notify the Department hotline. The facility summary of each r to the Department	cidents and Accidents notify the Department of any accident. For purposes of this neans any incident or accident al harm or injury to a resident. by fax or phone, notify the hin 24 hours after each or accident. If a reportable t results in the death of a v shall, after contacting local ursuant to Section 300.695, Office by phone only. For the action, "notify the Regional ly" means talk with a entative who confirms over the urement to notify the Regional s been met. If the facility is ne Regional Office, it shall ent's toll-free complaint registry shall send a narrative eportable accident or incident within seven days after the NT was not met as evidenced	t e			
	failed to report a fa	eview and interview, the facility Il with a fracture to the State our residents (R5) reviewed				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6003750			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		- В. WING		06/	25/2015	
	PROVIDER OR SUPPLIER		DDRESS, CITY, ST		00/	23/2013
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S9999	Continued From pa	ige 5	S9999			
	a.m., states, "(E4 F (R5's) call light was (R5's) room, (R5) w bathroom floor and herself to the bathr did hit (R5's) head Hospice and Docto Hospice came to th and an order was m Emergency Room f R5's Right Tibia an dated 10/18/14, do fractures involving proximal tibia. R5's Left ankle Rac documents that R5 displaced fractures and posterior malle displacement of the plafond." R5's Operative Reg "(R5) is a 55-year of end-stage lung dise hypertension, and of sustaining a proxim the right as well as fracture on the left. The Facility's Occu 6/24/15, documents the fall was not rep On 6/24/15 at 1:05 stated, "I didn't report the State Agency."	d Fibula Radiology report, cuments that R5 has acute the fibular head as well as the diology report, dated 10/18/14, has new moderately through the medial malleolus tolus with posterior talus relative to the tibial port, dated 10/19/14, states, old female unfortunately with ease, severe pulmonary diabetes who unfortunately fell hal tibia and fibula fracture on a distal tibia and fibula				