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S 000	Initial Comments Annual Licensure and Certification	S 000		
S9999	Final Observations Statement of Licensure Findings: 300.610a) 300.1010h) 300.1210b) 300.1210c) 300.1210d)2)3)4)A)5) 300.1220b)3) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days.	S9999		

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The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.

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.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

2) All treatments and procedures shall be administered as ordered by the physician.

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

4) Personal care shall be provided on a 24-hour, seven-day-a-week basis. This shall

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S9999	Continued From page 2 include, but not be limited to, the following: A) Each resident shall have proper daily personal attention, including skin, nails, hair, and oral hygiene, in addition to treatment ordered by the physician. 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.	S9999		

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S9999	Continued From page 3 This Requirement was not met as evidenced by: Based on observation, interview, and record review the facility failed to update the care plan with pressure relieving interventions, implement pressure relieving interventions to prevent facility acquired pressure ulcers, conduct routine skin checks, and perform Braden Scale Assessments (Pressure Risk Assessments) quarterly as directed by the facility's policy for three of five residents (R4, R10, and R32) reviewed for pressure ulcers in the sample of 44. These failures resulted in R4 developing two facility acquired painful stage two pressure ulcers to R4's buttocks, R32 developing a facility acquired unstageable deep tissue pressure injury to R32's right heel that continues to worsen, and R10 developing a facility acquired painful unstageable pressure ulcer to R10's right heel that required surgical debridement (removing of damaged tissue). Findings include: The facility's Measurement of Alterations in Skin Integrity policy dated January 2025 documents "Policy: 1. At first observation of any skin condition, the charge nurse or treatment nurse is responsible to measure and/or describe skin condition in the clinical record. 2. All measurements will be recorded in centimeters. All wounds/ulcers (i.e. (example) pressure, arterial, diabetic, venous) will be measured weekly and results recorded in a clinical record. Wound Assessment: 2. Pressure Injuries: A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs	S9999		

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as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, comorbidities and condition of the soft tissue. Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis. Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions). Stage 3 Pressure Injury: Full-thickness skin loss. Full-thickness loss of skin, in which adipose fat is visible in the ulcer and granulation tissue epibole (rolled wound edges) are often present. Sloth and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss. Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If sloth or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. (example) dry, adherent, and intact without

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erythema or fluctuance) on the heel or ischemic limb should not be softened or removed. Deep Tissue Pressure Injury (DTPI): Persistent non-blanchable deep red, maroon, or purple discoloration. Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood-filled blister. Pain and temperature change often precedes skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent or tissue injury or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness, pressure injury (Unstageable Stage 3 or Stage 4). Do not use (DTPI) (Deep Tissue Pressure Injury) to describe vascular, traumatic, neuropathic, or dermatologic conditions."

The facility's Prevention of Pressure Wounds policy dated January 2017 documents "Purpose: The purpose of this procedure is to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors. Preparation: 1. Review the resident's care plan to assess for any special needs of the resident. 2. See policy and procedure for specific task, such as bathing, incontinent care, and repositioning. General Guidelines: 1. Pressure injuries are usually formed when a resident remains in the same position for an extended period of time causing increased pressure or a decrease of circulation (blood flow) to that area and subsequent destruction of tissue. 2. The most common site of a pressure injury is where

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the bone is near the surface of the body including the back of the head around the ears, elbows, shoulders blades, backbone, hips, knees, heels, ankles, and toes. 3. Pressure can also come from splints, casts, badges, and wrinkles in the bed linen. If pressure injuries are not treated when discovered, they quickly get larger, become very painful for the resident, and often time become infected. 4. Pressure injuries are often made worse by continual pressure, heat, moisture, irritating substances on the resident's skin (i.e. (example), perspiration, feces, urine, wound discharge, soap residue, etc. (et cetera) decline in nutrition and hydration status, acute illness and/or decline in the resident's physical and/or mental condition. 5. Once a pressure injury develops, it can be extremely difficult to heal. Pressure injuries are a serious skin condition for the resident. 6. The facility should have a system/procedure to assure assessments are timely and appropriate and changes in condition are recognized, evaluated, reported to the practitioner, physician, and family, and addressed. Interventions and Preventive Measures: General Preventive Measures 1. Identify risk factors for pressure injury development. 2. For a person in bed: a. Change position at least every two hours or more frequently if needed; b. Determine if resident needs a special mattress; c. If a special mattress is needed, use one that contains foam, air, as indicated; 13. Protect bony prominence's as needed. Residents with Risk Factors - Bed-fast 1. Change position at least every two hours and more frequently as needed. 2. Use a special mattress that meets clinical condition. 5. Unless resident has both sacral and ischial pressure injuries, avoid placing directly on the greater trochanter for more than momentary placement. Resident with Risk Factors -Chair-fast 2.

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Residents who are able to cooperate and understand should be taught to shift weight every 15 minutes while sitting in a chair. Equipment and Supplies 1. Tools for assessing skin and pressure injury risk: a. Braden Risk Assessment Form."

The facility's Braden Pressure Ulcer Risk Assessment Tool dated 2/20/2013 documents "The Braden scale is recognized by the AHCPR (Agency for Healthcare Research and Quality) as being an appropriate clinical tool for determining Pressure ulcer risk because of the amount of clinical research supporting its reliability and validity. The Braden Scale has 6 (six) subscales: sensor, perception, moisture, activity, mobility, nutrition, and friction/shear. Form Completion Instructions: 1. This form should be completed for every new admission, weekly for the first month, at least quarterly, and with any significant change in condition. 7. Use the scale listed on the top of the page to determine the resident's Risk Level. A score of 19 or above indicates no risk. A score of 18 or less indicates risk of pressure ulcer development. 9. Review the subscales scores in each category to determine appropriate individualized interventions to be implemented where needed. These individualized interventions should be part of the plan of care."

1.) R10's current Physician's Order Report dated 05/02/2025 through 06/02/2025 documents R10 is an 88-year-old with the diagnoses of a history of a right femur fracture with closed reduction, Type II Diabetes Mellitus, Transient Cerebral Ischemic Attack, Hyperlipidemia, and Lack of Coordination.

R10's MDS (Minimum Data Set) Assessment dated 11/14/2024 documents required substantial/maximum assistance of staff for

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rolling left and right and transfers, was at risk for developing pressure ulcers, and currently had no pressure ulcers at that time.

R10's MDS Assessment dated 04/24/2025 documents R10 is severely cognitively impaired, requires substantial/maximum assistance of staff for rolling left and right and transfers. This same MDS documents R10 is at risk for developing pressure ulcers and currently has an unstageable pressure ulcer that was facility acquired.

R10's Electronic Health Record dated 10/09/2025 through 06/03/2025 does not document that R10 receives routine skin checks.

R10's Braden Scale Assessment dated 11/14/2024 documents R10 had a score of 15, indicating R10 was at a mild risk of developing a pressure ulcer. This same assessment documents R10's mobility was very limited.

R10's Braden Scale Assessment dated 01/27/2025 documents R10 had a score of 16, indicating R10 was at a mild risk of developing a pressure ulcer. This same assessment documents R10's mobility was slightly limited.

R10's Electronic Health Record does not include any further Braden Scale Assessment since 01/27/2025.

R10's Pressure Ulcer Assessment dated 11/19/2024 documents, "Date Pressure Ulcer Observed: 11/19/2024. Length 3.5 cm (centimeters) by width 2.0 cm by depth 0.5 cm. Moderate serosanguinous (pale red to pink, thin, and watery) exudate (drainage). Stage: Unstageable-slough (dead tissue) and or eschar (layer of dead tissue)."

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R10's Progress Notes dated 11/20/2024 documents, "Pressure ulcer noted to right heel."

R10's current Care Plan does not include any pressure relieving interventions until 11/19/2024, once R10 already developed a pressure ulcer to the right heel.

R10's Wound Center Progress Notes dated 5-28-25 and signed by V20 (Advanced Practice Nurse) documents, "History of Present Illness: 02/03/2025: Has heel boots, however at nursing home, not been consistently applied. 02/17/2025: Follow/up for right heel pressure injury. (R10) has not had foam heel lift boot on during the day, only at night. Bilateral heel lift boots. (R10) still complains of pain. Discussed the importance of off-loading. 03/05/2025: Follow/up for right heel pressure injury. Slough debrided today. Wound Assessment: Right heel is a chronic stage three pressure injury pressure ulcer acquired on 11/02/2024 and has received a status of not healed. 05/28/2025 subsequent wound encounter measurements are 2.5 cm (centimeters) length by 0.7 cm width, by 0.1 cm depth. There is a moderate amount of sero-sanguineous drainage noted. 1-25% (percent) slough, 51-75% eschar. The peri-wound skin exhibited edema. (R10) to wear heel lift boots at all times even when in the wheelchair during the day. Start betadine (anti-septic solution) paint to the area. Continue with heel lift boots."

On 06/01/2025 from 9:30 AM to 10:15 AM R10 was sitting in her wheelchair with her heels in padded boots. These boots did not have a pressure off-loading cavity to the heels, therefore pressure was not being relieved to either of R10's

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heels.

On 06/01/2025 at 10:00 AM V7 (Registered Nurse/RN) provided a treatment of betadine solution to R10's right heel pressure ulcer. R10's right pressure ulcer was dark purple in color and approximately 2.5 cm long by 0.6 cm wide with an unmeasurable depth.

On 06/01/2025 at 10:15 AM V7 (RN) stated, "(R10's) wound to the right heel was caused by pressure. (R10) did not wear any kind of pressure relieving boots and did not have her heel off-loaded while in bed prior to development of the pressure ulcer."

On 06/03/2025 V2 (Director of Nursing/DON) stated, "Braden Scale Assessments are supposed to be performed quarterly and with a significant change in status. (R10) has not had a Braden Scale Assessment completed since 01/27/2025. (R10) was due to have a Braden Scale Assessment done on 04/27/2025. Either I or (V11/MDS Coordinator) were responsible for completing (R10's) Braden Scale Assessment in April."

On 06/03/2025 at 11:20 AM V20 (Wound Clinic Advanced Practice Registered Nurse) stated, "(R10's) wound to the right heel was caused by pressure. (R10) should have had her heels off-loaded and pressure relieving interventions implemented prior to (R10) developing the pressure ulcer to the right heel. That would have help to prevent (R10) from developing a pressure ulcer to the right heel. (R10's) pressure relieving boots should have had a hole cutout in the heel to prevent pressure. Regular padded boots would not relieve pressure and (R10) would need her heels always off-loaded if the boots did not have

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a heel cutout. (R10) does have pain to the right heel pressure ulcer. I had to surgically debride (R10's) right heel wound on 03/05/2025. (R10) should always have someone doing weekly skin checks while at the facility."

On 06/03/2025 at 11:30 AM V2 (DON) stated, "I looked back in (R10's) medical record and (R10) has not been receiving skin checks since October 2024. Somehow this was missed. If (R10) was receiving skin checks prior to 11/14/2024 the pressure ulcer would have been found before it was found as bad as it was. When the pressure ulcer to (R10's) right heel was found it was unstageable and very big. (R10) did not have any care planned pressure relieving interventions prior to the development of (R10's) pressure ulcer to the right heel."

2.) On 06/02/25 at 8:49 AM, R4 was laying supine in R4's bed. R4 stated that R4 has a wound on her coccyx. R4 stated the staff don't put a bandage on the area, but they clean it when she is changed. R4 further stated R4's bottom hurts all the time. R4's mattress was a standard foam mattress.

On 06/02/25 at 9:40 AM, V17 (Certified Nursing Assistant), V18 (Certified Nursing Assistant), and V19 (Certified Nursing Assistant) provided perineal care to R4 in R4's bed. V17 cleaned barrier cream off R4's coccyx and there were two small open areas each comparable in size to a pea at the top of each side of R4's buttocks. V17 confirmed R4 was not on a pressure relieving air mattress. V17, V18, and V19 stated they were unsure of how long R4's coccyx had openings.

R4's current care plan documents R4 is at risk for developing pressure ulcers related to decreased

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mobility, incontinence, and morbid obesity. This same care plan documents R4 requires extensive assistance for mobility and transfers with a mechanical lift.

R4's Braden Assessment dated 2/25/25, documents R4 has mild risk for skin impairment.

R4's current care plan documents R4 is to have a pressure relieving mattress on R4's bed.

R4's Physician order dated 2/25/25 documents R4's bed is to have a pressure relieving mattress.

On 6/2/25 at 10:00 AM, V23 (Registered Nurse) stated V23 was not aware R4 had open areas on R4's buttocks.

On 6/2/25 at 10:05 AM, R4's electronic medical chart does not contain documentation of any pressure areas on R4's buttock.

R4's Nurse progress note dated 6/3/25 by V2 (Director of Nursing) documents R4 has two stage two pressure ulcers on R4's coccyx and wound nurse will evaluate.

3.) R32's Nurse Progress Note dated 5/13/25 at 11:13 AM, documents R32 received a shower and R32's heels on R32's feet were soft and boggy and R32 seemed like R32 had pain when heels were touched. R32's right heel appears to have a deep tissue injury (DTI). R32 was placed in heel boots for protection and comfort. Staff educated on ensuring repositioning every two hours and offloading heels.

R32's MDS dated 5/26/25 documents R32 is severely cognitively impaired. R32's MDS documents R32 is dependent on staff for all

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003750	A. BUILDING: _____ B. WING _____	06/03/2025

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) COMPLETE DATE
S9999	Continued From page 13	S9999		

ADLs.

R32's Braden assessment dated 5/23/25 documents R49 is at high risk for skin alterations.

R32's current care plan documents R32 is at risk for skin alterations related to dementia, poor safety awareness, and fragile skin. R32's current care plan does not contain pressure relieving interventions to prevent pressure ulcers.

R32's Wound Note dated 5/27/25 documents to apply zero pressure heel boots while in bed with a wedge cushion and skin prep (preparation) twice daily.

R32's Wound Note dated 5/27/25 documents R32 has an unstageable pressure ulcer to the right heel measuring 2.5 cm x 4 cm that continues to worsen. This note documents R32's pressure ulcer was found 5/14/25 and the area was pale and soft. R32's pressure ulcer on 5/27/25 was dark red in color and unblanchable. R32 has orders for skin prep to heels twice daily, heel protectors while in bed, and turn and reposition while in bed every two hours. R32 is unable to communicate her needs due to cognitive decline secondary to dementia. R32 is non ambulatory.

R32's Nurse Progress Note dated 6/3/25 documents R32's left heel has a 3.5 cm x 2.0 cm intact wound that was black in color and was irregular shaped. Skin prep as ordered, and heel protectors are in place.

On 6/2/25 at 9:30 AM, R3 was sitting in R32's high back wheelchair with socks on R32's feet. R32's heels were touching the floor of the dining room with no pressure relieving interventions in

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S9999	Continued From page 14 place, including heel protector boots as ordered. On 06/02/25 at 11:41 PM, R32 's right heel was open to air and R32's heel had a large dark brown/black pressure ulcer covering the right heel. R32 was lying in bed with bilateral heels on a foam mattress. R32 did not have an air mattress and did not have heel protector boots on as ordered. On 06/03/25 at 2:21 PM, V26 (Nurse Practitioner) stated R32's right heel continues to worsen and V26 states it's because pressure is not being relieved to the heel as V26 directed the staff to do. V26 further stated whether it's when R32 is sitting up in R32's chair or in bed and the boots are not being applied correctly, the continued pressure to R32's heel is still an issue that would cause R32's right heel pressure ulcer to worsen. (B)	S9999		