STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146074	A. BUILDING _____ B. WING _____	**09/22/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MASON POINT	**ONE MASONIC WAY SULLIVAN, IL 61951**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0655 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to complete a baseline careplan for one (R1) of five residents reviewed for careplans. Findings include: R1's undated Face Sheet documents R1 admitted to facility on 2/21/20 and had [DIAGNOSES REDACTED]. R1's Minimum Data Set ((MDS) dated [DATE] documents R1 as requiring limited assistance of one staff for bed mobility, transfers, walking, dressing, eating, toileting and personal hygiene. This same MDS documents a Brief Interview for Mental Status score of 8/15 (moderate cognitive impairment). R1's Power of Attorney for Healthcare dated 12/11/19 documents V15 as R1's Power of Attorney for Healthcare. R1's Physician order [REDACTED]. Care Plan. This same POS documents R1 as having a Peripherally Inserted Central Catheter (PICC) line for intravenous antibiotics which were not included in R1's Baseline Care Plan. R1's Baseline Care Plan dated 2/21/20 does not include documentation for R1's Enabler/Positioning Device/Positioning Cushion/Alarm/Safety Device Plan of Care, Identified Skin Risks: Skin Plan of Care, Sensory and Communication, Cognition and Oral Care needs. On 9/17/20 at 11:35 AM V6, Social Service Director stated R1's Power of Attorney was unable to care for R1's Percutaneous Endoscopic Gastrostomy (PEG) tube and that was one of the primary reasons for R1's stay at facility. V6 stated R1's baseline Care Plan was not completed and should have been. On 9/17/20 at 2:20 PM V8, Care Plan Coordinator (CPC) stated every admission should have a baseline Care Plan completed upon admission. V8 stated this baseline Care Plan is placed in the care plan book at the nurses station corresponding to which unit resident resides so that staff know how to care for a resident. On 9/17/20 at 2:30 PM V3, Licensed Practical Nurse (LPN) stated nursing staff rely on the Care Plan to be in place to be able to know how to care for the residents. On 9/18/20 at 9:55 AM V2, Director of Nurses stated baseline Care Plan aide the staff in knowing what the resident needs are and how to care for residents between the time a resident first admits and the time the comprehensive Care Plan would be completed. V2 stated R1's baseline Care Plan was not complete. The facility policy titled 'Baseline Care Planning' revised 11/1/2017 documents the following: It is the policy of the facility to promptly assess and plan care for each resident admitted to facility. A Plan of Care (Baseline Care Plan) shall be developed to include instructions needed to provide effective person centered care to each resident, based on his/her initial assessment and professional standards of quality care, to serve as a functional guide in delivery of care until such time as a comprehensive plan is developed. The Baseline Care Plan shall serve to briefly discuss the immediate assessed needs of the new resident, promote continuity of care and communication among nursing staff, increase resident safety, safeguard against potential adverse events and ensure the resident/resident representative are informed of the initial plan of delivery of care and services. The Baseline Careplan and Care Plan Summary shall be completed within 48 hours of admission by the admitting nurse or designee.
F 0660 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Plan the resident's discharge to meet the resident's goals and needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to provide discharge planning instructions and education related to medication administration, Insulin sliding scale education and information on new physician ordered medications and follow up physician appointments for one (R1) of five residents reviewed for discharge. Findings include: R1's undated Face Sheet documents [DIAGNOSES REDACTED]. R1's Minimum Data Set ((MDS) dated [DATE] documents R1 as requiring limited assistance of one staff for bed mobility, transfers, walking, dressing, eating, toileting and personal hygiene. This same MDS documents a Brief Interview for Mental Status score of 8/15 (moderate cognitive impairment). R1's Physician order [REDACTED]. R1's Power of Attorney for Healthcare dated 12/11/19 documents V15 as R1's Power of Attorney for Healthcare. R1's Care Plan focus area dated 2/21/20 documents R1's original discharge plan was to return home. This same Care Plan documents a discharge goal to make a smooth transition from facility to home, to assess need for home health services and make referrals as indicated/desired and to keep resident/family informed. R1's hospital records from 3/14/20 to 3/27/20 hospital stay documents R1 as having a Percutaneous Endoscopic Gastrostomy (PEG) tube in place for several months which was removed on 3/20/20 during this hospital stay. This same hospital record documents R1 was to wear abdominal binder after removal of PEG tube with no date to stop wearing abdominal binder documented. This same hospital record documents two new physician prescribed medications initiated during hospital stay that were to continue after discharge from hospital. These two new medications were: Aspirin 325 milligrams (mg) daily and Quetiapine [MEDICATION NAME] (Atypical Antipsychotic) 125 mg every evening. This same hospital record documents R1 was to continue [MEDICATION NAME] (Insulin) on a sliding scale based on blood glucose result give one to seven units subcutaneous every four hours, one unit for every 25 milligrams/deciliter (mg/dl) blood glucose greater than 150, up to seven units max. On 9/18/20 at 11:35 AM V6, Social Service Director stated R1 was to be discharged from hospital on [DATE] to the care of the facility. V6 supplied information that R1 was actually discharged to home on 3-27-20. V6 stated did not complete discharge instructions with R1 or R1's Power of Attorney. V6 stated did not have any communication after 3/27/20 with R1 or R1's Power of Attorney regarding discharge education or needs. On 9/18/20 at 10:30 AM V2, Director of Nurses stated the any resident who is discharging to home is educated on medications including how to read sliding scale insulin, how to obtain blood glucose, which medications should be taken at certain times of day, etc V2 stated the resident should also be assisted with home health services, hospice services, oxygen use at home, follow up appointments, etc to make sure the resident has the safest discharge to home as possible. V2 stated the discharge plan for R1 was to return to facility after hospital stay and then return to R1's home when able. V2, Director of Nurses stated R1's Power of Attorney changed the plan after the facility van had already left to pick up R1 from hospital. R1's wife met R1 at facility where staff assisted in returning belongings, gave copy of physician orders [REDACTED]. The undated facility policy titled 'Transfer and Discharge Policy and Procedure' documents the following: A resident shall be voluntarily discharged from the facility after he/she has given as least seven days written notice to the Administrator, Director of Nursing or any other licensed nurse of the facility notice of his/her desire to be discharged . In those cases when seven days' notice cannot be given the facility requires a physician's approval in the residents clinical record, and/or a written, witnessed statement releasing the facility from responsibility signed by the resident, guardian, or the residents' representative.
F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to maintain a complete medical record with accurate documentation for one (R1) of five residents reviewed for complete medical records. Findings include: R1's undated Face Sheet documents

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) [DIAGNOSES REDACTED]. R1's Minimum Data Set ((MDS) dated [DATE] documents R1 as requiring limited assistance of one staff for bed mobility, transfers, walking, dressing, eating, toileting and personal hygiene. This same MDS documents a Brief Interview for Mental Status score of 8/15 (moderate cognitive impairment). R1's medical record did not include documentation of a physician order [REDACTED]. R1's Nurse Progress Note dated 8/14/20 (nearly 3 months following R1's discharge) 3-11 shift note documents R1 as having paranoid delusions and that staff assisted R1 to facility chapel to pray which calmed R1. R1's Behavior Monitoring Record dated March 2020 documents R1 as having hallucinations and delusions on 3/13/20 and 3/14/20. This same Behavior Monitoring Record has areas for staff to document what intervention was attempted, the outcome of interventions attempted, recheck time, a second outcome area to be completed and a space for initials to be signed. None of these areas were completed for the 3/13/20 and 3/14/20 behaviors documented on R1's Behavior Monitoring Record. R1's medical record did not include documentation of a Bed Hold Policy being provided to and signed by R1's Power of Attorney. On 9/18/20 at 11:30 AM V1, Administrator stated all documentation for R1 should have been completed entirely and was not. The undated facility policy titled 'Transfer and Discharge Policy and Procedure' documents the following: In those cases when seven days' notice (for discharge) cannot be given the facility requires a physician's approval in the residents clinical record, and/or a written, witnessed statement releasing the facility from responsibility signed by the resident, guardian, or the residents' representative.