STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146074	A. BUILDING _____ B. WING _____	05/30/2007

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

(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 456	Continued From page 2 that the plate surface temperature was not getting hot from the final rinse. E5 turned off the machine and opened up the side doors so a visual inspection of the machine spray jets could be completed. The spray arms all looked clean without any debris or areas of concern. E5 agreed with this visual inspection. E5 then called E3, Director of Physical Plant, to come to the Dietary Department at approximately 10:50am. The pressure gauge was checked and was above the recommended Pound per Square Inch (psi) which is 15 to 25 psi . The pressure gauge was showing around 35 psi according to E3, stating that when the pressure release valve went out he was told by the machine repairman that they didn't need to replace the valve because they probably already had low enough pressure in the water lines. E3 then turned down the pressure to 20 psi and the test tapes were tried two more times. The thermal test tapes failed to turn black, indicating that the pressure was still too high and the water was bouncing off the surface, not heating the plate surface. E3 stated he would put on a new pressure valve and then check the machine again with a thermal test tape. After doing so the machine was checked with another thermal test tape with successful results.	F 456		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 300.1210b)6) 300.1220b)2)3) Section 300.1210 General Requirements for	F9999		

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F9999	Continued From page 3 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. b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. 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	F9999		

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F9999	Continued From page 4 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview the facility failed to maintain visual control for 1 of 1 resident (R101) when a body alarm was not in use. This failure resulted in R101 falling and hitting her head causing an intracranial bleed and subdural hematoma. The intracranial bleed caused a significant decline in R101's cognitive and functional status. R101 experienced increased pain and anxiety, requiring pain and antianxiety medications. R101 expired. Findings include: R101's May 2007 Physician Order Sheet has diagnoses listed as, Parkinson, Paralysis Agitans, Dementia, Reactive Confusion, Hypertension, and Congestive Heart Failure. The most recent Minimum Data Set (MDS) dated 03/12/07 has R101 listed with moderately impaired cognition-decisions poor, cues/supervision required. R101 is also listed with short-term memory problems and requiring extensive staff assistance for transfers and ambulation. The MDS also has marked that R101 has had falls in the past 30 days and past 31-180 days.	F9999		

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F9999	Continued From page 5 The current Care Plan dated 05/02/07 lists a problem of R101 as a high risk for falls: history of falls, dizziness, Parkinson's Disease, is vision impaired and removes personal alarm. The Care Plan of 5/02/07 lists for approaches, to have a motion alarm for fall precautions. The Facility Falls Protocols for Care Plans for residents at high risk has listed, "place resident in view of staff when out of bed." Nurses Notes dated 4/28/07, 4/29/07 and 4/30/07 document that R101 was found on the floor each day with no injuries. On 5/1/07 documentation in the Nursing Notes records includes increased confusion that continued through 5/4/07. Interview with E4, Certified Nurse Aide on 5/21/07 at 11:10am, found that E4 was in R101's room at 6:00am on 5/7/07. E4 said that R101 was standing in front of the closet and was picking out her clothes. E4 said that the motion alarm was laying in the recliner chair in R101's room. E4 also said that R101 had removed the alarms before and seemed to do okay at the closet. E4 then left the room, leaving R101 alone. At 6:15am the nurse on duty found R101 sitting on the floor with two lacerations on the left side of the forehead and bleeding was present. Nurses Note dated 5/07/07 at 6:25 am states, "Res found on floor at end of bed sitting on buttocks (L)(left) side of head (2) lacerations-pressure applied." R101 was sent to the Emergency Room for an evaluation. Nurses Note of 5/7/07 at 9:30am states Z1, Physician called the facility stating that R101 "has an intercranial bleed and will consult Neurosurgery." Nurses Notes of 5/10/07 document Z1 called the facility stating R101 would return to the facility	F9999		

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F9999	Continued From page 6 and was referred to Hospice. Nurses notes of 5/11/07 on the 3-11 shift states, "Res (resident) returned to facility from hospital by ambulance around 4:00pm accompanied by her daughter. Res has two sutured intact wounds L (left) temporal area. Bruising on scalp, eye et (and) cheek, Lg (large) skin tear L forearm. Bruising BL (bilateral) hands, knees and feet. Res alert but restless. Ativan 0.5 mg(milligrams) po(orally) at (5:50pm)." Nurses Notes from 5/11/07 through 5/20/07 show a decline in R101's overall condition (compared to before her fall) with increased pain and restlessness: R101 choked easily on sips of water, had periods of unresponsiveness, experienced periods of labored respirations, and her activity was limited to bed. These notes document numerous episodes of restlessness with R101 attempting to climb over the bed rails, and holding her head and moaning as if in pain. The entries show that from the time R101 returned to the facility on 5/11/07 until 5/20/07 R101 received 28 doses of Roxinal 0.25mg (milligram) for pain. The Nurses Notes show that on 5/11/07 R101 received Ativan 0.5mg, on 5/12/07 R101 received 3 doses of Ativan 1mg, on 5/13/07 R101 received 2 doses of Ativan 2mg, and until 5/20/07 R101 received 5 more doses of Ativan 1mg for restlessness. Interview with Z1, Physician, on 5/30/07 at 2:25pm found that R101 had two small intracranial bleeds and a subdural hematoma as a result of the fall on 5/07/07. A Neurosurgeon was consulted and said that due to the type and the depth of the intracranial bleeding, Z1 stating, "deep in the center of the brain" R101 would not	F9999		

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F9999	Continued From page 7 survive the surgery or the continued bleeding. Z1 also said that R101 should not have been left unsupervised while up and out of bed. Z1 also said that right after the fall, R101's prognosis was very poor. Interview with Z1 on 5/30/07 also found that R101 died the weekend of 5/26/07. On 5/21/07 Z2, family member, stated to keep R101 comfortable, Z2 felt a referral to Hospice would be the best for R101. Hospice took over R101's care and ordered Roxinal for pain as needed and Ativan for increased agitation. (A)	F9999		