

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/09/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185388	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/26/2012
NAME OF PROVIDER OR SUPPLIER MASONIC HOME OF LOUISVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 240 MASONIC HOME DRIVE MASONIC HOME, KY 40041	
(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 000	INITIAL COMMENTS A standard health survey was conducted from 07/24/12 through 07/26/12. Deficiencies were cited with the highest scope and severity of an "E" with the facility having the opportunity to correct the deficiencies before remedies would be recommended for imposition. The Life Safety Code survey was conducted on 07/24/12 with no deficiencies cited.	F 000	<i>This plan of correction is being submitted in compliance with specific regulatory compliance. Neither its completion nor content is to be construed as an admission by the provider of the validity of any findings or citations contained herein.</i>	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential;	F 272	F272 1. Resident #4 was assessed and Dr. and responsible party notified July 25, 2012. Documentation including wound measurements were placed in Resident #4 medical chart and assessment completed, care plan updated on July 25, 2012. Dr. assessed on July 25, 2012, ARNP assessed July 27, 2012 and wound consult order obtained on July 27, 2012 with consult on August 1, 2012. Discipline was given to RN #3 who failed to conduct an accurate comprehensive nursing assessment and develop a plan of care which resulted in discharge from employment. 2. A facility wide skin assessment audit was completed by nurse leader and any findings were addressed by ARNP and care	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X8) DATE

Cheri A. Hess

Administrator *Aug 17, 2012*

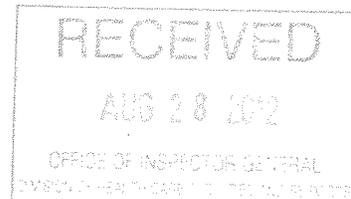
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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.

AUG 28 2012

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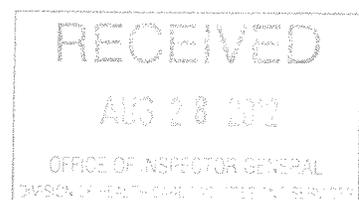
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F 272	Continued From page 1 Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, Resident Care Plan, it was determined the facility failed to conduct an accurate comprehensive nursing assessment for one (1) of twenty-five (25) sampled residents, Resident #4 upon admission. In addition, the facility failed to develop an appropriate plan of care for Resident #4 based on an accurate comprehensive nursing assessment. The facility assessed the resident as having no skin impairment, therefore, he/she was not care planned for skin impairment monitoring and/or treatment. The findings include: Review of the facility's policy regarding Resident Care Plan revealed every resident of the facility will have an individualized care plan generated upon their admission. Resident's needs, conditions and abilities will be reflected in this care plan.	F 272	plan revised as indicated on July 25, 2012 for all residents. 3. Re education provided to licensed nurses regarding accurate skin assessments and developing an appropriate plan of care by DON, ADON and/or nurse leaders between August 14 to August 24, 2012. For 30 days within 72 hours of a new move in a second skin assessment will be completed and documented by either the nurse leader, DON or ADON. Findings that are inconsistent with the admission skin assessment will be addressed and reported to Quality Assurance committee by DON weekly for 90 days. Statement of deficiencies and plan of correction along with skin assessment reviewed with Medical Director by Administrator, DON and ADON on August 15, 2012. 4. A facility wide skin assessment audit will be completed by the nurse leader, DON or ADON weekly for four weeks, then monthly for three months. Results of audits will be presented by DON to Quality Assurance committee weekly for 90 days for further		



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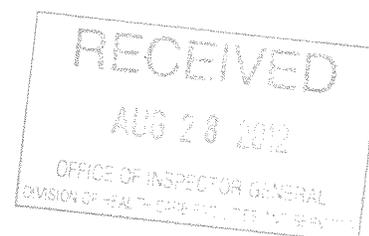
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F 272	<p>Continued From page 2</p> <p>Review of the facility's Admission/Readmission Checklist revealed the staff were to use the correct skin assessment for the impairment, if there is an ulcer, note the type of ulcer.</p> <p>Review of a hospital discharge summary, dated 06/29/12, for Resident #4 revealed the resident had an exploratory laparotomy with right hemicolectomy and gastrostomy tube placement prior to being admitted to the facility on 07/19/12.</p> <p>Review of the clinical record for Resident #4 revealed the facility was in the process of completing the Minimum Data Set resident assessment that was to be completed by day fourteen (14) of admission (07/26/12 was day 8 of the admission). The facility assessed the resident with a cognitive score of eight (8) by 07/26/12 indicating moderately impaired cognition. Review of the initial comprehensive nursing assessment completed on 07/19/12 revealed no skin assessment was completed. However, skin assessments completed on 07/20/12 and 07/24/12 by RN #3 revealed Resident #4 had no skin impairments. Review of the initial care plan for Resident #4 revealed no need/problem of skin impairment with interventions to monitor and/or treat the open wound to the resident's buttock.</p> <p>Observation of a skin assessment by RN #2, on 07/25/12 at 10:10 AM, revealed Resident #4 had two (2) surgical wounds to the abdomen, a gastrostomy tube placed in the left upper</p>	F 272	<p>recommendations and continue until the Quality Assurance team determines discontinuance is acceptable.</p> <p>5. Compliance Date: August 24, 2012</p>		



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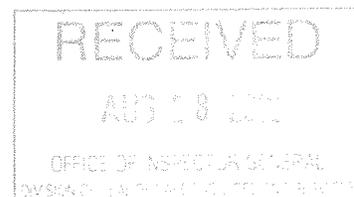
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F 272	<p>Continued From page 3</p> <p>abdomen, and a .5 X .6 centimeter wound to the right upper outer posterior buttock with a purple tinged outside margin and a bright red interior surface. RN #2 palpated the skin surrounding the wound with a resultant purulent sero-sanguinous (appearing infected and blood tinged) drainage of approximately fifteen (15) milliliters (one {1} tablespoon).</p> <p>Interview with RN #2, on 07/25/12 at 10:30 AM, revealed she was not aware of the wound to Resident #4's buttock. She stated she was not informed of the wound in the morning report at the beginning of her shift. RN #2 declined to identify the type of wound to Resident #4's buttock and stated she would need to review the resident's record.</p> <p>Interview with the Marsh House Nurse Leader, on 07/26/12 at 2:10 PM, revealed RN #3 did not complete the initial nursing assessment for Resident #4 as she had been trained to do. He stated the initial nursing care plan could not be accurate and thorough without the skin assessment. He also stated RN #3 did not document an accurate skin assessment for Resident #4, on 07/20/12 and 07/24/12, as it was documented both times the resident had no skin impairment.</p> <p>Interview with the Director of Nursing (DON), on 07/26/12 at 2:20 PM, revealed it was a requirement of the facility for an accurate initial nursing assessment be completed for each resident when admitted or readmitted. The DON</p>	F 272		



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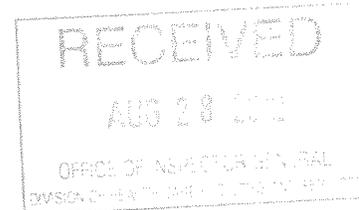
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F 272	Continued From page 4 stated RN #3 had been trained on the facility requirement to do an accurate initial nursing assessment to complete an accurate initial nursing care plan and was suspended for failure to do so. The DON stated the result of an inaccurate nursing care plan would be lack of care to meet resident needs.	F 272		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, review of the facility's policy Positioning the Resident, it was determined the facility failed to follow the comprehensive nursing care plan for one (1) of twenty-five (25) sampled residents, Resident #4. The facility staff failed to check on, change or toilet the resident for three (3) hours on 07/25/12. The findings include: Review of the facility's policy regarding Positioning the Resident revealed 6. Position resident off of pressure areas at least every two hours and document those position changes on the Positioning Record using the appropriate codes. Note that residents need to be positioned according to their condition and may need to be more frequent than every two hours.	F 282	F 282 1. Resident #4 turned and positioned every 2 hours (even) and incontinence/toileting needs every 2 hours (even) and as indicated based on individual assessment. Documentation in place regarding turning, positioning, toileting and incontinence needs per care plan and caregiver assignment with ongoing documentation in ADL constant. CNA #2 and #3 educated in writing regarding turning, repositioning, toileting and incontinence protocol. 2. Facility wide Braden scale done as a base line to ensure those residents with a score of 14 or less (high risk) are accurately assed and on an individual turning and repositioning schedule. Facility wide audit to identify residents whom would benefit from an individualized toileting	



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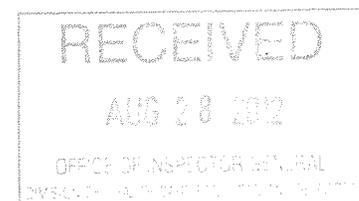
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F 282	<p>Continued From page 5</p> <p>Review of the orientation checklist used by the facility for certified nursing assistants revealed staff are to turn and reposition a resident in the bed every two hours.</p> <p>Observation of Resident #4's room, on 07/25/12 from 7:00 AM to 10:10 AM, revealed no staff entering the resident's room to check on the resident, toilet, change, or turn and reposition the resident. A skin assessment observation of Resident #4, on 07/25/12 at 10:15 AM, revealed the resident to be in a wet (with urine) and feces soiled adult brief.</p> <p>Record review revealed the facility admitted Resident #4 on 07/19/12 and was assessed with a cognitive score of eight (8) on the Minimum Data Set (a resident assessment tool) which indicated he/she had a moderately impaired cognition (short and long-term memory loss). Review of a hospital discharge summary, dated 06/29/12, for Resident #4 revealed the resident had an Exploratory Laparotomy with Right Hemicolectomy (removal of portion of the colon) and Gastrostomy tube (feeding tube) placement prior to being admitted to the facility.</p> <p>Review of the initial nursing care plan for Resident #4 revealed he/she was to have assist of one staff for ambulation and toileting and was to have turning, positioning and incontinence checks per the facility policy. Review of the CNA's care plan revealed Resident #4 was incontinent (of bladder and bowel at times) and was to have the assist of one staff to toilet and ambulate.</p> <p>Interview with CNA #2, on 07/25/12 at 10:40 AM,</p>	F 282	<p>program conducted by nurse leaders. Care plan, caregiver assignment sheet revised and documentation completed in ADL constant.</p> <p>3. Re education provided for licensed nurses, cmts and caregivers regarding turning, & repositioning and checking every two hours for toileting needs by DON, ADON and/or nurse leaders between August 14 to August 24, 2012. New staff members will be educated during new hire orientation on turning and repositioning protocol by ADON, DON or nurse leader. Statement of deficiencies, plan of correction and turning and repositioning protocol reviewed with Medical Director by Administrator, DON and ADON on August 15, 2012</p> <p>4. Nurse Leaders, DON or ADON will audit for turning and repositioning and toileting one resident three times weekly for eight weeks, then one resident one time weekly for four weeks. Results of audits will be presented by DON to Quality Assurance committee weekly for 90 days for further</p>		



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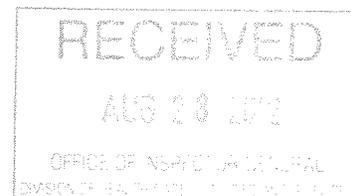
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F 282	<p>Continued From page 6</p> <p>revealed he did not have time to check on Resident #4 due to his required duties in the Marsh House kitchen and with cleaning of the hall/resident rooms although he knew he should have. He stated Resident #4 was confused at times and did not put the call light on when he/she needed to toilet. He stated Resident #4 was incontinent and needed to be changed every two (2) hours. CNA #2 stated it was his understanding that he was to check on his residents and change or toilet them every two (2) hours on the odd hours as his shift started at 7:00 AM.</p> <p>Interview with CNA #3, on 07/25/12 at 10:50 AM, revealed she was trained by the facility to check on her residents every two (2) hours and to change or toilet them and her understanding was that she was to do that on the odd hours of the day.</p> <p>Interview with the Marsh House Nurse Leader, on 07/26/12 at 2:10 PM, revealed the CNA's were to check on and change or toilet their residents at least every two (2) hours and that it should be done on the even hours of the day (i.e. 8:00 AM, 10:00 AM). He stated he did monitor the resident hallways and rooms for safety but he did not check on or document the performance of the CNA's in regards to checking on their assigned residents.</p> <p>Interview with the Director of Nursing, on 07/26/12 at 2:20 PM, revealed it was her expectation that the CNA's check on and toilet or change their residents every two (2) hours and that it should be done on the even hours of the day (i.e. 8:00 AM, 10:00 AM). She stated she</p>	F 282	<p>recommendations and continue until the Quality Assurance team determines discontinuance is acceptable.</p> <p>5. Compliance Date: August 24, 2012.</p>		



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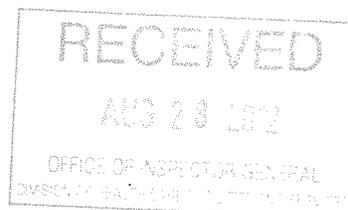
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F 282	Continued From page 7	F 282			
F 309 SS=D	<p>was new to the facility and had things to work on which needed improving.</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to follow physician orders for one (1) of twenty-five (25) sampled residents, Resident #4. The facility staff failed to provide an ordered gastrostomy tube feeding to Resident #4 on the night of admission to the facility and on the following night.</p> <p>The findings include:</p> <p>No policy was presented regarding following physician orders.</p> <p>Review of a hospital discharge summary, dated 06/29/12, for Resident #4 revealed the resident had an Exploratory Laparotomy with Right Hemicolectomy (removal of portion of the colon) and Gastrostomy tube (feeding tube) placement prior to being admitted to the facility.</p> <p>Record review revealed the facility admitted Resident #4 on 07/19/12 and was assessed with</p>	F 309	<p>F 309</p> <ol style="list-style-type: none"> 1. Investigation and report completed related to failure to follow physician order. Resident #4 physician order reviewed and verified. Physician notified July 25, 2012 and order for gastrostomy tube feedings followed. Discipline was given to licensed nurse who failed to provide an ordered gastrostomy tube feeding which resulted in discharge from employment. 2. Nurse Leaders completed a physician order vs. gastrostomy tube feeding accuracy audit on July 26, 12 to identify if any additional issues related to physician orders. No other concerns found. 3. Licensed nurses re educated on process for obtaining pump for gastrostomy tube feedings and following physician orders by DON, ADON and/or nurse leaders between August 14 to August 24 2012. New staff members will be educated during new hire orientation on 		



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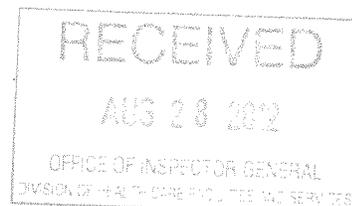
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F 309	<p>Continued From page 8</p> <p>a cognitive score of eight (8) on the Mlnimum Data Set (a resident assessment tool). Review of the physician's orders for 07/19/12 revealed Resident #4 was to receive a night time feeding of Isosource at fifty (50) cc's per hour from 7:00 PM to 7:00 AM. Review of the Medication Administration Record documentation revealed the tube feeding was not administered on 07/19/12 and 07/20/12 to Resident #4. The Medication Record documentation revealed the first tube feeding was documented as being given on 07/21/12.</p> <p>Interview with Resident #4's family member, on 07/25/12 at 3:30 PM, revealed she was aware the resident was to have tube feedings at night. She stated she was told the first night a pump used to administer the tube feeding could not be located and the second night the unit nurse stated he did not know how to operate the tube feeding pump.</p> <p>Interview with the Marsh House Nurse Leader, on 07/26/12 at 2:10 PM, revealed he was not aware of the delay in the tube feeding for Resident #4 and he stated equipment was always available to staff. He stated it was a standard of nursing practice for physician orders to be followed and there was no excuse for the delay in following the order for Resident #4's tube feeding. Review of Resident #4's weights during the interview revealed he/she had no significant weight loss. The Marsh House Nurse Leader stated that could have been a consequence of the delayed tube feedings. He also stated the delay in tube feedings could have caused a decline in Resident 4's overall nutritional status and wound healing.</p> <p>Interview with the Director of Nursing (DON), on</p>	F 309	<p>how to obtain a pump for gastrostomy tube feedings and following physician orders by ADON, DON or nurse leader . Statement of deficiencies, plan of correction and tube feeding process reviewed with Medical Director by Administrator, DON and ADON on August 15, 2012</p> <p>4. Audit of 100% of feeding tubes will be conducted weekly for four weeks and then one time monthly for two months ensuring physician order if being followed. Results of audits will be presented by DON to Quality Assurance committee weekly for 90 days for further recommendations and continue until the Quality Assurance team determines discontinuance is acceptable.</p> <p>5. Compliance Date: August 24, 2012</p>	



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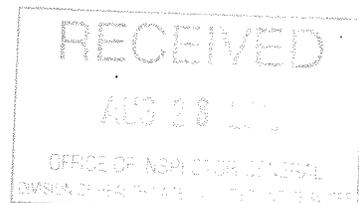
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F 309	Continued From page 9 07/26/12 at 2:30 PM, revealed her expectation was for all of the nursing staff at the facility to follow physician orders in a timely manner. She stated the delay in tube feedings for Resident #4 could have consequences of weight loss, decline in nutritional status and decline in wound healing.	F 309		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, it was determined the facility failed to properly maintain a feeding tube to prevent the tube from clotting for one (1) of twenty-five (25) sampled residents. Resident #25. The findings include: Record review revealed the facility admitted Resident #25 on 03/10/12 with medical diagnoses of Cancer of the stomach, Cancer In-situ of the Colon. Review of the Care Plan (CP) revealed on 03/11/12 Resident #25 was care planned for maintenance of the J-tube and G-tube. Included in the interventions was to check for residual, flushing of the J-tube, observation of the skin around the tubed. In addition the resident had a	F 322	F 322 1. Orders in place and being followed on resident #25 for maintenance of feeding tube. 2. Nurse Leaders completed a physician order vs. tube feeding accuracy audit to identify if any additional issues related to physician orders. No other concerns found. 3. Licensed nurses re educated on instructions for checking residuals, flushing and site care by DON, ADON and/or nurse leaders between August 14 to August 24, 2012. New staff members will be educated during new hire orientation on checking residuals, flushing and site care by ADON, DON or nurse leader. Statement of deficiencies, plan of correction and tube feeding process reviewed with Medical Director by Administrator, DON and ADON on August 15, 2012	



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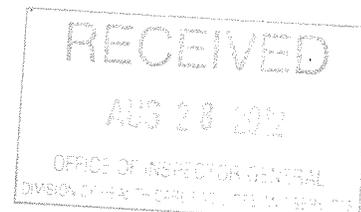
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F 322	<p>Continued From page 10 CP for monitoring for Dehydration and Comfort measures.</p> <p>Observation of Resident #25, on 07/26/12 at 8:50 AM, revealed he/she had a gastric tube to bed side drainage, and a J-tube for tube feedings. A Foley catheter was to bed side drainage, with reddish brown urine. There was a Medi-Port in the left upper chest and a Subcutaneous Port in the left middle abdomen. He/she spoke softly and had a BIMS score of fourteen (14). The resident could turn with assistance and often requested not to get out of bed.</p> <p>Interview with Resident #25's family member, on 07/26/12 at 4:40 PM, revealed Resident #25 has had numerous trips to the hospital for a clogged tube and was concerned regarding the loss of the ability to continue the tube feedings and give needed pain medications.</p> <p>Review of the medical record revealed since July 1, 2012 Resident #25 had been sent to the ER four (4) times to have the clogged J-tube replaced.</p> <p>Interview with the Marsh House Manager, on 07/26/12 at 9:00 AM, revealed the resident has had numerous trips to the hospital for a clogged J-Tube. On 07/25/12 around 7:15 PM, the family member of Resident #25 came to his office and was concerned the J-tube was clotted. A night shift nurse had reported the tube was open on the night before 07/24/12. The family member requested Resident #25 be sent to the Emergency Room (ER). A call was placed to the physician. Resident #25 refused to be sent to the ER. A coke solution was placed in the tube and</p>	F 322	<p>4. Audit of 100% of feeding tubes will be conducted weekly for four weeks and then one time monthly for two months ensuring physician order if being followed. Results of audits will be presented by DON to Quality Assurance committee weekly for 90 days for further recommendations and continue until the Quality Assurance team determines discontinuance is acceptable.</p> <p>5. Compliance Date: August 24, 2012</p>		



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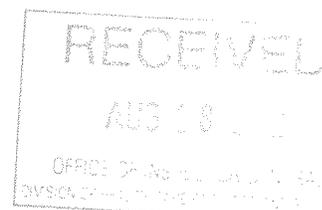
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F 322	Continued From page 11 after three (3) attempts the tube was opened.	F 322			
F 323 SS=D	<p>Interview with Registered Nurse (RN) #2, on 07/26/12 at 10:10 AM, revealed she cared for Resident #25 on 07/25/12. The J-tube was clotted when she attempted to administer a pain medication. In addition, RN #2 stated she did not flush tubes, check for residual, or turn off the pump when giving a medication.</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the residents' environment remained free from accident hazards. A laundry room was unlocked in one (1) of six (6) resident houses and hazardous chemicals were observed in an unlocked cabinet in the room.</p> <p>The findings include: The facility did not provide a policy regarding locking/storage of hazardous chemicals. Observation of the laundry room In the Marsh</p>	F 323	<p>1) Chemical bottles were removed and placed in locked cabinet on July 24, 2012.</p> <p>2) All other laundry rooms were checked and all chemicals stored properly in locked cabinet on July 24, 2012 by house leaders.</p> <p>3) Environmental Services, Food Service, cmts, caregivers, licensed nurses were re educated on proper storage of chemicals by the DON, ADON, Environmental Services Director or Dining Services Manager during re education held between August 14 to 24, 2012. Medical Director, DON and Executive Director reviewed statement of deficiencies and discussed plan of correction on August 15, 2012.</p>		



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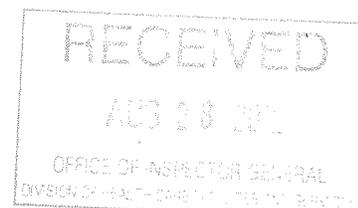
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F 323	Continued From page 12 House, on 07/24/12 at 9:30 AM, revealed the room was unlocked and there were four (4) containers of hazardous chemicals in an unlocked cabinet in the room. The four (4) containers of chemicals were: 1) Antibacterial All Purpose Cleaner; 2) Hospital Dispatch Towels; 3) Glass Cleaner; and 4) Alkaline Bathroom Cleaner. All of the containers had manufacturer labels which read Dangerous if Ingested. Interview with the LPN Nurse Leader of the Marsh House, on 07/24/12 at 9:35 AM, revealed the containers of chemicals should not be in an unlocked cabinet in an unlocked room and accessible to residents. He did not know why they were there. He stated all staff were trained to keep all chemicals securely locked and not accessible to the residents. Interview with the Director of Nursing, on 07/26/12 at 2:10 PM, revealed it was all the employees responsibility to ensure chemicals were kept locked and not accessible to the residents. She stated it was a safety concern for the residents residing in Marsh House.	F 323	4) Household coordinators and Office Manager will audit all households ensuring chemicals are in locked cabinet three times weekly for eight weeks and report audit findings to Executive Director. Thereafter, household coordinators and Office Manager will audit each house one time weekly for four weeks and report findings to Executive Director. Results of audits will be reviewed by Executive Director and any areas of concern addressed. Executive Director will present audit to Quality Assurance committee weekly for 90 days for further recommendations and continue until the Quality Assurance team determines discontinuance is acceptable.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be	F 431	5) Compliance Date: August 24, 2012 F 431 1. All expired equipment was immediately removed and discarded on July 26, 2012. 2. A facility-wide audit was completed on July 26, 2012 to identify expired lab equipment any equipment within 60 days of expiration discarded.	



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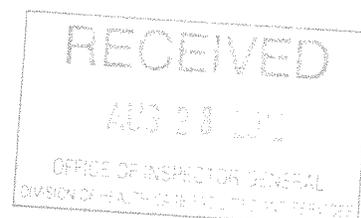
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F 431	<p>Continued From page 13</p> <p>labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure expired biologicals were not stored in medication rooms. Laboratory Vacutainer were observed in two (2) medication rooms accessible to the nursing staff for laboratory blood draws.</p> <p>The findings include: The facility did not provide a policy regarding checking biologicals for expired dates.</p>	F 431	<p>3. Licensed nurses re educated on checking for expiration dates when using lab equipment by DON, ADON and/or nurse leaders between August 14 to August 24, 2012. New staff members will be educated during new hire orientation on checking for expiration dated when using lab equipment by ADON, DON or nurse leader. Statement of deficiencies and plan of correction reviewed with Medical Director by Administrator, DON and ADON on August 15, 2012</p> <p>4. Monthly wide facility audit will be conducted by the ADON or DON for three months checking for any expired lab equipment. Results of audits will be presented by DON to Quality Assurance committee weekly for 90 days for further recommendations and continue until the Quality Assurance team determines discontinuance is acceptable.</p> <p>5. Compliance Date: August 24, 2012</p>	



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F 431	Continued From page 14 Observation, on 07/26/12 at 9:00 AM, of the Marsh House's medication room revealed two hundred and ten (210) laboratory Vacutainer with expired usage dates. Observation, on 07/26/12 at 9:00 AM, of the Chandler House's medication room revealed forty (40) laboratory Vacutainer with expired dates. Interview with the LPN House Leader for the Chandler House, on 07/26/12 at 9:15 AM, revealed she checked the medication room about once a week for expired supplies but she had not thought to check the Vacutainer expiration dates. She stated it was her responsibility to ensure all supplies with expired dates were removed from the medication room. Interview with the LPN House Leader for the Marsh House, on 07/26/12 at 2:10 PM, revealed the use of expired laboratory Vacutainer by the nursing staff for laboratory blood draws could result in inaccurate laboratory results. Interview with the Director of Nursing, on 07/26/12 at 2:20 PM, revealed it was the responsibility of the Nurse House Leaders to check for expired biologicals in the medication rooms and she did not know why the laboratory Vacutainer had not been removed in a timely manner. She also stated the use of expired Vacutainer for blood draws could result in inaccurate laboratory results.	F 431			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a	F 441	F 441 1. LPN #8 on July 25, 2012 and LPN #2 on July 26, 2012 were promptly re educated and disciplined for failing to wash		



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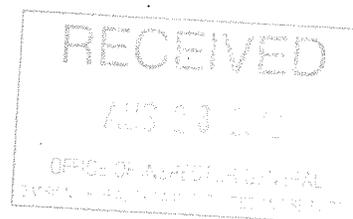
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F 441	<p>Continued From page 15 safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 441	<p>their hands between glove changes.</p> <p>2. Licensed nurses working in identified households were re educated on 7/27/2012 by nurse leader.</p> <p>3. Licensed nurses re educated on hand washing with dressing change technique by DON, ADON and/or nurse leaders between August 14 to August 24, 2012. New staff members will be educated during new hire orientation on hand washing with dressing change technique by ADON, DON or nurse leader. Statement of deficiencies, plan of correction and infection control policy and procedures reviewed with Medical Director by Administrator, DON and ADON on August 15, 2012</p> <p>4. An audit of five treatments will be conducted within thirty days of facility-wide education by nurse leader, ADON or DON. The second month an audit of three treatments, the third month an audit of one treatment by nurse leader, ADON or DON. Results of audits will be presented by DON to Quality Assurance committee weekly</p>		



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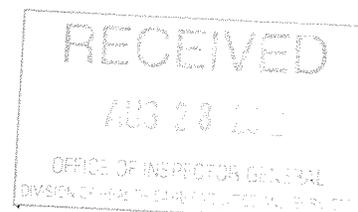
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F 441	<p>Continued From page 16</p> <p>Based on observation, interview and review of the facility's policies, it was determined the facility failed to implement hand hygiene practices consistent with accepted standards of practice, to reduce the spread of infections and prevent cross-contamination. The facility staff failed to wash their hands between glove changes during dressing changes on two (2) of twenty-five (25) sampled residents, Resident #6 and Resident #18.</p> <p>The findings include:</p> <p>Review of the facility's Handwashing/Hand Hygiene Policy, undated, revealed the facility considered handwashing/hand hygiene to be the primary means to prevent the spread of infections. It stated if hands were not visibly soiled, the use of an alcohol-based hand rub containing 60-95% ethanol or isopropanol was to be used after removing gloves. In addition, the policy stated the use of gloves was not to replace handwashing/hand hygiene.</p> <p>Review of the policy Infection Control-Dressings, Dry/Clean, Revised 06/23/11, revealed in the steps of the dressing change procedure, gloves were put on to remove the soiled dressing, then removed, hands washed thoroughly, and clean gloves put on to continue the dressing change.</p> <p>Observation, on 07/25/12 at 2:45 PM, revealed during the dressing change for Resident #6, Licensed Practical Nurse (LPN) #8 discarded her</p>	F 441	<p>for 90 days for further recommendations and continue until the Quality Assurance team determines discontinuance is acceptable.</p> <p>5. Compliance Date: August 24, 2012</p>		



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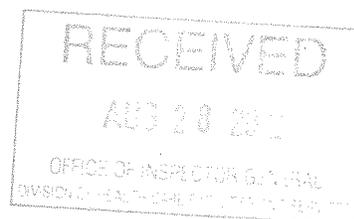
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F 441	<p>Continued From page 17</p> <p>gloves after removing a soiled dressing and did not wash her hands before putting on new gloves to complete the dressing change.</p> <p>Observation, on 07/26/12 at 11:15 AM, revealed during the dressing change for Resident #18, LPN #2 discarded her gloves after cleansing the resident's buttock and did not wash her hands before putting on new gloves to complete the dressing change.</p> <p>Interview, on 07/25/12 at 2:45 PM, with LPN #6 revealed hands were to be washed before and after a dressing change. She stated gloves were only to be changed if they became soiled or when going from a dirty to a clean area.</p> <p>Interview, on 07/26/12 at 11:15 AM, with LPN #2 revealed hands were to be washed before and after a treatment and when leaving the resident's room. She was unfamiliar with the facility's policy on hand washing and glove changes.</p> <p>Interview, on 07/26/12 at 10:25 AM, with the Owen/Campbell House Nurse Manager revealed gloves were to be changed after a dirty dressing was removed and a new pair of gloves put on, after washing your hands. She stated the policy of the facility was to wash hands between glove changes.</p> <p>Interview, on 07/26/12 at 1:00 PM, with LPN #6 revealed she was trained in nursing school about</p>	F 441			



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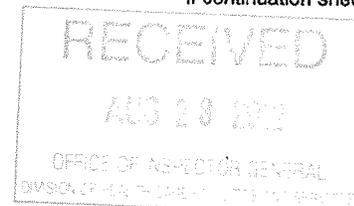
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F 441	<p>Continued From page 18</p> <p>hand washing and changing gloves. She stated gloves were put on to remove a dirty dressing, then removed, hands washed, and a new pair of gloves were put on. She revealed hands were washed between glove changes to prevent the transfer of bacteria from one place to another and to protect yourself.</p> <p>Interview, on 07/26/12, at 1:50 PM, with LPN #7 revealed staff were educated about hand washing and glove changes in a computer class provided by the facility. She stated hands were to be washed between glove changes. She revealed you may have contaminated your hands when you removed your gloves, so washing your hands would protect the resident from contamination. She revealed there was not a system in place to monitor if staff were appropriately washing their hands when gloves were changed during a treatment.</p> <p>Interview, on 07/26/12 at 3:30 PM, with the Director of Nursing (DON) revealed the staff were trained on handwashing and glove changes through a computer educational program shown to employees called Upstairs Solutions. Related to the use of gloves she revealed staff were shown videos, had policies available and given training. Personal protective gear was addressed to employees. As a new DON to the facility, she did not have knowledge of any system in place to monitor if the facility's policy on handwashing and/or glove changes were being monitored. She revealed gloves were to be changed and hands washed anytime you go from clean to dirty. She gave the reason as being you do not want to</p>	F 441			



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F 441	Continued From page 19 contaminate your clean field from your dirty with microorganisms or bacteria. The handwashing between glove changes was important because it can affect the resident with respect to infection control.	F 441			
F 463 SS=E	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy Healthsense Call Monitoring System, it was determined the facility failed to provide a resident emergency call system in nine (9) of twenty-six (26) unlocked staff and public restrooms accessible to residents. The findings include: Review of the facility's policy Healthsense Call Monitoring System revealed call cords and pendant call devices would be used to activate the call monitoring system. However, the policy stated pendants may be given to residents if they request it or if nursing feels they are appropriate. These pendants will allow the resident to be more mobile not only in their room but through the entire facility. Observation of the Marsh House, on 07/24/12 at 9:30 AM, revealed an unlocked staff restroom	F 463	F 463 1. Resident emergency pull cords were installed in the nine identified staff and public restrooms on August 8, 2012. 2. Two other areas identified and emergency pull cords installed on August 8, 2012. 3. Functioning of emergency pull cords will be monitored via nurse call monitoring system by Administrator, Office Manager or IT department with automated reports sent daily detailing any cause for concern. 4. Results of automated reports will be presented by Administrator to Quality Assurance committee weekly for 90 days for further recommendations and continue until the Quality Assurance team determines discontinuance is acceptable. 5. Compliance Date: August 24, 2012		



DEPARTMENT OF HEALTH AND HUMAN SERVICES
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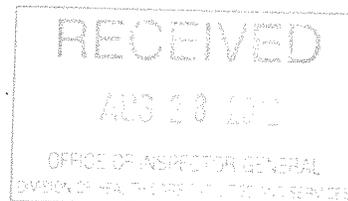
PRINTED: 08/09/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185388	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/26/2012
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NAME OF PROVIDER OR SUPPLIER MASONIC HOME OF LOUISVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 240 MASONIC HOME DRIVE MASONIC HOME, KY 40041
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(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)	(X6) COMPLETION DATE
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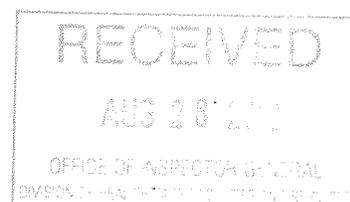
F 463	<p>Continued From page 20 (accessible to residents) without an emergency pull cord or other means for a resident to communicate with nursing staff in the event of an emergency.</p> <p>Observation of the main facility hallway, on 07/24/12 at 10:00 AM, revealed two (2) unlocked public restrooms (accessible to residents) without emergency pull cords or other means for a resident to communicate with nursing staff in the event of an emergency.</p> <p>Observation of the Campbell House and Chandler House, on 07/25/12 at 2:30 PM and 3:00 PM, revealed an unlocked staff restroom in each of those houses (accessible to residents) without emergency pull cords or other means for a resident to communicate with nursing staff in the event of an emergency.</p> <p>Observation of the Judy House, on 07/26/12 at 8:15 AM revealed one (1) unlocked staff restroom (accessible to residents) without an emergency pull cord or other means for a resident to communicate with nursing staff in the event of an emergency.</p> <p>Observation of the Owen House, on 07/26/12 at 10:00 AM, revealed an unlocked staff restroom (accessible to residents) without an emergency pull cord or other means for a resident to communicate with nursing staff in the event of an emergency and observation of the main hallway past the first interior double doors, on 07/26/12 at 1:00 PM, revealed two (2) public restrooms (accessible to residents) without emergency pull cords or other means for a resident to communicate with nursing staff in the event of an</p>	F 463		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185388	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/26/2012
NAME OF PROVIDER OR SUPPLIER MASONIC HOME OF LOUISVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 240 MASONIC HOME DRIVE MASONIC HOME, KY 40041		
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F 463	<p>Continued From page 21 emergency.</p> <p>Observation of the Marsh House for sampled residents #4, #21 and #20, on 07/26/12 at 1:15 PM, revealed none of those residents were wearing a pendant call device.</p> <p>Interview with the Marsh House Nurse Leader, on 07/26/12 at 2:10 PM, revealed he was not aware the unlocked staff restroom in Marsh House should have an emergency call pull cord or other system in place to communicate with nursing staff in the event of a resident emergency in that restroom. He stated the unlocked restroom was accessible to residents in Marsh House as well as any other unlocked restrooms in the other houses and hallways.</p> <p>Interview with the Director of Nursing, on 07/26/12 at 2:20 PM, revealed she was aware residents should have an emergency pull cord or other means to communicate with nursing staff in the event of an emergency when in an accessible restroom in the facility. However, she was not aware there were unlocked restrooms (accessible to residents) in the facility.</p>	F 463			



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185388	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - SAM SWOPE CARE CENTER B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2012
NAME OF PROVIDER OR SUPPLIER MASONIC HOME OF LOUISVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 240 MASONIC HOME DRIVE MASONIC HOME, KY 40041		
(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	
K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR §483.70 (a)</p> <p>BUILDING: 02 PLAN APPROVAL: 2010</p> <p>SURVEY UNDER: 2000 New</p> <p>FACILITY TYPE: S/NF DP</p> <p>TYPE OF STRUCTURES: Two (2) stories, Type II (222) protected construction.</p> <p>SMOKE COMPARTMENTS: Sixteen (16) smoke compartments.</p> <p>FIRE BARRIER: The non-certified facility and the Skilled Nursing Facility were separated by a two-hour fire barrier.</p> <p>FIRE ALARM: Complete automatic fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic (wet) sprinkler system.</p> <p>GENERATOR: Type II generator, fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 07/24/12. Masonic Home of Louisville was found to be in compliance with the Requirements for Participation in Medicare and Medicaid in accordance with Title 42, Code of Federal Regulations, 483.70 (a) et. seq. (Life Safety from Fire).</p>	K 000			

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185388	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - SAM SWOPE CARE CENTER B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2012
NAME OF PROVIDER OR SUPPLIER MASONIC HOME OF LOUISVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 240 MASONIC HOME DRIVE MASONIC HOME, KY 40041		
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